

## PALAU PRIME PLAN

The medical services listed are benefits for Palau Prime Plan. For detailed description of your benefits, co-payments and procedures, please refer to your Group Service Agreement or Plan Documents. For listing of participating providers within our network, you may refer to NetCare's Provider Directory by calling our office at 671-472-3610 or log on to www.netcarelifeandhealth.com

Description         PARTICIPATING PROVIDERS           ANUAL DEDUCTINE         None           PHanay Cac Ottor Viag         20% of covered charges           Phanay Cac Ottor Viag         20% of covered charges           1         Scond Sargtal Option         20% of covered charges           2         Scond Sargtal Option         20% of covered charges           3         Scond Sargtal Option         20% of covered charges           4         Home Healt Case         20% of covered charges           5         Logital Software         20% of covered charges           0         Uncovered charges         20% of covered charges           0         Logital Software         20% of covered charges           1         Device Software         20% of covered charges           1         Logital Software         20% of covered charges	BENEFIT DESCRIPTION	WHAT YOU PA	
PHYSICLAN & OUTPATENT BENEFTS         20% of covered charges           1. Primary Care Office Visit         20% of covered charges           2. Specially Care Office Visit         20% of covered charges           2. Specially Care Office Visit         20% of covered charges           3. Distributed Specially and Orthopedic Injections)         20% of covered charges           4. Distributed Specially and Orthopedic Injections)         20% of covered charges           7. Outpatient Lawy Services         20% of covered charges           9. Protein Data Networks         20% of covered charges           1. Root A board for semi-private room, Intensive care, coronary care &         20% of covered charges           2. Hospital Setting         20% of covered charges         20% of covered charges           2. Hospital Setting         20% of covered charges         20% of covered charges           2. Hospital Setting         20% of covered charges         20% of covered charges           1. Room A board for semi-private room, Intensive care, coronary care &         20% of covered charges         20% of covered charges           1. Poetral & Poet-statil & Poet-statil Care Visit (reduction erosonic)         20% of covered charges         20% of covered charges           2. Proversition Care Visit Models for the color shown for the coverge of charges         20% of covered charges         20% of covered charges           2. Pholecy	ANNUAL DEDUCTIBLE		OVIDER5
1. Primary Care Office Visit 20% of covered charges  2. Special Care A Chire Visit 20% of covered charges  3. Scond Surgical Option  2. Special Care A Charges  2. Social Surgical Option  2. Social Care A Charges  3. Social Car		None	
2. Special Care Office Visit 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh Care 20% of covered charges 5. Jame 1 ladh Care 20% of covered charges 5. Jame 1 ladh Care 20% of covered charges 4. Jame 1 ladh C		20% of covered cha	17000
3. Second Surgical Optionin 20% of covered charges  5. Injections (Does not include Specialty and Orthopedic Injections) 20% of covered charges  5. Optimized Neurophysics  2. Private Dark Numing 20% of covered charges  2. Private Dark Numing 20% of covered cha			
4 Home Holfh Caré 20% of covered Charges 5. Directions (Does not include Specially and Orthopedic Injections) 20% of covered Charges 20%			
6. Outpatient Laboratory Services 20% of overed charges 20% of ove	4. Home Health Care		
7. Outplatent X-ray Services 20% of covered charges 20% of covered c	5. Injections (Does not include Specialty and Orthopedic Injections)		
8. Outpatient Sargery 20% of covered charges			
9. Priviale Duty Nursing 20% of covered charges 20% of covered charg			
I. Clink: Sching       20% of covered charges         2. Hospital Setting       20% of covered charges         1. Room & board for semi-private room, intensive care, coronary care & surgery, all other inputs in thousing laboratory, x-ray, operating room, anesthesia, medication & physician's services       20% of covered charges         2. Inputs the Media Health & Chenical/Substance Treatment       20% of covered charges         2. Inputs the Media Health & Chenical/Substance Treatment       20% of covered charges         2. Inputs the Media Health & Chenical/Substance Treatment       20% of covered charges         2. Inputs the Media Health & Chenical/Substance Treatment       20% of covered charges         2. Substary - Indepits Incluids of data stars       20% of covered charges         2. Carcuncision (Covered with all system stars)       No Clarge         2. Carcuncision (Covered with all system stars)       20% of covered charges         2. Ambulance Service (Linited to ground tansportation tor boat lide emergency)       20% of covered charges         2. Ambulance Service (Linited to ground tansportation tor boat lide emergency)       20% of covered charges         2. Media Health & Chenical (Substance Step errorited period)       20% of covered charges         2. Well-Ably Crept (pio tage 2: Linited to see same promited period       20% of covered charges         2. Well-Child Care       20% of covered charges         3. Routine Annual Physical Exam - Linited			
1. Clinic Setting 20% of covered charges 20%			nges
2. Hospital Setting         20% of covered charges           11. Room & board for semi-private room, intensive care, coronary care &         20% of covered charges           surgery: ALLATION (Inplatient Services)         20% of covered charges           surgery: ALLATION (Inplatient Services)         20% of covered charges           2. Inplatient Mether inplatient Services         20% of covered charges           2. Inplatient Metherina/Substance Treatment         20% of covered charges           3. Corrundicion (Severed within Solver to mate or build)         20% of covered charges           3. Corrundicion (Severed within Solver to mate or build)         20% of covered charges           3. Corrundicion (Severed within Solver to mate or build)         20% of covered charges           3. Corrundicion (Severed within Solver to mate or build)         20% of covered charges           3. Moultine Annual Physical Services, laboratory, x-rays         20% of covered charges           3. Moultine Annual Physical Services (Severed With Solver to mate devine)         20% of covered charges           3. Moultine Annual Physical Start Childs & Balv         20% of covered charges           4. Routine Annual Physical Start - Limited to one eam per centrat period         20% of covered charges           3. Routine Annual Physical Start - Limited to one eam per centrat period         20% of covered charges           4. Routine Annual Marmnogram, Sol Unity per centrat period         <		20% of covered cha	rges
<b>HOSPITALIZATION</b> [Inputient Services] All inputient admissions require a NetCare approved referral within 48 hours of admission.         1. Room & board for semi-private room, intension cance cance, roomany care & surgery. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia, medication & physician's services.       20% of covered charges         2. Inpatient Mental Health & Chemical/Substance Treatment       20% of covered charges         2. Delivery - Hospital Facility & Professional Fee       20% of covered charges         (a separate copayment will apply for newborn child)       20% of covered charges         2. Delivery - Hospital Facility & Professional Fee       20% of covered charges         2. ADD Covered Charges       20% of covered charges         3. Routine Annual Propage Linearch to sists per contract period       20% of covered charges </td <td></td> <td colspan="2"></td>			
1. Room & board for semi-private room, intensive care, coronary care &         20% of covered charges           surgery: Al. Under inpatient hospital services including laboratory, x-ray, operating room, anesthesia, medication & physician's services         20% of covered charges           I. Pre-ratal & Fost-hard I care Visit (Includes one routine ultrasound)         No Charge           I. Pre-ratal & Fost-hard Care Visit (Includes one routine ultrasound)         No Charge           2. Delivery - Hospital Facility, & Professional Fee         20% of covered charges           3. Circuncision (Covered vatina 3d day tom date of butt)         20% of covered charges           3. Circuncision (Covered vatina 3d day tom date of butt)         20% of covered charges           3. Ambitance Service (Instel to guond anaportation for ban fails covered charges         20% of covered charges           4. Ambitance Service (Instel to guond anaportation for ban fails covered charges         20% of covered charges           9. Well-Child & Baby         20% of covered charges         20% of covered charges           9. Well-Child & Baby         20% of covered charges         20% of covered charges           9. Well-Child & Baby         20% of covered charges         20% of covered charges           9. Well-Child & Baby         20% of covered charges         20% of covered charges           9. Well-Child & Baby         20% of covered charges         20% of covered charges           8			
surgery: All other impatient hospital services including laboratory, x-ray, operating room, anothesia, medication & physician's services 2. Inpatient Mental Health & Chemical/Substance Treatment 2. Inpatient Mental Health & Chemical/Substance Treatment 1. Pre-natal & Post-natal Care Visit (Includes one routine ultrasound) 2. Delivery - Hospital Facility & Professional Fee (a separate copayment will apply for newborn Child) 3. Circumcistom (Covered vitas) days from dase of hoth) 2. Delivery - Hospital Facility & Professional Fee (a separate copayment will apply for newborn Child) 3. Circumcistom (Covered vitas) and separate one does of hoth) 2. Delivery - Hospital Facility of a possible of hoth and the one papery) 2. Delivery - Hospital Facility of the one of the one face enceptory) 2. Delivery - Hospital Facility of the one of the one face enceptory) 2. Delivery - Hospital Facility of the one of the one of the one paper on the period 2. Weil-Child Care 3. Routine Annual Typixical Exam - Limited to one exam per contract period 3. Routine Annual Typixical Exam - Limited to one exam per contract period 3. Routine Annual Typixical Exam - Limited to one exam per contract period 3. Routine Annual Typixical Exam - Limited to one exam per contract period 3. Routine Annual Typixical Exam - Limited to one exam per contract period 3. Routine Annual Typixical Exam - Limited to one exam per contract period 3. Routine Annual Typixical Exam - Limited to one exam per contract period 3. Routine Annual Typixical Exam - Limited to one exam per contract period 3. Routine Annual Typixical Exam - Limited to an exam, 500 limit per contract period 3. Routine Annual Typixical Exam - Limited to period 3. Routine Annual Typixical Exam - Limited to an exam, 500 limit per contract period 3. Routine Annual Hospital Exam - Limited to an exam, 500 limit per contract period 3. Routine Annual Hospital Exam - Limited to an exam, 500 limit per contract period 3. Routine Annual Hospital Exam - Limited to an exam, 500 li			
2. Inplation? Montal Health & Chemical/Substance Treatment     20% of covered charges       1. Pre-natal & Post-natal Care Visit (Includes one routine ultrasound)     No Charge       2. Delivery - Hospital Facility & Professional Fee (a separate copayment will apply for newborn child)     20% of covered charges       2. Circunction (Covered within 30 days from date of birth)     20% of covered charges       EMERGENCY BENETIS     20% of covered charges       1. On & Off-Stand emergency facility, physician services, laboratory, x-rays     20% of covered charges       2. Ambulance Service (Lamited to ground transportation for bons file emergency)     20% of covered charges       2. Multich ANNUAL EXANK & IMMUNIZATIONS     EMERGENCY General Charges       2. Woll-Baby Care (Up to age 2: Limited to 5 visits per contract period)     20% of covered charges       2. Woll-Child Care     20% of covered charges       2. Routine Annual Physical Exan - Limited to one exam per contract period     20% of covered charges       3. Routine Annual Physical Exan - Limited to one exam, 50 limit per contract period     20% of covered charges       4. Routine Annual Immunications - Per CDC caddiens     20% of covered charges       5. Routine Annual Immunications - Per CDC caddiens     20% of covered charges       8. Routine Annual Immunications - Per CDC caddiens     20% of covered charges       9. Unite Annual Immunications - Per CDC     5 5 per unit     5 0 (00 days)       3. Non-Annual Immunicating Caddiens <td< td=""><td></td><td></td><td>8</td></td<>			8
MATERNITY CARE       No Charge         2. Delivery - Hospital Facility & Professional Fee       20% of covered charges         2. Delivery - Hospital Facility & Professional Fee       20% of covered charges         (a separate copayment will apply for newborn child)       20% of covered charges         3. Circuncision (Covered within 30 days from date of birth)       20% of covered charges         2. Anbulance Service Limited to ground transportation for boan false mengency)       20% of covered charges         2. Anbulance Service Limited to ground transportation for boan false mengency)       20% of covered charges         ROUTINE ANNUAL EXAMS & IMMUNIZATIONS       20% of covered charges         Preventive Care for Adults, Child & Baby       20% of covered charges         3. Routine Annual Typiscial Exam - Limited to one ecam per contract period       20% of covered charges         4. Routine Annual Crynecological Exam - Limited to one ecam per contract period       20% of covered charges         5. Routine Annual Kersens       20% of covered charges         6. Routine Annual Fore Serving/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         7. Routine Annual Fore Serving/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         8. Routine Annual Fore Serving/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         9. Odo days)       30% of covered charges       30% of overend charges <td></td> <td></td> <td></td>			
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2) Delivery - Hospital Facility & Professional Fee (a separate value) apply for newborn child) 3. Circumcision (Covered within 30 days from date of birth) 20% of covered charges EMERGENCY DENEITS 1. On & Off-island emergency facility, physician services, laboratory, x-rays 20% of covered charges 20% of covered			
(a separate coparment will apply for newborn child) 3. Circumcisking days for a dev birth) 20% of covered charges  EMEGENCY EENETTS 1. On & Off-island emergency facility, physician services, laboratory, x-rays 2. Ambulance Service (Limited to ground transportation for hom fide emergency) 20% of covered charges 2. Ambulance Service (Limited to ground transportation for hom fide emergency) 20% of covered charges 2. Multiply and the full to ground transportation for hom fide emergency) 20% of covered charges 2. Multiply Care (Up to age 2. limited to 5 visits per contract period) 2. Well-Raby Care (Up to age 2. limited to 5 visits per contract period) 2. Well-Child Care 2. Well-Child Care 2. Well-Child Care 3. Routine Annual Physician services, limite to one exam per contract period 2. Well-Child Care 3. Routine Annual Spreecological Exam - Limited to one exam per contract period 2. So of covered charges 3. Routine Annual Marmograms - Age 40 2. Routine Annual Functions - Per CDC Guidelines 2. Routine Annual Immunitations - Per CDC Guidelines 3. So (0 overed charges 3. So (0 overed charges 3. So (0 overed charges 3. Routine Annual Immunitations - Per CDC Guidelines 3. So (0 overed charges 3. So (0 overed charges 3. Routine Annual Immunitations - Per CDC Guidelines 3. So (0 overed charges 3. So (0 overed charge			
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TREGENCY PENEPTIS           1. On & Official on emergency facility, physician services, laboratory, x-rays         20% of covered charges           2. Ambulance Service (Limited to ground transportation for bona fide emergency)         20% of covered charges           ROUTINE ANNUAL EXAMS & IMMUNIZATIONS         Preventive Care for Adults, Child & Baby           1. Well-Child Care         20% of covered charges           2. Well-Child Care         20% of covered charges           3. Routine Annual Physical Ixam - Limited to one exam per contract period         20% of covered charges           4. Routine Annual Gynecological Exam - Limited to one exam per contract period         20% of covered charges           5. Routine Annual Fyte Exam Limited to one exam per contract period         20% of covered charges           7. Routine Annual Fyte Exam Limited to one exam \$50 limit per contract period         20% of covered charges           8. Routine Annual Health Screening/Outpatient Laboratory/Outpatient X-ray         8 bail Order           1. Generic drugs         \$ 5 per unit         \$ 0 (90 days)           2. Brand drugs         20% of covered charges         \$ 30 (90 days)           3. Non-formulary drugs         30% of covered charges         \$ 30 (90 days)           4. Injectables (includes specially injectable drugs)         20% of covered charges         \$ 30 (90 days)           5. Specially (recludes singictable drugs)	a separate copayment will apply for newborn child)	20% of covered che	17005
1. On & Off-island emergency facility, physician services, laboratory, x-rays       20% of covered charges         2. Ambulance Service (Limited to ground transportation of boan fide emergency)       20% of covered charges         Preventive Care for Adults, Child & Baby       20% of covered charges         2. Well-Child Care       20% of covered charges         3. Notline Annual Physical Exam - Limited to one exam per contract period       20% of covered charges         4. Routine Annual Mysical Exam - Limited to one exam per contract period       20% of covered charges         5. Routine Annual Mysical Exam - Limited to one exam per contract period       20% of covered charges         6. Routine Annual Mysicality, Outpatient Laboratory, /Outpatient X-ray       20% of covered charges         7. Routine Annual Immunizations - Per CL Guidelines       20% of covered charges         8. Routine Annual Immunizations - Per CL Guidelines       20% of covered charges         9. Rescription DNROS       Ketail/Pharazy       Mail Order         9. Rescription DNROS       S per unit       \$ 0 (00 days)         3. Non-formulary drugs       20% of covered charges       30 (00 days)         3. Non-formulary drugs       20% of covered charges       30 (00 days)         3. Non-formulary drugs       20% of covered charges       30 (00 days)         3. Non-formulary drugs       20% of covered charges       20% of covered ch		20% 61 covered cha	liges
2. Ambulance Service (Limited to ground transportation for bona fide emergency)       20% of covered charges         ROUTTRE VAULAL EXAMS & IMMUNIZATIONS       20% of covered charges         Preventive Care for Adults, Child & Baby       20% of covered charges         2. Well-Child Care       20% of covered charges         2. Well-Child Care       20% of covered charges         3. Routine Annual Physical Exam - Limited to one exam per contract period       20% of covered charges         5. Routine Annual Gynecological Exam - Limited to one exam, 50 limit per contract period       20% of covered charges         7. Routine Annual Free Exams - Limited to one exam, 50 limit per contract period       20% of covered charges         7. Routine Annual Health Screening/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         8. Routine Annual Health Screening / Outpatient Laboratory/Outpatient X-ray       20% of covered charges         9. Routine Annual Free DCC Guidelines       20% of covered charges         9. Routine Annual Free DCC Guidelines       5 per unit       0 (90 days)         2. Brand drugs       30% of covered charges       \$ 30 (90 days)         3. Non-formulary drugs       30% of covered charges       \$ 30 (90 days)         4. Injectables (includes specially injectable drugs)       30% of covered charges       30% of covered charges         5. Specialty (circulues injectable drugs)       20% of c		20% of covered cha	raes
ROUTINE ANNUAL EXAMS & IMMUNIZATIONS         Preventive Care for Adults, Child & Baby         1. Well-Baby Care (Up to age 2; Limited to 5 visits per contract period)       20% of covered charges         2. Well-Child Care       20% of covered charges         3. Routine Annual Physical Exam - Limited to one exam per contract period       20% of covered charges         4. Routine Annual Mymorgams - Age 40+       20% of covered charges         5. Routine Annual Synexological Exam - Limited to one exam per contract period       20% of covered charges         6. Routine Annual Infrunzitations - Per CD Caliddines       20% of covered charges         7. Routine Annual Infrunzitations - Per CD Caliddines       20% of covered charges         8. Routine Annual Infrunzitations - Per CD Caliddines       20% of covered charges         9. Rescription DNBUGS       Retail/Pharmacy       Mail Order         1. Generic drugs       5 per unit       \$ 0 (90 days)         3. Non-formulary drugs       20% of covered charges       \$ 30 (90 days)         3. Non-formulary drugs       20% of covered charges       \$ 0 (90 days)         3. Non-formulary drugs       20% of covered charges       \$ 0 (90 days)         3. Non-formulary drugs       20% of covered charges       \$ 0 (90 days)         3. Non-formulary drugs       20% of covered charges       20% of covered charges			
Preventive Care for Adults, Child & Baby         1. Well-Baby Care (Up to age 2: Limited to 5 visits per contract period)       20% of covered charges         2. Well-Child Care       20% of covered charges         3. Routine Annual Eynecological Exam - Limited to one exam per contract period       20% of covered charges         4. Routine Annual Eynecological Exam - Limited to one exam per contract period       20% of covered charges         5. Routine Annual Eynecological Exam - Limited to one exam, 550 limit per contract period       20% of covered charges         7. Routine Annual Excreming/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         8. Routine Annual Floatin Screening/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         9. Routine Annual Floatin Screening/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         9. Routine Annual Floatin Screening/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         9. Routine Annual Floatin Screening/Outpatient Screening/Outpatient X-ray       8 of govered charges         9. Routine Annual Physics (Includes specially injectable drugs)       30% of covered charges       5 0 (90 days)         9. Stread drugs       20% of covered charges       30% of covered charges         9. Soperally (excludes singclub drugs)       30% of covered charges       30% of covered charges         1. Brinnary & Specially Care Office Visit       20% of covered char			
1. Well-Baby Care (Up to age 2) Limited to 5 visits per contract period       20% of covered charges         2. Well-Child Care       20% of covered charges         3. Routine Annual Cynecological Exam - Limited to one exam per contract period       20% of covered charges         5. Routine Annual Cynecological Exam - Limited to one exam per contract period       20% of covered charges         6. Routine Annual Dynecological Exam - Limited to one exam per contract period       20% of covered charges         7. Routine Annual Immunizations - Per CDC Guidelines       20% of covered charges         8. Routine Annual Integrituations - Per CDC Guidelines       20% of covered charges         9. RescRIPTION DRUGS       Retail/Pharmacy       Mail Order         1. Greneric drugs       \$ 5 per unit       \$ 0 (90 days)         3. Non-formulary drugs       30% of covered charges       \$ 30 (90 days)         3. Instrict drugs       30% of covered charges       \$ 50 (90 days)         3. Non-formulary drugs       30% of covered charges       \$ 50 (90 days)         4. Injectables (includes injectable drugs)       20% of covered charges       \$ 0 (90 days)         5. Specialty (excludes injectable drugs)       20% of covered charges       \$ 0 (90 days)         6. Routine Annual The Annual Dimensional in this document       pocket max       Pocket max         RLOOD, RLOOD PRODUCTS & DERLVATIVES (Limited to cost o			
3. Routine Annual Physical Exam - Limited to one exam per contract period       20% of covered charges         4. Routine Annual Mammograms - Age 40+       20% of covered charges         5. Routine Annual Immitted to ene exam, \$50 limit per contract period       20% of covered charges         7. Routine Annual Immunizations - Per CDC Guidelines       20% of covered charges         8. Routine Annual Immunizations - Per CDC Guidelines       20% of covered charges         8. Routine Annual Immunizations - Per CDC Guidelines       20% of covered charges         8. Routine Annual Immunizations - Per CDC Guidelines       20% of covered charges         8. Routine Annual Integes       5 0 (90 days)         2. Brand drugs       20% of covered charges       5 30 (90 days)         3. Non-formulary drugs       30% of covered charges       5 0 (90 days)         4. Injectables (includes specialty injectable drugs)       30% of covered charges       30 (90 days)         5. Specialty (scludes injectable drugs)       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Cardiac pacemaker and cardiac stent. Pre-certification is required.       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to cardiac pacemaker and cardiac stent. Pre-certification is required		20% of covered cha	irges
4. Routine Annual Gynecological Exam - Limited to one exam per contract period       20% of covered charges         5. Routine Annual Eye Exam - Limited to one exam, 550 limit per contract period       20% of covered charges         6. Routine Annual Health Screening/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         7. Routine Annual Health Screening/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         7. Generic drugs       \$ 5 per unit       \$ 0 (90 days)         2. Brand drugs       \$ 5 30 (90 days)       30% of covered charges       \$ 30 (90 days)         3. Non-formulary drugs       30% of covered charges       \$ 30 (90 days)         4. Injectables (includes specially injectable drugs)       30% of covered charges       \$ 30 (90 days)         5. Specialty (excludes injectable drugs)       20% of covered charges       \$ 30 (90 days)         6. Routine Annual Health Screening, Viewer and Cardiac stem.       pocket max       Not Covered         1. Primary & Specialty Care Office Visit       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Carles acemaker and cardiac stem. Pre-certification is required.       CARDE       20% of covered charges         1. Primary & Specialty Care Office Visit       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Carles roeans arear and cardiac stem. Pre-certification is required. </td <td></td> <td></td> <td></td>			
5. Routine Annual Sexam - Linited to one exam, 550 linit per contract period 6. Routine Annual Fuel to one exam, 550 linit per contract period 20% of covered charges 7. Routine Annual Health Screening/Outpatient Laboratory/Outpatient X-ray 20% of covered charges 7. Rescription DRUGS 1. Generic drugs 2. Brand drugs 2. Brand drugs 2. Brand drugs 3. Non-formulary drugs 3. Specialty injectable drugs) 3. Specialty (excludes injectable drugs) 3. Specialty (excludes injectable drugs) 3. Specialty (excludes injectable drugs) 4. Injectables (includes specialty injectable drugs) 5. Specialty (excludes injectable drugs) 4. Diffectables (includes specialty interable drugs) 4. Diffectables (includes specialty interable drugs) 5. Specialty (excludes injectable drugs) 4. Diffectables (includes specialty interable drugs) 4. Diffectables (includes specialty interable drugs) 5. Specialty (excludes injectable drugs) 4. Diffectables (includes specialty interable drugs) 5. Specialty (excludes injectable drugs) 4. Diffectables (includes specialty interables drugs) 5. Specialty (Excludes injectable drugs) 5. Specialty (Excludes injectable drugs) 6. Cardiac CARE 1. Primary & Specialty Care Office Visit 2. Cardiac Surgery (Linited to centers of Care in the Philippines) Cardiac Eurgery (Linited to centers of Care in the Philippines) Cardiac Eurgery (Excludes in second charges Excludes Catheterization, Coronary Angiography, Bone Scan, Biopsy and other diagnostic procedures. (Pre-certification is required for some procedures. Approval is subject to medical review) CHRONIC ORTHOPEDIC DEFORMITY & CONDITIONS (Linited to 55,000 per Contract Period) 1. Primary & Specialty Care Office Visit 2. Hospitalization 1. Primary & Specialty Care Office Visit 2. Review (Cortract Period) 1. Primary & Specialty Care Office Visit 2. Review (Cortract Period) 2. Non Charge 2. ANIVAL OUT-OF-POCKET MAXIMUM 1. Per Individual P	3. Routine Annual Physical Exam - Limited to one exam per contract period		
6. Routine Annual Igve Exam - Limited to one exam, \$50 limit per contract period 7. Routine Annual Ileve Exam - Limited to one exam, \$50 limit per contract period 8. Routine Annual Health Screening/Outpatient Laboratory/Outpatient X-ray 8. Routine Annual Health Screening/Outpatient Laboratory/Outpatient X-ray 9. Some Charges 9. 0 (90 days) 1. Senard drugs 1. Incertables (includes specialty injectable drugs) 3. Non-formulary drugs 4. Injectables (includes specialty injectable drugs) 3. Non-formulary drugs 4. Injectables (includes specialty injectable drugs) 3. Some forward charges 3. Sopeialty (excludes injectable drugs) 3. Some forward charges 3. Of covered charges 3. Cardiac Surgery (Limited to Centers of Care in the Philippines) 2. Cardiac Surgery (Limited to Centers of Care in the Philippines) 2. Cardiac Surgery (Limited to cardiac pacemaker and cardiac stent. Pre-certification is required. CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE 0. Of covered charges 2. Cardiac Surgery (Limited to Cardiac pacemaker and cardiac stent. Pre-certification is required. CHEMOTIC DEFORMITY & CONDITIONS (Limited to \$5,000 per Contract Period) 1. Primary & Specialty Care Office Visit 2. Of covered charges 1. Rovidual Cardia Cardiac Stress Test, Cardiac Catheterization, Coronary Angiography, Bone Scan, Biopsy and other diagnostic procedures. (Pre-certification is required for some procedures. Approval is subject to medical review) CHENOTIC DEFORMITY & CONDITIONS (Limited to \$5,000 per Contract Period) 1. Primary & Specialty Care Office Visit 2. Hospitalization 1. Rovidual Lifetime Maximum Plan pays \$1,000,000 2. Individual Lifetime			
7. Routine Annual Immunizations - Per CDC Guidelines       20% of covered charges         8. Routine Annual Health Screening/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         9. RescRIPTION DRUGS       Retail/Pharmacy       Mail Order         1. Generic drugs       \$ 5 per unit       \$ 0 (90 days)         2. Brand drugs       20% of covered charges       \$ 3 0 (90 days)         3. Non-formulary drugs       30% of covered charges       \$ 60 (90 days)         4. Injectables (includes specialty injectable drugs)       30% of covered charges       30% of covered charges         5. Specialty (excludes injectable drugs)       20% of covered charges       30% of covered charges         2. DCOD, BLOOD PRODUCTS & DERIVATIVES (Limited to cost of administration o       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Centers and cardiac stent. Pre-certification is required.       CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE       20% of covered charges         DIAGNOSTIC TESTING       No       No       No       Retail/Philippines)       20% of covered charges         Cardiac Care in the Philippines)       20% of covered charges       20% of covered charges       20% of covered charges       20% of covered charges			
8. Routine Annual Health Screening/Outpatient Laboratory/Outpatient X-ray       20% of covered charges         PRESCRIPTION DRUGS       Retail/Pharmacy       Mail Order         1. Generic drugs       \$ 5 per unit       \$ 0 (90 days)         2. Brand drugs       20% of covered charges       \$ 30 (90 days)         3. Non-formulary drugs       30% of covered charges       \$ 30 (90 days)         4. Injectables (includes specialty injectable drugs)       30% of covered charges       30% of covered charges         5. Specialty (excludes injectable drugs)       20% up to \$150 out of       Not Covered         Additional drug information can be found within this document       pocket max       Dot of covered charges         1. Primary & Specialty Care Office Visit       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to cardiac pacemaker and cardiac stent. Pre-certification is required.       CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE       20% of covered charges         DIAGNOSTIC TESTING       No Charge       (Pre-certification is required for some procedures. Approval is subject to medical review)       No Charge         (Limited to \$5,000 per Contract Period)       1. Primary & Specialty Care Office Visit       20% of covered charges         1. Hor			
PRESCRIPTION DRUGS       Retail/Pharmacy       Mail Order         1. Generic drugs       \$ 5 per unit       \$ 0 (90 days)         2. Brand drugs       20% of covered charges       \$ 30 (90 days)         3. Non-formulary drugs       30% of covered charges       \$ 60 (90 days)         4. Injectables (includes specialty injectable drugs)       30% of covered charges       300 + shipping         5. Specialty (excludes injectable drugs)       20% up to \$150 out of       Not Covered         Additional drug information can be found within this document       pocket max       DOOD, BLOOD PRODUCTS & DERIVATIVES (Limited to cost of administration o       20% of covered charges         CARDIAC CARE       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to cardiac pacemaker and cardiac stent. Pre-certification is required.       20% of covered charges       20% of covered charges         DIAGNOSTIC TESTING       20% of covered charges       20% of covered charges       20% of covered charges         PHAGNOSTIC TESTING       20% of covered charges       20% of covered charges       20% of covered charges         (Initied to \$5,000 per Contract Period)       No Charge       20% of covered charges       20% of covered charges			
1. Generic drugs       \$ 5 per unit       \$ 0 (90 days)         2. Brand drugs       20% of covered charges       \$ 30 (90 days)         3. Non-formulary drugs       30% of covered charges       \$ 60 (90 days)         4. Injectables (includes specialty injectable drugs)       30% of covered charges       30% + shipping         5. Specialty (excludes injectable drugs)       20% up to \$150 out of       Not Covered         Additional drug information can be found within this document       pocket max       20% of covered charges         BLOOD, BLOOD PRODUCTS & DERIVATIVES (Limited to cost of administration o       20% of covered charges       20%         CARDIAC CARE       20% of covered charges       20% of covered charges         1. Primary & Specialty Care Office Visit       20% of covered charges       20% of covered charges         2. Cardiac Implant is limited to centers of Care in the Philippines)       20% of covered charges       20% of covered charges         CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE       20% of covered charges       20% of covered charges         DIAGNOSTIC TESTING       No Charge       (Pre-certification is required for some procedures. Approval is subject to medical review)       No Charge         CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE       20% of covered charges       20% of covered charges         I. Individual fore Office Visit       20% of covered cha			0
2. Brand drugs       20% of covered charges       \$ 30 (90 days)         3. Non-formulary drugs       30% of covered charges       \$ 60 (90 days)         4. Injectables (includes specialty injectable drugs)       30% of covered charges       30% + shipping         5. Specialty (excludes injectable drugs)       20% up to \$150 out of       Not Covered         Additional drug information can be found within this document       pocket max       Docket max         BLOOD PRODUCTS & DERIVATIVES (Limited to cost of administration o       20% of covered charges       Carclia Carclia Carclia Carclia the Philippines)       20% of covered charges         2. Cardiac Surgery (Limited to centers of Care in the Philippines)       20% of covered charges       20% of covered charges         Cardiac Implant is limited to cardiac pacemaker and cardiac stent. Pre-certification is required.       20% of covered charges       20% of covered charges         DIAGNOSTIC TESTING       20% of covered charges       20% of covered charges       20% of covered charges         Climited to 55,000 per Contract Period)       No Charge       No Charge         (Pre-certification is required for some procedures. Approval is subject to medical review)       20% of covered charges       20% of covered charges         2. Hospitalization       20% of covered charges       20% of covered charges       20% of covered charges         2. Hospitalization       20% of covere			
4. Injectables (includes specialty injectable drugs)       30% of covered charges       30% + shipping         5. Specialty (excludes injectable drugs)       20% up to \$150 out of       Not Covered         6. Specialty (excludes injectable drugs)       20% up to \$150 out of       Not Covered         7. Additional drug information can be found within this document       pocket max       20% of covered charges         7. Additional drug information can be found within this document       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         2. Cardiac Implant is limited to cardiac pacemaker and cardiac stent. Pre-certification is required.       20% of covered charges       20% of covered charges         DIACNOSTIC TESTING       20% of covered charges       20% of covered charges       20% of covered charges         DIACNOSTIC TESTING       20% of covered charges       20% of covered charges       20% of covered charges         Chenonic ORTHOPEDIC DEFORMITY & CONDITIONS       No Charge       No Charge         (Pre-certification is required for some procedures. Approval is subject to medical review)       No Charge         CHENONIC ORTHOPEDIC DEFORMITY & CONDITIONS       20% of covered charges       20% of covered charges         1. Primary & Specialty Care Office Visit       20% of covered charges <t< td=""><td></td><td></td><td></td></t<>			
5. Specialty (excludes injectable drugs)       20% up to \$150 out of pocket max       Not Covered         Additional drug information can be found within this document       pocket max       Not Covered         BLOOD, BLOOD PRODUCTS & DERIVATIVES (Limited to cost of administration o       20% of covered charges       Carcial Cancer         1. Primary & Specialty Care Office Visit       20% of covered charges       20% of covered charges         2. Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         Cardiac Surgery (Limited to Centers of Care in the Philippines)       20% of covered charges       20% of covered charges         DIAGNOSTIC TESTING       Coronary Angiography, Bone Scan, Biopsy and other diagnostic procedures.       No Charge       No Charge         (Pre-certification is required for some procedures. Approval is subject to medical review)       No Charge       No Charge         CIARDOLO DEFORMITY & CONDITIONS       1. Primary & Specialty Care Office Visit       20% of covered charges       20% of cov	3. Non-formulary drugs	30% of covered charges	
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ANNUAL OUT-OF-POCKET MAXIMUM 1. Per Individual Per Contract Period None			
	ANNUAL OUT-OF-POCKET MAXIMUM	* *	
2. Per Family Per Contract Period None		None	
	2. Per Family Per Contract Period	None	



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.

EMERGENCY CARE - Coverage for medical emergencies outside of Palau is subject to limitations of your Plan. NetCare must be notified immediately for hospitalization.

PHILIPPINE/TAIWAN CARE - All covered benefits and services rendered at NetCare's Centers of Care in Philippines and Taiwan are payable 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. PROVIDER NETWORK - Covered benefits and services are payable at participating providers within Palau, Philippines and Taiwan. Services rendered other than participating providers in Palau, Philippines and Taiwan are not covered benefits. Services at non-participating providers are not covered. REFERRALS - Referrals are not required for primary, specialty care or covered ancilliary services at approved participating providers in Palau. A NetCare approved referral is required for all services rendered outside Palau. Services outside Palau are limited to NetCare's Centers of Care & Participating Providers in Philippines and Taiwan.

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

UCR means Usual, Customary & Reasonable charges of the geographical location where service was rendered based on the current Medicare RBRVS/DRG. Covered services at Non-participating Providers are subject to UCR, when applicable. Charges in excess of UCR are not payable by the Plan.

Medical	<b>Exclusions:</b>	Services NOT covered by NetCare
		<ul> <li>Nasal reconstruction except to correct a defo</li> </ul>

• Airfare.

- - Allergy testing and treatment.

Acupuncture care & 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 Medicare is or would be primary for a member who is eligible and entitled 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 health care provider.
- Chronic Brain Syndrome, or custodial care charges resulting from senile deterioration.
- Chiropractic services.
- · Cost of care and services related to or for replacement of joints and use of prosthetic devices and artificial limbs.
- 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.
- Cost of services for Sterilization (Tubal Ligation, Vasectomy)
- 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
- Durable Medical Equipment.
- · 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.
- Experimental medical, surgical and other health-care procedures.
- Executive Physical Exam/ECU (inpatient physical exam).
- 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 Mental Health Care.
- 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.
- Maternity care for non-spouse dependent including but not limited to ectopic pregnancy, antepartum hemorrhage.
- Mental Health treatment and services.

- prmity 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.
- 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 at non-participating providers.
- Services rendered outside Palau without a NetCare approved referral, limited to Philippines and Taiwan participating providers.
- Speech related services.
- 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 hepatits without a NetCare approved prior authorization and strict criteria satisfaction.
- Treatment and services related to ESRD, including dialysis.
- Treatment and services related to Organ Transplants.
- 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 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.
- 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.