



ADVANTAGE PLAN POS

**MEDICAL** BENEFITS & TERMS

The medical services listed on this page are your benefits for the Advantage Plan, For a detailed description of your benefits, co-payments and procedures, please refer to your Group Service Agreement or Member Handbook. For a listing of Primary Care Providers within the Advantage Plan network, please refer to the Advantage Plan Participating Provider Directory.

Covered Services	Limits/Maximums/Requirements	Member Co-Payment
<b>Professional Services</b> <ul style="list-style-type: none"> <li>Primary Care</li> <li>Specialty Care and care at non-PCP</li> <li>Home Health Care</li> </ul>	Each Member must select a Primary Care Physician (PCP) from the Advantage Plan Provider Directory	\$10.00 co-pay \$25.00 co-pay \$25.00 co-pay
<b>Routine Annual Exams</b> 1. Annual Physical Exams and Annual Gynecological Exams 2. Annual Mammograms (over the age of 40 years) 3. Annual Eye Exam (maximum of \$50 per contract period)		\$10.00 co-pay \$10.00 co-pay \$10.00 co-pay
<b>Outpatient Radiology &amp; Diagnostic</b> <ul style="list-style-type: none"> <li>X-Ray Services</li> <li>Laboratory Services</li> <li>Outpatient Diagnostic Testing</li> </ul> MRI, CT Scan, Ultrasound, Cardiac Stress Test, Cardiac Catheterization, Coronary Angiography Bone Scan, Biopsy and any other diagnostic procedures. One per contract period per anatomical region.	100% Coverage after Co-Payment  Pre-Certification Required	\$10.00 co-pay \$10.00 co-pay \$100.00 co-pay per procedure
<b>Hospital Services</b> <ul style="list-style-type: none"> <li>Inpatient Admission</li> <li>Outpatient/Ambulatory Surgery</li> <li>Pre-Admission Testing</li> </ul>	100% Coverage after Co-Payment (co-payment maximum \$500 per admission) Pre-Certification Required Pre-Certification Required	\$100.00 co-pay per day for the first 5 days \$100.00 co-pay \$25.00 co-pay
<b>Emergency Services</b> <ul style="list-style-type: none"> <li>Urgent Care at Physician's Office</li> <li>Hospital Emergency Room</li> <li>Ambulance Service</li> </ul>	100% Coverage after Co-Payment  (in or outside of service area) (limited to ground transportation only)	\$25.00 co-pay \$100.00 co-pay \$100.00 co-pay
<b>Non-Emergency Care</b> <b>Prescription Drugs</b> <ul style="list-style-type: none"> <li>Generic</li> <li>Brand drugs</li> <li>Non-Formulary Brand</li> <li>Injectable drugs</li> </ul>	80% Coverage after Co-Payment  <b>Retail/Pharmacy</b> \$5.00 per unit \$10.00 per unit \$25.00 per unit 10% per unit <b>Mail Order</b> \$10.00 (90 days) \$20.00 (90 days) \$50.00 (90 days) 10% + shipping	\$100.00 co-pay  <b>Out of Network</b> 70% of AWP 70% of AWP 70% of AWP 70% of AWP
<b>Maternity Care</b> <ul style="list-style-type: none"> <li>Pre-Natal, Post Natal &amp; Well Baby Care</li> <li>Delivery</li> <li>Circumcision</li> </ul>	100% Coverage after Co-Payment  Hospital Facility Birthing Center (on Guam only) (covered within 30 days of date of birth)	\$10.00 co-pay per visit \$100.00 co-pay per day, for the first 5 days \$100.00 co-pay \$50.00 co-pay
<b>Immunizations &amp; Injections</b>	100% Coverage after Co-Payment	\$10.00 co-pay
<b>Cardiac Care</b> <ul style="list-style-type: none"> <li>Outpatient Office Visit</li> <li>Inpatient Cardiac Services/Surgery</li> </ul>	100% Coverage after Co-Payment  Pre-Certification Required	\$25.00 co-pay \$100.00 co-pay per day, for the first 5 days
<b>Radiation Therapy &amp; Nuclear Medicine</b>	Maximum of \$15,000 per Contract Period	\$100.00 co-pay
<b>Congenital Disease</b> <ul style="list-style-type: none"> <li>Primary Care Visit</li> <li>Specialist Visit</li> <li>Inpatient Hospitalization Services</li> </ul>	Maximum of \$15,000 per Contract Period	\$10.00 co-pay \$25.00 co-pay \$100.00 co-pay per day for the first 5 days
<b>Outpatient Mental Health Services</b> <ul style="list-style-type: none"> <li>Outpatient Evaluation and Crisis Intervention</li> </ul>	100% Coverage after Co-Payment for the first 20 visits 80% Coverage after Co-payment for all visits thereafter	\$25.00 co-pay per visit \$50.00 co-pay per visit
<b>Sterilization Procedures</b> <ul style="list-style-type: none"> <li>Tubal Ligation</li> <li>Vasectomy</li> </ul>	100% Coverage after Co-Payment  Outpatient Services Only Outpatient Services Only	\$50.00 co-pay \$50.00 co-pay
<b>Blood &amp; Blood Derivatives</b>	Plan covers cost of administration only	\$25.00 co-pay
<b>Physical Therapy</b>	Maximum of 20 visits per contract period	\$25.00 co-pay
<b>Speech Therapy</b>	Maximum of \$400 per contract period Lifetime maximum of 100 2-hour sessions	\$25.00 co-pay
<b>Durable Medical Equipment (DME)</b>	Includes standard hospital bed, standard wheelchair, crutches, oxygen concentrator, bili-lite	\$100.00 co-pay
<b>Reconstructive Breast Surgery</b> 1. Reconstruction of the breast on which a Mastectomy was performed due to cancer. 2. Surgery and reconstruction of other breast to produce symmetrical appearance 3. Prosthesis and treatment of physical complication, including Lymphedemas	Limited to the following:	\$100.00 co-pay per day for the first 5 days
<b>Alcohol/Substance Abuse Treatment</b> (Outpatient Services)	Maximum of \$8,000 per member per contract period Lifetime maximum of \$16,000 per member	\$25.00 co-pay
<b>Annual Plan Maximum</b>	Individual Lifetime Maximum Individual Off-Island Maximum	\$1,000,000.00 \$200,000.00
<b>Annual Co-Payment Maximum</b>	Individual Family	\$2,000.00 \$6,000.00

## REFERRALS

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

### PRIMARY CARE PHYSICIAN

All members enrolling in the NetCare Advantage POS Plan will be required to select a Primary Care Physician (PCP). Each member of the family may select a different PCP if desired. All primary care services must be rendered by your PCP in order for stated co-pays to apply. Services rendered by a physician other than the selected PCP will be subject to a \$25.00 Non-PCP co-payment.

### SPECIALIST CARE

Advantage Plan members may self-refer to a Specialist on Guam without an approved referral from their PCP. Members may not self-refer to specialists off-island. Referrals approved by NetCare are required for all services rendered outside of Guam.

### ADVANTAGE PLAN PARTICIPATING PROVIDER NETWORK

For a listing of participating providers for members enrolled in the Advantage Plan POS, please refer to the Advantage Plan Provider Directory. Only the providers listed in this directory are available to Advantage Plan members. There is no non-participating provider coverage under the Advantage Plan. Services rendered at providers outside the Advantage Plan provider network will be denied.

### EMERGENCY CARE OFF ISLAND

Emergency is defined as the sudden and unexpected onset of a severe medical condition, which if not treated immediately would be life threatening or result in permanent disability. For treatment of medical emergencies off-island, please proceed to the nearest facility. You will be covered subject to the limitations of your Plan. If you are hospitalized, please notify NetCare as soon as reasonably possible.

## Medical Exclusions:

The medical services listed below are NOT covered by NetCare.

- Airfare (unless criteria as set forth by the Plan has been met).
- Allergy Testing.
- Acupuncture Services.
- Chiropractic Services.
- Non-Spouse Dependent Maternity Care.
- Biofeedback and other forms of self-care or self-help training.
- Care for military service-connected disabilities to which a member is legally entitled.
- Care and services normally covered by Medicare Parts A & B for which the member is eligible and entitled to at no cost, but declined to enroll.
- Care and services rendered by immediate relatives or members of the enrollee's household, rendered as a duly licensed medical practitioner employed by a healthcare provider.
- Chronic Brain Syndrome, or custodial care charges resulting from senile deterioration.
- Cost of care or treatment related to diseases, illness, or injuries where payment is provided for under local laws or programs, federal acts, industrial insurance, automobile insurance or Worker's Compensation programs.
- Custodial care, domiciliary or convalescent care, or rest cures.
- Dental services except for surgical procedures as a result of accidental injury to natural teeth or jaw. Such services do not include capping, bridges or retainers as benefits.
- Elective cosmetic treatment including but not limited to breast implants (unless after mastectomy due to cancer) cosmetic eye surgery (ie;lasik), etc.
- Emergency treatment provided outside the service area if the need for care could have been foreseen before departing the service area.
- Experimental medical, surgical and other health-care procedures.
- Gastric Bypass, stapling or reversal, surgical correction (except as approved by the Plan).
- Hearing Aids.
- Hip & Joint replacement surgery and all related treatment and services.
- Hyperbaric Oxygen Treatment (HBO).
- Implants including a non-human, artificial or mechanical organ, breast implants, penile prosthesis, cornea, intra-ocular lenses, artificial joints and limbs, etc., except for cardiac pacemakers and stents.
- Infertility services and care related to conception by artificial means, including artificial insemination, in-vitro fertilization and embryo transfers, sterilization unless medically necessary, cost of care and treatment for reversal of sterilization and treatment or correction of infertility.
- In-patient services related to non-spouse maternity (eg: ectopic pregnancy, antepartum hemorrhage).
- Intentionally self-inflicted injury, while sane or insane unless or from a domestic violence dispute.
- Injury or illness incurred as a result of attempted suicide.
- Interrupted pregnancy (non-medically necessary), non life-threatening abortions unless medically necessary.
- Living expenses including meals, hotel rooms, transportation, etc.
- Long term rehabilitation and physical therapy.
- Medical treatment and services related to dialysis.

- Nasal reconstruction except to correct a deformity as a result of an accidental injury which occurred within 90 days of the date of surgery, or the removal or treatment of cancer of the nose.
- Non-medical treatment of obesity (except as approved by the Plan).
- Orthopedic and external prosthetic devices including but not limited to shoes, orthotics, artificial limbs, etc.
- Over-the-counter drugs or drugs for which a prescription from a licensed physician is not required under federal law.
- Personal comfort items, such as but not limited to; telephone, television, guest trays, electrical power, water and disposal systems, baths and pools at their installation, hospital room upgrades & surcharges.
- Physical examinations and all services related thereto when required for obtaining or continuing employment, insurance, schooling, government licensing or sports activities.
- Pre-existing conditions and medical conditions excluded and noted on the policy.
- Primary Care services rendered at a participating provider other than the member's elected PCP will be subject to a \$25.00 non-PCP co-payment.
- Services provided by the covered person's spouse, child, brother, sister or parents, whether by blood or by law.
- State & Local taxes, administrative fees and handling/shipping charges.
- Temporomandibular (jaw) joint disorders and related diseases (TMJ).
- The purchase and/or fitting of eyeglasses or contact lenses (unless the vision care rider is elected), radical keratotomy or lasik.
- Transsexual surgery and related services.
- Treatment for acne related services.
- Treatment for adult circumcision procedures, if provided solely for cosmetic or religious purposes.
- Treatment and services related to dialysis
- Treatment for chronic orthopedic deformities.
- Treatment and services related to Hip and Joint replacement surgery.
- Treatment for services related to occupational therapy including hand therapy.
- Treatment and services related to organ transplant
- Treatment and services related to sleeping disorders, sleep evaluation and diagnosis
- Treatment for services and supplies related to sexual dysfunction (including Viagra).
- Treatment for injuries sustained in the commission of an illegal act including, but not limited to drunk driving (driving while intoxicated, or with an alcohol level of .08 or greater on the Draeger Alco Test, or blood alcohol level of 100-250 MG/DL).
- Treatment of injuries or illnesses sustained as a result of war or any acts of war, declared or undeclared.
- Whole blood and blood derivatives.
- Services rendered at providers outside of NetCare's specified Advantage Plan provider network.
- Any portion of an expense, charge or fee that exceeds the eligible charges and the Usual, Customary and Reasonable charge.
- Benefits and services not specified as covered.