



PRIME PLAN MEDICAL

BENEFITS & TERMS

The medical services listed on these two pages are your benefits for the Prime Plan. For a detailed description of your benefits, co-payments, deductibles and procedures, please refer to your Group Service Agreement or Member Handbook. For a listing of participating providers within our network, please refer to your Participating Healthcare Providers Directory.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
DEDUCTIBLE (subject to UCR)	NONE	\$500 Individual/\$1500 Family
PHYSICIAN & OUTPATIENT BENEFITS		
1. Office visits, which include Primary care and Specialist care	80% of covered charges	70% of UCR
2. Well-baby care up to age 2	No co-payment	70% of UCR
3. Other physician services:		
• Voluntary second surgical opinion	80% of covered charges	70% of UCR
• Home health care	80% of covered charges	70% of UCR
• Private duty nursing	80% of covered charges	Not Covered
• Hospice care	80% of covered charges	Not Covered
3. Outpatient surgery	80% of covered charges	70% of UCR
4. Outpatient laboratory & x-ray services	80% of covered charges	70% of UCR
HOSPITALIZATION & INPATIENT BENEFITS		
1. Room & board for a semi-private room, intensive care, coronary care and surgery	100% of covered charges at designated Centers of Care. (COC)	70% of UCR
2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia & medication	80% of covered charges at other participating providers. (including GMH)	70% of UCR
3. Physician's hospital services	80% of covered charges	70% of UCR
4. Skilled Nursing Facility (limited to 60 days per contract period)	80% of covered charges	70% of UCR
5. Inpatient Mental health	80% of covered charges	70% of UCR
MATERNITY CARE		
1. Pre-natal & post-natal care	80% of covered charges	70% of UCR
2. Delivery Hospital Facility Birthing Center (Limited to Guam only)	100% of covered charges @ COC. 80% of covered charges at any other participating providers	70% of UCR Not covered
3. Circumcision (covered within 30 days of date of birth)	80% of covered charges	70% of UCR
4. Non-Spouse Maternity (outpatient pre-natal services only/\$500 per contract period)	80% of covered charges	70% of UCR
EMERGENCY BENEFITS		
1. On-island emergency facility, physician services, laboratory, x-rays	80% of covered charges	80% of UCR
2. Off-island emergency facility, physician services, laboratory, x-rays	80% of covered charges	80% of UCR
3. Ambulance Service (limited to ground transportation)	80% of covered charges	80% of UCR
NON-EMERGENCY BENEFITS		
Non-emergency treatment in a hospital emergency room	50% of covered charges	50% of UCR
ROUTINE ANNUAL EXAMS		
1. Annual Physical exams	80% of covered charges	70% of UCR
2. Annual Gynecological exams	80% of covered charges	70% of UCR
3. Annual Mammograms (over the age of 40 years)	80% of covered charges	70% of UCR
4. Annual Eye Exam (maximum of \$50 per contract period)	80% of covered charges	Not covered
ROUTINE IMMUNIZATIONS & INJECTIONS		
Per U.S. Public Health Schedule of Immunizations to age 16	80% of covered charges	70% of UCR
PRESCRIPTION DRUGS		
Limited to generic brands unless otherwise specified by physician	Retail/Pharmacy	Mail Order
1. Generic drugs	\$5.00 per unit	\$10.00 (90 days)
2. Brand name drugs	\$10.00 per unit	\$20.00 (90 days)
3. Non-Formulary drugs	\$25.00 per unit	\$50.00 (90 days)
4. Injectable drugs	10% per unit	10% + shipping
		Out of Network
		70% of AWP
		70% of AWP
		70% of AWP
		70% of AWP
DIAGNOSTIC TESTING		
MRI, CT Scan, Ultrasound, Cardiac Stress Test, Cardiac Catheterization, Coronary Angiography, Bone Scan, Biopsy and any other diagnostic procedures. Limited to one test per contract period per anatomical region. Pre-certification required. Approval based on medical review.	80% of covered charges	70% of UCR
CARDIAC SURGERY		
COC & participating provider coverage	100% covered at COC	Not covered
	80% covered at non-COC	70% of UCR
RADIATION THERAPY & NUCLEAR MEDICINE	80% of covered charges	70% of UCR
COVERAGE FOR AIDS	80% of covered charges	50% of UCR
CONGENITAL DISEASES Maximum of \$15,000 per contract period	80% of covered charges	70% of UCR
STERILIZATION PROCEDURES		
1. Tubal ligation	80% of covered charges	70% of UCR
2. Vasectomy	80% of covered charges	70% of UCR
BLOOD & BLOOD DERIVATIVES Plan covers cost of administration only	80% of covered charges	70% of UCR
ORGAN TRANSPLANT COVERAGE Lifetime maximum of \$50,000	80% of covered charges	70% of UCR
ALLERGY TESTING Maximum of \$500 per contract period	80% of covered charges	70% of UCR
ACUPUNCTURE Limited to 20 visits/\$50 per visit per contract period	80% of covered charges	Not covered
CHIROPRACTIC Maximum of \$300 per contract period	80% of covered charges	70% of UCR
SLEEP EVALUATION & DIAGNOSIS Evaluation & Diagnosis only; one per contract period	80% of covered charges	70% of UCR
HYPERBARIC OXYGEN TREATMENT (HBO) Maximum of \$5,000 per contract period	80% of covered charges	70% of UCR
PHYSICAL THERAPY Maximum of 20 visits per contract period	80% of covered charges	70% of UCR
SPEECH THERAPY		
Maximum of \$400.00 per contract period.		
Lifetime maximum of 100 2-hour sessions.	80% of covered charges	70% of UCR

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BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
DURABLE MEDICAL EQUIPMENT (DME) Includes standard hospital bed, standard wheelchair, crutches, oxygen concentrator, bili-lite	80% of covered charges	Not covered
RECONSTRUCTIVE BREAST SURGERY Limited to the following: 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. Prostheses and treatment of physical complication, including Lymphedemas.	80% of covered charges 80% of covered charges 80% of covered charges	70% of UCR 70% of UCR 70% of UCR
OUTPATIENT MENTAL HEALTH First 20 visits All visits thereafter	80% of covered charges 40% of covered charges	70% of UCR 70% of UCR
ALCOHOL/SUBSTANCE ABUSE TREATMENT Maximum of \$8,000 per member per contract period. Lifetime maximum of \$16,000 per member	80% of covered charges	70% of UCR
ANNUAL PLAN MAXIMUM 1. Individual lifetime maximum 2. Individual annual maximum (Off-island)		\$1,000,000.00 \$100,000.00
ANNUAL CO-PAYMENT MAXIMUM 1. Per individual per contract period 2. Per family per contract period	\$1,500.00 \$4,500.00	None None

UCR: Usual, Customary & Reasonable charges of the geographical location where service was rendered based on the current Medicare RBRVS/DRG.
REFERRALS: Referrals are not required for primary or specialty care at participating providers in Guam, Philippines, Asia, Hawaii or the Continental United States.
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 elect a different PCP if desired. All primary care services must be rendered by the PCP you have chosen. Services rendered by a physician other than the member's elected PCP will be subject to a \$25.00 Non-PCP co-payment.

Medical Exclusions: *The medical services listed below are NOT covered by NetCare.*

- Airfare (unless criteria as set forth by the Plan has been met).
- Biofeedback and other forms of self-care or self-help training.
- Care for military service-connected disabilities to which a member is legally entitled.
- Care and services normally covered by Medicare Parts A & B for which the member is eligible and entitled to at no cost, but declined to enroll.
- Care or services rendered by immediate relatives or members of the enrollee's household, rendered as a duly licensed medical practitioner employed by a health care 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.
- 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, governmental licensing or sports activities.
- Pre-existing conditions and medical conditions excluded and noted on the policy.
- Services provided by the covered person's spouse, child, brother, sister or parents, whether by blood or by law.
- State & local taxes, administrative fees and handling/shipping charges.
- Temporomandibular (jaw) joint disorders and related diseases (TMJ).
- The 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 for chronic orthopedic deformities.
- Treatment and services related to Hip and Joint replacement surgery.
- Treatment for services and supplies related to sexual dysfunction (i.e. Viagra).
- Treatment for injuries sustained in the commission of an illegal act including, but not limited to drunk driving (driving while intoxicated, or with an alcohol level of .08 or greater on the Draeger Alco Test, or blood alcohol level of 100-250 MG/DL).
- Treatment of injuries or illnesses sustained as a result of war or any acts of war, declared or undeclared.
- Treatment of injuries sustained while participating in hazardous sports, such as, but not limited to off-road activities, skydiving, etc.
- Treatment and services related to Occupational therapy, including hand therapy.
- Treatment and services related to sleeping disorders.
- Whole blood and blood derivatives.
- Any portion of an expense, charge or fee that exceeds the eligible charges and the Usual, Customary and Reasonable charge.
- Benefits and services not specified as covered.