



CNMI LIMITED PLAN MEDICAL

Schedule of Benefits
2022

The medical services listed on these pages are medical benefits for the CNMI Limited Plan. This PPO Medical Plan is a summation of benefits. Detailed description of benefits, co-payments, deductibles & procedures are found in your Summary Plan Description, Summary of Benefit Coverage, or Uniform Glossary. A list of participating providers can be found in NetCare's Provider Directory. Copies of these documents may be obtained by calling NetCare at 671-472-3610 or at www.netcarelifeandhealth.com

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS																							
DEDUCTIBLE (Subject to UCR)	NONE																							
PHYSICIAN & OUTPATIENT BENEFITS																								
1. Primary Care Office Visit	No Charge for covered charges																							
2. Specialist Care Office Visit	No Charge for covered charges																							
3. Second Surgical Opinion	No Charge for covered charges																							
4. Home Health Care	No Charge for covered charges																							
5. Injections (Does not include Specialty and Orthopedic Injections)	No Charge for covered charges																							
6. Outpatient Laboratory Services	No Charge for covered charges																							
7. Outpatient X-ray Services	No Charge for covered charges																							
8. Outpatient Surgery	No Charge for covered charges																							
9. Private Duty Nursing	No Charge for covered charges																							
URGENT CARE																								
1. Clinic Setting	No Charge for covered charges																							
2. Hospital Setting	No Charge for covered charges																							
HOSPITALIZATION (Inpatient Services) All inpatient admissions require a NetCare approved referral within 48 hours of admission.																								
1. Room & board for semi-private room, intensive care, coronary care & surgery; All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia, medication & physician's services	<ul style="list-style-type: none"> • Centers of Care & Philippine Providers - No charge for covered inpatient charges. • CHC & Other Hospitals - 20% of covered inpatient charges. 																							
2. Inpatient Mental Health & Chemical/Substance Treatment																								
EMERGENCY SERVICES																								
1. On or Off-island Emergency services (when not followed by admission)	No Charge for covered charges																							
2. Ambulance Service (Limited to ground transportation for bona fide emergenc	No Charge for covered charges																							
ROUTINE ANNUAL EXAMS & IMMUNIZATIONS - Preventive guidelines established by U.S. Preventive Services Task Force, Grades A or B																								
Preventive Care for Adults, Child & Baby																								
1. Well-Baby/Child Care	No Charge for covered charges																							
2. Routine Annual Physical Exam - Limited to one exam per contract period	No Charge for covered charges																							
3. Routine Annual Gynecological Exam - Limited to one exam per contract period	No Charge for covered charges																							
4. Routine Annual Mammograms - Age 40+	No Charge for covered charges																							
5. Routine Annual Eye Exam - Limited to one exam per contract period	No Charge for covered charges																							
6. Routine Annual Immunizations - Per CDC Guidelines	No Charge for covered charges																							
7. Routine Annual Health Screening	No Charge for covered charges																							
8. Routine Annual Outpatient Laboratory	No Charge for covered charges																							
9. Routine Annual Outpatient X-ray	No Charge for covered charges																							
PRESCRIPTION DRUGS (www.optumrx.com)																								
	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Retail/Pharmacy</th> <th style="text-align: center;">Mail Order</th> <th style="text-align: center;">Out of Network</th> </tr> </thead> <tbody> <tr> <td>1. Generic drugs</td> <td style="text-align: center;">\$ 5 per unit</td> <td style="text-align: center;">\$ 0 (90 days)</td> <td style="text-align: center;">Not Covered</td> </tr> <tr> <td>2. Brand drugs</td> <td style="text-align: center;">20% of covered charges</td> <td style="text-align: center;">\$ 30 (90 days)</td> <td style="text-align: center;">Not Covered</td> </tr> <tr> <td>3. Non-formulary drugs</td> <td style="text-align: center;">30% of covered charges</td> <td style="text-align: center;">\$ 60 (90 days)</td> <td style="text-align: center;">Not Covered</td> </tr> <tr> <td>4. Injectables (includes specialty injectable drugs)</td> <td style="text-align: center;">30% of covered charges</td> <td style="text-align: center;">30%+shipping</td> <td style="text-align: center;">Not Covered</td> </tr> <tr> <td>5. Specialty (excludes injectable drugs)</td> <td style="text-align: center;">20% up to \$150 out of pocket max</td> <td style="text-align: center;">Not Covered</td> <td style="text-align: center;">Not Covered</td> </tr> </tbody> </table>	Retail/Pharmacy	Mail Order	Out of Network	1. Generic drugs	\$ 5 per unit	\$ 0 (90 days)	Not Covered	2. Brand drugs	20% of covered charges	\$ 30 (90 days)	Not Covered	3. Non-formulary drugs	30% of covered charges	\$ 60 (90 days)	Not Covered	4. Injectables (includes specialty injectable drugs)	30% of covered charges	30%+shipping	Not Covered	5. Specialty (excludes injectable drugs)	20% up to \$150 out of pocket max	Not Covered	Not Covered
Retail/Pharmacy	Mail Order	Out of Network																						
1. Generic drugs	\$ 5 per unit	\$ 0 (90 days)	Not Covered																					
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4. Injectables (includes specialty injectable drugs)	30% of covered charges	30%+shipping	Not Covered																					
5. Specialty (excludes injectable drugs)	20% up to \$150 out of pocket max	Not Covered	Not Covered																					
Additional drug information can be found within this document																								
AUTISM SPECTRUM DISORDER																								
	No Charge for covered charges																							
BLOOD, BLOOD PRODUCTS & DERIVATIVES																								
Limited to cost of administration only																								
CARDIAC CARE																								
Limited to \$30,000 per contract period. Cardiac Implant is limited to cardiac pacemaker and cardiac stent.																								
1. Primary & Specialist Office Visit	No Charge for covered charges																							
2. Cardiac Surgery (Limited to Centers of Care)	No Charge for covered charges																							

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS
DEDUCTIBLE (Subject to UCR)	NONE
CHEMICAL DEPENDENCY/SUBSTANCE ABUSE (OUTPATIENT)	No Charge for covered charges
CHEMOTHERAPY Limited to \$20,000 per Contract Period	No Charge for covered charges
CHRONIC ORTHOPEDIC DEFORMITY & CONDITIONS Limited to \$5,000 per Contract Period for all related services	20% of covered charges
DIAGNOSTIC TESTING MRI, Mammogram, CT Scan, EKG, Ultrasound, Cardiac Stress Test, Cardiac Catherization, Coronary Angiography, Bone Scan, Biopsy and any other diagnostic procedure. Limited to one test per anatomical region per contract period. Pre-certification required. Approval based on medical review.	No Charge for covered charges
FITNESS BENEFIT & REWARD Plan pays up to \$20/month (up to \$200 per Contract Period) for attendance 8 times/month & completion of NetCare's online Health Risk Assessment.	Plan pays up to \$200 Cash Reward
MATERNITY CARE 1. Pre-natal / Post-natal Care Visit (Includes one routine ultrasound) 2. Delivery: Hospital Facility and Professional Fee (a separate copayment will apply for newborn child) 3. Circumcision: Within 30 days of date of birth 4. Breastfeeding Equipment (limited to rental only)	No Charge for covered charges • Centers of Care & Philippine Providers - no charge for covered inpatient charges; • CHC & Other Hospitals - 20% of covered for covered inpatient charges. No Charge for covered charges No Charge for covered charges
MENTAL HEALTH TREATMENT (OUTPATIENT)	No Charge for covered charges
NUCLEAR MEDICINE Limited to \$20,000 per Contract Period	No Charge for covered charges
OCCUPATIONAL THERAPY Limited to 5 visits per Contract Period	No Charge for covered charges
PHYSICAL THERAPY Maximum of 4 visits per Contract Period	No Charge for covered charges
RADIATION THERAPY Limited to \$20,000 per Contract Period	No Charge for covered charges
RECONSTRUCTIVE BREAST SURGERY Limited to the following in accordance with the Women's Health & Cancer Rights Act of 1998 •Reconstruction of the breast on which a Mastectomy was performed due to cancer •Surgery and reconstruction of other breast to produce symmetrical appearance •Prostheses and treatment of physical complication, including Lymphedemas & wigs	No Charge for covered charges
SPEECH THERAPY (OUTPATIENT) Limited to 5 visits per Contract Period	No Charge for covered charges
TELEHEALTH/ TELEMEDICINE Limited to CNMI and Philippine provider networks	No Charge for covered charges
WELLNESS Member co-insurance may be reimbursed upon program completion	20% of covered charges
ANNUAL PLAN MAXIMUM	Unlimited
LIFETIME MAXIMUM	Unlimited
ANNUAL OUT-OF-POCKET MAXIMUM 1. Per Individual Per Contract Period 2. Per Family Per Contract Period	Not Applicable Not Applicable

CENTERS OF CARE shall be defined as a Participating Provider that is a Hospital or Ambulatory Surgical Center located outside of the Service Area. The Hospital or Ambulatory Surgical Center shall be a Participating Provider at the time services are rendered to the Covered Person and shall be specifically designated by name as a Center of Care in the more recent of NetCare's most current brochure or NetCare's most current updated Provider Directory.

COVERED CHARGES for Participating Providers are charges 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. Covered Charges or Eligible Charges shall be defined as the reimbursement amounts agreed between the Company and the Participating Provider.

COVID-19 - NetCare will pay covered benefits for COVID related services to include medically necessary testing, treatment and services based on guidelines established by CDC and FDA approved prescription drugs. Coverage shall include but not limited to inpatient services, prescription drugs, physician office visit, diagnostic procedures and laboratory testing. A precertification or prior authorization of service is not required. Coverage does not include services for screening or clearance for school, employment or travel purposes. Vaccination - NetCare will cover FDA approved COVID related vaccinations using guidelines established by CDC. No copayment or deductible will apply for administration fees associated with the vaccination. Contact NetCare at 671-472-3610 for coverage details.

DEDUCTIBLE is the dollar amount applied to non-participating providers for covered benefits only. Non-covered benefits are not applicable toward your annual deductible. The individual deductible does not apply toward the family deductible amount. Therefore, the entire family must meet the family deductible before First Dollar benefits apply.

NON-GRANDFATHERED STATUS DISCLOSURE - This group health plan believes this plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act. Being a non-grandfathered health plan means that your policy includes certain consumer protections. Questions may be directed at NetCare at 671-472-3610 or EBSA at www.dol.gov/ebsa or DHHS at www.healthreform.gov.

PHILIPPINE CARE - All covered benefits/services rendered at NetCare's Philippine Centers of Care are 100% of covered charges, subject to pre-certification requirements and plan benefit limits.

PRESCRIPTION DRUGS - NetCare adopted a mandatory generic program, which means prescription drugs are limited to covered generic drugs. Additional charges will apply for non-generic prescription drugs that include copayment of the non-generic drug plus the ingredient cost difference of the non-generic and generic drug. Contraceptives, including injectable contraceptives, are covered at no charge for generic retail & generic mail order at participating providers. Brand & non-formulary contraceptives at participating providers are subject to Plan benefits. Preventive drug benefits are payable based on guidelines established by the U.S. Preventive Services Task Force grades A or B. Injectable drug copayments for specific drug classes may fall under another copayment tier. Please refer to NetCare's current drug formulary for coverage and copayment tier.

PROVIDER NETWORK - Covered benefits and services rendered outside CNMI are limited to Philippines. Services rendered outside CNMI and Philippines and at non-participating providers are not covered benefits.

REFERRALS - Referrals are not required for primary, specialty care or covered ancillary services at approved providers in CNMI. A NetCare approved referral is required for all services outside CNMI. No coverage will be provided outside CNMI without a NetCare approved referral. We recommend members to contact NetCare for referral assistance and allow ample time (2-4 weeks) to schedule appointments.

RESIDENCY - Enrollment is limited to members who live on CNMI and do not reside outside CNMI for more than 90 consecutive days per Contract Period. A NetCare approved authorization is required for members receiving continuous medical care outside CNMI that is not for long term medical treatment.

SERVICE AREA - The service area for this policy shall be defined as CNMI.

UCR means Usual, Customary & Reasonable charges of the geographical location where service was rendered based on the current Medicare RBRVS/DRG. Covered services and annual deductibles at Non-participating Providers are subject to UCR.

MEDICAL EXCLUSIONS

Medical services listed below are NOT covered by NetCare

- Acupuncture care & services.
- Airfare (unless criteria as set forth by the Plan has been met).
- Allergy testing & treatment.
- Biofeedback and other forms of self-care or self-help training.
- Blood derivatives for experimental purposes.
- 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 Medicare is or would be primary for a member who is eligible and entitled to at no cost and 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 healthcare providers.
- Chiropractic services.
- 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 include capping, bridges or retainers as benefits.
- Durable Medical Equipment.

MEDICAL EXCLUSIONS (continued)

Medical services listed below are NOT covered by NetCare

- Elective cosmetic treatment including but not limited to breast implants (unless after mastectomy due to cancer) cosmetic eye surgery (i.e.. Lasik), etc.
- Emergency treatment provided outside the service area if the need for care could have been foreseen before departing the service area.
- Executive Physical Exams/Executive Check-up (Inpatient Physical Exam).
- Experimental medical, surgical and other health-care procedures.
- Gastric Bypass, stapling or reversal, surgical correction (except as approved by the Plan).
- Hearing Aids.
- Hip Joint replacement surgery and all related treatment and services.
- Implants including but not limited to dissolvable implants, non-human artificial or mechanical organ, breast implants, penile prosthesis, cornea, intra-ocular lenses, artificial joints and limbs, etc. except for cardiac pacemakers, cardiac stents, & covered contraceptive devices.
- 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 and outpatient services and care provided to dependents of a non-spouse dependent.
- 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 including but not limited to physical therapy, speech therapy, hand therapy, and occupational therapy.
- Medical treatment and services related to End Stage Renal Disease, including 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, inclusive of OTC contraceptives and devices and all non FDA approved drugs.
- 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 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.
- Prenatal ultrasound (except as approved by the Plan). Routine ultrasounds are limited to one per pregnancy term. Subsequent ultrasounds are not covered unless medically necessary and approved by the Plan.
- Services provided by the covered person's spouse, child, brother, sister or parents whether by blood or by law.
- Services rendered outside CNMI without a NetCare approved referral.
- Services and treatment other than at CNMI & Philippine providers and at non-participating providers.
- Specialty drugs purchased at pharmacies other than participating providers in CNMI & Philippines.
- Sterilization procedures (Tubal Ligation or Vasectomy).
- 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 & services for hepatitis, including drugs, without a NetCare approved prior authorization and strict criteria satisfaction.
- Treatment and services related to Organ Transplant.
- Treatment and services related to Congenital abnormalities.
- 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 (i.e.. Viagra)
- Treatment and services related to sleeping disorders.
- 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.
- Whole blood & 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.