SUMMARY OF PLAN DESCRIPTION

TABLE OF CONTENTS

Article I SUMMARY OF COVERAGE

WELCOME! All of us at NetCare Life & Health Insurance Company pledge to you that we will provide the best service we can in the administration of your group health plan. The following information summarizes your group's benefits. It also summarizes conditions, limitations and exclusions to those benefits. There are sections explaining and defining certain words, too. Please be sure to read this information in its entirety. This information is a "Summary Plan Description" as defined by ERISA, the Employee Retirement Income Security Act of 1974 as amended.

This booklet contains a summary of your plan rights and benefits. If you have difficulty understanding any part of this booklet, contact NetCare's Customer Service Department at 1-617-472-3610 between the hours of 8:00 am to 5:00 pm Monday through Fridays. You may also contact your Human Resources Department of Benefits Officer for more information.

Article II ELIGIBILITY

(i) Your Coverage

You are in an Eligible Class if you are:

- A Regular Full-Time (RFT) or Regular Part-Time (RPT) employee scheduled to work at least 20 hours per week, who is paid on the U.S. dollar payroll, and who is a U.S. citizen or resident alien living in the United States, the District of Columbia, Puerto Rico or Guam.

The following groups are not in an Eligible Class:

- Flexible employees.

(ii) Dependents

You may cover your:

- wife or husband, including a common-law wife or husband, and domestic partner.
- unmarried children under 19 years of age.
- unmarried children under age 25 who are full-time students in actual attendance at an accredited educational institution, are not working on a regular full-time basis, and depend on you for support.
- any child over the maximum age who is determined to be incapable of self-support due to a handicap.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren who live with you and are dependent upon you for support.
- Your common-law children who live with you and are dependent upon you for support.
- Any other child who is not your biological, adopted, or stepchild, but who lives with you and is dependent upon you for financial support. Evidence proving dependency is required in the form of documentation of legal guardianship.

Evidence proving dependency may be requested for submission to NetCare for certain enrollment criteria of your dependent.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

A Subscriber shall be denied coverage for any of the following reasons:

- The child was born out of wedlock;
- The child is not claimed as a dependent on the parent's Guam tax return;
- The child does not reside with the parent or in the Service Area;
- The child has a pre-existing or excluded medical condition;
- The child is adopted or the subject of adoption proceedings.

(iii) Enrollment Procedure

Your enrollment packet will include an Enrollment Form to complete. This form will allow your Employer to deduct your contributions from your pay to cover your contributions for the plan you elect during enrollment.

IMPORTANT - You must sign, date and return the completed enrollment form to your Human Resources Manager within 30 days of your Eligibility Date for you and your dependents to be covered. Your Human Resource Office representative will sign and date the enrollment form to acknowledge receipt. If you don't sign and return your form within 30 days of your Eligibility Date, you may not elect Health Expense Coverage until the next open enrollment period established by your Employer.

If you want dependent coverage for a newly eligible dependent (for example, you get married or adopt a baby), complete a Change of Status Form (available from your Human Resources Manager) within 30 days of the Eligibility Date (i.e. date of marriage). When you elect dependent coverage, you must list all their names on the appropriate section of the enrollment form. If you do not request dependent coverage within 30 days of the Eligibility Date, you may not elect Health Coverage for such dependent until the next open enrollment period established by your Employer. Dependent coverage for newborn children are given 45 days of the Eligibility Date (date of birth) to elect Health Coverage.

Evidence proving eligibility or dependency of a dependent may be requested for submission to NetCare.

(iv) Group Participation Requirements

Companies with ten (10) or less eligible employees must have 100% participation of enrollment of all eligible employees. Companies with more than ten (10) eligible employees, but less than twenty-five (25) employees must enroll 75% of all eligible employees.

(v) Enrollment Requirements for Dental, Vision, and Orthodontic Plans

NetCare also offers dental, vision and orthodontic benefit plan in addition to your medical plan. If your group employer chooses to enroll in the dental or vision or orthodontic plan, please be aware of certain enrollment and eligibility requirements that must be met. These requirements are as follows:

1. Dental Plan
   - For groups of 2 to 15 employees enrolled, enrollment in the dental plan must have 100% employee participation.
   - For groups of 16 or more employees enrolled, enrollment in the Dental plan must have 50% employee participation.

2. Vision Plan - Must have 100% employee participation requirement regardless of size of the group.

3. Orthodontic - Applicable only if a group employs more than fifty (50) full-time eligible employees. The orthodontic benefit is not be applicable to groups under 50 employees. Orthodontic coverage is offered as a supplemental coverage to Dental Plan A, which require a 50% employee participation.

(vi) Enrollment Classifications

Single Class – Employee only
Two-Party Class – Employee and
1. spouse; or
2. child

Family Class – Employee and
1. spouse and one child; or
2. children

Dental Enrollment Limitation
You are permitted to enroll in the dental only plan if:

- You or your dependent has an active medical coverage with another employer group that is enrolled under NetCare; or
- You or your dependent has an active medical coverage with the military armed forces. Proof of coverage must be provided to NetCare.

If during the Contract Year, you delete dental coverage, you must also delete medical coverage, with the exception if deletion is done during your employer group open enrollment period.

Depending on your group size and employee participation requirement, you may choose a different enrollment class type for medical and dental coverage. For example, you may enroll in a Class III (Family) medical coverage and a Class I (Single) dental coverage.

NetCare must approve any exceptions to this policy.

(vii) Effective Date of Coverage

a. Your Coverage

- Your coverage will take effect on the later to occur of:
- The effective date of this Policy;
- The first day of the calendar month following the date he or she complete the waiting period set forth in this Policy;
- The first day of the calendar month following the date you return your signed group coverage enrollment form to your Human Resource Manager.

b. Your Dependents

If you do not sign and return your form within 30 days of your Eligibility Date, you will not be able to elect coverage until the next open enrollment period established by your Employer. Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You must report any new dependents. This may affect your contributions. If you do not do so within 30 days of any dependent's Eligibility Date, you will not be able to elect coverage for such dependent until the next open enrollment period established by your Employer.

- If you have employee coverage only and you request dependent coverage for a *newly eligible* dependent

within 30 days of their Eligibility Date, the effective date of coverage is the date that the dependent first became eligible for coverage under the Plan.

- If you have employee coverage and want to change to dependent coverage but did not request such coverage within 30 days of this Eligibility Date, you will not be able to elect coverage for such dependent until the next open enrollment period established by your Employer.

(viii) Special Enrollment Procedures Under HIPAA

You will be able to elect coverage at any time after 30 days without waiting for the next open enrollment period if:

- You did not elect Health Expense Coverage for the person involved within 30 days of the date you were first eligible (or during an open enrollment) because at that time:
  a. the person was covered under other "creditable coverage" as defined below; and
  b. you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- The person loses such coverage because:
  a. of termination of employment in a class eligible for such coverage;
  b. of reduction in hours of employment;
  c. your spouse dies;
  d. you and your spouse divorce or are legally separated;
  e. such coverage was COBRA like continuation and such continuation was exhausted; or
  f. the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- You elect coverage within 30 days of the date the person loses coverage for one of the above reasons.

Coverage will be effective on the date of the change in status.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

Also, you will be able to elect coverage without waiting for the next open enrollment period if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A spouse or child who meets the definition of a dependent, but you elect it later and within 30 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order.

- Yourself, and you subsequently acquire a dependent, which meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the election.

- Yourself, and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

- Yourself and your spouse, and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

Article III PRESCRIPTION DRUG EXPENSE COVERAGE

Prescription Drug coverage

When the prescription is purchased through:	And the prescription is for a "generic" drug, the expense is covered at:	And the prescription is for a "brand-name" drug, the expense is covered at:	And the prescription is for a non-fomulary drug:	And the prescription is for an injectable drug:
Mail Order Pharmacy – Express Pharmacy Services *	PPO–Airlines & GU HMO 100% after a $20 co-pay per prescription or refill up to a 90-day supply. PPO-Islands 100% after a $6 co-pay per prescription or refill up to a 90-day supply.	PPO–Airlines & GU HMO 100% after a $40 co-pay per prescription or refill up to a 90-day supply** PPO-Islands 100% after a $10 co-pay per prescription or refill up to a 90-day supply**	PPO–Airlines & GU HMO 100% after a $80 co-pay per prescription or refill up to a 90-day supply. PPO-Islands 100% after a $20 co-pay per prescription or refill up to a 90-day supply.	PPO–Airlines & GU HMO 100% after a 10% co-pay per prescription or refill up to a 90-day supply. PPO-Islands 100% after a $10% co-pay per prescription or refill up to a 90-day supply.
A Participating Pharmacy	PPO–Airlines & GU HMO 100% after a $10 co-pay per prescription or refill up to a 30-day supply*** PPO-Islands 100% after a $3 co-pay per prescription or refill up to a 30-day supply***	PPO–Airlines & GU HMO 100% after a $20 co-pay per prescription or refill up to a 30-day supply**/*** PPO-Islands 100% after a $5 co-pay per prescription or refill up to a 30-day supply**/***	PPO–Airlines & GU HMO 100% after a $40 co-pay per prescription or refill up to a 30-day supply*** PPO-Islands 100% after a $10 co-pay per prescription or refill up to a 30-day supply***	PPO–Airlines & GU HMO 100% after a 10% co-pay per prescription or refill up to a 30-day supply. PPO-Islands 100% after a 10% co-pay per prescription or refill up to a 30-day supply.
A Non-Participating Pharmacy	Not Covered	Not Covered	Not Covered	Not Covered

* The Mail Order Pharmacy feature of the Prescription Drug Benefit is designed to be used by individuals using maintenance type medication for the treatment of chronic or long-term conditions such as, but not limited to, diabetes, arthritis, heart conditions and high blood pressure, for periods of 30 days or longer. This program covers any prescription drug covered by the Plan.

**If the prescriber does not indicate that a brand name drug has to be used to fill a prescription and there is a generic equivalent available, you will pay the applicable co-pay plus a Separate Brand Name Fee (the difference between the cost of the brand name drug and the generic equivalent) if you decide you want the brand name drug. (See the "Benefit Amount" section in your Booklet for details).

***Prescription or refill for birth control pills is payable at 100% after applicable co-pay up to a 90-day supply.

Co-payments are to be paid at the Participating Pharmacy at the time of purchase. No other prescription drug benefits are payable.

Refills for prescription drugs will be filled in accordance with the terms of the Plan, provided that:

- for a 10 to 30 day supply at least 50% of the prior prescription or refill has been used; or
- for a supply greater than 30 days at least 75% of the prior prescription or refill has been used; or
- for a supply furnished by a mail order pharmacy at least 60% of the prior prescription or refill has been used.

The date of the most recent prescription or refill will be used to determine the percentage used.

Article IV COMPRENSIVE MEDICAL EXPENSE COVERAGE

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, NetCare will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if NetCare finds that such action is warranted by reason of a change in factors used in the allocation.

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. NetCare will determine the pro rata share. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

NetCare assumes no responsibility for the outcome of any covered services or supplies. NetCare makes no express or implied warranties concerning the outcome of any covered services or supplies.

All maximums included in this Plan are combined maximums between Participating Care and Non-Participating Care, where applicable, unless specifically stated otherwise.

(i) Certification Requirement

Certain types of care must be certified as necessary to avoid a reduction in the benefits payable. Read the Comprehensive Medical Expense Coverage section of the Booklet for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

If you do not obtain certification, the following Penalty in the form of an Excluded Amount of coverage will apply.

Certification for Hospital Expenses

Excluded Amount (Penalty)	50% Of Covered Charges

(ii) The Benefits Payable

After any applicable co-payment, the Health Expense Benefits payable under this Plan in a contract year are paid at the Payment Percentage, which applies, to the type of Covered Medical Expense that is incurred, except for any different benefit level that may be provided later in this Booklet. Benefits may vary depending upon whether a Participating Provider is utilized. A Participating Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge."

Any charge for a service or supply furnished by a Participating Provider in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the group contract. This rule will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are payable.

Lifetime Maximum Benefit:	$1,000,000.00 Lifetime Maximum Benefit (overall limit) that applies to the Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.
Off-Island Maximum Benefit:	$300,000.00
Co-Payment Maximum Benefit:	
Individual	$2,000.00
Family	$6,000.00

(iii) Covered Medical Expenses

Covered Medical Expenses shall include only the usual, customary and reasonable charges, incurred while covered, for the following types of medical services, supplies and treatment which are prescribed by an attending physician:

1. Semi-private room and board in a hospital;

2. Other hospital services as required for medical and surgical care or treatment;

3. Charges made by a legally qualified physician for diagnosis, treatment and surgery;

4. Services of a Registered Nurse, Licensed Practical or Licensed Vocational Nurse if not a member of the Covered Person's family related by blood or marriage;

5. Anesthetics and the administration of anesthesia for a covered surgical procedure;

6. Diagnostic x-ray and laboratory procedures;

7. Coverage for radiation therapy, chemotherapy, and nuclear medicine;

8. Services of a qualified physiotherapist;

9. Necessary local professional ground ambulance service to and from the nearest hospital or Extended Care Facility where care and treatment of the covered injury or sickness can be given;

10. Blood and blood products are not covered under the policy. Only the cost of administration shall be covered based on policy specifications.

11. Charges for treatment and nursery care for a newborn child, if covered under this Policy, due to Injury or Sickness. Injury and Sickness include: birth abnormalities, congenital defects, and premature birth. Hospital and surgical eligible expenses for covered newborn children will be payable as eligible

expenses according to the Provisions under "Hospital and Surgery". All treatment of whatever kind for newborn children is limited to the amount shown on the Policy Specifications during the lifetime of any insured child.

12. MRI's and CT-Scans are limited to one test per Contract Year per anatomical Region. Pre-authorization is required for any additional diagnostic tests required in the same contract period.

13. Charges of a qualified speech therapist for purposes of correcting speech loss or damage which is due to a sickness or surgery due to such sickness or following surgery to correct birth defect will be covered based under policy specifications.

14. Hospital and Skilled Nursing Facility. Skilled Nursing admission and services shall be limited to thirty (30) days per Contract Year and subject to the co-payments and policy specifications.

15. Routine Immunization and Injections and in compliance with the U.S. Public Health Service Schedule of Immunizations up to 16 years of age.

16. Maternity Care, including pre-natal, delivery and well baby care.

17. Physical Therapy with a maximum coverage of twenty (20) visits per Contract Year.

18. Speech Therapy with a maximum coverage of $400.00 per Contract Year with a lifetime maximum of one-hundred (100) two-hour sessions for the Continental PPO Plans and limited to 20 visits per contract year under the Continental HMO Plan.

19. Coverage for Acquired Immune Deficiency Syndrome (AIDS).

20. Coverage for Cardiac Care Services.

21. Coverage for Congenital Diseases with an annual maximum of $15,000 per Contract Year.

22. Coverage for outpatient Sterilization Procedures, including tubal ligation and vasectomy.

23. Coverage for eye examination. Limited to one (1) eye examination per Contract Year up to a maximum of $75.00 (for refraction only).

24. Coverage for Sleep Apnea. Coverage is limited to sleep evaluation and diagnosis only and is covered at 80% of Covered Charges under the Continental PPO Plans. This benefit is not covered for Covered Persons enrolled under the Continental HMO Plan.

25. Coverage for Acupuncture Services. Limited to twenty (20) visits per Contract Year up to $50.00 per visit under the CAL PPO Plans. This benefit is not covered for Covered Persons enrolled under the Continental HMO Plan.

26. Coverage for Hyperbaric Oxygen (HBO) Treatment. Limited to 80% of Covered Charges up to $5,000 per Contract Year under the Continental PPO Plans. This benefit is not covered for Covered Persons enrolled under the Continental HMO Plan.

27. Charges for allergy testing and treatment. Limited to $500 per Contract Year for all services related to allergy testing including serum and prescription drugs.

28. Non-spouse maternity services will be covered and limited up to $500 per Contract Year for outpatient pre-natal services only under the Continental PPO Plans. This benefit is no covered for Covered Persons enrolled under the Continental HMO Plan.

29. Coverage for Hip and Joint Replacement. Coverage is limited to designated NetCare Centers of Care at 80% of covered charges and a $50,000 maximum per Contract Year.

30. Coverage for Organ Transplant. Coverage is limited to a lifetime maximum of $100,000 per Covered Person (Cornea Transplants are limited to $15,000) and at 80% of covered charges under the Continental PPO Plans. This benefit is not covered for Covered Persons enrolled under the Continental HMO Plan.

31. Coverage for Alcohol/Substance Abuse Treatment. Coverage is limited to a maximum of $8,000 per member per Contract Year, $16,000 per member per Lifetime under the Continental PPO & HMO Plans. This benefit is not covered for Covered Persons enrolled under Continental PPO Airlines. Coverage is subject to co-payments specified in the Policy Specifications.

(iv) Payment (Out-of-Pocket) Limit

This limit applies only to Covered Medical Expenses except expenses applied against any deductible, fee, or co-pay amount.

(v) Payment (Out-of-Pocket) Limit Which Applies to Expenses for a Person

When a person's co-payment from Covered Medical Expenses incurred from a Participating

Provider reach a maximum dollar limit in a contract year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that contract year as shown in this policy and the Policy Specifications.

When a person's Covered Medical Expenses incurred from a Non-Participating Provider, for which no benefits are paid because of the deductible reach a maximum dollar limit in a contract year, benefits will be payable at a percentage for all of his or her Covered Medical Expenses to which this limit applies and which are incurred at a Non-Participating Provider in the rest of that contract year as shown in this policy and Policy Specifications.

(vi) Payment (Out-of-Pocket) Limit Which Applies to Expenses for a Family

When a family's co-payment from Covered Medical Expenses incurred from a Participating Provider reach a maximum dollar limit in a contract year, benefits will be payable at 100% for all their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that contract year as shown in this policy and Policy Specifications.

When a family's Covered Medical Expenses incurred from a Non-Participating Provider, for which no benefits are paid because of the deductible reach a maximum dollar limit in a contract year, benefits will be payable at a percentage for all of his or her Covered Medical Expenses to which this limit applies and which are incurred at

a Non-Participating Provider in the rest of that contract year as shown in this policy and Policy Specifications.

(vii) Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement, such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If a person is discharged earlier, benefits will be payable for 2 post-delivery visits to a health care provider.

The expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, no benefits will be paid.

(viii) Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization.

(ix) Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

(x) General

The Policy Specifications replaces any Policy Specifications previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Policy and Policy Specifications cannot be accepted.

(xi) Comprehensive Medical Expense Coverage

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, co-payment features and stated maximum benefit amounts. These are all described in the Booklet.

(xii) Covered Medical Expenses

The Policy Specifications outlines the Payment Percentages that apply to the Covered Medical expenses described below.

They are the expenses for certain hospital and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses:

(xiii) Hospital Expenses

1) Inpatient Hospital Expenses

Charges made by a hospital for giving board and room and other hospital services and supplies to a person who is confined as a full-time inpatient.

Covered Medical Expenses charged by a hospital for semi-private accommodations or the Most Common Semi-private Accommodation rate or as may otherwise be stated on the Policy Specifications for a hospital that does not have semi-private accommodations will be covered at the percentage shown on the Policy Specifications; Intensive Care Unit, Cardiac Care Unit, or Burn Unit accommodations will be limited to the percentage of eligible expenses shown on the Policy Specifications, not to exceed two (2) times the Most Common Semi-private Accommodation rate; all other hospital charges are covered at the percentage shown on the Policy Specifications.

2) Outpatient Hospital Expenses

Charges made by a hospital for hospital services and supplies that are given to a person who is not confined as a full-time inpatient.

(xiv) Routine Physical Exam Expenses and Well Child Care

The charges made by a physician for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a physician in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, laboratory and other tests given in connection with the exam; and
- Charges for one routine gynecological exam, including pap smear during any contract year; and
- Charges for one screening by mammography given to a female age 40 or over for the presence of occult breast cancer; and
- Charges in connection with one screening for cancer of the prostate, including a prostate specific antigen (PSA) test and a digital rectal exam, given to a male age 40 and over during any one contract year; and
- Materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For your dependent child:

- The physical exam must include at least:
  1) a review and written record of the patient's complete medical history;
  2) a check of all body systems; and

3) a review and discussion of the exam results with the patient or with the parent or guardian.

- For all exams given to you and your spouse, Covered Medical Expenses will not include charges for more than one exam per contract year.

Also included, as Covered Medical Expenses are charges made by a physician for one annual routine gynecological exam.

Limitations To Routine Physical Exam and Well Child Care Expenses
Not covered as Routine Physical Exam and Well Child Care Expenses are charges for:

- services that are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer;
- services that are for diagnosis or treatment of a suspected or identified injury or disease;
- exams given while the person is confined in a hospital or other place for medical care;
- services not given by a physician or under his or her direction;
- medicines, drugs, appliances, equipment or supplies;
- psychiatric, psychological, personality or emotional testing or exams;
- exams in any way related to employment or school;
- pre-marital exams;
- vision, hearing or dental exams;
- a physician's office visit in connection with immunization or testing for tuberculosis.

NOTE: These limitations apply to Routine Physical Exam and Well Child Care Expenses only. They may be included as Covered Expenses in other areas of your coverage.

(xv) <u>High-Risk Factors</u>

In addition to normal screenings and immunizations performed in connection with a routine physical exam, certain screenings and immunizations will be covered for persons identified as being at a higher risk for certain diseases or conditions. These procedures include the following:

3) Serum Cholesterol (HDL)

Testing for serum cholesterol will be provided once between two and six years of age, and once every five years thereafter for children with a family history (either a biological parent or grandparent) of premature cardiovascular disease*, or where a biological parent has had hypercholosterolemia**.

* Premature cardiovascular disease is defined as the onset of such a disease at an age equal to or less than fifty-five years old.
** Hypercholosterolemia is defined as a total cholesterol level greater than 240 mg/dl.

4) Tuberculin (PPD) Testing

For children, high-risk factors for tuberculosis will include but are not limited to:
- The child has had contact with adults with infectious tuberculosis.
- The child was born in a foreign country or region, or has parents who were born in a foreign country or

region, where tuberculosis is common.
- The child exhibits clinical evidence of tuberculosis.
- The child is HIV seropositive.
- The child has other medical conditions, including but not limited to, Hodgkin's disease, lymphoma, diabetes mellitus, chronic renal failure and malnutrition.
- The child is an incarcerated adolescent.
- The child is frequently exposed to: HIV infected individuals, homeless persons, users of intravenous drugs and other street drugs, poor and medically-indigent city dwellers, residents of nursing homes, or migrant farm workers.

Testing will be provided in accordance with your Routine Physical Exam and Well Child Care benefit when determined necessary.

For Adults, high-risk factors for tuberculosis will include but are not limited to:
- Persons with signs, symptoms, or laboratory abnormalities suggestive of clinically active tuberculosis.
- Recent contacts with persons known to have or suspected of having clinically active tuberculosis.
- Persons with HIV infection.
- Persons with abnormal chest x-rays compatible with past tuberculosis.
- Persons with other medical conditions that increase the risk for tuberculosis.
- Persons who have been determined to be part of a group at high risk of recent M. tuberculosis, such as immigrants from foreign countries where tuberculosis is common, medically underserved populations.

Testing will be provided in accordance with your Annual/Routine Physical Exam benefit when determined necessary.

5) Lead Screening

For children age 6 months through 6 years one screening will be performed if it is determined that there is a high risk of lead poisoning. High-risk factors include but are not limited to:
- Living in a dwelling built before 1960 with peeling or chipped paint, or where renovations have recently been made.
- Living near a factory where lead is used or released into the environment.
- A sibling, playmate, or other household member is currently being treated for lead poisoning.
- A household member has a job or hobby involving exposure to lead.

6) Hepatitis B Vaccination

Three doses will be provided for persons age 20 and over only if such person is determined to be in a high-risk group. High-risk factors include but are not limited to:
- Persons with an occupational risk of contracting Hepatitis B.
- Hemodialysis patients.
- Individuals with bleeding disorders who receive blood products.
- Persons who have household or sexual contact with person have known to be Hepatitis B carriers.
- Persons who are intravenous elicit drug users.
- Persons who are sexually active homosexual or bisexual males.
- Persons who are heterosexual and who have or have had more than one sex partner in the past six months, or who have recently contracted a sexually transmitted disease.

- Persons who are international travelers to geographic areas where Hepatitis B is common.
- Persons who are inmates of long-term correctional facilities.

7) Menginococcal Vaccination

One dose will be provided for children age 2 and over (or once for adults if it has not been previously administered) with one or more of the following high-risk factors:

- Persons with asplenia (sickle-cell disease).
- Persons with anatomic asplenia (surgical or congenital).

8) Pneumovax

One dose will be provided for children age 2 or older (or for adults if it has not been previously administered) with one or more the following high-risk factors:

- Persons infected with HIV or AIDS.
- Persons with asplenia (sickle-cell disease).
- Persons with anatomic asplenia (surgical or congenital).

(xvi) Routine Eye Exam Expenses

Covered Medical Expenses include charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist to a person.

Covered Medical Expenses will not include charges for more than one eye exam per contract year.

Limitations To Routine Eye Exam Expenses

Not included as Routine Eye Exam Expenses are charges for:

- any eye exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any services or supplies that are included as covered expenses under any other benefit section included in this Plan or under any other plan of group benefits provided through your Employer;
- any services or supplies for which benefits are provided under any workers' compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges;
- any service or supply that does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a hospital or other facility for medical care; or
- any eye exam required by an employer as a condition of employment, or an employer is required to provide under a labor agreement or is required by any law of a government.

NOTE**:** These limitations apply to Routine Eye Exam Expenses only. They may be included as Covered Expenses in other areas of your coverage.

(xvii) Prescription Eyewear Reimbursement

Covered medical expenses will include those for medically necessary prescription eyewear (lenses, frames, and contact lenses). Covered expenses are not subject to the deductible for any combination of medically necessary prescription eyewear. Covered expenses will not include charges for more than the Prescription Eyewear Reimbursement Maximum per contract year, per person.

(xviii) Routine Hearing Exam Expenses

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by:

- a physician certified as an otolaryngologist or otologist; or

- an audiologist who either:
  1) is legally qualified in audiology; or

  2) holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and

  3) who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Covered Medical Expenses will not include charges for more than one hearing exam per contract year.

Limitations to Routine Hearing Exam Expenses
Not included as Routine Hearing Exam Expenses are charges for:

- any ear or hearing exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply that does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a hospital or other facility for medical care; or
- any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

NOTE: These limitations apply to Routine Hearing Exam Expenses only. They may be included as Covered Expenses in other areas of your coverage.

(xix) Hearing Aid Expenses

No benefits will be payable as to the following:

Charges for a hearing aid.

Charges for a hearing aid for which benefits are provided under any workers' compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges.

(xx) Second Surgical Opinion Expenses

Charges of a physician for a second surgical opinion on the need or advisability of performing a surgical or oral

surgical procedure:

- for which the charges are a Covered Medical Expense; and
- which is recommended by the first physician who proposed to perform the surgery; and
- which is not for an emergency condition.

A benefit is also paid for charges made for a third surgical opinion. This will be done when the second one does not confirm the recommendation of the first physician who proposed to perform the surgery.

A surgical opinion is:

- an exam of the person; and
- x-ray and lab work; and
- a written report by the physician who renders the opinion.

The surgical opinion must both:

- be performed by a physician who is certified by the American Board of Surgery or other specialty board; and
- take place before the date the proposed surgery is scheduled to be done.

Benefits are not paid for a surgical opinion if the physician who renders the surgical opinion is associated or in practice with the first physician who recommended and proposed to perform the surgery.

(xxi) Preoperative Testing Expenses

Charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery if:

- the tests are related to the scheduled surgery;
- the tests are done *within the 7 days prior* to the scheduled surgery;
- the person undergoes the scheduled surgery in a hospital or surgery center; this does not apply if the tests show that surgery should not be done because of his physical condition;
- the charge for the surgery is a Covered Medical Expense under this Plan;
- the tests are done while the person is not confined as an inpatient in a hospital;
- the charges for the tests would have been covered if the person were confined as an inpatient in a hospital;
- the test results appear in the person's medical record kept by the hospital or surgery center where the surgery is to be done; and
- the tests are not repeated in or by the hospital or surgery center where the surgery is done.

If the person cancels the scheduled surgery, benefits are paid at the payment percentage that would have applied in the absence of this benefit.

(xxii) Surgical Expenses

These are the charges made by a physician for surgical services. Surgical Services are the services of the operating physician in performing a surgical procedure. A "surgical procedure" is:

- The incision or excision of any part of the body.
- The electrocauterization of any part of the body.
- The manipulative reduction of a fracture or dislocation.
- The suturing of a wound.
- Voluntary sterilization.
- The removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder or ureter.

Included as part of a "surgical procedure" are the following services of the operating physician:

- The usual and related preoperative care.
- The administering of anesthetic.
- The usual and related postoperative care.

Limitations to Surgical Expenses
Not covered as Surgical Expenses are charges for:
- Diagnostic laboratory and x-ray services.
- Drugs or medicines.
- Services of a resident physician or intern of a hospital.
- Reversal of sterilization.

NOTE: These limitations apply to Surgical Expenses only. They may be included as Covered Expenses in other areas of your coverage.

(xxiii) <u>Outpatient Surgical Expenses</u>

Charges made in its own behalf by:

- A surgery center; or
- The outpatient department of a hospital;

for Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a hospital. The procedure must meet these tests:

- It is not expected to:
    1) result in extensive blood loss;
    2) require major or prolonged invasion of a body cavity; or
    3) involve any major blood vessels.
- It can safely and adequately be performed only in a surgery center or in a hospital.
- It is not normally performed in the office of a physician or a dentist.

9) Outpatient Services and Supplies
These are services and supplies furnished by the center or by a hospital on the day of the procedure.

10) Limitations to Outpatient Surgical Expenses
No benefit is paid for charges incurred while the person is confined as a full-time inpatient in a hospital.

NOTE: These limitations apply to Outpatient Surgical Expenses only. They may be included as Covered

Expenses in other areas of your coverage.

(xxiv) Acupuncture Therapy Expenses

Acupuncture therapy treatments is included as Covered Medical Expenses only in specific Benefit Plans. To be covered, the treatment must be performed by (not under the direction of) a physician for the treatment of any one of the following illnesses:

Acupuncture is considered a non-surgical procedure, as it does not involve incision in accordance with a surgical procedure. Covered Medical Expenses does not apply to the HMO Plan.

(xxv) Home Health Care Expenses

Home health care expenses are covered if:

- the charge is made by a home health care agency; and
- the care is given under a home health care plan; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- The following to the extent they would have been covered under this Plan if the person had been confined in a hospital:

  1) medical supplies;

  2) drugs and medicines prescribed by a physician; and

  3) lab services provided by or for a home health care agency.

There is a maximum to the number of visits covered in a contract year. Each visit by a nurse or therapist is one visit.

11) Limitations To Home Health Care Expenses

This section does not cover charges made for:

- Services or supplies that are not a part of the home health care plan.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

NOTE: These limitations apply to Home Health Care Expenses only. They may be included as Covered Expenses in other areas of your coverage.

(xxvi) Hospice Care Expenses

Charges made for the following furnished to a person for Hospice Care when given as a part of a Hospice Care Program are included as Covered Medical Expenses in specific Benefit Plans.

12) Facility Expenses

The charges made in its own behalf by a:

- hospice facility;
- hospital.

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:

  1) pain control; and

  2) other acute and chronic symptom management.

- Not included is any charge for daily board and room in a private room over the Private Room Limit.
- Services and supplies furnished to a person while not confined as a full-time inpatient.

13) Other Expenses

Charges made by a Hospice Care Agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day.
- Medical social services under the direction of a physician. These include:

  1) assessment of the person's:

     a) social, emotional, and medical needs; and

     b) the home and family situation;

     c) dentification of the community resources which are available to the person; and

     d) assisting the person to obtain those resources needed to meet the person's assessed needs.

- Psychological and dietary counseling.
- Consultation or case management services by a physician.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a physician.

Charges made by the providers below, but only if: the provider is not an employee of a Hospice Care Agency; and such Agency retains responsibility for the care of the person.

- A physician for consultant or case management services.
- A physical or occupational therapist.
- A Home Health Care Agency for:

  1) physical and occupational therapy;

  2) part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;

  3) medical supplies;

  4) drugs and medicines prescribed by a physician; and

  5) psychological and dietary counseling.

Limitations to Hospice Care Expenses
Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services that are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not; attend to the person's needs.

NOTE: These limitations apply to Hospice Care Expenses only. They may be included as Covered Expenses in other areas of your coverage.

(xxvii) <u>Infertility Services Expenses</u>

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will not include expenses incurred by a covered female for infertility.

There exists a condition that is a demonstrated cause of infertility and has been recognized by a gynecologist or infertility specialist and if all the following tests are met:

- The procedures are performed while not confined in a hospital or any other facility as an inpatient.
- For a female under age 35, she has not been able to conceive after one year or more without contraception or 12 cycles of artificial insemination; and for a female age 35 and older, she has not been able to conceive after six months without contraception or 6 cycles of artificial insemination.
- FSH levels are less than or equal to 19 miU on day 3 of the menstrual cycle.
- The infertility is not caused by voluntary sterilization or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

The following infertility services expenses is not part of Covered Medical Expenses:

- Ovulation induction with menotropins, subject to a maximum of 6 courses of treatment in a covered person's lifetime.
- Artificial insemination, subject to a maximum of 6 courses of treatment in a covered person's lifetime.

These expenses will not be covered on the same basis as for disease.

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.
In figuring the above Lifetime Maximums, NetCare will not take into consideration all of the following, whether past or present:

- Services received while covered, under a plan of benefits on an individual or group basis, whether insured or self-insured, offered by NetCare or one of its affiliated companies; and
- Services received while covered under a plan of benefits on an individual or group basis, whether insured or self-insured, offered by any other carrier; and
- Services received while no plan coverage was provided.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Prescription drugs, including injectable infertility medications (coverage for injectable infertility medications is described in the section on Prescription Drug Benefits).
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.
- Reversal of sterilization surgery.
- Services and supplies furnished by a Non-Participating Provider.

(xxviii) <u>Short-Term Rehabilitation Expenses</u>

The charges made by:

- a physician; or
- a licensed or certified physical, occupational or speech therapist;

For the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy that is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:

- an injury;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:

- physical therapy

furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

The charges for Short-Term Rehabilitation services are Covered Medical Expenses for no longer than the Short-Term Rehabilitation Maximum Days for each person during any one-contract period.

Limitations to Short-Term Rehabilitation Expenses

Not covered as Short-Term Rehabilitation Expenses are charges for:

- Services that are covered to any extent under any other part of this Plan.
- Any services that are covered expenses in whole or in part under any other group plan sponsored by an Employer.
- Services received while the person is confined in a hospital or other facility for medical care.
- Services not performed by a physician or under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:

  1) disease;

  2) injury; or

  2) congenital defect.

- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- details the treatment to be rendered and the frequency and duration of the treatment.

- provides for ongoing reviews and is renewed only if therapy is still necessary.

NOTE: These limitations apply to Short-Term Rehabilitation Expenses only. They may be included as Covered Expenses in other areas of your coverage.

(xxix) <u>Other Medical Expenses</u>

These Other Medical Expenses are covered at the Payment Percentage indicated on the Policy Specifications after any applicable deductible is met. They include:

- Charges made by a physician.

- Charges made by a R.N. or L.P.N. or a nursing agency for skilled nursing care.

  1) As used here, "skilled nursing care" means these services:

     a) Visiting nursing care by a R.N. or L.P.N. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

     b) Private duty nursing by a R.N. or L.P.N. if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

  3) Benefits will not be paid for private duty nursing.

  4) Not included as "skilled nursing care" is:

     a) that part or all of any nursing care that does not require the education, training, and technical skills of a R.N. or L.P.N.; such as transportation, meal preparation, charting of vital signs, and companionship activities; or

     b) any private duty nursing care given while the person is an inpatient in a hospital or other health care facility; or

     c) care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or

     d) care provided solely for skilled observation except as follows:
        i) for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

        ii) change in patient medication;

        iii) need for treatment of an emergency condition by a physician or the onset of symptoms indicating the likely need for such treatment;

        iv) surgery; or

        v) release from inpatient confinement; or

     e) any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a R.N. or L.P.N.

- Charges for the following:

  1) Diagnostic lab work and X-rays.

  2) X-ray, radium, and radioactive isotope therapy.

  3) Anesthetics and oxygen.

4) Rental of durable medical and surgical equipment. In lieu of rental, the following may be covered:

   a) The initial purchase of such equipment if NetCare is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

   b) Repair of purchased equipment.

   c) Replacement of purchased equipment if NetCare is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

5) Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given.

6) Artificial limbs and eyes. Not included are such things as:

   a) eyeglasses;

   b) vision aids;

   c) hearing aids;

   d) communication aids; and

   e) orthopedic shoes, foot orthotics, or other devices to support the feet.

(xxx) <u>Airfare Benefit Program</u>

NetCare will pay a benefit for Travel Expenses but only to the extent described below and only if charges incurred for the covered member at specified Centers of Care facilities are Covered Medical Expenses.

NetCare provides a round-trip benefit when a member meets the following criteria:

- Has obtained a written medical referral from a participating provider to receive medical care off-island;
- Has an approved pre-certification form from the Plan;
- Has NetCare as his/her primary insurance coverage;
- Has a chronic or catastrophic illness for which treatment is unavailable on Guam as determined by the Plan and the referring provider.
- Premium payments are current and in good standing; and
- Has met the Plan's Utilization Review criteria.

Any charges made by the Centers of Care facility for services and supplies which are:

- furnished in connection with any of the procedures or treatment listed below; and
- are included under this Plan as Covered Medical Expenses;

will be considered to be expenses incurred.

14) Procedure and Treatment Types

Open Heart Surgery	Cancer Surgery
Angioplasty	Neurosurgery
Cardiac Catherization	Gamma Knife

15) Travel Expenses

Round-trip airline tickets are payable for direct flights to the Plan's Centers of Care and are purchased at the lowest economy fare available. The plan will only pay for the Patient's airfare.

Airfare expenses will be applied to the Patient's off-island plan maximum per contract period.

Covered Medical Expenses will not include expenses incurred by a covered member for transportation between his or her home and the facility to receive services in connection with any listed procedure or treatment.

Also not included are expenses incurred by a Companion for transportation when traveling with the Patient between the Patient's home and the facility to receive such services.

Article V LIMITATIONS

(i) Mouth, Jaws, and Teeth

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, physician includes a dentist.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:

  1) teeth partly or completely impacted in the bone of the jaw;

2) teeth that will not erupt through the gum;

3) other teeth that cannot be removed without cutting into bone;

4) the roots of a tooth without removing the entire tooth;

5) cysts, tumors, or other diseased tissues.

- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

1) due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the contract year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of orthodontic treatment after the injury.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;

- for routine tooth removal (not needing cutting of bone).

Not included are charges:

- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:

  1) muscle training therapy; or

  2) training to correct or control harmful habits.

(ii) Emergency Room Treatment

15) Emergency Care

If treatment:

- is received in the emergency room of a hospital while a person is not a full-time inpatient; and
- the treatment is emergency care;

Covered Medical Expenses for charges made by the hospital for such treatment will be paid at the Payment Percentage after any applicable copay or deductible.

16) Non-Emergency Care

If treatment:

- is received in the emergency room of a hospital while a person is not a full-time inpatient; and
- the treatment is not emergency care;

Covered Medical Expenses for charges made by the hospital for such treatment will be paid at the Reduced Payment Percentage.

No benefit will be paid under any other part of this Plan for charges made by a hospital for care in an emergency room that is not emergency care.

(iii) Certification Program

Pre-Certification is a utilization management program that ensures that Covered Persons will receive the highest standard health care, in the most appropriate setting, and in the best interests of the patient. NetCare shall require pre-certification review and approval for all outpatient elective surgery, testing for MRI and CT Scan, home health care, skilled nursing confinements, and other major procedures such as ultrasounds, mammography, extended hospital length of stay (LOS) beyond the allowed LOS, as well as non-formulary prescriptions not listed in the Plan's Prescription Formulary. This pre-certification requirement applies to the health care provider notifying NetCare before services or procedures are rendered to the patient. Pre-Certification allows NetCare to authorize payment and to recommend alternate courses of action

(iv) Certification For Hospital Admissions

This certification section applies to admissions other than those for the treatment of alcoholism, drug abuse or mental disorders. A separate section applies to such admissions.

NOTE: Make sure you, your dependents and your physician know about the certification requirement under your plan. This is especially important in case of an emergency if you are unable to obtain certification for yourself.

If:

- a person becomes confined in a hospital as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is necessary; and
- the confinement has not been ordered and prescribed by a physician who is a Participating Provider.

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

As to Hospital Expenses incurred during the confinement:

If certification has been requested and denied:

1) No benefits will be paid for Hospital Expenses incurred for board and room.

2) No Benefits for all other Hospital Expenses will be paid.

Certification of days of confinement can be obtained as follows:

If the admission is a non-urgent admission, you must get the days certified by calling the number shown on your ID card. This must be elective done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency admission or an urgent admission, you, the person's physician, or the hospital must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an urgent admission; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already certified, you, the physician or the hospital may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.

(v) Certification for Home Health Care and Skilled Nursing Care

If a person incurs Covered Medical Expenses:

- for a service or a supply for home health care or hospice care while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is necessary; or
- such other services or supplies (either specifically or as a part of a planned program of care) are necessary, and
- the confinement or service or supply has not been ordered or prescribed by a physician who is a Participating Provider;

Such Covered Medical expenses will be paid only as follows:

- As to Covered Medical Expenses incurred for services or supplies either as stated or as part of a planned program of care for home health care while not confined as an inpatient, or skilled nursing care:

  1) If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not necessary, no benefits will be paid for the denied or unnecessary service or supply.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan

- To the extent that such service or supply has been certified for home health care or skilled nursing care, the exclusion of services or supplies because they are not necessary will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's physician believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:

- services and supplies for hospice care provided to a person have been certified; and
- the person later requires confinement in a hospital for pain control or acute symptom management;

any other certification requirement in this Plan will be waived for any such day of confinement in a hospital.

(vi) <u>Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse or Mental Disorders</u>

If, in connection with the effective treatment of alcoholism or drug abuse or treatment of mental disorders, a

person incurs Covered Medical Expenses while confined in a hospital or treatment facility; and

- it has not been certified that such confinement (or any day of such confinement) is necessary; and
- the confinement has not been ordered and prescribed by a physician who is a Participating Provider:

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

1) With respect to expenses for hospital and treatment facility board and room:

   a) If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not necessary, no benefits will be paid.

   b) If certification has not been requested and the confinement is necessary, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

2) With respect to all other hospital and treatment facility expenses:

   a) If certification has been requested and denied, or if certification has not been requested and the confinement is necessary, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

   b) If certification has not been requested and the confinement is not necessary, no benefits will be paid.

(vii) <u>Treatment of Alcoholism, Drug Abuse, or Mental Disorders</u>

Certain expenses for the treatment shown below are Covered Medical Expenses for specific Benefit Plans.

17) Inpatient Treatment

If a person is a full-time inpatient either:

- in a hospital; or
- in a treatment facility;

then the coverage is as shown below.

18) Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- Effective treatment of alcoholism or drug abuse.
- Treatment of mental disorders.

19) Treatment Facility

Certain expenses for the effective treatment of alcoholism or drug abuse or the treatment of mental disorders are covered. The expenses covered are those for:

- Board and room. Not covered is any charge for daily board and room in a private room over the Semi-Private Room Limit.
- Other necessary services and supplies.

20) Outpatient Treatment

If a person is not a full-time inpatient either:

- in a hospital; or
- in a treatment facility;

then the coverage is as shown below.

Expenses for the effective treatment of alcoholism or drug abuse or the treatment of mental disorders are covered.

For such treatment given by a hospital, treatment facility or physician, benefits will not be payable for more than the Maximum Visits or dollar in any one contract year as shown in the Policy Specifications. This benefit does not apply to Airlines Guam PPO and HMO Plans.

Article VI PRESCRIPTION DRUG EXPENSE COVERAGE

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all prescription drugs. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

The Policy Specifications outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

(i) An Explanation of Certain Terms

Prescription Drugs. Any of the following:

- A drug, biological, or compounded prescription which, by Federal Law: may be dispensed only by prescription and which is required to be labeled "Caution : Federal Law prohibits dispensing without prescription."
- Injectable insulin, glucose test strips and lancets.
- Disposable needles and syringes which are purchased to administer a covered injectable prescription drug or agent.

Participating Agreement. An agreement between NetCare and a Pharmacy Benefit Manager (PMB) with terms regarding payment for Prescription Drugs dispensed under the agreement.

Pharmacy. An establishment where Prescription Drugs are legally dispensed.

Mail Order Pharmacy. An establishment where Prescription Drugs are legally dispensed by mail.

Participating Pharmacy. A Pharmacy, including a Mail Order Pharmacy, which is party to an Agreement with NetCare's PBM to dispense drugs to persons covered under this Plan, but only:

- while the Participating Agreement remains in effect; and
- when such a Pharmacy dispenses a Prescription Drug under the terms of its Participating Agreement with NetCare's PBM.

Non-Participating Pharmacy. A Pharmacy not party to a Participating Agreement with NetCare, or a Pharmacy who is party to such a Participating Agreement but who does not dispense Prescription Drugs in accordance with its terms.

Prescriber. A physician or dentist who is licensed in the United States and has the legal authority to write an order for a Prescription Drug.

Prescription. An order of a Prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

Generic Prescription Drug or Medicines. A Prescription Drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Service Area. This is the geographic area, as determined by NetCare's PBM, in which Participating Pharmacies for this Plan are located.

Emergency Situation. This means the sudden and at that time, unexpected onset of a change in a person's physical or mental condition which, if the treatment was not performed right away could, as determined by NetCare, reasonably be expected to result in:

- loss of life or limb; or
- significant impairment to bodily function; or
- permanent dysfunction of a body part.

(ii) Prescription Drug Expense Benefit

If a Prescription Drug is dispensed by a Participating Pharmacy to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount section, but only if the Participating Pharmacy's charge for the drug is more than the Co-pay or Fee per prescription or refill.

Benefits are not payable if a Prescription Drug is dispensed by a Non-Participating Retail Pharmacy.

(iii) Benefit Amount

The Benefit Amount for each covered Prescription Drug or refill will be an amount equal to the Payment Percentage (100%) of the total charges in excess of the Co-pay or Fee per prescription or refill as shown in the

Policy Specifications. The total charge is determined by:

- the PBM'S Participating Pharmacy, including a Mail Order Pharmacy; and
- NetCare.

Any amount so determined will be paid to the Participating Pharmacy on your behalf.

For Non-Participating Retail Pharmacy, benefit will not be paid for a Prescription Drug dispensed by a Non-Participating Pharmacy under this benefit section and as specified in the Prescription Drug Expense Coverage. In an emergency situation, the benefit amount for each covered Prescription Drug or refill is equal to the Payment Percentage (100%) of the Participating Pharmacy's charge for the drug, in excess of the Co-pay or Fee per prescription or drug.

Benefits are payable using a mandatory generic program, which means prescriptions are limited to generic brands only. If the prescriber does not indicate that a brand name drug has to be dispensed to fill a prescription and there is a generic equivalent available, but you decide you want the brand name drug, a Separate Brand Name Fee will have to be paid by you, in addition to any applicable co-pay. The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the brand name drug and the generic equivalent. Therefore, the Separate Brand Name Fee will apply to any brand name drug dispensed unless there is no generic equivalent to the brand name drug.

(iv) Limitations

No benefits are paid:

- For a device of any type unless specifically included above as Prescription Drugs.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a Mail Order Pharmacy.
- For contraceptive drugs, except oral contraceptives, and IV contraceptives.
- For more than 48 dispensing kits per year for injectable drugs which are used for treatment of migraine headaches (e.g. Imitrex)
- For appetite suppressants and weight control drugs.
- For any smoking cessation aids or drugs. However, Nicorette may be covered as an "Other Medical Expense" under your Comprehensive Medical Expense Coverage if NetCare determines such aid is medically necessary to treat certain conditions accentuated by smoking.
- For cosmetic drugs.(e.g., Rogaine).
- For immunization agents (e.g., routine or travel related).
- For any "over the counter" drugs (non-prescription) unless specifically included in the definition of a prescription drug.
- For any prescription drugs obtainable without a prescription on an "over-the counter" basis.
- For more than a 30 day supply per prescription or refill. However, this limitation does not apply to a supply of up to 90 days per Prescription or refill for drugs which are provided by a Mail Order Pharmacy.
- For any refill of a drug if it is more than the number of refills specified by the Prescriber. NetCare, before recognizing charges, may require a new Prescription, or evidence as to need, if the Prescriber has not specified the number of refills, or if the frequency or number of Prescriptions or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest Prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any healthcare facility; or for any drug

provided on an outpatient basis in any such institution to the extent benefits are paid for it under any other part of this Plan, or under any other medical or prescription drug expense benefit plan carried or sponsored by your Employer.

Article VII GENERAL EXCLUSION

(i) General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not necessary, as determined by NetCare, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician or dentist.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending physician or dentist.
- Those for or in connection with services or supplies that are, as determined by NetCare, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

if required by the FDA, approval has not been granted for marketing; or

a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if NetCare determines that:

the disease can be expected to cause death within one year, in the absence of effective treatment; and the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination NetCare will take into account the results of a review by a panel of independent medical professionals. They will be selected by NetCare. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if NetCare determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.

- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.

- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.

- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.

- Those for services of a resident physician or intern rendered in that capacity.

- Those that are made only because there is health coverage.

- Those that a covered person is not legally obliged to pay.

- Those, as determined by NetCare, to be for custodial care.

- Those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.

- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.

- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

  Improve the function of a part of the body that:

  1) is not a tooth or structure that supports the teeth; and

  2) is malformed:

     a) as a result of a severe birth defect; including harelip, webbed fingers, or toes; or

        as a direct result of:

        i) disease; or

        ii) surgery performed to treat a disease or injury.

  3) Repair an injury. Surgery must be performed:

     a) in the contract year of the accident which causes the injury; or

     b) in the next contract year.

- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

  1) sildenafil citrate;
  2) phentolamine;
  3) apomorphine;
  4) alprostadil; or
  5) any other drug that
     a) is in a similar or identical class,
     b) has a similar or identical mode of action or exhibits similar or identical outcomes.

  This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not

limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.

- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.

- Those for or related to sex change surgery or to any treatment of gender identity disorders.

- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in your Booklet.

- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.

- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.

- Those to the extent they are not reasonable charges, as determined by NetCare.

- Those for the reversal of a sterilization procedure.

- Those for a service or supply furnished by a Participating Provider in excess of such provider's Negotiated Charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage. Please refer to your Policy Specification for detailed list of Exclusions applicable to your benefit plan.

These excluded charges will not be used when figuring benefits.

Article VIII CLAIM APPEALS FOR HEALTH EXPENSE BENEFITS

Claim Procedures for Health Expense Benefits

Your booklet contains information on reporting claims. Claim forms may be obtained at your place of employment or through NetCare.

If your claim is denied in whole or in part, you will receive a written notice, either in writing or electronically, of the denial from NetCare after the claim was filed for benefits. The notice will explain specifi reason for the denial and a description of our appeal process.

You must exhaust all NetCare formal appeal procedures before submitting a final appeal to your Plan Administrator. You have at least 180 days to request a full and fair review of your denied claim. Your request must be in writing and addressed to your Plan Administrator. Include your reasons for requesting the appeal. For additional information and guidance, please refer to Article XVI Appeals and Grievance Procedure of this booklet.

Your appeal will be reviewed and ordinarily you will be notified of the final decision within a reasonable period of time but no later than specific periods of time for certain claims to be reviewed after receipt of your request.

Urgent care Claims – no later than 72 hours
Pre-service Claims – 30 days
Post-service Claims – 60 days

If special circumstances require an extension of time, you will be notified beforehand of such extension and reason before the specified periods following receipt of your request. The Plan needs your persmission for an extension.

We have provided this claim appeal information as an aid to you in keeping claim material related to health coverage together. If you have any questions or problems, contact:

- NetCare Life & Health Insurance Co; or
- Your Human Resource Office.

Article IX COORDINATION OF BENEFITS

(i) Other Plans Not Including Medicare

Some persons have group health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision. Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a contract year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that contract year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the

      health are expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers

the child as a dependent child.

c. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a contract year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, NetCare can release or obtain data. NetCare can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a contract year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

(ii) Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

(iii) Coordination of Benefits Examples

The following information is provided to help clarify specific situations which may arise in the coordination of benefits when a person is covered under more than one plan.

Example One
A female employee works for a group employer and is covered under a employer sponsored medical plan. She elects family coverage, and enrolls her husband as a dependent. At the same time, her husband works for a different employer (other than any branch of the US Armed Forces) and also elects family coverage under *his* employer sponsored medical plan. He names his wife as a dependent under such plan.

For the medical care of the female employee, her employer's sponsored medical plan of benefits will be considered primary. Her husband's plan (under which she is a dependent) would be considered secondary.

For the medical care of the husband, his employer's plan of benefits (under which he is covered as an employee) would be considered primary. The sponsored medical plan of benefits would be considered secondary under his spouse.

Example Two
If a retiree of a group employer:
- has post-retirement medical coverage under the employer sponsored medical plan; and
- is also eligible for post-retirement coverage under another employer's medical plan (provided that the employer is not a branch of the US Armed Forces); and
- the same person is covered as a dependent spouse under a Tricare (military) plan;

For the medical care of a retiree who meets the conditions above, the plan of benefits considered to be primary will be either the employer's sponsored medical plan, or the plan sponsored by the person's other former employer. The plan in which the person has been enrolled for a greater length of time will be considered the primary plan.

The Tricare plan will always be the last plan to pay benefits when other plans of benefits are involved.

(iv) Effect of Prior Coverage

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan. The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

(v) Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

    1) having refused it;
    2) having dropped it;
    3) having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by NetCare. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

(vi) Health Benefits Plan Primary to Medicare

Federal law requires that for certain covered individuals who elect the Plan as primary coverage, such plan benefits will be payable before any benefits available through Medicare. Medicare's benefits, if any, will be secondary to this Plan. ***Federal law applies to the following individuals:***

- an active employee regardless of age,

- a totally disabled employee if not terminated or retired,

- a dependent wife or husband, who is eligible for Medicare, of an active employee or a totally disabled employee if not terminated or retired, and

- any other covered individual for whom this Plan's benefits are payable because of compliance with such Federal law.

If this Plan is the primary coverage, NetCare will determine the benefits payable without considering the benefits for Medicare.

For any individual eligible for Medicare due to End Stage Renal Disease (ESRD), the Plan will be considered to be the primary plan of benefits for the first 30 months of a persons entitlement. Such plan benefits will be payable before any benefits available through Medicare. Medicare will become primary beginning with the 31st month of entitlement due to ESRD.

(vii) <u>Health Benefits Plan Secondary to Medicare</u>

A Medicare *(Government Exclusion)* approach is applicable to persons listed below who are eligible for Medicare:

- a retired employee,

- a totally disabled employee who is terminated or retired,

- a dependent, who is eligible for Medicare, of a retired employee or totally disabled employee who is terminated or retired, and

- any other covered dependent for whom this Plan's benefits are payable because of compliance with Federal law.

NOTE: When the Plan is secondary to Medicare, coverage will be provided under the provisions of the Traditional Choice Plan.

(viii) <u>Under this Government Exclusion approach, this is how your Comprehensive Medical Expense Coverage changes if you are eligible for Medicare:</u>

1. All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.

2. Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by NetCare. Two or more charges received at the same time will be applied starting with the largest first.

3. Medicare benefits will be taken into account for any person while he or she is eligible for Medicare.

This will be done whether or not he or she is entitled to Medicare benefits.

4. Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

5. A participant, otherwise eligible for Medicare, who is unable to receive the benefits of Medicare while residing outside the U.S., the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa, will be entitled to medical expense benefits without reduction for Medicare. This provision only applies to your medical treatment performed outside the U.S. If you reside outside the U.S. or a territory, you should participate in Part B of Medicare. If you receive medical treatment in the U.S. this plan's benefits will be reduced as if you were enrolled in Part B.

Article X GENERAL INFORMATION ABOUT YOUR COVERAGE

(i) Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- End of month in which employment ceases. Ceasing active work will be deemed to be cessation of employment.
- Date the employee dies.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.
- When the group falls below the minimum of two (2) employees.
- When the group fails to make timely premium payments.
- Date when NetCare determines that a member has intentionally misrepresented any enrollment information
- Date when you fail to submit any required documents or information after reasonable notice from NetCare to submit the request and required documents or information.

Your Employer will notify NetCare of the date your employment ceases for the purposes of termination of coverage under this Plan. The effective date of termination is always the last day of the month. Your Employer will use the same rule for all employees.

A Change of Status Form must be submitted to NetCare for the termination of coverage. The Change of Status Form may be submitted by the 30th of the month prior to the effective date of termination.

You must sign, date and return the completed Change of Status Form to your Human Resources Manager. Your Human Resource Manager or representative must also sign and date the form prior to submission to NetCare.

In the case of employment terminations, your Human Resource Manager or representative may sign on your behalf.

If you are not at work due to disease, injury, temporary lay-off or leave of absence, your employment may be continued until stopped by your Employer.

If the employee becomes totally disabled, the date following a period of 90 consecutive days during which the employee has not been in the Active Service of the employer.

(ii) Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.
- When you fail to make any required contribution for coverage.
- When the employee dies.
- When NetCare determines that a member has intentionally misrepresented any enrollment information.
- When the member fails to submit any required documents or information after reasonable notice from NetCare to submit the request and required documents or information.

A Change of Status Form must be submitted to NetCare for the termination of dependent coverage. The form must be submitted prior to the last day of the month to be effective the first day of the following month.

You must sign, date and return the completed Change of Status Form to your Human Resources Manager. Your Human Resource Manager or representative must also sign and date the form prior to submission to NetCare.

(iii) Continuation of Coverage For Surviving Dependents

If you die as an active employee covered under any part of this Plan, and if your dependents are enrolled as a dependent in the Plan on the day of your death, your covered dependents, including your spouse, will be eligible for up to 36 months of medical coverage through the Continuation Health Law Program described on Page 83 of this booklet. This coverage is available to your dependents at a cost of 102% of the total employer and employee premium.

Your covered dependents are required to make contributions toward the cost of their coverage equal to the contributions then being charged to active employees for like coverage.

Any dependents' coverage (other than coverage for your spouse) will cease when any one of the following happens:

- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for like coverage under this Plan.
- Termination of all dependents' coverage under the group contract.
- When your group coverage terminates.
- When you fail to make any required contribution for coverage.
- When the member dies.
- When NetCare determines that a member has intentionally misrepresented any enrollment information.

If Health Expense Coverage is being continued for your dependents, your child born after your death will also be covered. The completed enrollment form must be returned to your Human Resources Manager within 30 days of the date the child is born.

(iv) Overage Children

Enrollment of an unmarried dependent child under this agreement shall terminate upon the attainment of his or her 19th birthdate.

Coverage for an unmarried overage dependent may be continued until the attainment of age 25 years if the child is attending school full-time as defined by an accredited institution of secondary education, college, university, or other institution of higher learning learning, including trade schools.

In order to maintain coverage for your overage dependent, a certificate of full-time attendance must be submitted every spring and fall semesters to NetCare.

(v) Children With Disabilities

Health Expense Coverage for your fully handicapped child may be continued past the maximum age for a dependent child if the child has not been issued a personal medical conversion policy or enrolled as a policy holder..

Your child is fully disabled if:

- he or she is not able to earn his or her own living because of a mental or physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child has a disability must be submitted to NetCare no later than 30 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the disability;
- Failure to give proof that the disability continues;
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

NetCare will have the right to require proof at anytime of the continuation of the disability.

(vi) Type of Coverage

Coverage under this Plan is non-occupational. Only non-occupational accidental injuries and non-occupational diseases are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered. Conditions that are related to pregnancy may be covered under this Plan. The Policy Specification will say if they are.

(vii) Residency Requirements

Coverage under this Policy is applicable to only those person(s) who maintain their principal residence in Guam, the CNMI, or where this Policy or applicable certificate is delivered and such persons must be physically residing in said jurisdiction during at least nine (9) months of each Contract Year while this Policy remains in force.

For those person(s) not physically residing at least nine (9) months of each Contract Year in the jurisdiction

where this Policy or applicable certificate is delivered, the only liability of the company is a refund of all premiums paid for persons who do not qualify under this residency requirement, from this Policy's inception or its last renewal, whichever is most recent, less deduction of any amount already paid for claims incurred while the claimant did not qualify under the residency requirement.

Dependent children who reside outside the designated service area, the 90-day residency requirement shall not apply.

(vii) Physical Examinations

NetCare will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

(viii) Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims. NetCare will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

(ix) Assignments

Coverage may be assigned only with the written consent of NetCare.

(x) Recovery of Benefits Paid

As a condition to payment of benefits under this Plan for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plan shall, to the extent of benefits it has paid, be subrogated to (has the right to pursue) all rights of recovery of covered persons against:

  1) such third party; or
  2) a person's insurance carrier in the event of a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy.

- The Plan shall have the right to recover from the covered person amounts received by judgment, settlement, or otherwise from:

  1) such third party or his or her insurance carrier; or
  3) any other person or entity, which includes the auto insurance carrier which provides the covered person's uninsured or underinsured auto insurance coverage.

- The covered person (or person authorized by law to represent the covered person if he or she is not legally capable) shall:

  1) execute and deliver any documents that are required; and
  2) do whatever else is necessary to secure such rights.

(xi) Recovery of Overpayment

If a benefit payment is made by NetCare, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

(xii) Reporting of Claims

Proof of claim must be given to NetCare within ninety (90) days after the commencement of any claim covered by this Policy. On receipt of notice of the claim, NetCare will furnish members with forms for filing proof of claim, if applicable. If the forms are not furnished within fifteen (15) days after notice of claims is filed, you shall be deemed to have filed proof of claims by virtue of having filed notice of claim, and the following information:

1. How, when and where the loss occurred; and
2. The amount of the charges incurred. Written proof of claims for each Eligible Expense must be given to NetCare within 90 days following the date on which the expense was incurred, unless it is not reasonably possible to give proof of claim within ninety (90) days. However, when your coverage is terminated for any reason, written proof of claims must be given to NetCare within thirty (30) days of the termination of coverage, provided that this Policy remains in force. Claims will be paid within 45 working days upon receipt of satisfactory written proof.

The Plan will reimburse claims filed within forty five (45) days of receipt of all completed and required documents. Claims submitted after ninety (90) days will not be payable and will be the sole financial responsibility of the member (pursuant to Guam Public Law 25-189).

(xiii) Types of Claims

Urgent Care Claims – are a special kind of pre-service claim that requires a quicker decision because your health would be threatened.

Pre-service Claims – are requests for approval that NetCare requires you to obtain before you get medical care, such as preauthorization or a decision on whether a treatment or procedure is medically necessary.

Post-service Claims – are all other claims for benefits under NetCare, including claims after medical services have been provided, such as requests for reimbursement or payment of the costs of the services provided.

(xiv) Benefit Determination

Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you, the policy holder. However, this Plan has the right to pay any health benefits to the service provider. This will be done unless you have told NetCare otherwise by the time you file the claim.

Urgent Care Claims – benefits will be determined no later than 72 hours after the plan receives the claim. If pertinent information is missing to process the claim, you will be notified within 24 hours if more time is needed to process the claim. You then have 48 hours to provide the missing information. Upon receipt of the missing information, NetCare has 48 hours to process and notify you (orally) of the status of the claim. Written notification of the claim status will be furnished to you no later than three (3) days thereafter.

Pre-service Claims – benefits will be determined no later than 15 days after the plan has received the claim. If pertinent information is missing or additional time in needed for reason's beyond NetCare's control to review your claim, NetCare will provide notice to you prior to the 15th day period if an extended time period is needed, no more than an additional 15 days. If information is needed, you then have 45 days to supply NetCare the information. Upon NetCare's receipt of the requested information, the plan has 15 days to determine and inform you of the status of your claim.

Post-service Claims – benefits will be determined no later than 30 days after the plan received the claim. If pertinent information is missing or additional time in needed for reason's beyond NetCare's control to review your claim, NetCare will provide notice to you prior to the 30th day period if an extended time period is needed, no more than an additional 15 days. If information is needed, you then have 45 days to supply NetCare the information. Upon NetCare's receipt of the requested information, the plan has 15 days to determine and inform you of the status of your claim.

If your claim is denied, NetCare will send you a notice, either in writing or electronically, with a detailed explanantion of why your claim was denied and a description of our appeal process.

(xv) Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

Names of physicians, dentists and others who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

(xvi) Selection of Primary Care Provider

Each Covered Person enrolled under the Continental HMO Plan will be required to select a Primary Care Provider at the time of enrollment listed in the Plan's Participating Provider Directory. Primary Care Providers will be limited to Family Practice, General Practice, Internal Medicine, Gynecological, Obstetrics and Pediatrics. A Covered Person may change their Primary Care Provider once each month by the thirtieth (30th) day of the month. The PCP change will be effective the first day of the following month. Medical expenses incurred for services and treatment by a Primary Care Provider will be payable in accordance with the benefit schedule as indicated in the Policy Specification. Services and treatment incurred by a non-participating primary care provider will not be covered as indicated in the Policy Specification. This provision is not applicable to Covered Persons enrolled under the Continental PPO Plans.

(xvii) Participating Specialist Provider

Covered Persons enrolled under the Continental HMO Plan must get a referral from their Primary Care Provider for all Specialist services. A referral by a primary care provider to a participating specialist provider is required under this Policy. Referrals approved by NetCare are also required for specialist providers outside of Guam. Member co-payments for services incurred by a participating specialist are listed in the benefit schedule of the Policy Specification.

(xviii) Identification Card

A member identification card will be issued to members enrolled in the Plan. The card will be issued five (5) days upon receipt of a complete enrollment form. Your card will show your name, ID number and Plan benefit type. The back of your ID card contains a magnetic strip that enables medical providers on Guam to swipe the card to obtain eligibility and benenfit coverage co-payments.

Your ID card must be presented to the provider at the time of service. To request for a replacement card, you may contact our customer service department or log into our website at **www.netcarelifeandhealth.com** A replacement fee witll be charged for all replacement cards.

(xix) Explanation of Benefits

An Explanation of Benefits (EOB) is information of how we processed your claim. The EOB will tell you what, where, and when a service was done. It will show you the amount charged and the amount paid or denied by NetCare. This document will be mailed to you each time a claim has been processed or you may obtain an electronic copy through our website at **www.netcarelifeandhealth.com**

If you have concern that an error was made in determining your benefits or paying your claim, you may request in writing for a review within 180 days of the date the claim was paid. Your request must be submitted to our NetCare office.

(xx) Third Party Liability

If you incur an injury or illness that may have been caused by a third party and you may have a right to recover damages against the third party, NetCare shall not be liable to pay any benefits provided under this Plan. However, upon the execution and delivery to NetCare of all papers required by it to secure its rights of reimbursement, NetCare will pay benefits in connection with such injury or illness, but such payment shall be considered only in the nature of an advance or a loan to you which shall be repaid from the recovery, if any, from or on behalf of such third party.

If NetCare pays any benefits because of such injury or illness, NetCare shall have a lien against any recovery to the extent of such payments, which lien may be filed with such third party, the third party's agent, insurance company or the court and which lien shall be satisfied from any such recovery.

In order for NetCare to pay benefits, you will need to obtain, complete and submit the following forms to our NetCare office.

1. Subrigation & Recovery Application Form;
2. Subrogation Assignment Agreement

It is not the intent of this Policy that you should be reimbursed for more than 100% of your Allowable Expenses (as defined in the Coordination of Benefits provision). Therefore, NetCare reserves the right to recover any overpayment it makes on behalf you that results from the payment by a third party, another person, insurance company or from a judgment or settlement. You are required to reimburse NetCare on your behalf or your Dependent's behalf for any benefits so paid, out of the funds you might recover, to the extent of such payment by this Policy. Further, you must provide NetCare with all required information and assistance in the recover of such payment or overpayment. The term "information" includes any instruments and documents as NetCare may reasonably require enforcing its rights.

(xxi) Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a mis-statement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Article XI ADDITIONAL INFORMATION HEALTH BENEFITS PROGRAM

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:
(1) reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact our Customer Service Representative.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protect the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service.

Health Insurance Protection:

If an employee leaves his or her job to perform military service, the member have the right to elect to continue their existing employer-base health plan coverage for himself/herself and their dependents for up to 24 months while in the military.

Even if the employee does not elect to continue coverage during military service, the member has the right to be reinstated in the employer’s health plan when they are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

Additional information may be obtained at www.dol.gov/vets/programs/userra

Family Medical Leave Act (FMLA)

The Family Medical Leave Act was introduced for the purpose to balance to balance the demands of the workplace with the needs of families, to promote the stability and economic security of families, and to promote national interests in preserving family integrity and to entitle employees to take reasonable leave for medical reasons, for the birth or adoption of a child, and for the care of a child, spouse, or parent who has a serious health condition

Except for failure an employee to return from leave, during any period that an eligible employee takes eligible leave as required, the employer shall maintain coverage under any "group health plan" for the duration of such leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave.

Entitlement:

An eligible employee shall be entitled to a total of 12 workweeks of leave during any 12-month period for one or more of the following:

a. Because of the birth of a son or daughter of the employee and in order to care for such son or daughter.

b. Because of the placement of a son or daughter with the employee for adoption or foster care.

c. In order to care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition.

d. Because of a serious health condition that makes the employee unable to perform the functions of the position of such employee.

The entitlement to leave under subparagraphs for a birth or placement of a son or daughter shall expire at the end of the 12-month period beginning on the date of such birth or placement.

Group Health Plan Benefits:

During any FMLA leave, an employer must maintain the employee's coverage and benefit plan under any group health plan on the same conditions as coverage would have been provided if the employee had been continuously employed during the entire leave period.

If the group provides a new health plan or benefits or changes health benefits or plans while an employee is on FMLA leave, the employee is entitled to the new or changed plan/benefits to the same extent as if the employee were not on leave.

An employee may choose not to retain group health plan coverage during FMLA leave. However, when an employee returns from leave, the employee is entitled to be reinstated on the same terms as prior to taking leave, including family or dependent coverage, without any qualifying period, physical examination, exclusion of pre-existing conditions.

Benefits must be maintained on the same basis, as coverage would have been provided if the employee had been continuously employed during the FMLA leave period. Therefore, any share of group health plan premiums that had been paid by the employee prior to FMLA leave must continue to be paid by the employee

during the FMLA period. If premiums are raised or lowered, the employee would be required to pay the new premium.

The employers obligations to maintain health coverage cease under FMLA if an employee's premium payment is more than thirty (30) days late.

If coverage lapses because an employee has not made the required premium payments, upon the employee's return from FMLA leave the employer must still restore the employee to coverage/benefits equivalent to those the employee would have had if leave had not been taken and the premium payment had not been missed, including family or dependent coverage. In such case, an employee may not be required to meet any qualification requirements imposed by the plan, including any new pre-existing condition waiting period, to wait for an open season, or to pass a medical examination to obtain reinstatement of coverage.

Mental Health Parity Act (MHPA)

The Mental Health Parity Act (MHPA) requires the annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan.

MHPA applies to group health plans for plan years beginning on or after January 1, 1998.

The law:

a. Generally requires parity of mental health benefits with medical/surgical benefits with respect to the application of aggregate lifetime and annual dollar limits under a group health plan.

b. Provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families.

The law does not apply to benefits for substance abuse or chemical dependency.

The law also contains the following two exemptions:

a. Small employer exemption. MHPA does not apply to any group health plan or coverage of any employer who employed an average of between 2 and 50 employees on business days during the preceding calendar year, and who employs at least 2 employees on the first day of the plan year.

b. Increase cost exemption. MHPA does not apply to a group health plan or group health insurance coverage if the application of the parity provisions results in an increase in the cost under the plan or coverage of at least one percent.

Article XII GLOSSARY

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

(i) Board and Room Charges

Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

(ii) Companion

This is a person whose presence as a Companion or caregiver:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

(iii) Co-payment

This is a fee, charged to a person, which represents a portion of the applicable expense.

As to a prescription drug dispensed by a participating pharmacy, this is the fee charged to a person at the time the prescription drug is dispensed payable directly to the pharmacy for each

prescription or refill at the time the prescription or refill is dispensed. For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the prescription, kit, or refill.

It is specified in the Policy Specifications.

(iv) Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

(v) Dentist

This means a legally qualified dentist. Also, a physician who is licensed to do the dental work he or she performs.

(vi) Provider Directory

This is a listing of all Participating Providers for the class of employees of which you are a member. Copies of this Directory are given to your Employer to give to you.

(vii) Durable Medical and Surgical Equipment

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

(viii) Effective Treatment of Alcoholism Or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician and either:

- has a follow-up therapy program directed by a physician on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

(ix) Emergency Admission

One where the physician admits the person to the hospital right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by NetCare, reasonably be expected to result in:

    1) placing the person's health in serious jeopardy; or
    2) serious impairment to bodily function; or
    3) serious dysfunction of a body part or organ; or
    4) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(x) Emergency Care

This means the treatment given in a hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(xi) Emergency Condition

This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to

believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(xii) Home Health Care Agency

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one physician and one R.N.; and
- has full-time supervision by a physician or a R.N.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

(xiii) Home Health Care Plan

This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- prescribed in writing by the attending physician; and
- an alternative to confinement in a hospital or convalescent facility.

(xiv) Hospice Care

This is care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

(xv) Hospice Care Agency

This is an agency or organization which:

- Has Hospice Care available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:

  1) skilled nursing services; and

  3) medical social services; and

  4) psychological and dietary counseling.

- Provides or arranges for other services which will include:

  1) services of a physician; and

  2) physical and occupational therapy; and

  3) part-time home health aide services which mainly consist of caring for terminally ill persons; and

  4) inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:

  1) one physician; and

  2) one R.N.; and

  3) one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of Hospice Care.
- Assesses the patient's medical and social needs.
- Develops a Hospice Care Program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

(xvii) Hospice Care Program

This is a written plan of Hospice Care, which:

- Is established by and reviewed from time to time by:

  1) a physician attending the person; and

  2) appropriate personnel of a Hospice Care Agency.

- Is designed to provide:

  palliative and supportive care to terminally ill persons; and

  supportive care to their families.

- Includes:

  1) an assessment of the person's medical and social needs; and

  2) a description of the care to be given to meet those needs.

(xviii) Hospice Facility

This is a facility, or distinct part of one, which:

- Mainly provides inpatient Hospice Care to terminally ill persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians; at least one such physician must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a R.N.
- Has a full-time administrator.

(xix) Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of physicians.
- Provides 24 hour a day R.N. service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

(xx) L.P.N.

This means a licensed practical nurse.

(xxi) Mental Disorder

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.

- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

(xxii) Necessary

A service or supply furnished by a particular provider is necessary if NetCare determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;

- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, NetCare will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to NetCare's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or

- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

(xxiii) Negotiated Charge

This is the maximum charge a Participating Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

(xxiv) Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

(xxv) Non-Occupational Injury

A non-occupational injury is an accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

(xxvi) Non-Participating Care

This is a health care service or supply furnished by a health care provider that is not a Participating Provider; if, as determined by NetCare:

- the service or supply could have been provided by a Participating Provider; and
- the provider is of a type that falls into one or more of the categories of providers listed in the Directory.

(xxvii) Non-Participating Provider

This is:

- a health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

(xxviii) Non-urgent Admission

One which is not an emergency admission or an urgent admission.

(xxix) Orthodontic Treatment

This is any:

- medical service or supply; or

- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

(xxx) Parent-Child Relationship

A parent-child relationship exists between you and a child when the child is primarily dependent on you for support and the child is:

- unmarried;
- resides in the same household as you;
- has not reached the limiting age of the plan; and
- if school age and regularly attending school, resides primarily in your home.

When a natural parent lives in the same household, a parent-child relationship exists between you and a child only when both the natural parent and the child are primarily dependent upon you for support and the natural parent.

(xxxi) Physician

This means a legally qualified physician.

(xxxii) Participating Care Provider

Medical Expenses incurred for services and treatment by a participating provider for Covered Persons will be payable in accordance with the participating provider benefit schedule as indicated in the Policy Specification.

(xxxiii) Policy Specifications

The Health Plan's benefits and terms of Covered and Non-covered benefits with applicable co-payments and percentage.

(xxxiv) R.N.

This means a registered nurse.

(xxxv) Semiprivate Rate

This is the charge for board and room which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, NetCare will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

(xxxvi) Student

A student is one who;

- is enrolled on a full-time basis as defined by the school;
- is not employed full-time (working 7-8 hours a day, 5 days a week); and
- attends a school which is defined by an accredited institution of secondary education, college, university, or other institution of higher learning, including trade schools.

(xxxvii) Surgery Center

This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:

  1) physicians who practice surgery in an area hospital; and

  2) dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:

  1) a physician trained in cardiopulmonary resuscitation; and

  2) a defibrillator; and

  3) a tracheotomy set; and

  4) a blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.

- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

(xxxviii)Terminally Ill

This is a medical prognosis of 6 months or less to live.

(xxxix)Treatment Facility (Alcoholism Or Drug Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a physician.
- Provides, on the premises, 24 hours a day:

  1) Detoxification services needed with its effective treatment program.

  2) Infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical services that may be required.

  3) Supervision by a staff of physicians.

  Skilled nursing care by licensed nurses who are directed by a full-time R.N.

(xl) Urgent Admission

One where the physician admits the person to the hospital due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

(xli) Usual, Customary and Reasonable (UCR)

A. Usual - Fee consistently charged by a Physician or provider to a patient for a specific service or supply.

B. Customary - Fee that is within a given percentile of the range of usual charges for a given service or supply billed by most Physicians (or Providers) with like training and experience within a geographical area.

C. Reasonable:

1. A fee that is Usual and Customary; or

2. A fee that a local medical organization review committee or Physician's Review Organization (PRO) deems just, duty to specific conditions in a specific case.

D. NetCare's reimbursement fees are paid subject to UCR. NetCare utilizes the current Medicare Diagnosis Related Group (DRG) for the geographic region where the service was rendered, to determine the UCR Eligible Expense. The DRG fees are global which includes professional fees. For regions or states with no Medicare fees, the Medicare Region 99 will be used.

Article XIII CONTINUATION HEALTH LAW

The Continuation Health Law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986 contains provisions giving certain former employees, retirees, spouses' former spouses, and dependent children the right to temporary continuation of health coverage at group rates.

(i) Eligible Employees

Active/Retired employees and their dependents are eligible for Continuation of Coverage provided:

- The active/retired employee or his/her dependent is not eligible for Medicare;
- The individual was enrolled in the plan on the day preceding the "qualifying event."

(ii) Qualifying Event

"Qualifying Event" for the purposes of this continuation provision is defined as follows:

Employee (18 months continuation coverage)

1. Voluntary or involuntary termination of employment of reasons other than "gross misconduct";
2. Reduction in the number of hours of employment.

Spouse (36 months continuation coverage)

1. Voluntary or involuntary termination of the covered employees employment for any reason other thatn gross misconduct;
2. Reduction in the hours worked by the covered employee;
3. Covered employee's becoming entitled to Medicare;
4. Divorce or legal separation of the covered employee;
5. Death of the covered employee.

Dependent Children (36 months continuation coverage)

1. Loss of dependent child status under the plan rules.

(iii) General Rules

The single rate will be charged to anyone who wants coverage only for himself/herself and is eligible for that coverage because of their individual status. Otherwise, the family rate will be charged.

Monthly continuation rates for individuals who want to continue their participation in the group medical program are established as follows:

Single Rate
Monthly continuation rates for individuals who want to continue their participation in the group medical program are established to:

1. an employee who previously had single coverage;

2. an employee who previously had family coverage but only wants to cover himself/herself;

3. a spouse OR dependent who was previously covered under the employee's plan but only wants to cover himself/herself when the employee does not want continued coverage;

4. a divorced spouse (only) of an employee who is still covered under the plan;

5. the underage child of a deceased employee. The surviving spouse and any other underage dependent children are not covered;

6. the spouse of a deceased employee, underage children eligible but not covered;

7. a child who reaches the limiting age (19 or up to 23 if he/she is a full-time student) may be covered under a single rate even though a former spouse or surviving spouse is covered under a single rate;

8. a spouse covered under the single rate must change to the family rate in order to cover a newborn child; cannot cover a new dependent other than through birth or adoption.

Two-Party Rate
Employees who want to cover themselves and:

1. a spouse alone; or

2. a child alone

A spouse who want to cover themselves and a child alone.

Family Rate
Employees who want to cover themselves and:

1. a spouse and any number of children; or

2. any number of children

A spouse who want to cover themselves and any number of children.

(iv) Enrollment

An employee has 60 days after the regular plan of medical coverage terminates to enroll in the Program. You must enroll in the plan that is determined by your place of residence.

(v) Adjustments

Contribution rates will be adjusted at the same time that active employee contribution rates are adjusted.

(vi) Termination Provisions

The Program will discontinue as to a participant at the earliest to occur of the following:

- When the participant fails to make required contributions by the due date;
- When the participant becomes eligible for Medicare benefits;
- When the participant becomes eligible under another group coverage medical plan. An exception is made if the new plan contains pre-existing conditions which limit coverage.
- When the participant again becomes eligible for the regular plan of Medical Expense Coverage.
- When the 18 months has elapsed since the participant's regular coverage terminated (36 months for surviving dependents or disabled employees).
- When the plan terminates.

(vii) Additional Information

The Continuation Health Law applies to eligible participants who are allowed to "continue" in the GROUP Medical Plan but who pay 102% of the combined Employer/participant contribution rate for whichever continuation plan is selected.

Dental Expense Coverage and Vision Care Coverage is included. Single and Family rates are available based on the criteria established in this section.

The 18-month continuation period does not apply to persons who are eligible for Medicare.

(viii) Health Law Coverage for Employees who are Totally Disabled

Employees who are totally disabled when their medical coverage ends will be eligible for continuation of medical coverage for up to 36 months from the date medical coverage ends. The cost of this medical coverage depends on the length of time covered under the Plan. Employees in the Plan for less than 5 years pay 102% for 36 months of coverage, including dependents. Employees in the Plan for 5 or more years will be covered for 12 months with no payment of premiums, then will pay 102% for the next 24 months, including dependents.

The words "totally disabled" mean that due to injury or disease, you are not able to engage in your customary occupation and are not working for pay or profit.

To be eligible for temporary continuation of coverage under the disability provisions, the employee's attending physician must provide evidence of the disability to NetCare. You must submit proof of total disability within 60 days of the date coverage terminated.

The temporary disability coverage for the employee and dependents will cease to apply when the first of the following occurs:

- The employee ceases to be totally disabled.
- The employee becomes eligible for Medicare.
- The employee becomes eligible under another group coverage medical plan. An exception is made if the new plan contains pre-existing conditions which limit coverage.
- The employee fails to make required contributions by the due date.
- The plan terminates.

Article XIV HIPAA COMPLIANCE

(i) Privacy Practices

The protection of our members' health information is important to us at NetCare.

NetCare has provided a copy of it's Privacy Practices to all enrolled subscribers in order for them to become familiar with how personal health information will be used and safeguarded, as well as rights regarding the protection of a member's personal data.

The HIPAA Privacy Practices is effective April 14, 2003.

(ii) Pre-Existing Conditions

HIPAA defines "pre-existing conditions" as a condition, whether physical or mental, for which medical advise, diagnosis, care or treatment was recommended or received within the six month period ending prior to the enrollment date, regardless of the cause of the condition.

(iii) Restriction Based on Pre-Existing Conditions

HIPAA provides that a plan may restrict the payment of benefits for a period not to exceed 12 months for a pre-existing condition. In the case of a "late enrollee" (i.e., an individual who enrolls later than he or she was first eligible to enroll, other than during a special enrollment period), the plan may limit benefits for a period of up to 18 months for a pre-existing condition. The period of a plan's pre-existing condition exclusion must be reduced by periods of "creditable coverage." Creditable coverage is coverage under a previous group health plan.

(iv) Portability

Portability allows the time served under a previous health plan coverage to be credited toward a pre-existing condition exclusion of a new employer's group health plan. This time is called "creditable coverage." Credit is given for previous coverage that occurred without a break in coverage of 63 days or more. The law also guarantees that an employer's health plan must accept a new employee, regardless of health status – *a policy that has been the cornerstone of NetCare Life & Health Insurance Company*.

(v) Certificate of Coverage

In order to provide a new employer with proof of coverage, the law requires that a Certificate of Coverage be issued by NetCare when an individual leaves a group health plan. To receive credit from a previous carrier, the certificate of coverage should be sent to NetCare Life & Health Insurance Company with the employee's enrollment application.

NetCare will automatically issue a Certificate of Coverage to participants who terminate their coverage. Any certificate that we issue will reflect only coverage with NetCare.

Article XV NETCARE'S PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Venida Farnum, HIPAA Privacy Officer for NetCare Life & Health Insurance Company at (671) 472-3610 or at vfarnum@netcarelifeandhealth.com

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

(i) Acknowledgment Of Receipt Of Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your coverage, and will use and disclose your protected health information for treatment, claims payment and health care operations when necessary.

(ii) Duties To You Regarding Protected Health Information

"Protected health information" is individually identifiable health information. This information includes demographics, for example, age, address, e-mail address and relates to your past, present or future physical or mental health or condition and related health care services. NetCare is required by law to do the following:

- Make sure that your protected health information is kept private
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in the notice to you.

We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. You may obtain a Notice of Privacy Practices by calling NetCare's HIPAA Privacy Officer and requesting a copy be mailed to you.

(iii) How We May Use or Disclose Your Protected Health Information

Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

Required Uses and Dsclosures

By law, we must disclose your health information to you unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose health information to the Secretary of the Department of Health and Human Services (DHHS) for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a NetCare contractor who provides care to you. We may disclose your protected health information from time-to-time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment. This includes pharmacists who may be provided information on other drugs you have been prescribed to identify potential interactions.

In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that NetCare might undertake before it approves or pays for the health care services recommended for you such as determining eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay might require that your relevant protected health information be disclosed to obtain approval for the hospital admission.

Health Care Operation

We may use or disclose, as needed, your protected health information to support the daily activities related to health care. These activities include, but are not limited to, quality assessment activities, investigations, oversight or staff performance reviews, training of medical students, licensing, communications about a product or service, and conducting or arranging for other health care related activities.

For example, we may disclose your protected health information to medical schools students seeing patients at a contracted medical facility. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third-party "business associates" who perform various activities (for example, billing, transcription services) for NetCare. The business associates will also be required to protect your health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about NetCare and the services we offer. We may also send you information about products or services that we believe might benefit you such as NetCare's wellness or disease management programs.

Required By Law

We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health

We may disclose your protected health information to a public health authority that is permitted by law to collect or receive the information. The disclosure may be necessary to do the following:

- Prevent or control disease, injury or disability
- Report births or deaths
- Report child abuse or neglect
- Report reactions to medications or problems with products
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Communicable Diseases

We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefits programs, other government regulatory (federal or local) programs and civil rights laws.

Food and Drug Administration

We may disclose your protected health information to a person or company required by the Food and Drug Administration to do the following:

- Report adverse events, product defects, or problems and biologic product deviations.
- Track products.
- Enable product recalls
- Make repairs or replacements
- Conduct post-marketing surveillance as required.

Legal Proceedings

We may disclose protected health information during any judicial or administrative proceeding, in response to a court or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement

We may disclose protected health information for law enforcement purposes, including the following:

- Responses to legal proceedings
- Information requests for identification and location
- Circumstances pertaining to victims of a crime
- Deaths suspected from criminal conduct
- Crimes occurring at a NetCare office site

- Medical emergencies believed to result from criminal conduct

Coroners, Funeral Directors, and Organ Donations
We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donations.

Research
We may disclose your protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity
Under applicable Federal and local laws, we may disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission including determination of fitness for duty; (2) for determination by the Department of Veterans Affairs (VA) of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Worker's Compensation
We may disclose your protected health information to comply with worker's compensation laws and others similar legally established programs.

Disclosures by the Health Plan
NetCare Life & Health Insurance Company may also disclose your protected health information. Examples of these disclosures include verifying your eligibility for health care and for enrollment in various health benefits and coordinating benefits for those who have other health insurance or eligible for other benefit programs.

Parental Access
Local law concerning minors permit or require disclosure of protected health information to parents, guardians and persons acting in a similar legal status. We will act consistently with local law where the treatment is provided and will make disclosures accordingly.

(iv) Uses and Disclosures of Protected Health Information Requiring Your Permission

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following is an example in which your agreement or objection is required.

Individuals Involved in your Health Care

Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

(viii) Rights Regarding Your Health Information

You may exercise the following rights by submitting a written request to electronic message to NetCare's HIPAA Privacy Officer. Depending on your request, you may also have rights under the Privacy Act of 1974. NetCare's HIPAA Privacy Officer can guide you in pursuing these options. Please be aware that NetCare may deny your request; however, you may seek a review of the denial.

Right to Inspect and Copy
You may inspect and obtain a copy of your protected health information that is contained in a 'designated record set' for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that NetCare uses for making decisions about you.

This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

Right to Request Restrictions
You may ask us not to use or disclose any part of your protected health information for treatment, payment, or health care operations. Your request must be made in writing to NetCare's HIPAA Privacy Officer where you wish the restriction instituted. In your request, your must tell us (1) what information you want restricted; (2) whether you want to restrict our use, disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date.

Right to Request Confidential Communications
You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment
If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information.

While we will accept requests for amendments, we are not required to agree to the amendment however.

Right to an Accounting of Disclosures
You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. The disclosure must have been made after April 14, 2003, and no more than 6 years from the date of request. This right excludes disclosures made to you, to a family member or friends involved in your care, or for notification. The right to receive this information is subject to additional exceptions, restrictions, and limitations as

described earlier in this notice.

(ix) Federal Privacy Laws

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act, the Privacy Act and the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act. These laws have not been superseded and have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

(x) Complaints

If you believe these privacy rights have been violated, you may file a written complaint with NetCare's HIPAA Privacy Officer or the Department of Health and Human Services or the U.S. Office of Civil Rights. No retaliation will occur against you for filing a complaint.

(xi) Contact Information

You may contact NetCare's HIPAA Privacy Officer for further information about the complaint process, or for further explanation of this document. NetCare's HIPAA Privacy Officer may be contacted at the following:

Venida Farnum
HIPAA Privacy Officer
NetCare Life & Health Insurance Company
Julale Center
Hagatna, Guam 96910

Phone: (671) 472-3610
Facsimile: (671) 472-3615
E-Mail: vfarnum@netcarelifeandhealth.com

Article XVI APPEAL AND GRIEVANCE PROCEDURES

(i) Policy

NetCare is required by Guam law to offer certain appeal and grievance procedures. These procedures are listed below. NetCare does have the option to impose time limitations on filing the appeals or grievances. These specific plan limitations, as well as any other plan specific information, are listed below.

(ii) Process

You have two separate appeal routes. One takes place when you contests a decision to deny or limit health care services "non-certification decision". This is called an appeal. The other appeal route occurs when you are unhappy with other aspects of the plan's operations. A complaint about other operations of the plan is called a grievance.

You have the right to two (2) levels of review, for both appeals and grievances. The first level of review has a different name and a slightly different process depending on whether it is a first-level appeal or first-level grievance review. However, the second-level review is the same regardless of whether the dispute is a denial of services or another problem with the plan's operation. This is referred to as a second-level grievance hearing.

You who contest non-certification decisions (denials of services or procedures) have a right to ask for expedited review if the normal time limits could hurt the person's health. Otherwise, the normal time limits apply. There is not an expedited process for first-level grievance decisions, because first-level grievance hearings do not deal with non-certification decisions (these are handled at the first level appeals).

Level One

Informal Reconsideration. NetCare has an informal process where it can resolve disputes quickly. The informal process is voluntary.

First Level Appeals: You can file an appeal on your own behalf or a physician or other person acting on your behalf can file an appeal. NetCare offers at least two levels of appeals. A physician who was not involved in the original decision must hear the first appeal. Normally the physician has 30 days to decide the first level appeal. If the appeal is for a denied claim, the physician has between 15 and 30 days, depending on the type of claim, to decide the first level appeal. All appeal request must be made in writing and submitted to our NetCare office.

NetCare will provide a written decision to you and your provider (if appropriate) within the decision timeline given to the physician. The decision will contain the qualifications of the person reviewing the appeal, the reviewer's decision including the medical rationale and evidence used as the basis for the decision, and instructions on how to file a second-level grievance hearing.

First Level Expedited Appeals: You can request an expedited appeal if your health would be harmed by the 30-day delay. In an expedited appeal, the physician and the Plan has up to 36 hours to make a decision and inform you of the first level appeal. However, you can request the decision be made immediately if there is a more immediate health care need. You will have your health services covered until you are notified of the expedited review decision, if the appeal involves concurrent review such as continued stay in a hospital. You are not entitled to expedited review if the health care services have already been provided and the issue is whether the care was appropriate.

First Level Grievance Hearings: You can file an appeal on your own behalf or a physician or other person acting on your behalf can file a first-level grievance. NetCare will provide you with information on how to submit written materials, within seven (7) business days after receiving notice of the grievance. The person reviewing the grievance cannot be the same person who initially handled the grievance. If the issue is a clinical one, at least one of the reviewers must be a medical physician with appropriate expertise. NetCare will make a grievance decision 30-days after receiving the complaint. The notice of the decision must include the same

information as provided in first-level appeal decisions.

Seceond Level

Second Level Grievance Hearings: NetCare also has second-level grievance reviews for members who are dissatisfied with the decision of the non-certification appeal or first level grievance review. NetCare will notify the member of the name and telephone number of the grievance coordinator, as well as information about the second-level grievance process within seven (7) business days of receiving a request for a second-level grievance. You have more extensive due-process rights at the second-level grievance review. Specifically, you can attend the second-level grievance-hearing, request and receive all information relevant to the case in order to prepare for the hearing. You may present your case to the review panel, submit supporting materials before and at the review meeting, ask questions of any member of the review panel and bring another person to help in the review hearing that could include a family member, employer representative or attorney. If you choose to bring an attorney, then an attorney may also represent NetCare. NetCare will convene a hearing panel to hear second-level grievances. The panel will usually be comprised of people who are not employees of NetCare or utilization review organization, who were not previously involved in the decision, and who do not have a financial interest in the outcome of the review. All of the people reviewing a second-level grievance involving a non-certification or clinical decision should be providers who have appropriate expertise in the health issue in dispute.

The review panel has up to 45 days to hold the hearing, and up to 15 days thereafter to make a decision. If the second level grievance is due to the denial of a claim, the review panel has between 15 and 30 days depending on the type of claim to hold the hearing and make a decision. This decision is a recommended decision to NetCare.

NetCare will provide a written decision to you and your physician (if appropriate) within the decision timeline given to the review panel. The decision will contain the qualifications of the people reviewing the grievance, the reviewer's decision, including the medical rationale for the decision and the evidence used as the basis for the decision. The account states that the decision is the insurer's final determination in the matter.

Second Level Expedited Appeals: You can request an expedited second-level review if your health could be harmed because of any time delays. You may request an expedited second-level review even if the first-level appeal or grievance review was not expedited. In an expedited appeal, the physician and the Plan has up to 36 hours to make a decision and inform you of the second level appeal. If necessary, NetCare may conduct the hearing over the phone or through submission of written information.

(iii) Types of Claims

The types of claims referenced in the appeal process may be found in General Information About Your Coverage, Article X Section xiii. Specific review periods for claims may be found in Claim Appeals For Health Expense Benefits, Article VIII.

Article XVII CONTACT INFORMATION

You may contact our office with any questions or concerns that you may have regarding your eligibility status, benefits, medical referrals, participating providers, reimbursements, premium billing or claims status.

Office Address:

424 W. O'Brien Drive
Julale Center, Suite 200
Hagatna, Gu 96910

Hours of Operation:

8:00 am to 5:00 pm, Monday through Friday

Contact:

Customer Service:
Telephone: (671) 472-3610
Facsimile: (671) 472-5672 or (671) 472-3615
Email: tquichocho@netcarelifeandhealth.com

Website Information:

You may also log onto our website to check your enrollment information, request for an identification cards, check your claims status, review benefits and provider listings, and view newsletters and updates at www.netcarelifeandhealth.com