



The medical services listed on these two pages are your benefits for the Kmart Medical Plan. For a detailed description of your benefits, co-payments, and procedures please call NetCare's Customer Service Representatives at (671) 472-3610 or refer to your Group Service Agreement or Member Handbook. To enroll, add, or delete dependents, please contact the Benefits Center at 800-33-Kmart. For a listing of participating providers within our network, you may refer to NetCare's Provider Directory or log on to our website at www.netcarelifeandhealth.com

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	
PHYSICIAN & OUTPATIENT BENEFITS			
1. Primary Care Office Visit	\$10.00 co-payment	Not Covered	
2. Specialist Care Office Visit	\$25.00 co-payment	Not Covered	
3. Second Surgical Opinion	\$25.00 co-payment	Not Covered	
4. Home Health Care	\$25.00 co-payment	Not Covered	
6. Outpatient Laboratory Services	\$10.00 co-payment per service	Not Covered	
7. Outpatient X-ray Services	\$10.00 co-payment per x-ray	Not Covered	
8. Outpatient Surgery	\$100.00 co-payment	Not Covered	
HOSPITALIZATION & INPATIENT BENEFITS			
1. Room & board for semi-private room, intensive care, coronary care & surgery	\$100.00 co-payment / 10% co-insurance	50% of UCR	
2. All other inpatient hospital services including laboratory, x-ray physician services, operating room, anesthesia & medication	\$100.00 co-payment / 10% co-insurance	50% of UCR	
3. Skilled Nursing Facility (limited to 60-days per contract period)	\$100.00 co-payment / 10% co-insurance	50% of UCR	
4. Inpatient Mental Health/Substance Abuse Treatment	\$100.00 co-payment / 10% co-insurance	50% of UCR	
MATERNITY CARE			
1. Pre-natal & Post-natal Care	\$10.00 co-payment	Not Covered	
2. Delivery - Hospital Facility (Hospital Benefits Apply) Birthing Center (Limited to Guam only)	\$100.00 co-payment / 10% co-insurance	Not Covered	
3. Circumcision (covered within 30 days from date of birth)	\$100.00 co-payment / 10% co-insurance	Not Covered	
EMERGENCY BENEFITS			
1. On & Off-island emergency at Hospital Emergency Room	\$100.00 co-payment	\$100.00 co-payment	
2. Urgent Care Visit	\$25.00 co-payment	Not Covered	
3. Ambulance Service (limited to ground transportation)	\$100.00 co-payment	\$100.00 co-payment	
NON-EMERGENCY BENEFITS			
Non-emergency treatment in a hospital emergency room	\$100.00 co-payment / 20% co-insurance	Not Covered	
ROUTINE ANNUAL EXAM/PREVENTIVE CARE			
1. Well-Baby Care (Up to age 2; Limited to 5 visits per Contract Period)	\$10.00 co-payment	Not Covered	
2. Annual Physical Exam	\$10.00 co-payment	Not Covered	
3. Annual Gynecological Exam	\$10.00 co-payment	Not Covered	
4. Annual Mammogram (over 40 years of age)	\$10.00 co-payment	Not Covered	
5. Annual Eye Exam (maximum of \$50 per contract period)	\$10.00 co-payment	Not Covered	
ROUTINE IMMUNIZATIONS			
	\$10.00 co-payment	Not Covered	
PRESCRIPTION DRUGS			
(Limited to generics unless specified by physician (additional co-pay may apply)	Retail	Mail	Out of Network
1. Generic drugs	\$ 5.00 co-payment	\$10.00 for 90-days	Not Covered
2. Brand name drugs	\$10.00 co-payment	\$20.00 for 90-days	Not Covered
3. Non-Formulary drugs	\$25.00 co-payment	\$50.00 for 90-days	Not Covered
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.	\$100.00 co-payment	Not Covered	
CARDIAC CARE			
1. Specialist Care Office Visit	\$25.00 co-payment	Not Covered	
CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE			
(Limited to \$15,000 per Contract Period)	\$100.00 co-payment	Not Covered	
CONGENITAL DISEASES			
(Limited to \$15,000 per Contract Period)			
1. Primary Care Office Visit	\$10.00 co-payment	Not Covered	
2. Specialist Care Office Visit	\$25.00 co-payment	Not Covered	
STERILIZATION PROCEDURES (Outpatient Tubal Ligation or Vasectomy)			
	\$50.00 co-payment	Not Covered	
BLOOD & BLOOD DERIVATIVES (Limited to cost of administration only)			
	\$25.00 co-payment	Not Covered	
ALLERGY TESTING (Limited to \$500 per Contract Period)			
	\$25.00 co-payment	\$25.00 co-payment	
PHYSICAL THERAPY (Limited to 20 visits per Contract Period)			
	\$25.00 co-payment	Not Covered	
SPEECH THERAPY (Limited to 20 visits per Contract Period)			
	\$25.00 co-payment	Not Covered	
DURABLE MEDICAL EQUIPMENT (DME)			
Includes standard hospital bed, standard wheelchair, crutches, oxygen concentrator, bili-lite. Limited to rental only & 90 reimbursable days.	\$25.00 co-payment Member responsible for deposit	Not Covered	
CHRONIC ORTHOPEDIC CONDITION (Limited to \$50,000 per Contract Period)			
1. Primary & Specialty Care Office Visit	80% of covered charges	Not Covered	
ALCOHOL/SUBSTANCE ABUSE TREATMENT			
Maximum of \$8,000 per member per contract period Lifetime maximum of \$16,000 per member	\$25.00 co-payment	Not Covered	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MENTAL HEALTH (OUTPATIENT)	\$25.00 co-payment	Not Covered
RECONSTRUCTIVE BREAST SURGERY		
1. Primary Office Visit	\$10.00 co-payment	Not Covered
2. Specialty Care Office Visit	\$25.00 co-payment	Not Covered
3. Hospitalization	\$100.00 co-payment / 10% co-insurance	Not Covered
Limited to the following:		
<ul style="list-style-type: none"> • Reconstruction of the breast on which a Mastectomy was performed due to cancer • Surgery and reconstruction of other breast to produce symmetrical appearance • Prosthesis and treatment of physical complication, including Lymphedemas 		
ANNUAL PLAN MAXIMUM		
1. Individual Lifetime Maximum		\$1,000,000.00
2. Individual Annual Maximum		\$200,000.00
ANNUAL CO-PAYMENT MAXIMUM		
1. Per individual per contract period	\$2,000.00	None
2. Per family per contract period	\$6,000.00	None

COVERED CHARGES - The charge determined by NetCare to be the maximum amount that it will pay for a covered service to a health care provider. Any applicable co-payment will apply to the Eligible Charge. The Eligible Charge will be the lesser of the actual charge of the negotiated charge for Participating Provider services. For non-participating provider services, the Eligible Charge will be the lesser of the actual charge or UCR in the geographic region where the service was rendered.

PROVIDER NETWORK - Services must be rendered by participating providers. There is limited coverage for services rendered by non-participating providers. For a detailed list participating providers, please refer to NetCare's Provider Directory.

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

REFERRALS - Referrals approved by NetCare are required before services are rendered by non-PCP & Specialty services and services outside of Guam.

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

UCR - Usual Customary & Reasonable charges of the geographical location where service was rendered based on the current Medicare RBRVS/DRG.

Medical Exclusions: Services NOT covered by NetCare.

- Airfare (unless criteria as set forth by the Plan has been met).
- Allergy Testing.
- Acupuncture & Chiropractic Services.
- Biofeedback and other forms of self-care or self-help training.
- Care for military service connected disabilities to which a member is legally entitled.
- Care and services normally covered by Medicare Parts A & B for which the member is eligible and entitle to at no cost, but declined to enroll.
- Care or services rendered by immediate relatives or members of the enrollee's household, rendered as a duly licensed medical practitioner employed by a health care provider.
- Chronic Brain 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.
- Executive Physical Exams/Executive Check-up (Inpatient Physical Exam).
- Experimental medical, surgical and other health-care procedures.
- Gastric Bypass, stapling or reversal, surgical correction (except as approved by the Plan).
- Hearing Aids.
- Hip Joint replacement surgery and all related treatment and services.
- Hyperbaric Oxygen Treatment (HBO).
- Implants including a non-human artificial or mechanical organ, breast implants, penile prosthesis, cornea, intra-ocular lenses, artificial joints and limbs, etc. except for cardiac pacemakers and stents.
- Infertility services and care related to conception by artificial means, including artificial insemination, in-vitro fertilization and embryo transfers, sterilization unless medically necessary, cost of care and treatment for reversal of sterilization and treatment or correction of infertility.
- Inpatient services related to non-spouse maternity (e.g. ectopic pregnancy, antepartum hemorrhage).
- Intentionally self-inflicted injury, while sane or insane unless or from a domestic violence dispute.
- Injury or illness incurred as a result of attempted suicide.
- Interrupted pregnancy (non-medically necessary), non-life threatening abortions unless medical necessary.
- Living expenses including meals, hotel rooms, transportation, etc.
- Long term rehabilitation and physical therapy.

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