Summary Plan Description

GUAM HMO PLAN

Advantage POS Plan

Issued by NetCare Life & Health Insurance Company

NetCare
Life & Health Insurance

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Article I INTRODUCTION

WELCOME! All of us at NetCare Life & Health Insurance Company pledge to you that we will provide the best service we can in the administration of your group health plan. The following information summarizes your group's benefits. It also summarizes conditions, limitations and exclusions to those benefits. There are sections explaining and defining certain words, too. Please be sure to read this information in its entirety.

This information is a "Summary Plan Description" as defined by ERISA, the Employee Retirement Income Security Act of 1974 as amended. The Summary Plan Description for this Plan is a Point of Service (POS), which is a managed care arrangement in which participating providers provide services at negotiated fees. Under this Plan, you are required to select a Primay Care Provider (PCP) who coordinates your care. This Plan also has restrictive networks and only care provided within the network and within the service area is covered. The POS networks offer a wide range of providers from multiple specialty areas which allows you to seek covered medical expenses but at a higher cost (copayment/coinsurance) to you. If you seek care from a specialist provider or a non-PCP, a referral from your PCP is not needed. This POS plan also offer managed care services such as utilization review, hospital pre-certification and case management. Also, your health care is closely managed and preventive medicine is encouraged.

This booklet contains a summary of your plan rights and benefits. If you have difficulty understanding any part of this booklet, contact NetCare's Customer Service Department at 1-671-472-3610 between the hours of 8:00 am to 5:00 pm Monday through Fridays. You may also contact your Human Resources Department of Benefits Officer for more information.

Article II MEMBER ELIGIBILITY

YOUR COVERAGE

You are in an Eligible Class if you are:

- A Regular Full-Time (RFT) or Regular Part-Time (RPT) employee scheduled to work at least 20 hours per week, who is paid on the U.S. dollar payroll, and who is U.S. citizen or resident alien living in Guam, the CNMI, or where this Policy or applicable certificate is delivered**.**

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the date you become part of an Eligible Class.

The following groups are not in an Eligible Class:

- Flexible employees.
- Working less than 20 hours per week.

DEPENDENTS

You may cover your:

- wife or husband, which includes common-law or domestic partner.
- children up to the attainment age 26.
- any child over the maximum age who is determined to be incapable of self-support due to a handicap.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren who live with you and are dependent upon you for support.
- Your common-law or domestic partner children who live with you and are dependent upon you for support.
- Any other child who is not your biological, adopted, or stepchild, but who lives with you and is dependent upon you for financial support. Evidence proving dependency is required in the form of documentation of legal guardianship.

Evidence proving dependency may be requested for submission to NetCare for certain enrollment criteria of your dependent.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee under the same employer.

ENROLLMENT PROCEDURE

Your enrollment packet will include an Enrollment Form to complete. This form will allow your Employer to deduct your contributions from your pay to cover your contributions for the plan you elect during enrollment.

IMPORTANT - You must sign, date and return the completed enrollment form to your Human Resources Manager WITHIN 30 DAYS of your Eligibility Date for you and your dependents to be covered. Your

Human Resource Office representative will sign and date the enrollment form to acknowledge receipt. If you don't sign and return your form within 30 days of your Eligibility Date, you may not elect Health Expense Coverage until the next open enrollment period established by your Employer.

If you want dependent coverage for a newly eligible dependent (for example, you get married or have a baby), complete a Change of Status Form (available from your Human Resources Manager) within 30 days of the Eligibility Date (that is date of marriage or baby's date of birth). When you elect dependent coverage, you must list all their names on the appropriate section of the enrollment form. If you do not request dependent coverage within 30 days of the Eligibility Date, you may not elect Health Coverage for such dependent until the next open enrollment period established by your Employer.

Enrollment that does not meet special enrollment qualifications under HIPAA or open enrollment is considered late enrollment that is subject to NetCare's approval and completion of a Health Statement, subject to pre-existing eclusiosn under HIPAA.

Evidence proving eligibility or dependency of a dependent may be requested for submission to NetCare.

Submittal of enrollment documents must be submitted to NetCare on or prior to the twentieth (20^{th}) of the month prior to the first day of the following month of coverage.

GROUP PARTICIPATING PREQUIREMENTS

MEDICAL

Coverage for Companies with ten (10) or less eligible employees must have 100% participation of enrollment of all eligible employees. Companies with more than ten (10) eligible employees, but less than twenty-five (25) employees must enroll 75% of all eligible employees.

DENTAL

Companies that elected group dental coverage must maintain 50% employee participation of the total group enrollment Active dental coverage must remain in avtive status for the entire contract period.

ORTHODONTIC

Companies that elect Orthodontic coverage must maintain 50% employee participation of the total group enrollment that corresponds with dental enrollment. Eligibile employees and dependents are not permitted to enroll solely for orthodontic coverage that must run concurrent with enrollment in a dental benefit plan, within the same group policy, for the entire contract period.

VISION

Companies that elect Vision Care must have 100% employee and dependent participation requirement regardless of company size.

ENROLLMENT CLASSIFICATION

Single – Employee Only
2-Party - Employee and spouse; or Employee and one (1) child.
Family - Employee, spouse and child(ren); or Employee and children

EFFECTIVE DATE OF COVERAGE

a. Your Coverage

Your coverage will take effect on the latter of:

- The effective date of this Policy;
- The first day of the calendar month following the date he or she complete the waiting period set forth in this Policy;
- The first day of the calendar month following the date you return your signed group coverage enrollment form to your Human Resource Manager.

b. Your Dependents

If you do not sign and return your form within 30 days of your Eligibility Date, you will not be able to elect coverage until the next open enrollment period established by your Employer. Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You must report any new dependents. This may affect your contributions. If you do not do so within 30 days of any dependent's Eligibility Date, you will not be able to elect coverage for such dependent until the next open enrollment period established by your Employer.

- If you have employee coverage only and you request dependent coverage for a *newly eligible* dependent within 30 days of their Eligibility Date, the effective date of coverage is the date that the dependent first became eligible for coverage under the Plan.

- If you have employee coverage and want to change to dependent coverage but did not request such coverage within 30 days of this Eligibility Date, you will not be able to elect coverage for such dependent until the next open enrollment period established by your Employer.

TERMINATION OF EMPLOYEE COVERAGE

Coverage under this Plan terminates at the first occurrance of:

- End of month in which employment ceases. Ceasing active work will be deemed to be cessation of employment.
- Date the employee dies.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.
- When the group falls below the minimum of two (2) employees.
- When the group fails to make timely premium payments.
- Date when NetCare determines that a member has intentionally misrepresented any enrollment information
- Date when you fail to submit any required documents or information after reasonable notice from NetCare to submit the request and required documents or information.

- Date following a period of 90 consecutive days during which the employee has not been in the Active Service of the employer due to total disability.

Your Employer will notify NetCare of the date your employment ceases for the purposes of termination of coverage under this Plan. The effective date of termination is always the last day of the month. Your Employer will use the same rule for all employees.

- A Change of Status Form must be submitted to NetCare for the termination of coverage. The Change of Status Form may be submitted by the 30th of the month prior to the effective date of termination.

- You must sign, date and return the completed Change of Status Form to your Human Resources Manager. Your Human Resource Manager or representative must also sign and date the form prior to submission to NetCare. In the case of employment terminations, your Human Resource Manager or representative may sign on your behalf.

- If you are not at work due to disease, injury, temporary lay-off or leave of absence, your employment may be continued until stopped by your Employer.

TERMINATION OF DEPENDENT COVERAGE

A dependent's coverage will terminate at the first occurrence of:
- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer meets the definition of dependent.
- When your coverage terminates.
- When you fail to make any required contribution for coverage.
- When the employee dies.
- When NetCare determines that a member has intentionally misrepresented any enrollment information.
- When the member fails to submit any required documents or information after reasonable notice from NetCare to submit the request and required documents or information.

A Change of Status Form must be submitted to NetCare for the termination of a dependent coverage. The form may be submitted at the end of the month prior to the first day of the month of deletion.

You must sign, date and return the completed Change of Status Form to your Human Resources Manager. Your Human Resource Manager or representative must also sign and date the form prior to submission to NetCare.

CONTINUATION OF COVERAGE FOR SURVIVING DEPENDENTS

If you die as an active employee covered under any part of this Plan, and if your dependents are enrolled as a dependent in the Plan on the day of your death, your covered dependents, including your spouse, will be eligible for up to 36 months of medical coverage through the Continuation Health Law Program described in this booklet. This coverage is available to your dependents at a cost of 102% of the total employer and employee premium.

Your covered dependents are required to make contributions toward the cost of their coverage equal to the

contributions then being charged to active employees for like coverage.

Any dependents' coverage (other than coverage for your spouse) will cease when any one of the following happens:

- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for like coverage under this Plan.
- Termination of all dependents' coverage under the group contract.
- When your group coverage terminates.
- When you fail to make any required contribution for coverage.
- When the member dies.
- When NetCare determines that a member has intentionally misrepresented any enrollment information.

If Health Expense Coverage is being continued for your dependents, your child born after your death will also be covered. The completed enrollment form must be returned to your Human Resources Manager within 30 days of the date the child is born. Proof of claim may be given by your spouse or by the custodial guardian of a minor child. Benefits will be paid to the person providing the proof.

OVER AGE CHILD

Enrollment of a dependent child under this agreement shall terminate upon the attainment age of his or her 26th birthdate. Coverage for a dependent child, within the service are, may be continued until the attainment age of 26 years regardless if the dependent is married, living with you, in school, financially dependent on you, eligible to enroll in their employer's plan (with one exception, grandfathered group plan do not have to offer dependent coverage up to age 26 if a young adult is eligiblefor group coverage outside the parent plan). Coverage does not include a child of a child receiving dependent coverage.

DEPENDENT CHILD WITH DISABILITIES

Health Expense Coverage for your fully handicapped child may be continued past the maximum age for a dependent child with the following conditions:

Your child is disabled if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends primarily on you for support and maintenance.

A physician certification must be submitted to NetCare no later than 30 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the disability exists.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

NetCare has the right to require the submission of a physician certification of disability at any given time.

SERVICE AREA REQUIREMENTS

Coverage under this Policy is applicable to only those person(s) who maintain their principal residence in Guam, the CNMI, or where this Policy or applicable certificate is delivered and such persons must be physically residing in said jurisdiction during at least nine (9) months of each Contract Period while this Policy remains in force.

Notwithstanding the foregoing, any time spent out of the designated service area shall apply towards the fulfillment of the nine (9) month physical presence requirement, provided that (i) such time is limited to the time that the person is receiving continuous and required medical care at a skilled nursing facility, a hospital, or a hospice inpatient unit; and (ii) NetCare approves such time in advance following a medical review to determine and confirm the necessity and continuation of the medical care.

For those person(s) not physically residing at least nine (9) months of each Contract Period in the jurisdiction where this Policy or applicable certificate is delivered, the only liability of the company is a refund of all premiums paid for persons who do not qualify under this Service Area Requirement, from this Policy's inception or its last renewal, whichever is most recent, less deduction of any amount already paid for claims incurred while the claimant did not qualify under the Service Area Requirement.

The Service Area Requirements do not apply to over age dependent children who reside outside the designated service area for secondary educational purposes.

SPECIAL ENROLLMENT PROCEDURES UNDER HIPAA

You will be able to elect coverage at any time after 30 days without waiting for the next open enrollment period if:

- You did not elect Health Expense Coverage for the person involved within 30 days of the date you were first eligible (or during an open enrollment) because at that time:
    a. the person was covered under other "creditable coverage" as defined below; and
    b. you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and

- The person loses such coverage because:
    a. of termination of employment in a class eligible for such coverage;
    b. of reduction in hours of employment;
    c. your spouse dies;
    d. you and your spouse divorce or are legally separated;
    e. such coverage was COBRA like continuation and such continuation was exhausted; or
    f. the other plan terminates due to the employer's failure to pay the premium or for any other reason

- You elect coverage within 30 days of the date the person loses coverage for one of the above reasons.

Coverage will be effective on the date of the change in status.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

Also, you will be able to elect coverage without waiting for the next open enrollment period if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A spouse or child who meets the definition of a dependent, but you elect it later and within 30 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order.

- Yourself, and you subsequently acquire a dependent, which meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the election.

- Yourself, and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

- Yourself and your spouse, and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

Article III COMPREHENSIVE MEDICAL EXPENSE COVERAGE

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. NetCare will determine the pro rata share. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

NetCare assumes no responsibility for the outcome of any covered services or supplies. NetCare makes no express or implied warranties concerning the outcome of any covered services or supplies.

All maximums included in this Plan are combined maximums between Participating Care and Non-Participating Care, where applicable, unless specifically stated otherwise.

GENERAL

This SPD and Policy Specification replace any SPD and Policy Specification previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with your Policy Specification cannot be accepted.

ADJUSTMENT RULE

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

PRE-CERTIFICATION REQUIREMENT

Certain types of care must be approved by NetCare to avoid a reduction in payable benefits. Additional information may be found in the Pre-Certification section of this Booklet for details of the types of care affected, how to get a referral and the effect on you benefits of failure to obtain one.

THE BENEFITS PAYABLE

After any applicable co-payment or co-insurance, the benefits payable under this Plan in a contract year are payable as specifiec in the Schedule of Benefits. A Participating Provider is a pharmacy provider who agreed to provide services or supplies at a "negotiated charge."

Any charge for a service or supply furnished by a Participating Provider in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the group contract. This rule will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are payable.

Co-payment, co-insurance and deductibles are waived for all Covered Medical Expenses, except for Prescription Drugs, at Philippine Centers of Care.

CONTRACT PERIOD MAXIMUM PER MEMBER

DEDUCTIBLE

A deductible is not applicable under this plan.

PAYMENT (OUT OF POCKET) LIMIT

A separate out-of-pocket limit will apply to covered medical expenses and prescription drug expenses filled at participating providers except expenses applied against any deductible, fee, or co-pay amount.

PAYMENT (OUT OF POCKET) LIMIT WHICH APPLIES TO EXPENSES FOR AN INDIVIDUAL

When enrolled in a single status, a person’s out-of-pocket expense from covered medical expenses incurred from a participating medical provider reaches the individual out-of-pocket maximum within a contract year, benefits will be payable at 100% for covered drug expense to which this limit applies and which are incurred in the rest of that contract year. The out-of-pocket limit for covered medical expenses do not include covered prescription drug expenses.

When enrolled in a single status, a person’s out-of-pocket expense from covered prescription drug expenses incurred from a pharmacy provder reaches the individual out-of-pocket maximum within a contract year, benefits will be payable at 100% for covered drug expense to which this limit applies and which are incurred in the rest of that contract year. The out-of-pocket limit for covered prescription drug expenses do not include covered medical expenses.

PAYMENT (OUT OF POCKET) LIMIT WHICH APPLIES TO EXPENSES FOR A FAMILY

When enrolled in a family status, a person's out-of-pocket expense from covered medical expenses incurred from a participating medical provider reaches the family out-of-pocket maximum within a contract year, benefits will be payable at 100% for covered drug expense to which this limit applies and which are incurred in the rest of that contract year. The out-of-pocket limit for covered medical expenses do not include covered prescription drug expenses.

When enrolled in a family status, a person's out-of-pocket expense from covered prescription drug

expenses incurred from a pharmacy provider reaches the individual out-of-pocket maximum within a contract year, benefits will be payable at 100% for covered drug expense to which this limit applies and which are incurred in the rest of that contract year. The out-of-pocket limit for covered prescription drug expenses do not include covered medical expenses.

PAYMENT (LIFETIME) LIMIT

A lifetime maximum dollar benefit limit will apply to the listed benefit plans.
Hospice – 180 days Lifetime

REFERRALS

Referrals are not required for primary, specialty care or covered ancillary services at participating providers within the service area. Covered members may self-refer to Participating Providers within the service area. Referrals approved by NetCare are required for all services outside the service area. Covered Medical Expenses are payable based on covered benefits and limitation specified in the Schedule of Benefits.

COVERED MEDICAL EXPENSES

Covered Medical Expenses shall include the usual, customary and reasonable charges, incurred while covered, for the following types of medical services, supplies and treatment by an attending physician. Payable benefits are payable per service, per visit for Covered Medical Expenses listed below are subject to limitations listed in your Schedule of Benefits.

- **Acquired Immune Deficiency Syndrome (AIDS)** – testing, services, and treatment for AIDS will be payable on the basis of a covered illness for outpatient and inpatient benefits.

- **Allergy Testing/Treatment** – testing to determine what allergens cause a particular reaction and the degree of the reaction and provides justification for recommendations of specific avoidance measures in the home or work environment or the institution of particular medicines or immunotherapy. Covered Medical Expense for Allergy Testing will include allergy tests, allergy treatment, administration of allergy shots/injections; stinging insect and snake bite antigen, and allergy serum.

  The administration of allergy shots/injections will be payable as a physician office visit specified in the Schedule of Benefits.

- **Ambulance** – Local medically necessary professional ground ambulance service. A charge for this item will be Covered Medical Expense only if the service is due to a bona fide emergency to the nearest Hospital or Extended Care Facility where necessary care and treatment can be provided for the covered injury or sickness.

- **Anesthetic** – Anesthetic; oxygen; intravenous injections and solutions.

- **Blood and Blood Derivatives** – Covered Medical Expense for Whole Blood and Blood Derivatives. Coverage includes administration of blood.

- **Cardiac Care** – Treatment and services for Cardiac conditions, which include surgery not limited to Cardiac catherization, Coronary artery bypass graft (CABG), Percutaneous trascatheter coronary angioplasty (PTCA), Open mitral commisurotomy (OMC), closed mitral commisurotomy (CMC).

  Covered Medical Expenses for Cardiac Surgery may or may not be due to a congenital condition include the following but are not limited to repair of Atrial Septal Defect (ASD), Repair of Ventricular Septal Defect (VSD), Blalock Tausig, Repair of closed or Patent Ductus Arteriosus (PDA), Open repair of congenital cardiac malformation. Benefits for Congenital Cardiac Conditions are payable under Congenital Diseases.

- **Cardiac Rehabilitation** - As deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with an acute myocardial infarction within the preceding 12 months; (c) for coronary occlusion or coronary bypass surgery initiated within 12 weeks after other treatment; (d) stable angina pectoris; (e) heart valve repair or replacement; (f) percutaneous transluminal coronary angioplasty; (g) coronary stenting; and/or (h) heart or lung transplant; and in a Medical Care Facility as defined and approved by this Plan.

- **Chemotherapy, Radiation, Nuclear Medicine** – Treatment with radioactive substances to include materials and services of technicians are included.

- **Chiropractic Care** – Treatment and services of therapy for mechanical musculoskeletal spinal disorders which is performed by participating providers. Ancillary Treatments, in conjunction with manipulation (including but not limited to heat, electro stimulations, and massage) are covered. Services performed by a licensed M.D., D.O., or D.C. Xray services relating to Chiropractic care shall be covered under Chiropractic maximums.

- **Chronic Orthopedic Condition** – The diagnosis and treatment for Chronic Orthopedic conditions. Covered Medical Expenses are payable based on benefits described in the Schedule of Benefits. Eligible Expenses exclude orthopedic and external prosthetic devices including but not limited to shoes, orthotics, artificial limbs, etc.

- **Congenital Diseases** – Services and treatment for the disease, deformity or deficiency existing at the time of birth. Benefits for Congenital Diseases include but not limited to Congenital Cardiac Conditions. Covered Medical Expenses for Congenital Diseases are subject to limitations specified in the Schedule of Benefits.

- **Diagnostic Testing & Procedures** – Procedures for diagnostic imaging, or diagnostic radiology such as axial tomography (CAT or CT) scans, magnetic resonance imaging (MRI), angiography and aortography; additional procedures include ultrasound, cardiac stress testing, cardiac catherization, bone scan, biopsy, and nerve conduction tests.

  Covered Medical Expenses for Diagnostic Services and Testing are payable based on medical necessity and as described in the Schedule of Benefits.

- **Durable Medical Equipment** – The rental of durable medical or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by

the Plan Administrator.

Covered Medical Expenses will include charges associated with the initial purchase of a wig after chemotherapy.

- **Eye/Vision Exam** – Services and treatment performed by a licensed M.D. or O.D. Covered Medical Expenses for Eye/Vision Exam is limited to one (1) exam per Contract Year and does not include coverage for eyeglasses - frames & lenses, or contact lenses.

- **Home Health Care Services and Supplies** - Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

  Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

  A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

- **Hospice Care Services and Supplies** - Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under the Hospice Care Plan.

  Covered Medical Expenses for Hospice Care Services and Supplies are payable as described in the Policy Specifications.

- **Hospitalization -** Covered Medical Expenses charged by a hospital for semi-private accommodations or the Most Common Semi-private Accommodation rate or as may otherwise be stated on the Schedule of Benefits for a hospital that does not have semi-private accommodations will be covered at the percentage shown on the Schedule of Benefits; Intensive Care Unit, Cardiac Care Unit, or Burn Unit accommodations will be limited to the percentage of eligible expenses shown on the Schedule of Benefits, not to exceed two (2) times the Most Common Semi-private Accommodation rate; all other hospital charges are covered at the percentage shown on the Schedule of Benefits.

  Except at Philippine Centers of Care, the maximum allowable is up to private room allowance.

  Hospital Admission on Friday, Saturday or Sunday - Charges incurred on Friday, Saturday or Sunday, will NOT be covered, except as follows: 1) Medical Emergency - if confinement begins on Friday, Saturday or Sunday because non-confinement would seriously impair the Covered Person's health or endanger his or her life, such charges will be covered; 2) admission at Philippine Centers of Care

  Hospital Next Day Surgical Procedure – Friday, Saturday or Sunday admissions will be covered when accompanied by a surgical procedure the next day.

Hospital Diagnostic (Pre-Admission) Testing Benefit - Medical Expenses for Diagnostic (Pre-Admission) testing procedures for surgery or treatment which are performed on an outpatient basis in an Ambulatory Surgical Center or Physician's office will be covered, unless it is medically necessary to perform them on an inpatient basis or services and admission at Philippine Centers of Care. See Schedule of Benefits.

Hospital Emergency Room Benefit - Covered Medical Expenses for use of a hospital emergency room when required for the treatment of a medical Emergency, as defined in this Policy, will be covered at the percentage shown in the Schedule of Benefits. Benefits for non-emergency use of a hospital emergency- room are payable at the percentages as shown in the Schedule of Benefits, after the deductible, if applicable.

Hospitalization at NetCare's Center of Care – Covered Medical Expenses for hospitalization at NetCare's Center of Care are 100% of covered charges, up to the allowed contract year dollar maximum.

Inpatient admission requires a NetCatre approved referral from the Provider within 48 hours of admission.

- **Laboratory** – Covered Medical Expenses shall include charges for medically necessary laboratory services and supplies.

- **Maternity Care -** Benefits are payable for pregnancy-related expenses of covered female employees and covered female dependent spouse on the same basis as for a disease. Benefits are payable as defined in your Policy Specification.

  Limitation applies to non-spouse maternity care. Please refer to your Policy Specification for benefit and coverage or non-spouse maternity care.
  In the event of a covered inpatient confinement, such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery.

  The expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, no benefits will be paid.

- **Mental and Nervous Disorders -** Mental Health Expenses incurred on an outpatient and inpatient basis will be covered as indicated in the Policy Specification or Summary of Benefits and Coverage.

- **Mental Disorders and Alcohol/Substance Abuse** – Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse for inpatient and outpatient care will be limited as follows: (a) All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits; (b) Psychiatrist (M.D.), psychologists (Ph.D.), counselors (IMFT) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

- **Mouth, Teeth and Gums** – Injury to or care of the mouth, teeth and gums. Charges for injury to

or care for the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures due to medical necessity:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
- Excision of benign bony growths of the jaw and hard palate;
- External incision and drainage of cellulites;
- Incision of sensory sinuses, salivary glands or ducts;
- Removal of impacted teeth;
- Reduction of dislocations and excision of temporomandibular joints (TMJ).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth.

- **Nursery Care** - The covered physician's charges for a routine newborn nursery care are the standard medical care provided to the newborn after birth, while still in-patient including room and board.

  This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent.

  The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

  Covered Medical Expenses for routine nursery care will be applied toward the Plan of the newborn child.
  Charges for treatment and nursery care for a newborn child, if covered under this Policy due to Injury or Sickness. Injury and Sickness include: birth abnormalities, congenital defects, and premature birth. Hospital and surgical eligible expenses for covered newborn children will be payable as Covered Medical Expenses subject to the specified Plan benefit limitation in the Policy Schedule (e.g. Congenital Abnormality).

- **Occupational Therapy** - Any service offered by a certified occupational therapist who is concerned with restoring useful physical functionality following disabling accidents and sickness. The goal of occupational therapy is to assist the patient in achieving the maximum level of independent function.

- **Office Visits** – Primary Care Office Visit – the treatment and service by a licensed practitioner who provides care for common medical problems in an outpatient setting.

  Specialist Care Office Visit – the treatment and service by a licensed practitioner who provides specialty care or advanced diagnosis in an outpatient setting.

  Specialized Care – Specialized health care provided by physicians whose training focused primarily in a specifiec field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopaedics, opthamology, and other specialized fields.

- **Private Duty Nursing** - Private Duty Nursing is defined as the provision of medically necessary, complex skilled care in the home on a fee-for-service basis by a Registered Nurse (RN). The purpose of private duty nursing is to assess, monitor and provide skilled nursing care in the home on an hourly basis, to assist in the transition of care from a more acute setting to home and to teach competent caregivers the assumption of this care when the condition of the individual is stabilized. The length and duration of private duty nursing services is intermittent and temporary in nature and is not intended to be provided on a permanent basis. Such services are normally billed at an hourly or shift rate. Private duty nursing services, in accordance with physician orders, are utilized when a patient requires continuous nursing services beyond the scope of care available from certified home health care agencies. Private Duty Nursing requires an approved Pre-Certification from the Plan.

  Private duty nursing services are typically covered under the following circumstances:
  - Claimant has skilled needs and the individual's condition is unstable requiring frequent nursing assessments and changes in the plan of care;
  - Placement of the nurse is done to meet the skilled needs of the claimant only and not for the convenience of the family; and
  - Care must be approved by the claimant's treating physician, with a written treatment plan that includes long and short term goals

  Private duty nursing services for claimants who are on ventilators or continuous CPAP at home is typically covered when all of the following criteria are met:
  - Claimant is on either a pressure or volume ventilator or CPAP;
  - Claimant meets the coverage criteria for confinement in a skilled nursing facility;
  - Treating physician has approved the care plan; and
  - Placement of the nurse is for the care and benefit of the claimant only.

  Private duty nursing services in the home are not considered medically necessary when it is provided for one or more of the following:
  - Solely for convenience;
  - For a stable medical condition;
  - To allow the claimant's family to work or to provide respite for the family; and
  - Custodial care.

  Physician Care - The professional services of a Physician for medical or surgical services.

  Physician Care for Surgical services:
  Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

  If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge (UCR) that is allowed for the primary procedures; 50% of the UCR will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

  If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate

operative fields, benefits will be based on UCR for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the UCR percentage allowed for that procedure; and

If an assistance surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

- **Physical Therapy** – Therapy performed by a licensed physical therapist in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Covered Medical Expenses include services of a qualified physiotherapist.

- **Reconstructive Breast Surgery** – The reconstructive mammoplasties is considered Covered Charges.

  The mammoplasty coverage will include reimbursement for:
  - Reconstruction of the breast on which a mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas.

  Covered charges for Reconstruction Surgery are payable as described in the Schedule of Benefits.

Routine (Annual) Physical Exam/Preventive Care and Well Child Care Expenses - The charges made by a participating provider for a routine physical exam and or preventive services given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a physician in connection with a routine physical exam and or preventive services are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease.

Coverage with no cost sharing includes Preventive Services, performed by a participating provider, with an A or B rating from the U.S. Preventive Services Task Force. Coverage for services other than an A or B rating and or services performed by a non-participating provider are payable as defined in the Policy Specification with applicable cost sharing.

Also included as a part of routine annual exams are:

1) X-rays, laboratory and other tests given in connection with the exam; and

2) Charges for screening for high blood pressure and high blood cholesterol and other lipid abnormalities for men ages 35-65 and women ages 45-65; and

3) Charges for colorectal (colon) cancer screening: Annual fecal occult blood test (FOBT), Sigmoidoscopy/Colonoscopy or both, for males and females ages 50 years and older – initial screening; with subsequent follow-up screenings based on the recommended guidelines set by the Centers for Disease Control; and

4) Charges for one routine gynecological exam, including pap smear for Cervical Cancer Screening during the contract year; and

5) Charges for one screening by mammography every 1-2 years given to a female age 40 or over for the presence of occult breast cancer; and

6) Charges in connection with one screening for cancer of the prostate, including a prostate specific antigen (PSA) test and a digital rectal exam, given to a male age 40 and over during any one contract year; and

7) Charges for one vision screening; and

8) Charges for hearing screening (recommended by Department of Health and Human Services, Centers for Disease Control and Prevention); and

9) Routine immunizations as recommended by Centers for Disease Control and Prevention, approved by Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP) and American Academy of Family Practitioners (AAFP).

10) Charges for Pre-natal Care, including one routine ultrasound. Benefits are payable for subsequent ultrasounds due to medical necessity and prior approval from NetCare.

11) For your dependent child the physical exam must include at least:

    a) a review and written record of the patient's complete medical history;
    b) a check of all body systems; and
    c) a review and discussion of the exam results with the patient or with the parent or guardian.

12) Charges for Well-Baby and Well-Child Care is limited to age 2 years.

<u>Limitations to Routine Physical Exam and Well Child Care Expenses</u>

Not covered as Routine Physical Exam and Well Child Care Expenses are charges for:

a) services that are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer;
b) services that are for diagnosis or treatment of a suspected or identified injury or disease;
c) exams given while the person is confined in a hospital or other place for medical care;
d) services not given by a physician or under his or her direction;
e) medicines, drugs, appliances, equipment or supplies (Note: medicines or drugs may be covered under Prescription Drug Expense; please refer to the Prescription Drug Expense section in this booklet);
f) psychiatric, psychological, personality or emotional testing or exams;
g) exams in any way related to employment;
h) pre-marital exams;
i) dental exams.

Coverage also includes Preventive Services that have a rating of A or B from the U.S. Preventive

Services Task Force that are relevant for implementing the Affordable Care Act.

- **Skilled Nursing Facility Care** - The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

  - the patient is confined as a bed patient;
  - the confinement starts within 7 days of a Hospital confinement of at least 5 consecutive days;
  - the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
  - the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

  Covered Medical Expenses for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Policy Schedule.

- **Specialty Care** – Specialized health care provided by physicians whose training focused primarily in a specific field such as neurology, cardiology, rheumatology, dermatology, oncology, orthpaedics, ophthalmology,and other specialized fields.

- **Speech Therapy** – Therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; b) an Injury; or c) a Sickness that is other than a learning or Mental Disorder. Speech Therapy resulting from a congenital condition will be subject to limitations specified in the Policy Specification for congenital diseases.

- **Sterilization** – Sterilization procedures for Tubal Ligation or Vasectomy performed in an outpatient setting.

- **Surgery** - Covered Surgical Expenses incurred as a result of surgery performed on an inpatient or outpatient basis in a Hospital, Ambulatory Surgical Center or a Physician's office, will be covered at the percentage shown on the Schedule of Benefits. A surgical copayment for covered surgical expenses shall apply regardless Place of Service. Deductible applies for services not provided by a contracted participating provider.

  Covered Medical Expenses for Surgical procedures are payable (a) when the Plan determines that such procedures is medically necessary in consultation with the member's primay care physician; (b) when pre-certification is approved by the Plan; and (c) when the covered surgical procedure is performed by a Participating Provider or Non-Participating Provider.

- **X-rays** – Covered Medical Expenses shall include charges for medically necessary x-rays.

AIRFARE BENEFIT PROGRAM

NetCare will pay a benefit for Travel Expenses but only to the extent described below and only if charges incurred for the covered member at specified Centers of Care facilities are Covered Medical Expenses.

NetCare will provide a round-trip airfare benefit, at the most economical route when a member meets the following criteria:

- Member is referred to the Plans Center of Care;
- Member will undergo a covered qualifying procedure;
- Has obtained a written medical referral from a participating provider to receive medical care off-island;
- Has an approved pre-certified form from the Plan;
- Has NetCare as his/her primary insurance coverage;
- Treatment is unavailable in the service area as determined by the Plan and the referring provider.
- Premium payments are current and in good standing; and
- Has met the Plan's Utilization Review criteria.

Qualifying Procedures

Open Heart Surgery	Oncology Surgery
Cardiac Angioplasty	Neurosurgery
Cardiac Catherization	Gamma Knife

Travel Expenses

Round-trip airline tickets are payable for direct flights to the Plan's Centers of Care and are purchased at the lowest economy fare available. The plan will only pay for the Patient's airfare. Airfare for a companion, including medical escorts, are the sole responsibility of the member. Also, the professional fee of the medical escort is not covered.

Airfare expenses will be applied to the Patient's off-island plan maximum per contract period.

Covered Medical Expenses will not include expenses incurred by a covered member for transportation between his or her home (hotel or lodging place) and the facility to receive services in connection with any listed procedure or treatment.

Covered Medical Expenses will not include Repatriation Benefits. Repatriation benefits is a form of travel insurance or emergency coverage that pays for the expenses of transporting a body home while traveling overseas.

WELLNESS/FITNESS BENEFIT PROGRAMS AND DISEASE MANAGEMENT PROGRAMS

NetCare offers Wellness, Fitness, and Disease Management Programs that are designed to better your health by including Covered Medical Expenses for preventive screenings, examinations, educational and treatment programs.

Covered Medical Expenses will include services and treatment by the Plans contracted wellness and fitness partners to improve and manage chronic diseases, weight loss management, and lifestyle management.

Covered expenses may include portion of a monthly membership fee, percentage cost of a program, or partial cost of a program of each wellness or fitness partner or as defined in the Schedule of Benefits. Benefits are applied per contract period.

Covered expenses are payable based on member reimbursement, up to the allowable amount specified in

the Schedule of Benefits.

SUPPLEMENTAL BENEFIT RIDERS

Supplemental Riders are additional Covered Expenses that are offered to an employer group. Coverage is not automatic and Benefits are payable only when specific riders are elected by the group and by each covered member.

Enrollment Classifications for Dental, Vision, and Orthodontic Benefits

Enrollment classification for medical and dental coverage may vary. An employee may choose a different enrollment class type for medical and dental for self and each enrolled dependent. For example, an employee may choose medical coverage for Family and dental coverage for self.

Enrollment Class Type
Employee
2-Party (Employee and Spouse; Employee and child)
Family (Employee, Spouse & Child(ren); Employee and Children)

Dental & Orthodontic Limitation
If offered as a group benefit, strict requirements apply to dental and orthodontic coverage. Dental and orthodontic enrollment must have the same enrollment class. For example, if your group offers orthodontic coverage, eligible employees and dependents who have dental coverage may elect orthodontic coverage only under the same group and same enrollment class. Let's say if an employee has medical only coverage, the employee is not eligible for orthodontic coverage. Under the same employee policy, if a dependent has medical and dental coverage, only the dependent will be eligible for orthodontic coverage. The dental coverage must be in force and run concurrent with the orthodontic coverage. You may not elect coverage for orthodontic only. You may elect coverage for dental only.

Dental Rider

NetCare offers a dental benefit plan in addition to your medical plan**.** The dental benefit is only applicable if the dental plan is elected by your employer group. If your group chooses to enroll in a dental plan, please be aware of certain enrollment and eligibility requirements that must be met. The requirements are as follows:

1. The dental plan must have at least 50% employee participation of the total group enrollment;

2. Employees & dependents are allowed to enroll for dental only benefits during the group enrollment period or the Effective Date of Coverage specified in this policy ;

3. Termination of group or employee dental benefits is not permitted within the Contract Year. Termination of dental benefits is permitted during your group enrollment period or for cause specified in Termination of Coverage specified in this policy;

4. Addition of group or employee dental benefits is not permitted within the Contract Year. Addition of dental benefits is permitted during your group enrollment period or eligibility

specified in the Effective Date of Coverage of this policy.

NetCare must approve any exceptions to this policy.

Dental Expense Benefits	Amount of Benefit
Contract year maximum per person	$1,500.00 – Brite Plan $1,000.00 – Smile Plan

Class Code		Percentages at Participating Providers
CLASS I	Diagnostic/Preventive Expenses	100%
CLASS II	Restorative Care Expenses	80%
CLASS III	Basic/Restorative Expenses	80%
	-General Anesthesia	80%
	-Endodontics	80%
	-Periodontics	80%
CLASS IV	Major/Replacement Expenses	50%

Benefits are payable based upon the Usual, Customary and Reasonable fee.

Payment of Benefits

Subject to the Exclusions which follow, benefits are payable in connection with Covered Dental Expenses you incur while covered for the type of Covered Dental Expenses described in this section, after you have satisfied the applicable deductible amount. The benefits payable for each Class of covered Dental Services will be payable as shown under (Schedule of Dental Insurance and Schedule of Benefits).

Maximum Benefits

The maximum amounts of Dental Benefits payable for each type of Covered Dental Expenses during any one year, and during your lifetime, are shown under (Schedule of Dental Insurance and Schedule of Benefits).

Covered Dental Expenses means those costs you incur while covered for eligible medical necessary dental services, treatment or supplies that are:

1. Normally recognized in the dentist's field of specialty as essential for the medically necessary of the condition; and

2. Performed or ordered by:

    A. A licensed dentist acting within the scope of his license; or

B. A licensed physician performing dental services within the scope of his license; or

C. A licensed dental hygienist acting under the supervision and direction of a dentist; and

3. Not in excess of the usual, customary and reasonable fee for services, treatment of supplies furnished.

Course of Treatment means the plan of treatment recommended by your dentist or physician, which is based upon a diagnosis, established by an initial examination including, but not limited to, the following diagnostic procedures:

1. A panoramic radiograph or full-mouth set of x-rays, and bitewing x-rays;

2. Other specialized films (such as sialography, TMJ films, cephalometric films, posteroantero films) taken at the dentist's or physician's discretion based on the covered person's symptoms;

3. Study models;

4. Pulp vitality test;

5. Bacteriological culture for determination of pathologic agents;

6. Caries susceptibility test;

7. Pocket depth charts; and

8. Other tests and laboratory examinations, which may be required to establish a diagnosis treatment, plan.

Alternate Benefit

If (1) it is determined that a less expensive alternate procedure, service or course of treatment can be performed in place of the proposed treatment to correct your dental condition; and (2) the alternate treatment will produce a professionally satisfactory result; then the maximum Covered Dental Expenses that will be considered for payment will be the charge for the less expensive treatment.

Incurred Date

The incurred date for Covered Dental Expenses is a follows:

Treatment	Incurred Date
Dentures	On the date the impression is taken
Fixed Bridges and Crowns	On the date the tooth is first prepared.
Root Canal Therapy	On the date the tooth is opened by the dentist.

All other Treatments On the date the work is done.

Benefits will be payable only upon completion of the treatment.

Usual, Customary and Reasonable (UCR)

1. Usual - A fee consistently charged by a Physician or provider to a patient for a special service or supply.

2. Customary - A fee that is within the range of usual charges for a given service or supply billed by most Physicians (or providers) with like training and experience within a geographic area.

3. Reasonable: 1) A Fee that is Usual and Customary; or 2) A fee that a local medical organization's review committee or Physician's Review Organization (PRO) deems just due to specific conditions in a special case.

NetCare utilizes the current National Dental Advisory Service Fees, based on the geographic location where service was incurred, to determine the UCR Eligible Expense.

Covered Dental Expenses Benefits

Class I. Diagnostic/Preventive

1. Routine oral examination once in any six-month period.

2. Prophylaxis (cleaning) once in any six-month period.

3. Fluoride treatments for children up to age 19, once in any twelve-month period.

4. Dental x-rays, but not more than: (1) one full mouth series of x-rays in any period of three consecutive contract years.

5. Space maintainers for children under age 16, including all adjustments made within six months of installation.

6. Sealants on non-carious /permanent molars for children up to age 16.

Class II. Restorative Care Expenses

1. Services for amalgams, composite, synthetic and plastic fillings, other than gold fillings. Restorative filling on posterior may include composite and amalgam fillings.

Class III. Basic & Restorative Expenses

1. Extractions.

2. Oral surgery, including impacted wisdom teeth.

3. General anesthesia given in connection with covered services.

4. Periodontal Prophylaxis (Cleaning) once in any two-month period. Benefit is subject to Plan maximums and documentation of necessity by the attending dentist.

5. Periodontal treatment and treatment of other diseases of the gums and tissues of the mouth.

6. Endodontic treatment and related endodontic surgery, including root canal therapy.

Class IV. Major/Replacement Expenses

1. Inlays, gold fillings and the first placement of Crowns, inlays, onlays, Bridges (fixed and removable).

2. The replacement of a crown restoration when the original crown was put in more than five years prior to replacement.

3. Repair or recementing of crowns, inlays bridgework or dentures, including the rebasing relining of dentures.

4. The first placement of full or partial removable dentures, temporary dentures or fixed bridgework. This will include adjustments during the six-month period following placement. The placement must be needed as a result of the extraction of one or more natural teeth. The extraction must take place after you or your dependent is covered under this provision. The denture or bridgework must include the replacement of the teeth, which were extracted, as above. Replacement of third molars (wisdom teeth) is not a covered expense.

5. The replacement or alteration of full or partial dentures, or fixed bridgework which is necessary because of oral surgery.

6. The replacement of full or partial dentures must be done within 12-months from the day of the oral surgery.

7. The replacement of a full or partial denture that is necessary because of:

   A. Structural change within the mouth such as the removal of a tumor, cyst, torus or redundant tissue and when more than five years have passed since the prior replacement;

   B. The repositioning of the jaws; or

   C. The prior placement of an immediate or temporary denture when the placement occurs within 12 months of the placement of the immediate or temporary denture.

8. Addition of teeth to, or replacement of, an existing partial or full removable denture of fixed bridgework when:

   A. The replacement or addition is needed to replace one or more additional natural teeth which are extracted while you or your dependent is covered under this provision; or

B. The existing denture or bridgework was put in at least five years prior to its replacement.

Dental Plan Exclusions

1. Any treatment, service or supply not shown under Covered Expenses Benefits.

2. Treatment of teeth or gum for cosmetic purposes, including realignment of teeth.

3. Expense incurred after coverage ends; however, prosthetics (an artificial replacement of one or more natural teeth), including bridges and crowns, which were fitted and ordered prior to the date coverage ends will be covered. You or your dependent must receive the prosthetic device within 30 days after the coverage ends.

4. Prosthetics, including bridges and crowns, started or under way prior to the date you or your dependent became covered under this provision.

5. Rebasing or relining of a denture less than six months after the first placement, and not more than one rebasing or relining in any two-year period.

6. Replacement of lost or stolen prosthetics.

7. Replacement of prosthetics less that five years after a previous placement, except as provided in (5), (6) or (7) (A) of Class IV Services.

8. A new denture or bridgework, if the existing denture or bridgework can be made serviceable.

9. Any charges for oral care and supplies which are used to change vertical dimension (TMJ Temporomandibular Joint Syndrome) except as stated under the Schedule of Insurance, or closure to include (but shall not be limited to) procedures used for diagnostic or balance, orthognathic surgery, subperiosteal and endosseous implants; joint injection/therapy, splints.

10. Any expense paid in whole or in part by any other provision of a Group Health Coverage Plan, provided by your employer, for which you or your dependent are eligible.

11. Sealants, except non-carious/permanent molars for children up to age 16.

12. TMJ and services related thereto.

13. Charges for non-dental expenses, including but not limited to federal, state and local taxes, finance and interest charges.

14. Orthodontic procedures and related services.

15. Prescription Drugs. Coverage is based on prescription drug coverage under the medical plan.

16. Charges outside the service area unless pre-approved and coordinated with the employer group and the Plan.

Orthodontic Rider

Covered Orthodontic Expenses will include charges, up to the allowed maximum coverage, specified in the Orthodontic Policy Specification. Benefits are payable if group and member election is made for the Orthodontic rider coverage.

After any applicable co-payment or co-insurance, the benefits payable under this Plan are payable per member per lifetime as specified in the Orthodontic Policy Specification. Benefits are payable for services rendered at a Participating Provider who is an orthodontic care provider who has agreed to provide services or supplies at a "negotiated charge." Benefits are not payable for services rendered at Non-Participating Providers.

Any charge for a service or supply furnished by a Participating Provider in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the group contract.

Lifetime Maximum Benefit: $1,000.00 Per Member

Covered Orthodontic Expenses:

A. Orthodontic benefits are payable for all service related treatment, supplies, diagnostics, maintenance, including teeth extractions, up to the maximum dollar amount allowed.

B. Benefits will be limited to $1,000 per member per lifetime maximum..

C. Pre-existing and on-going orthodontic treatments are covered benefits.

The following limitations apply to Covered Orthodontic Expenses:

- Dental coverage must be in force upon Orthodontic election within the same group policy.
- Payable benefits are limited to $1,000 maximum per member per lifetime.
- Coverage is limited to Participating Orthodontic Providers.
- Orthodontic coverage is available for all covered members regardless of age. Benefits will terminate on the last day of the member's eligibility.
- For dependent children, orthodontic treatment may be continued to completion up to the attainment age 26 years, if unmarried.
- Employee enrollment and eligibility requirement must be in force as described in the Eligibility Section of this handbook.

Group and member eligibility requirements are as follows:

1. The Orthodontic benefit must have 50% employee participation of the total group enrollment;

2. Employees & dependents are permitted to enroll in orthodontic benefits during group enrollment period or the Effective Date of Coverage section of this policy;

3. Termination of group or employee orthodontic benefits is not permitted within the Contract Year. Termination of orthodontic benefits is permitted during your group enrollment period

or for cause specified in Termination of Coverage section of this policy;

4. Groups are permitted to enroll in orthodontic benefits only during the group enrollment period.

Vision Care Rider

NetCare's Vision Care Rider is a supplemental benefit plan that covers vision hardware up to the allowed dollar maximum. The Vision benefit is only applicable if the Vision Care rider is elected by the employer group. If your employer group chooses to enroll in the vision benefit plan, please be aware of certain enrollment and eligibility requirements that must be met. These requirements are as follows:

1. The group must have 100% employee and dependent participation requirement regardless of size of the group.
2. NetCare must approve any exceptions to this policy.

Covered Vision Expenses - will include charges up to the allowed maximum coverage specified in theVision Policy Specification.

- Benefits are payable if group and member election is made for the Vision Care rider.
- Benefits under this Plan are payable up to the Contract Year Maximum Benefit at a Participating Provider who is a vision care provider who has agreed to provide services or supplies at a "negotiated charge."
- Benefits are not payable for services rendered at Non-Participating Providers.

Any charge for a service or supply furnished by a Participating Provider in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the group contract. This rule will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are payable.

Vision Expense Benefits		Amount of Benefit
Maximum Covered Vision Expense	=	**$150 per Contract Period**

Single Vision Lenses
Bifocal Lenses
Trifocal Lenses
Lenticular/aphakic lenses
Frames
Contact Lenses

Payment of Benefits

Subject to the Exclusions, which follow, we will pay the Vision Care Benefits each Contract Period in connection with Covered Vision Care Charges incurred while insured. The Benefits payable for each Type of Covered Vision Care Charges will be the Percentage payable subject to the Maximum Payment Limits shown under "Schedule of Vision Insurance" and Policy Specification or Summary of Benefits and Coverage.

Covered Vision Care Charges

Covered Vision Care Charges means those costs incurred by an insured person for necessary vision examination, lenses and frames that are:

1. Medically necessary under accepted standards of optical practice as essential for the necessary treatment of the insured person's eye condition.

2. Performed or ordered by an Ophthalmologist or Optometrist acting within the scope of his license or by an Optician; or

3. Billed by the Ophthalmologist or Optician who provided the service treatment or supply; and

4. Not in excess of the Prevailing Rate for the service, treatment or supply furnished.

Definitions

1. Ophthalmologist means a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.) who is legally qualified to practice medicine, including the diagnosis, treatment and prescribing of medications and lenses to conditions of the eye.

2. Optometrist means a person licensed to practice optometry as defined by the laws of the state in which the service is rendered.

3. Optician means a person who makes or sells eyeglasses and/or contact lenses prescribed by ophthalmologist or optometrist to cure or correct defects in the eyes, grinds and lenses or has them ground according to prescription, fits them into a frame, and adjust the frame to fit the face.

4. Qualified Provider means an Ophthalmologist, Optometrist of Optician as defined above, who is practicing within the scope of his license in the state where the Covered Vision Care Charge is incurred.

Maximum Payment Limits

The maximum Payment limits for each Type of Covered Vision Care Charges are shown under Vision Care Benefits in your Schedule of Vision Insurance.

Types of Covered Vision Care Charges

The types of Covered Vision Care Charges are as follows:

Type I: This consists of charges for:

1. One pair of single vision, bifocal, trifocal, Lenticular or aphakic lenses, or for one pair of contact lenses each year, but only if the lenses are prescribed as a result of an eye examination made while insured for Vision Care Benefits under this plan. The date on which the lenses are ordered shall be considered to be the date on which the charge is incurred and the lenses are furnished

2. One pair of frames in any two-year period if the frame is to be used with lenses prescribed as the result of any eye examination that was made by a qualified provider while you are insured for Vision Care Benefits under this plan. The date on which the frame is ordered shall be considered the date on which the charge is incurred and the frame is furnished.

Exclusions

No benefit will be paid under the Vision Care Benefits for:

1. Charges that are not Covered Vision Care Charges or for procedures, services or supplies that are not specifically included as Covered Vision Care Charges.

2. Any portion of a charge in excess of the Prevailing Rate, as defined.

3. Services or supplied which were furnished or rendered or for which charges were incurred prior to the effective date of Vision Care Benefits under this plan, or after such Vision Care Benefits terminate.

4. Orthoptics or vision training, sub-normal aids, aniseikonia coated lenses or any other special purpose vision aids.

5. Sunglasses, whether or not requiring a prescription, safety glasses and safety goggles. Tinted lenses with the tint other than number 1 or 2 are considered to be sunglasses for purpose of this exclusion.

6. Frames to be used with lenses, which do not require a prescription.

7. Duplicate lenses or contact lenses, or duplicate frames, except as specified under the Schedule of Vision Insurance.

8. Repair or replacement of broken, lost or stolen lenses, contact lenses or frames.

9. Medical or surgical treatment of the eyes or for any prescribed drug or other medication.

10. Any procedure, service or supplies which are payable under any medical expense benefit plan provided by your Employer, or provided through a medical department of client maintained by your Employer.

11. Services or supplies rendered of furnished primarily for Cosmetic purpose.

12. Services or supplies which are furnishes or rendered in connection with an illness, injury, disease or condition contracted or resulting from an act of war, declared or not, civil disobedience, participation in a criminal act, riot or nuclear or atomic explosion or accident.

Terminations of Riders are not permitted any time during the Contract Period except:

- End of month in which employment ceases. Ceasing active work will be deemed to be cessation of employment.
- Date the employee dies.

- When a dependent ceases to be a defined dependent.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.
- When the group falls below the minimum of two (2) employees.
- When the group fails to make timely premium payments.
- Date when NetCare determines that a member has intentionally misrepresented any enrollment information
- Date when you fail to submit any required documents or information after reasonable notice from NetCare to submit the request and required documents or information

Your maximum benefit amount is specified in your group Vision Policy Specification. NetCare must approve any exceptions to this policy.

Article IV PRE-CERTIFICATION

PRE-CERTIFICATION FOR COVERED MEDICAL EXPENSES

Services and treatment for Covered Medical Expenses, if provided as benefits shown in your Policy Specifications, require pre-certification and approval from NetCare prior to services or supplies rendered at participating providers. Pre-certification is only a determination of medical necessity and not an assurance of coverage or guarantee of payment.

This pre-certification requirement applies to the health care provider notifying NetCare before services or procedures are rendered to the patient. Pre-certification allows NetCare to authorize payment and to recommend alternate courses of action.

The purposes of the review for pre-certification are the following:

1. To determine the medical necessity of the service;
2. To determine the appropriate setting for service delivery.

Expenses for the following Covered Medical Expenses for:

- services rendered; and
- supplies needed

Require Pre-Certification for:

1. CT Scan /CTA

Including but not limited to :

a. Head
b. Neck
c. Chest
d. Abdomen
e. Pelvis
f. Upper Extremity /Shoulder
f. Lower Extremity/ Knee

2. MRI /MRA

Including but not limited to :

a. Head/Neck
b. Chest
c. Abdomen
d. Pelvis
e. Upper Extremity/Shoulder
f. Lower Extremity/ Knee

3. PET Scan

4. Nuclear Cardiology and Medicine Studies

Including but not limited to :

a. Thyroid

b. MIBI Scan/ Thallium/ Myocardial Perfusion Test

5. Interventional Radiology

Including but not limited to :

a. Angiogram/Angioplasty

b. Embolization / Embolectomy

c. Stent Procedures

d. Foreign Body Extraction

e. Hysterosalpingography, radiological supervision and interpretation

6. Elective Procedure (Major In-patient procedure)

a. Cardiac Surgery (including but not limited to CABG, Septal Defect Repair, Aneurysm Repair

b. Orthopedic Surgery (including but not limited to Laminectomy and Joint Replacement)

c. Neurosurgery (including but not limited to Craniotomy)

d. Gynecologic Surgery (including but not limited to TAHBSO)

f. Urology Surgery (including but not limited to TURBT)

e. Organ Transplant (including but not limited to Kidney Transplant and Heart Transplantation

7. Cosmetic Surgery

Including but not limited to :

a. Abdominoplasty

b. Augmentation Mammoplasty

c. Blepharoplasty/ Brow Lift

d. Chemical Peels

e. Dermabrassion

f. Excision of redundant skin

g. Keloid removal

h. Lipectomy/Liposuction/Panniculectomy

i. Mastopexy

k. Mastectomy for Gynecomastia

l. Otoplasty

m. Reduction Mammoplasty

n. Removal/Reinsertion of Breast Implants

o. Removal of Skin Tags any area

p. Rhinoplasty

q. Scar Revision

r. Varicose Vein Surgery

s. Wart Destruction

8. Operative and Diagnostic Endoscopies

9. Cancer Treatment (Chemotherapy and Radiotherapy)

10. Autonomic Testing

11. Intrauterine Device Implants

12. Non routine OB Ultrasound

13. Breast Freeding Equipment

If pre-certification is requested and approved by NetCare, Covered Medical Expenses for charges made for services or supplies will be paid less any applicable copay or deductible as specified in your Policy Specification

If pre-certification is requested and denied by NetCare, no benefits will be paid. If pre-certification is requested, no benefits will be paid if the charges for such service or supply are not covered as defined in your Policy Specification.

If pre-certification is requested, no benefits will be paid when benefits exceed the maximum visits or amounts in any one contract year and as defined in you Policy Specification.

If pre-certification was not requested or received by NetCare, benefits will be paid with a disallowance of up to 50% of eligible charges.

PRE-CERTIFICATION FOR HOSPITAL ADMISSIONS

This section applies to all hospital admissions for services and treatment of Covered Medical Expenses requiring pre-certification that are listed in this section..

NOTE: Make sure you, your dependents and your physician know about the pre-certification requirement under this plan. This is especially important in case of an emergency if you are unable to obtain authorization for yourself.

If:

- a person becomes confined in a hospital as a full-time inpatient; and
- it has not been pre-authorized that such confinement (or any day of such confinement) is necessary; and
- the confinement has not been ordered and prescribed by a physician

then Covered Medical Expenses incurred on any day not authorized during the confinement will not be paid unless deemed an emergency.

As to Hospital Expenses incurred during the confinement:

If pre-certification has been requested and denied:

1) No benefits will be paid for Hospital Expenses incurred for board and room.
2) No Benefits for all other Hospital Expenses will be paid.

Certification of days of confinement can be obtained as follows:

If the admission is a non-urgent admission, you must get the days certified by calling our NetCare office or the number shown on your ID card. This must be elective done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency admission or an urgent admission, you, the person's physician, or the hospital must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of an inpatient confinement which requires an urgent admission; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an emergency admission; unless it is not possible for the physician to request pre-certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already certified, you, the physician or the hospital may request that more days be certified by calling our NetCare office at the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.

PRE-AUTHORIZATION OF COVERED DRUG EXPENSES

Services and treatment for covered drug expenses require pre-certification and approval from NetCare or its PBM, prior to services or supplies filled at participating providers. Pre-authorization is only a determination of medical necessity and not an assurance of coverage or guarantee of payment.

This pre-authorization requirement applies to the participating provider notifying NetCare before services or procedures are rendered to the patient. Pre-certification allows NetCare to authorize payment and to recommend alternate courses of action.

The purposes of the review for pre-certification are the following:

3. To determine the medical necessity of the service;
4. To determine the appropriate setting for service delivery.

Expenses for the following covered medical expenses for:

- services rendered; and
- supplies needed

If pre-authorization is requested and approved by NetCare or PBM, covered drug expenses for charges made for services or supplies will be paid less any applicable copay or deductible as specified in your Schedule of Benefits

If pre-authorization is requested and denied by NetCare or PBM, no benefits will be paid. If pre-authorization is requested, no benefits will be paid if the charges for such service or supply are not covered as defined in your Schedule of Benefits.

If pre-authorization is requested, no benefits will be paid when benefits exceed the maximum amounts per fill in any one contract year and as defined in your Schedule of Benefits.

If pre-authorization was not requested or received by NetCare or PBM, benefits will be paid with a disallowance of up to 50% of eligible charges.

Article V PRESCRIPTION DRUG EXPENSE COVERAGE

PRESCRIPTION DRUG COVERAGE

When the prescription is purchased through:	And the prescription is for a "generic" drug, the expense is covered at:	And the prescription is for a "brand-name" drug, the expense is covered at**:	And the prescription is for a non-fomulary drug:	And the prescription is for an injectable drug:	And the prescription is for a specialty drug (excludes injectable drugs):
Mail Order Pharmacy*	100% after $0 co-pay per prescription or refill up to a 90-day supply.	100% after $0 co-pay per prescription or refill up to a 90-day supply.	100% after $150 co-pay per prescription or refill up to a 90-day supply.	100% after 30% co-pay per prescription or refill up to a 90-day supply.	Not Covered
A Participating Pharmacy	100% after $5 co-pay per prescription or refill up to a 30-day supply	100% after $15 co-pay per prescription or refill up to a 30-day supply	100% after 30% co-pay per prescription or refill up to a 30-day supply	100% after 30% co-pay per prescription or refill up to a 30-day supply	100% after 20% co-insurance[1] , up to $250 out of pocket max, per prescription or refill up to a 30-day supply
A Non-Participating Pharmacy	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

[1]Member co-payment and co-insurance amounts defined in the Plans Schedule of Benefits.

* The Mail Order Pharmacy feature of the Prescription Drug Benefit is designed to be used by individuals using maintenance type medication for the treatment of chronic or long-term conditions such as, but not limited to, diabetes, arthritis, heart conditions and high blood pressure, for periods of 30 days or longer. This program covers any prescription drug covered by the Plan.

**If the prescriber indicates a brand name drug has to be used to fill a prescription and there is a generic equivalent available, you will pay the applicable co-pay plus a Separate Brand Name Fee (the difference between the cost of the brand name drug and the generic equivalent) if you decide you want the brand name drug. (See the "Benefit Amount" in this section of your Booklet for details).

Co-payments, co-insurance or deductible amounts are to be paid at the Participating Pharmacy at the time of purchase. No other prescription drug benefits are payable.

Refills for prescription drugs will be filled in accordance with the terms of the Plan, provided that 70% of

the prior prescription or refill, furnished by retail or mail order pharmacy, has been used.

The date of the most recent prescription or refill will be used to determine the percentage used.

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all prescription drugs. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

The Schedule of Benefits outlines the Payment Percentages that apply to the covered prescription drug expenses described below.

Prescription Drug Coverage is inclusive of the Plans medical coverage.

AN EXPLANATION OF CERTAIN TERMS

***Prescription Drugs*.** Any of the following:

- A drug, biological, or compounded prescription which, by Federal Law: may be dispensed only by prescription and which is required to be labeled "Caution : Federal Law prohibits dispensing without prescription."
- Injectable insulin, glucose test strips and lancets.
- Disposable needles and syringes which are purchased to administer a covered injectable prescription drug or agent.

Participating Agreement - An agreement between NetCare and a Pharmacy Benefit Manager (PMB) with terms regarding payment for Prescription Drugs dispensed under the agreement.

Pharmacy - An establishment where Prescription Drugs are legally dispensed.

Mail Order Pharmacy - An establishment where Prescription Drugs are legally dispensed by mail.

Participating Pharmacy - A Pharmacy, including a Mail Order Pharmacy, which is party to an Agreement with NetCare's PBM to dispense drugs to persons covered under this Plan, but only:

- while the Participating Agreement remains in effect; and
- when such a Pharmacy dispenses a Prescription Drug under the terms of its Participating Agreement with NetCare's PBM.

Non-Participating Pharmacy - A Pharmacy not party to a Participating Agreement with NetCare, or a Pharmacy who is party to such a Participating Agreement but who does not dispense Prescription Drugs in accordance with its terms.

Prescriber - A physician or dentist who is licensed in the United States and has the legal authority to write an order for a Prescription Drug.

Prescription - An order of a Prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

Generic Prescription Drug or Medicines - A Prescription Drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Service Area - This is the geographic area, as determined by NetCare's PBM, in which Participating Pharmacies for this Plan are located.

Emergency Situation - This means the sudden and at that time, unexpected onset of a change in a person's physical or mental condition which, if the treatment was not performed right away could, as determined by NetCare, reasonably be expected to result in:

- loss of life or limb; or
- significant impairment to bodily function; or
- permanent dysfunction of a body part.

PRESCRIPTION DRUG EXPENSE BENEFIT

NetCare's Drug Formulary, a list of formulary drugs that is designed to be used as a guide for prescribing and dispensing., is an Open Formulary where products both off and on the formulary are covered by the benefit plan. This list is primarily educational and is designed to encourage use of formulary products.

Prescription Drugs are classified by tiers as generic, brand, non-formulary, or injectible drugs. Your copayment or coinsurance expense of a drug is determined by the tier classification at the time of fill. Classification of a drug may frequently change between tiers and that coverage, copayment or coinsurance expense is payable at the time of fill.

If a Prescription Drug is dispensed by a Participating Pharmacy to a person for treatment of a disease or injury, a benefit will be paid, determined on your Policy Specification, but only if the Participating Pharmacy's charge for the drug is more than the Co-pay or Fee per prescription or refill.

Prescription drug coverage is limited to generic brands only. If a brand named drug is requested and a generic substitute is available, a charge for the difference in drug cost between the brand name cost and the generic cost will be assessed in addition to the applicable prescription drug co-payment.

In addition, for Non-Participating Retail Pharmacy, no benefit will be paid as indicated on your Policy Specification for a Prescription Drug dispensed by a Non-Participating Pharmacy.

Prescription drug co-payment or fee incurred at Participating Providers may be applied toward the Plan's deductible. Prescription drug co-payment of fee is not applicable toward the Out-of-pocket limit.

Preventive drugs mandated under the Patient Protection and Affordable Care Act and corresponding regulations are subject to rating A or B from the U.S. Preventive Services Task Force (USPSTF) list. Coverage include prescription and over-the-counter (OTC) drugs in the USPSTF list. OTC drugs listed in the USPSTF are covered when written by a Prescriber.

BENEFIT AMOUNT

The Benefit Amount for each covered Prescription Drug or refill will be an amount equal to the Payment Percentage (100%) of the total charges in excess of the Co-pay or Fee per prescription or refill as shown

in the Policy Specification. The total charge is determined by:

- the PBM'S Participating Pharmacy, including a Mail Order Pharmacy; and
- NetCare.

Any amount so determined will be paid to the Participating Pharmacy on your behalf.

For Non-Participating Retail Pharmacy, benefit will be paid for a Prescription Drug dispensed by a Non-Participating Pharmacy under this benefit section and as specified in the Prescription Drug Expense Coverage. In an emergency situation, the benefit amount for each covered Prescription Drug or refill is equal to the Payment Percentage (100%) of the Participating Pharmacy's charge for the drug, in excess of the Co-pay or Fee per prescription or drug.

If the prescriber does not indicate that a brand name drug has to be dispensed to fill a prescription and there is a generic equivalent available, but you decide you want the brand name drug, a Separate Brand Name Fee will have to be paid by you, in addition to any applicable co-pay.

The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the brand name drug and the generic equivalent. Therefore, the Separate Brand Name Fee will apply to any brand name drug dispensed.

LIMITATIONS

No benefits are paid:

- For a device of any type unless specifically included above as Prescription Drugs.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a Mail Order Pharmacy.
- For contraceptive drugs, except oral contraceptives, and IUD contraceptives.
- For appetite suppressants and weight control drugs.
- For cosmetic drugs (e.g., Rogaine).
- For immunization agents (e.g., routine or travel related).
- For any "over the counter" drugs (non-prescription) unless specifically included in the definition of a prescription drug
- For any prescription drugs obtainable without a prescription on an "over-the counter" basis unless specifically covered by the PBM.
- For more than a 30 day supply per prescription or refill. However, this limitation does not apply to a supply of up to 90 days per Prescription or refill for drugs which are provided by a Mail Order Pharmacy.
- For any refill of a drug if it is more than the number of refills specified by the Prescriber. NetCare, before recognizing charges, may require a new Prescription, or evidence as to need, if the Prescriber has not specified the number of refills, or if the frequency or number of Prescriptions or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest Prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any healthcare facility; or for any drug provided on an outpatient basis in any such institution to the extent benefits are paid for it under any

other part of this Plan, or under any other medical or prescription drug expense benefit plan carried or sponsored by your Employer.

- Without the approval of the Plan or its PBM for limitations described above.

Article VI GENERAL EXCLUSION

GENERAL EXCLUSIONS APPLICABLE TO HEALTH EXPENSE COVERAGE

Coverage is not provided for the following charges:

1. Those for services and supplies not necessary, as determined by NetCare, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician or dentist.
2. Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending physician or dentist.
3. Those for or in connection with services or supplies that are, as determined by NetCare, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

   there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

   if required by the FDA, approval has not been granted for marketing; or

   a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

   the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

   However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if NetCare determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

4. Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
5. Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
6. Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
7. Those for services of a resident physician or intern rendered in that capacity.
8. Those that are made only because there is health coverage.
9. Those that a covered person is not legally obliged to pay.
10. Those, as determined by NetCare, to be for custodial care.
11. Those for services and supplies:
    Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

12. Those for or related to any eye surgery mainly to correct refractive errors.
13. Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
14. Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

    Improve the function of a part of the body that:
    A) is not a tooth or structure that supports the teeth; and
    B) is malformed:
        a) as a result of a severe birth defect; including harelip, webbed fingers, or toes; or as a direct result of:
            i) disease; or
            ii) surgery performed to treat a disease or injury.
    C) Repair an injury. Surgery must be performed within three (3) months of the injury.

15. Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
16. Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy .

    This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
17. Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
18. Those for or related to sex change surgery or to any treatment of gender identity disorders.
19. Those for or in connection with career, pastoral, or financial counseling.
20. Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury or sickness.
21. Those to the extent they are not reasonable charges, as determined by NetCare.
22. Those for a service or supply furnished by a Participating Provider in excess of such provider's Negotiated Charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.
23. Airfare (unless criteria as set forth by the Plan has been met).
24. Acupuncture.
25. Biofeedback and other forms of self care or self help training.
26. Blood derivatives used for experimental purposes.
27. Care for military service connected disabilities to which a member is legally entitled.
28. 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.

29. 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.
30. Chronic Brain Syndrome, or custodial care charges resulting from senile deterioration.
31. 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.
32. Custodial care, Domiciliary or convalescent care, or rest cures.
33. 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.
34. Elective cosmetic treatment including but not limited to breast implants (unless after mastectomy due to cancer) cosmetic cosmetic eye surgery (i.e. Lasik), etc.
35. Emergency treatment provided outside the service area if the need for care could have been foreseen before departing the service area.
36. Executive Physical Exams/Executive Check up (Inpatient Physical Exam)
37. Experimental medical, surgical, and other health care procedures.
38. Gastric Bypass, stapling or reversal, surgical correction (except as approved by the Plan).
39. Hearing Aids.
40. All Hip Joint Arthroplasties to include but not limited to hip arthroplasty (replacement), resurfacing arthroplasty, hip arthroscopy and all related treatment and services.
41. Hyperbaric Oxygen Treatment (HBO).
42. 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.
43. 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.
44. Inpatient and outpatient services and care provided to dependents of a non spouse dependent.
45. Intentionally self-inflicted injury, while sane or insane unless or from a domestic violence dispute.
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46. Interrupted pregnancy (non-medically necessary), non-life threatening abortions unless medically necessary.
47. Living expenses including meals, hotel rooms, transportation, etc.
48. Long term rehabilitation including but not limited to physical therapy, speech therapy, hand therapy and occupational therapy.
49. Medical treatment and services related to End Stage Renal Disease, including dialysis.
50. 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.
51. Non-medical treatment of obesity (except as approved by the Plan).
52. Orthopedic and external prosthetic devices including but not limited to shoes, orthotic, artificial limbs, etc.
53. 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.
54. 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.
55. Physical examinations and all services related thereto when required for obtaining or continuing employment, insurance, schooling, governmental licensing or sports activities.
56. Pre-existing conditions and medical conditions excluded and noted on the policy.
57. Prenatal ultrasound (except as approved by the Plan). Routine ultrasounds are limited to one per

pregnancy term. Subsequent ultrasounds are not covered unless medical necessity is established and approved by the Plan.

58. Prescription drugs not included in NetCare's mandatory generic drug program, unless approved by the Plan.
59. Preventive care & services rendered at participating specialist providers, except for OB/GYN related services.
60. Services provided by the covered person's spouse, child, brother, sister or parents whether by blood or by law.
61. Services rendered at a Non-Participating Provider, except for emergency care & services.
62. Services rendered outside Guam other than at NetCare's direct contracted providers and NetCare's Centers of Care.
63. Services render outside Guam without a NetCare approved referral.
64. Service rendered at a non-PCP without a NetCare approved referral.
65. Services rendered for pre-certified benefits not approved by NetCare.
66. Specialty drugs purchased at pharmacies other participating retail providers.
67. State & local taxes, administrative fees and handling/shipping charges.
68. Temporomandibular (jaw) joint disorders and related diseases (TMJ).
69. The purchases and/or fitting of eyeglasses or contact lenses (unless Vision Care Rider is elected), radical keratotomy or lasik.
70. Transsexual surgery and related services.
71. Treatment & services for hepatitis drugs without a NetCare approved prior authorization and strict criteria satisfaction.
72. Treatment and services related to Organ Transplants.
73. Treatment and services related to sleeping disorders, sleep evaluation & diagnosis.
74. Treatment of acne related services, including prescription drugs.
75. Treatment for adult circumcision procedures, if provided solely for cosmetic or religious purposes.
76. Treatment for services and supplies related to sexual dysfunction(i.e Viagra).
77. Treatment & services from intentionally self-induced or self-inflicted injuries from attempted suicide.
78. Treatment and services for Adoptive Cell Therapy to include but not limited to Gene Therapy, Immunotherapy, CAR T Cell Therapy TIL Therapy, NK Cell Therapy.
79. Treatment & services for Massage Therapy other than for therapeutic and manual therapy techniques defined by AMA guidelines.
80. 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).
81. Treatment of injuries or illnesses sustained as a result of war or any acts of war, declared or undeclared.
82. Treatment of injuries while participating in hazardous sports, such as but not limited to off-road, skydiving, etc.
83. Any portion of an expense, charge or fee that exceeds the eligible charges and the Usual, Customary and Reasonable Charge.
84. Benefits and services not specified as covered.

Article VII CLAIM APPEALS

CLAIM PROCEDURES FOR HEALTH EXPENSE BENEFITS

Your booklet contains information on reporting claims and how to appeal NetCare's decision of how it was processed. We have provided this claim appeal information as an aid to you in keeping claim material related to health coverage together. If you have any questions or problems, contact:

NetCare Life & Health Insurance Co. at 671-472-3610, www.netcarelifeandhealth.com or 424 W. O'Brien Drive, Ste 200, Hagatna Gu 96910.

Claims Review & Appeal

The Affordable Care Act ensures your right to an internal appeal to reconsider any decision to deny payment for a service or treatment. The law also permits you to have an independent review organization (an external review) determine whether to uphold or overturn NetCare's internal appeal decision. NetCare must comply with federal laws and regulations to provide you an opportunity for an independent review of an adverse determination or final adverse determination.

NetCare response to your internal appeal is based on the type of claim:

1. Urgent Care Claims – 72 Hours Response Time
A special kind of pre-service claim that requires a quick decision due to your health condition that may be threatened. If your appeal concerns urgent care, you may be able to have the internal appeal and external review take place at the same time.

2. Pre-Service Claims – 30 Days Response Time
Denials of non-urgent care you have not yet received.

3. Post-Service Claims – 60 Days Response Time
Claims for benefits under NetCare, including claims after medical care have been provided, such as reimbursement or payment of the costs of the services provided.

If a claim is denied, in whole or in part, NetCare will furnish notice to you specifing reason or describe any additional information required in perfecting the claim and your right to file an internal appeal. If you wish to review and discuss the reason for the denial, a request must be made in writing to NetCare within one-hundred eighty (180) days of receipt of a denial notice. NetCare will re-evaluate the claim in question and give a final written decision on the re-evaluation within sixty (60) days for services already incurred, thirty (30) days for non-urgent care not yet received, or seventy-two (72) hours for urgent care, after such request is received.

You may refer to Article XV Appeals and Grievance section of this booklet for detailed explanation of your appeal rights.

Article VIII COORDINATION OF BENEFITS

OTHER PLANS NOT INCLUDING MEDICARE

Some persons have group health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision. Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health are expenses of the child, the order of benefit determination rules specified in (3) above will apply.

b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

c. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a contract year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, NetCare can release or obtain data. NetCare can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a contract year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

OTHER PLAN

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

COORDINATION OF BENEFITS EXAMPLES

The following information is provided to help clarify specific situations which may arise in the coordination of benefits when a person is covered under more than one plan.

Example One
A female employee works for a group employer and is covered under an employer sponsored medical plan. She elects family coverage, and enrolls her husband as a dependent. At the same time, her husband works for a different employer (other than any branch of the US Armed Forces) and also elects family coverage under *his* employer sponsored medical plan. He names his wife as a dependent under such plan.

For the medical care of the female employee, her employer's sponsored medical plan of benefits will be considered primary. Her husband's plan (under which she is a dependent) would be considered secondary.

For the medical care of the husband, his employer's plan of benefits (under which he is covered as an employee) would be considered primary. The sponsored medical plan of benefits would be considered secondary under his spouse.

Example Two
If a retiree of a group employer:

- has post-retirement medical coverage under the employer sponsored medical plan; and
- is also eligible for post-retirement coverage under another employer's medical plan (provided that the

employer is not a branch of the US Armed Forces); and
- the same person is covered as a dependent spouse under a Tricare (military) plan;

For the medical care of a retiree who meets the conditions above, the plan of benefits considered to be primary will be either the employer's sponsored medical plan, or the plan sponsored by the person's other former employer. The plan in which the person has been enrolled for a greater length of time will be considered the primary plan.

The Tricare plan will always be the last plan to pay benefits when other plans of benefits are involved.

EFFECT OF PRIOR COVERAGE

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or this entire Plan. The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

EFFECT OF MEDICARE

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

    1) having refused it;
    2) having dropped it;
    3) having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by NetCare. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

HEALTH BENEFITS PLAN PRIMARY TO MEDICARE

Federal law requires that for certain covered individuals who elect the Plan as primary coverage, such plan benefits will be payable before any benefits available through Medicare. Medicare's benefits, if any, will be secondary to this Plan. *Federal law applies to the following individuals:*

- an active employee regardless of age,
- a totally disabled employee if not terminated or retired,
- a dependent wife or husband, who is eligible for Medicare, of an active employee or a totally disabled employee if not terminated or retired, and
- any other covered individual for whom this Plan's benefits are payable because of compliance with such Federal law.

If this Plan is the primary coverage, NetCare will determine the benefits payable without considering the benefits for Medicare.

For any individual eligible for Medicare due to End Stage Renal Disease (ESRD), the Plan will be considered to be the primary plan of benefits for the first 30 months of a person's entitlement. Such plan benefits will be payable for covered medical expenses before any benefits available through Medicare. Medicare will become primary beginning with the 31st month of entitlement due to ESRD.

For Health Expenses Coverage not covered by the Plan, Medicare will be considered to be the primary plan. Health Expense Coverage does not include benefits for End Stage Renal Disease under this Plan.

HEALTH BENEFITS PLAN SECONDARY TO MEDICARE

A Medicare *(Government Exclusion)* approach is applicable to persons listed below who are eligible for Medicare:

- a retired employee,
- a totally disabled employee who is terminated or retired,
- a dependent, who is eligible for Medicare, of a retired employee or totally disabled employee who is terminated or retired, and
- any other covered dependent for whom this Plan's benefits are payable because of compliance with Federal law.

NOTE: When the Plan is secondary to Medicare, coverage will be provided under the provisions of this Plan.

UNDER THIS GOVERNMENT EXCLUSION APPROACH, THIS IS HOW YOU COMPREHENSIVE MEDICAL EXPENSE COVERAGE CHANGES IF YOU ARE ELIGIBLE FOR MEDICARE.

All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.

2. Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by NetCare. Two or more charges received at the same time will be applied starting with the largest first.

3. Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

4. Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

5. A participant, otherwise eligible for Medicare, who is unable to receive the benefits of Medicare while residing outside the U.S., the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa, will be entitled to medical expense benefits without reduction for Medicare. This provision only applies to your medical treatment performed outside the U.S. If you reside outside the U.S. or a territory, you should participate in Part B of Medicare. If you receive medical treatment in the U.S. this plan's benefits will be reduced as if you were enrolled in Part B.

Article IX GENERAL INFORMATION ABOUT YOUR COVERAGE

TYPE OF COVERAGE

Coverage under this Plan is non-occupational. Only non-occupational accidental injuries and non-occupational diseases are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Policy Specification and information in this handbook will say if they are.

PHYSICAL EXAMINATIONS

NetCare will have the right and opportunity to have a physician or dentist of its choice examine any person for whom pre-certification or benefits have been requested. This will be done at all reasonable times while pre-certification or a claim for benefits is pending or under review. This will be done at no cost to you.

LEGAL ACTION

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims. NetCare will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

ASSIGNMENTS

Coverage may be assigned only with the written consent of NetCare.

RECOVERY OF BENEFITS PAID

As a condition to payment of benefits under this Plan for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plan shall, to the extent of benefits it has paid, be subrogated to (have the right to pursue) all rights of recovery of covered persons against:

    1) such third party; or

    2) a person's insurance carrier in the event of a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy.

- The Plan shall have the right to recover from the member amounts received by judgment, settlement, or otherwise from:

  1) such third party or his or her insurance carrier; or

  2) any other person or entity, which includes the auto insurance carrier which provides the covered person's uninsured or underinsured auto insurance coverage.

- The covered member (or person authorized by law to represent the covered person if he or she is not legally capable) shall:

  1) execute and deliver any documents that are required; and

  2) do whatever else is necessary to secure such rights.

RECOVERY OF OVERPAYMENT

If a benefit payment is made by NetCare, to or on behalf of a covered member, which exceeds the benefit amount such member is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or

- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of the covered member or his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

REPORTING OF CLAIMS

A claim, from a provider or member, must be submitted to NetCare in writing. It must give proof of the nature and extent of the medical expense. Your may obtain claim forms through your Employer, NetCare office, or through NetCare's website at www.netcarelifeandhealth.com

All claims should be submitted to NetCare with complete documentation 90 days from date of service. Detailed medical notes, translated in English, are required for all services rendered in Asia (including the Philippines). Incomplete reimbursement claims will be returned to the member. Claims filed beyond 90 days of the date of service will be denied and become the sole financial responsibility of the member.

PAYMENT OF BENEFITS

Benefits will be paid 45 business days of receipt of all completed and required documents. All benefits are payable to the employeeor service provider.

RECORDS OF EXPENSES

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:
Names of physicians, dentists and others who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

SELECTION OF PRIMARY CARE PROVIDER

A selection of a Primary Care Provider (PCP) for each Covered Person enrolled under NetCare's POS Plan (Advantage Plan) will be required at the time of enrollment. The selection of a Primary Care Provider will is limited to our network Providers who are available to accept your or your family members. Providers may be chosen in Family Practice, General Practice, Internal Medicine, Gynecological, Obstetrics and Pediatrics. A Covered Person may change their PCP anytime of the month by calling NetCare's office to be effective the day notice was given to NetCare. NetCare will not retroactively change a PCP in order to pay for incurred services and treatment.

Covered Medical Expenses incurred by a PCP for services and treatment within the service area (Guam) will be payable in accordance with your benefit schedule indicated in the Policy Specification. No benefits are payable for services and treatment incurred outside the service area and by a non-participating provider.

PARTICIPATING SPECIALIST PROVIDER

A referral by a Primary Care Provider (PCP) to a Participating Specialist Provider is not required under this Policy. Applicable co-payments for services incurred by a participating specialist are listed in the benefit schedule of the Policy Specification.

IDENTIFICATION CARD

A member identification card will be issued to each member enrolled in the Plan. The card will be issued five (5) days upon receipt of a completed Enrollment Form. Your card will show your name, ID number and Plan benefit type. The back of your ID card contains a magnetic strip that enables medical providers on Guam to swipe the card to obtain eligibility and benefit coverage co-payments.

Your ID card must be presented to the provider at the time of service. To request for a replacement card, you may contact NetCare's customer service department or log into our website at **www.netcarelifeandhealth.com** A replacement fee will be charged for all replacement cards.

EXPLANATION OF BENEFITS

An Explanation of Benefits (EOB) is information of how we processed your claim. The EOB will tell you what, where, and when a service was done. It will show you the amount charged and the amount paid or denied by NetCare. This document will be mailed to you each time a claim has been processed or you may obtain an electronic copy through our website at **www.netcarelifeandhealth.com**

If you have concern that an error was made in determining your benefits or paying your claim, you may request in writing for a review within 180 days of receipt of a denial notice. Your request must be submitted to our NetCare office.

THIRD PARTY LIABILITY

If you incur an injury or illness that may have been caused by a third party and you may have a right to recover damages against the third party, NetCare shall not be liable to pay any benefits provided under this Plan. However, upon the execution and delivery to NetCare of all papers required by it to secure its rights of reimbursement, NetCare will pay benefits in connection with such injury or illness, but such payment shall be considered only in the nature of an advance or a loan to you which shall be repaid from the recovery, if any, from or on behalf of such third party.

If NetCare pays any benefits because of such injury or illness, NetCare shall have a lien against any recovery to the extent of such payments, which lien may be filed with such third party, the third party's agent, insurance company or the court and which lien shall be satisfied from any such recovery.

In order for NetCare to pay benefits, you will need to obtain, complete and submit the following forms to our NetCare office.

1. Subrogation & Recovery Application Form;
2. Subrogation Assignment Agreement

It is not the intent of this Policy that you should be reimbursed for more than 100% of your Allowable Expenses (as defined in the Coordination of Benefits provision). Therefore, NetCare reserves the right to recover any overpayment it makes on behalf you that results from the payment by a third party, another person, and insurance company or from a judgment or settlement. You are required to reimburse NetCare on your behalf or your Dependent's behalf for any benefits so paid, out of the funds you might recover, to the extent of such payment by this Policy. Further, you must provide NetCare with all required information and assistance in the recover of such payment or overpayment. The term "information" includes any instruments and documents as NetCare may reasonably require enforcing its rights.

ADDITIONAL PROVISIONS

The following additional provisions apply to your coverage.

- In the event of a mis-statement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Article X GLOSSARY

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

BOARD AND ROOM CHARGES

Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

CERTIFICATION

The process of NetCare's review and approval of treatment and services. Benefits requiring certification are payable only if approved by NetCare.

COMPANION

This is a person whose presence as a Companion or caregiver:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

CO-PAYMENT

This is a fee, charged to a person, which represents a portion of the applicable expense.

As to a prescription drug dispensed by a participating pharmacy, this is the fee charged to a person at the time the prescription drug is dispensed payable directly to the pharmacy for each prescription or refill at the time the prescription or refill is dispensed. For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed.

CUSTODIAL CARE

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

CONTRACT YEAR/PERIOD

This is a one (1) year period that begins on the first of the month and ends one year later on the last day of the month prior to the beginning of the contract.

DENTIST

This means a legally qualified dentist. Also, a physician who is licensed to do the dental work he or she performs.

DURABLE MEDICAL AND SURGICAL EQUIPMENT

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

EFFECTIVE TREATMENT OF ALCOHOLISM OR DRUG ABUSE

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician and either:

- has a follow-up therapy program directed by a physician on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

EMERGENCY ADMISSION

One where the physician admits the person to the hospital right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by NetCare, reasonably be expected to result in:

    1) placing the person's health in serious jeopardy; or
    2) serious impairment to bodily function; or
    3) serious dysfunction of a body part or organ; or
    4) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMERGENCY CARE

This means the treatment given in a hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMERGENCY CONDITION

This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to

believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

HOME HEALTH CARE AGENCY

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one physician and one R.N.; and
- has full-time supervision by a physician or a R.N.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

HOME HEALTH CARE PLAN

This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- prescribed in writing by the attending physician; and
- an alternative to confinement in a hospital or convalescent facility.

HOSPICE CARE

This is care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

HOSPICE CARE AGENCY

This is an agency or organization which:

- Has Hospice Care available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  1) skilled nursing services; and
  2) medical social services; and
  3) psychological and dietary counseling.

- Provides or arranges for other services which will include:
  1) services of a physician; and
  2) physical and occupational therapy; and
  3) part-time home health aide services which mainly consist of caring for terminally ill persons; and
  4) inpatient care in a facility when needed for pain control and acute and chronic symptom management.

- Has personnel which include at least:
  1) one physician; and
  2) one R.N.; and
  3) one licensed or certified social worker employed by the Agency.

- Establishes policies governing the provision of Hospice Care.
- Assesses the patient's medical and social needs.
- Develops a Hospice Care Program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

HOSPICE CARE PROGRAM

This is a written plan of Hospice Care, which:

- Is established by and reviewed from time to time by:
  1) a physician attending the person; and
  2) appropriate personnel of a Hospice Care Agency.

- Is designed to provide:
  1) palliative and supportive care to terminally ill persons; and
  2) supportive care to their families.

- Includes:
  1) an assessment of the person's medical and social needs; and

2) a description of the care to be given to meet those needs.

HOSPICE FACILITY

This is a facility, or distinct part of one, which:

- Mainly provides inpatient Hospice Care to terminally ill persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians; at least one such physician must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a R.N.
- Has a full-time administrator.

HOSPITAL

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of physicians.
- Provides 24 hour a day R.N. service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N.

This means a licensed practical nurse.

MENTAL DISORDER

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

NECESSARY

A service or supply furnished by a particular provider is necessary if NetCare determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, NetCare will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to NetCare's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

NEGOTIATED CHARGE

This is the maximum charge a Participating Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

NON-OCCUPATIONAL DISEASE

A non-occupational disease is a disease that does not:
- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

NON-OCCUPATIONAL INJURY

A non-occupational injury is an accidental bodily injury that does not:
- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

NON-PARTICIPATING CARE

This is a health care service or supply furnished by a health care provider that is not a Participating Provider; if, as determined by NetCare:
- the service or supply could have been provided by a Participating Provider; and
- the provider is of a type that falls into one or more of the categories of providers listed in the Directory.

NON-PARTICIPATING PROVIDER

This is a health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

NON-URGENT ADMISSIONS

One which is not an emergency admission or an urgent admission.

ORTHODONTIC TREATMENT

This is any:
- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:
- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:
- the installation of a space maintainer; or

- a surgical procedure to correct malocclusion.

PARENT-CHILD RELATIONSHIP

A parent-child relationship exists between you and a child when the child is primarily dependent on you for support and the child is:
- unmarried;
- resides in the same household as you;
- has not reached the limiting age of the plan.

PHYSICIAN

This means a legally qualified physician.

PROVIDER DIRECTORY

This is a listing of all Participating Providers that have contractual arrangement with the Plan. The listing may be found at www.netcarelifeandhealth.com

PARTICIPATING CARE PROVIDER

This is a health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is, with NetCare's consent, included in the Directory as a Participating Provider for:
- the service or supply involved; and
- the class of employees of which you are member.

SCHEDULE OF BENEFITS

A summary of eligible services and benefits, applicable co-payments and co-insurance amounts, and deductibles. The Schedule of Benefits is also known as a Benefit Sheet.

R.N.

This means a registered nurse.

REASONABLE CHARGE

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:
- the provider's usual charge for furnishing it; and
- the charge NetCare determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge NetCare determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:
- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

NetCare may take into account factors, such as:
- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

SEMIPRIVATE RATE

This is the charge for board and room which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, NetCare will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

SERVICE AREA

The geographic area where the plan is administered. For purposes of this plan, the service area is Guam, CNMI, or where this Policy or applicable certificate is delivered**.**

Coverage under this Policy is applicable to only those person(s) who maintain their principal residence in Guam, the CNMI where this Policy or applicable certificate is delivered and such persons must be physically residing in said jurisdiction during at least nine (9) months of each Contract Period while this Policy remains in force.

SURGERY CENTER

This is a freestanding ambulatory surgical facility that:
- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  1) physicians who practice surgery in an area hospital; and
  2) dentists who perform oral surgery.

- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.

- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
  1) a physician trained in cardiopulmonary resuscitation; and
  2) a defibrillator; and
  3) a tracheotomy set; and
  1) a blood volume expander.

- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

TERMINALLY ILL

This is a medical prognosis of 6 months or less to live.

TREATMENT FACILITY (ALCOHOLISM OR DRUG ABUSE)

This is an institution that:
- Mainly provides a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a physician.
- Provides, on the premises, 24 hours a day:
  1) Detoxification services needed with its effective treatment program.
  2) Infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical services that may be required.
  3) Supervision by a staff of physicians.

  Skilled nursing care by licensed nurses who are directed by a full-time R.N.

URGENT ADMISSION

One where the physician admits the person to the hospital due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

USUAL, CUSTOMARY AND REASONABLE

1. Usual - A fee consistently charged by a Physician or provider to a patient for a special service or supply.

2. Customary - A fee that is within the range of usual charges for a given service or supply billed by most Physicians (or providers) with like training and experience within a geographic area.

3. Reasonable: 1) A Fee that is Usual and Customary; or 2) A fee that a local medical organization's review committee or Physician's Review Organization (PRO) deems just due to specific conditions in a special case.

NetCare utilizes Usual Customary and Reasonable charges on the current Medicare RBRVS, based on the geographic location where service was incurred, to determine the UCR Eligible Expense.

Article XI CONTINUATION HEALTH LAW (COBRA)

The Continuation Health Law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986 contains provisions giving certain former employees, retirees, spouses' former spouses, and dependent children the right to temporary continuation of health coverage at group rates.

ELIGIBLE EMPLOYEES

Active/Retired employees and their dependents are eligible for Continuation of Coverage provided:

- The active/retired employee or his/her dependent is not eligible for Medicare;
- The individual was enrolled in the plan on the day preceding the "qualifying event."

QUALIFYING EVENT

"Qualifying Event" for the purposes of this continuation provision is defined as follows:

Employee (18 months continuation coverage)

1. Voluntary or involuntary termination of employment of reasons other than "gross misconduct";
2. Reduction in the number of hours of employment.

Spouse (36 months continuation coverage)

1. Voluntary or involuntary termination of the covered employees employment for any reason other than gross misconduct;
2. Reduction in the hours worked by the covered employee;
3. Covered employee's becoming entitled to Medicare;
4. Divorce or legal separation of the covered employee;
5. Death of the covered employee.

Dependent Children (36 months continuation coverage)

1. Loss of dependent child status under the plan rules.

GENERAL RULES

The single rate will be charged to anyone who wants coverage only for himself/herself and is eligible for that coverage because of their individual status. Otherwise, the family rate will be charged.

Monthly continuation rates for individuals who want to continue their participation in the group medical program are established as follows:

Single Rate
Monthly continuation rates for individuals who want to continue their participation in the group medical program are established to:

1. an employee who previously had single coverage;
2. an employee who previously had family coverage but only wants to cover himself/herself;
3. a spouse OR dependent who was previously covered under the employee's plan but only wants to cover himself/herself when the employee does not want continued coverage;
4. a divorced spouse (only) of an employee who is still covered under the plan;
5. the underage child who was covered under the deceased employee's plan. The surviving spouse and any other underage dependent children who were not covered under the deceased employee's plan are not covered;
6. the spouse of a deceased employee, underage children eligible but not covered;
7. a child who reaches the limiting age (attainment of 26 years) may be covered under a single rate even though a former spouse or surviving spouse is covered under a single rate;
8. a spouse covered under the single rate must change to the family rate in order to cover a newborn child; cannot cover a new dependent other than through birth or adoption.

Single coverage not allowed

1. Death of employee; spouse and one child could not be individually covered as two singles. (Except as noted under "Single Rate," item 7 above.)
2. Terminated employee; spouse of underage child who both want coverage could not apply for single coverage individually.
3. Terminated employee and spouse could not each apply for single coverage.

Family Rate

Terminated employees who want to cover themselves and:

1. a spouse alone; or
2. a child alone; or
3. children; or
4. a spouse and any number of children; or
5. the spouse of a deceased employee. Spouse wishes self coverage and coverage for any number of children.

ENROLLMENT

An employee has 60 days after the regular plan of medical coverage terminates to enroll in the Program. You must enroll in the same plan previous to your continuation of health coverage.

ADJUSTMENTS

Contribution rates will be adjusted at the same time that active employee contribution rates are adjusted.

TERMINATION PROVISIONS

The Program will discontinue as to a participant at the earliest to occur of the following:

- When the participant fails to make required contributions by the due date;
- When the participant becomes eligible for Medicare benefits;
- When the participant becomes eligible under another group coverage medical plan. An exception is

made if the new plan contains pre-existing conditions which limit coverage.
- When the participant again becomes eligible for the regular plan of Medical Expense Coverage.
- When the 18 months has elapsed since the participant's regular coverage terminated (36 months for surviving dependents or disabled employees).
- When the plan terminates.

ADDITIONAL INFORMATION

The Continuation Health Law applies to eligible participants who are allowed to "continue" in the GROUP Medical Plan but who pay 102% of the combined Employer/participant contribution rate for whichever continuation plan is selected.

Dental Expense Coverage and Vision Care Coverage are included. Single and Family rates are available based on the criteria established in this section. The 18-month continuation period does not apply to persons who are eligible for Medicare.

HEALTH LAW COVERAGE FOR EMPLOYEES WHO ARE TOTALLY DISABLED

Employees who are totally disabled when their medical coverage ends will be eligible for continuation of medical coverage for up to 36 months from the date medical coverage ends. The cost of this medical coverage depends on the length of time covered under the Plan. Employees in the Plan for less than 5 years pay 102% for 36 months of coverage, including dependents. Employees in the Plan for 5 or more years will be covered for 12 months with no payment of premiums, and then will pay 102% for the next 24 months, including dependents.

The words “totally disabled” mean that due to injury or disease, you are not able to engage in your customary occupation and are not working for pay or profit.

To be eligible for temporary continuation of coverage under the disability provisions, the employee’s attending physician must provide evidence of the disability to NetCare. You must submit proof of total disability within 60 days of the date coverage terminated.

The temporary disability coverage for the employee and dependents will cease to apply when the first of the following occurs:
- The employee ceases to be totally disabled.
- The employee becomes eligible for Medicare.
- The employee becomes eligible under another group coverage medical plan. An exception is made if the new plan contains pre-existing conditions which limit coverage.
- The employee fails to make required contributions by the due date.
- The plan terminates.

Article XII HIPAA COMPLIANCE

PRIVACY PRACTICES

The protection of our members' health information is important to us at NetCare.

NetCare provides a copy of its Privacy Practices to all enrolled subscribers in order for them to become familiar with how personal health information will be used and safeguarded, as well as rights regarding the protection of a member's personal data. NetCare's Privacy Practices is posted in our website at www.netcarelifeandhealth.com You may also request a copy by calling our NetCare office at 671-472-3610.

The HIPAA Privacy Practices is effective April 14, 2003.

PORTABILITY

Portability allows the time served under previous health plan coverage to be credited toward a pre-existing condition exclusion of a new employer's group health plan. This time is called "creditable coverage." Credit is given for previous coverage that occurred without a break in coverage of 63 days or more. The law also guarantees that an employer's health plan must accept a new employee, regardless of health status – *a policy that has been the cornerstone of NetCare Life & Health Insurance Company*.

CERTIFICATE OF COVERAGE

In order to provide a new employer with proof of coverage, the federal law requires that a Certificate of Coverage be issued by NetCare when an individual leaves a group health plan. To receive credit from a previous carrier, the certificate of coverage should be sent to NetCare Life & Health Insurance Company with the employee's enrollment application. NetCare will automatically issue a Certificate of Coverage to participants who terminate their coverage. Any certificate we issue will reflect only coverage with NetCare. All certificates are mailed and addressed to the employee. You may request for additional copies, free of charge, by contacting our NetCare office. Additional certificates are mailed and addressed to the employee.

Article XIII NETCARE'S PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Venida Farnum, HIPAA Privacy Officer for NetCare Life & Health Insurance Company at (671) 472-3610 or at vlujan@netcarelifeandhealth.com

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your coverage, and will use and disclose your protected health information for treatment, claims payment and health care operations when necessary.

DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

"Protected health information" is individually identifiable health information. This information includes demographics, for example, age, address, e-mail address and relates to your past, present or future physical or mental health or condition and related health care services. NetCare is required by law to do the following:

- Make sure that your protected health information is kept private
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in the notice to you.

We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. You may obtain a Notice of Privacy Practices by calling NetCare's HIPAA Privacy Officer and requesting a copy be mailed to you.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

Required Uses and Discloser

By law, we must disclose your health information to you unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose health information to the Secretary of the Department of Health and Human Services (DHHS) for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a NetCare contractor who provides care to you. We may disclose your protected health information from time-to-time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment. This includes pharmacists who may be provided information on other drugs you have been prescribed to identify potential interactions.

In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that NetCare might undertake before it approves or pays for the health care services recommended for you such as determining eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay might require that your relevant protected health information be disclosed to obtain approval for the hospital admission.

Health Care Operation

We may use or disclose, as needed, your protected health information to support the daily activities related to health care. These activities include, but are not limited to, quality assessment activities, investigations, oversight or staff performance reviews, training of medical students, licensing, communications about a product or service, and conducting or arranging for other health care related activities.

For example, we may disclose your protected health information to medical school students seeing patients at a contracted medical facility. We may call you by name in the waiting room. We may use or disclose your protected health information, as necessary, to contact you.

We will share your protected health information with third-party “business associates” who perform various activities (for example, billing, transcription services) for NetCare. The business associates will also be required to protect your health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about NetCare and the services we

offer. We may also send you information about products or services that we believe might benefit you such as NetCare's wellness or disease management programs.

Required By Law
We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health
We may disclose your protected health information to a public health authority that is permitted by law to collect or receive the information. The disclosure may be necessary to do the following:

- Prevent or control disease, injury or disability
- Report births or deaths
- Report child abuse or neglect
- Report reactions to medications or problems with products
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefits programs, other government regulatory (federal or local) programs and civil rights laws.

Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food and Drug Administration to do the following:

- Report adverse events, product defects, or problems and biologic product deviations.
- Track products.
- Enable product recalls
- Make repairs or replacements
- Conduct post-marketing surveillance as required.

Legal Proceedings
We may disclose protected health information during any judicial or administrative proceeding, in response to a court or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement
We may disclose protected health information for law enforcement purposes, including the following:

- Responses to legal proceedings
- Information requests for identification and location
- Circumstances pertaining to victims of a crime
- Deaths suspected from criminal conduct
- Crimes occurring at a NetCare office site
- Medical emergencies believed to result from criminal conduct

Coroners, Funeral Directors, and Organ Donations

We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donations.

Research

We may disclose your protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity

Under applicable Federal and local laws, we may disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security

When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission including determination of fitness for duty; (2) for determination by the Department of Veterans Affairs (VA) of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Worker's Compensation

We may disclose your protected health information to comply with worker's compensation laws and other similar legally established programs.

Disclosures by the Health Plan

NetCare Life & Health Insurance Company may also disclose your protected health information. Examples of these disclosures include verifying your eligibility for health care and for enrollment in various health benefits and coordinating benefits for those who have other health insurance or eligible for other benefit programs.

Parental Access

Local law concerning minors permit or require disclosure of protected health information to parents, guardians and persons acting in a similar legal status. We will act consistently with local law where the treatment is provided and will make disclosures accordingly.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSIONS

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following is an example in which your agreement or objection is required.

Individuals Involved in your Health Care

Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

RIGHTS REGARDING YOUR HEALTH INFORMATION

You may exercise the following rights by submitting a written request to electronic message to NetCare's HIPAA Privacy Officer. Depending on your request, you may also have rights under the Privacy Act of 1974. NetCare's HIPAA Privacy Officer can guide you in pursuing these options. Please be aware that NetCare may deny your request; however, you may seek a review of the denial.

Right to Inspect and Copy

You may inspect and obtain a copy of your protected health information that is contained in a 'designated record set' for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that NetCare uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

Right to Request Restrictions

You may ask us not to use or disclose any part of your protected health information for treatment, payment, or health care operations. Your request must be made in writing to NetCare's HIPAA Privacy Officer where you wish the restriction instituted. In your request, your must tell us (1) what information you want restricted; (2) whether you want to restrict our use, disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date.

Right to Confidential Communication

You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment

If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendments, we are not required to agree to the amendment however.

Right to an Accounting of Disclosures

You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. The disclosure must have been made after April 14, 2003, and no more than 6 years from the date of request. This right excludes disclosures made to you, to a family member or friends involved in your care, or for notification. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this notice.

FEDERAL PRIVACY LAWS

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act, the Privacy Act and the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act. These laws have not been superseded and have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

COMPLAINTS

If you believe these privacy rights have been violated, you may file a written complaint with NetCare's HIPAA Privacy Officer or the Department of Health and Human Services or the U.S. Office of Civil Rights. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION

You may contact NetCare's HIPAA Privacy Officer for further information about the complaint process, or for further explanation of this document. NetCare's HIPAA Privacy Officer may be contacted at the following:

Venida Lujan
HIPAA Privacy Officer
NetCare Life & Health Insurance Company
Hagatna, Guam 96910
Phone: (671) 472-3610
Facsimile: (671) 472-3615
E-Mail: vlujan@netcarelifeandhealth.com

Article XIV APPEAL AND GRIEVANCE PROCEDURES

NOTICE OF APPEAL RIGHTS

The Affordable Care Act ensures your right to an internal appeal to reconsider any decision to deny payment for a service or treatment. The law also permits you to have an independent review organization (an external review) determine whether to uphold or overturn NetCare's internal appeal decision. NetCare must comply with federal laws and regulations to provide you an opportunity for an independent review of an adverse determination or final adverse determination.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact our office at 671-472-3610 when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Policy Specification;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

APPEALS

All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent in writing to our office at 424 W. O'Brien Drive Ste 200, Hagatna, Gu 96910 within 180 days of the date you receive our denial. We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have pertaining to your claim. We will notify you of our decision in writing within the listed specified timelines below. If you do not receive our decision within the noted response time of receiving your appeal, you may be entitled to file a request for an external review.

1. Urgent Care Claims – 72 Hours Response Time

A special kind of pre-service claim that requires a quick decision due to your health condition that may be threatened. If your appeal concerns urgent care, you may be able to have the internal appeal and external review take place at the same time.

2. Pre-Service Claims – 30 Days Response Time

Denials of non-urgent care you have not yet received.

3. Post-Service Claims – 60 Days Response Time

Claims for benefits under NetCare, including claims after medical care have been provided, such as reimbursement or payment of the costs of the services provided.

EXTERNAL REVIEW

If we have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review within 4 months after the date you receive our denial to the Office of the Insurance Commissioner at P.O. Box 13607 GMF Barrigada, Gu 96921, telephone 671-635-1817. For standard external review, a decision will be made within forty-five (45) days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an expedited external review of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also my be entitled to file a request for external review of our denial. For details, you may contact our office at 671-472-3610 or 424 W. O'Brien Drive Ste 200, Hagatna, Gu 96910.

Expedited External Review - An expedited process if you have a medical condition where the timeframe for completion of a standard external review, pursuant to the Uniform Health Carrier External Review Act, would seriously jeopardize your life or health or ability to regain maximum function. A decision will be made expeditiously as your medical condition or cirmumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of your request.

Article XV DISCLOSURES

Non-Grandfathered Status

This group health plan believes this plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act (The Affordable Care Act). Being a non- grandfathered health plan means that your policy includes certain consumer protections of the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 424 W. O'Brien Drive, Suite 200, Hagatna Gu 96910. You may also contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Transition to Affordable Care Act

Guam's Revenue & Taxation Banking and Insurance Commissioner Insurance Commissioner, Bulletin 2014-01, in reference to the U.S. Centers for Medicare and Medicaid Services (CMS) and the Department of Health & Human Services (HHS) Transitional Policy issued on March 5, 2014, allows Guam health insurance carriers in the individual, small and large group markets to issue renewal of grandfathered and non-grandfathered polices that are not in full compliance of the Patient Protection and Affordable Care Act under the transitional policy anytime in 2014 but not later than October 1, 2016. This group health plan participates in the guidelines provided by the Transitional Policy.

ERISA Employee Rights

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions;

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;

3. Special enrollment for you and your qualified dependents. If you or your dependents lose eligibility from other coverage (or if your employer stops contributing toward you or your dependent other coverage), this Plan may enroll you and your dependents if you declined enrollment under this Plan for yourself or your dependents because you had other coverage at that time. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents within 30 days after the marriage, birth, adoption, or placement for adoption.

4. Rewards for plans that allow Wellness benefit incentives. This Plan is committed to helping you achieve your best health. Plans that offer rewards for participating in a wellness program are available to employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different

means.

5. Benefits in accordance with the Genetic Information Nondiscrimination Act of 2008 (GINA). This Act prohibits your group health plan from using genetic information to adjust premiums or contribution, request or require an individual to undergo a genetic test or purchase genetic information for underwriting purposes for health coverage.

6. Health coverage in accordance with the Newborn and Mothers Health Protection Act. This Act may not restrict benefits or require authorization for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

7. Health coverage in accordance with the Women's Health and Cancer Rights Act (WHCRA). This Act provides additional benefits for certain breast reconstruction surgery and post-mastectomy procedures for a Covered Person who is receiving benefits for a medically necessary mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy was performed, 2) surgery and reconstruction of the other breast to produce a symmetrical appearance, 3) prostheses, and 4) physical complications resulting from mastectomy (including lymphedema).

8. Benefits in accordance with the Mental Health Parity Act (MHPA). This Act may not restrict annual or lifetime dollar limits on mental health benefits to be no lower than any such dollar limits for medical and surgical benefits. Criteria for medical necessity determinations made under this Plan with respect to mental health/substance use disorder benefits to any current or potential participant or beneficiary.

9. Health coverage in accordance with Michelle's Law. This law prohibits a group health plan from terminating coverage of a dependent child due to a medically necessary leave of absence from, or any other change in enrollment at, a postsecondary education institution that commences while such child is suffering from a serious illness or injury and that causes such child to lose student status for purposes of coverage under the plan, before the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. This Plan can require receipt of written certification by a treating physician of the dependent child which states that the dependent child is suffering from a serious illness or injury and the leave of absence (or other change of enrollment) is medically necessary.

10. Patient protection and rights under this Plan. When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If a Plan Participant's claim for a benefit is denied, in whole or in part, the Plan Participant must receive a written explanation of the reason for the denial. The Plan Participant has the right to have the Plan reviewed and reconsider the claim. Under ERISA there are steps that the Plan Participant can take to enforce the above rights.

Article XV CONTACT INFORMATION

You may contact our office with any questions or concerns that you may have regarding your eligibility status, benefits, medical referrals, participating providers, reimbursements, premium billing or claims status.

Office Address:
424 W. O'Brien Drive Suite 200
Hagatna, Gu 96910

Hours of Operation:
8:00am to 5:00pm, Monday through Friday

Customer Service:
Telephone: (671) 472-3610
Facsimile: (671) 477-5672 or (671) 472-3615
U.S. Mainland Assistance: (888) 966-9526
24 Hour Nurseline: (877) 585-5376

Website Information:

You may also log onto our website to check your enrollment information, request for an identification cards, check your claims status, review benefits and provider listings, and view newsletters and updates at www.netcarelifeandhealth.com

Article XVII SCHEDULE OF BENEFITS

Attached hereto is your Benefit Plan Design.

NetCare
Life & Health Insurance

ADVANTAGE PLAN POS MEDICAL

Schedule of Benefits 2025

The medical services listed on these pages are medical benefits for the ADVANTAGE PLAN POS. This POS 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 listing 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 www.netcarelifeandhealth.com

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS
DEDUCTIBLE (Subject to UCR)	**NONE**
PHYSICIAN & OUTPATIENT BENEFITS	
1. Primary Care Office Visit at PCP	$10 co-pay
2. Specialist Care Office Visit & Non-PCP Office Visit	$25 co-pay
3. Second Surgical Opinion	$25 co-pay
4. Home Health Care	$25 co-pay
5. Hospice ($50 per day/180 days Lifetime) Pre-certification required	$25 co-pay
6. Injections (Does not include Specialty and Orthopedic Injections)	$25 co-pay
7. Outpatient Laboratory Services	$10 co-pay
8. Outpatient X-ray Services	$10 co-pay per x-ray
9. Outpatient Surgery (Pre-certification required)	$100 co-pay
10. Private Duty Nursing	$25 co-pay
URGENT CARE	
1. Clinic Setting	$25 co-pay
2. Hospital Setting	$100 co-pay
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 2. Skilled Nursing Facility - Limited to 60 days per contract period 3. Inpatient Mental Health & Chemical/Substance Treatment	• Centers of Care - No charge for covered inpatient charges • GMHA & GRMC - $100 per day for the first 5 inpatient days • Other Hospitals - 20% of covered inpatient charges
EMERGENCY & NON-EMERGENCY SERVICES	
1. On or Off-island Emergency services	20% of covered charges
2. Non-emergency services rendered in a hospital emergency room	$100 co-pay plus 20% of covered charges
3. Ambulance Service (limited to ground transportation)	$100 co-pay
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. Routine Annual Physical Exam - Limited to one exam per contract period	No Charge
2. Routine Annual Gynecological Exam - Limited to one exam per contract period	No Charge
3. Routine Annual Mammograms - Age 40+	No Charge
4. Routine Annual Eye Exam - Limited to one exam per contract period	No Charge
5. Routine Annual Immunizations - Per CDC Guidelines	No Charge
6. Routine Annual Health Screening	No Charge
7. Routine Annual Outpatient Laboratory & Outpatient X-ray	No Charge

PRESCRIPTION DRUGS (www.optumrx.com)

Out of pocket maximum $3,000 Individual/$9,000 Family	**Retail/Pharmacy**	**Mail Order**	**Out of Network**
1. Generic drugs	$ 5 per unit	$ 0 (90 days)	Not Covered
2. Brand drugs	$ 15 per unit	$ 0 (90 days)	Not Covered
3. Non-formulary drugs	30% of covered charges	$150 (90 days)	Not Covered
4. Injectables (includes specialty injectable drugs)	30% of covered charges	30% + shipping	Not Covered
5. Specialty (excludes injectable drugs)	20% of covered charges, up to $250 out of pocket max	Not Covered	

ALLERGY	$25 co-pay
AUTISM SPECTRUM DISORDER	20% of covered charges
BLOOD, BLOOD PRODUCTS & DERIVATIVES Limited to $50,000 per Contract Period	20% of covered charges
CARDIAC CARE	
Specialist Office Visit	$25 co-pay
Cardiac Surgery (Pre-certification required) (Cardiac Implant is limited to cardiac pacemaker and cardiac stent)	• Centers of Care - No charge for covered inpatient charges. • GMHA & GRMC - $100 per day for the first 5 inpatient days. • Other Hospitals - 20% of covered inpatient charges.
CHEMICAL DEPENDENCY/SUBSTANCE ABUSE (OUTPATIENT)	$25 co-pay
CHEMOTHERAPY, RADIATION THERAPY & NUCLEAR MEDICINE Pre-certification required	$100 co-pay per procedure

Advantage Plan POS

BENEFIT DESCRIPTION	WHAT YOU PAY AT PARTICIPATING PROVIDERS
DEDUCTIBLE (Subject to UCR)	**NONE**
CHIROPRACTIC - Limited to $2,000 per Contract Period	$10 co-pay
CHRONIC ORTHOPEDIC DEFORMITY & CONDITIONS Pre-certification required Limited to $50,000 per Contract Period for all related services	20% of covered charges
CONGENITAL DISEASES - Limited to $15,000 per Contract Period. Pre-certification required.	
1. Primary Care Office Visit at PCP	$10 co-pay
2. Specialist Care Office Visit & Non-PCP Office Visit	$25 co-pay
3. Hospitalization (Hospitalization & Inpatient Benefits apply)	$100 co-pay per day for the first 5 inpatient days
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.	$100 co-pay per procedure
DURABLE MEDICAL EQUIPMENT (DME) Includes standard hospital bed, standard wheelchair, crutches, portable commode, oxygen concentrator, bili-lite, nebulizer, wigs after chemotherapy. Limited to rental only. Pre-certification required.	$100 co-pay
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 All inpatient admissions require a NetCare approved referral within 48 hours of admission.	
1. Pre-natal / Post-natal Care Visit (Includes one routine ultrasound)	No Charge
2. Delivery: Hospital Facility (a separate copayment will apply for newborn child)	$100 co-pay for the first 5 inpatient days
3. Delivery: Birthing Center (Limited to Guam) (a separate copayment will apply for newborn child)	$100 co-pay
4. Delivery: Centers of Care	No Charge
5. Delivery: Professional Fee	No Charge
6. Circumcision: Within 30 days of date of birth (Pre-certification required)	$50 co-pay
7. Breastfeeding Equipment (limited to rental only)	No Charge
MENTAL HEALTH TREATMENT (OUTPATIENT)	
First 20 visits	$25 co-pay
All visits thereafter	$50 co-pay plus 20% of covered charges
OCCUPATIONAL THERAPY Maximum of 10 visits per Contract Period. Pre-certification required.	$25 co-pay
PHYSICAL THERAPY Maximum of 20 visits per Contract Period. Pre-certification required.	$25 co-pay
RECONSTRUCTIVE BREAST SURGERY Limited to the following in accordance with the Women's Health & Cancer Rights Act of 1998. Pre-certification required.	
1. Primary Care Office Visit at PCP	$10 co-pay
2. Specialist Care Office Visit & Non-PCP Office Visit	$25 co-pay
3. Hospitalization (Hospitalization & Inpatient Benefits apply)	$100 co-pay per day for the first 5 inpatient days
•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	
SPEECH THERAPY (OUTPATIENT) Limited to 20 visits per Contract Period. Pre-certification required.	$25 co-pay
STERILIZATION PROCEDURES Outpatient Tubal Ligation or Vasectomy at PCP or Surgicenter Pre-certification required	No Charge
TELEHEALTH / TELEMEDICINE Limited to Guam, CNMI, Philippine & UHC provider networks	Primary Office Visit - $10 co-pay Specialist Office Visit - $25 co-pay
WELLNESS PROGRAMS- Guidelines established by USPSTF Member co-insurance may be reimbursed upon a program completion.	20% of covered charges
WELLNESS MASSAGE THERAPY Limited to Guam; One (1) 60 min visit per month; Age 18 years and above.	$10 co-pay

GROUP TERM LIFE INSURANCE (optional group benefit)	Plan pays $5,000 Basic + $5,000 AD&D
ANNUAL PLAN MAXIMUM | LIFETIME MAXIMUM	Unlimited
ANNUAL OUT-OF-POCKET MAXIMUM	
1. Per Individual Per Contract Period	$2,000.00
2. Per Family Per Contract Period	$6,000.00

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 services 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.

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.healthreformgov.

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

PRIMARY CARE PROVIDER (PCP) - A PCP is a physician who provides primary or routine care. Each enrolled member is paneled to a PCP by election or assignment. Member out-of-pocket expense is determined by care at a PCP or non-PCP. A specialist provider may be chosen as a PCP provided the specialist allows primary or routine patient care.

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. Specialty drugs are limited to retail purchase at participating providers. Preventive drug benefits are payable based on guidelines established by the U.S. Preventive Services Task Force grades A or B. Injectable drug copayment includes specialty drugs. Please refer to NetCare's current drug formulary for coverage and copayment tier.

PROVIDER NETWORK - Covered benefits and services are limited to participating providers on Guam. Charges for services rendered outside Guam and at non-participating providers are not covered by the plan.

REFERRALS - Referrals are not required for primary, specialty or covered ancillary services at participating providers on Guam. There is no coverage or payable benefits for services rendered outside Guam unless approved by NetCare.

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

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

UCR means Usual, Customary & Reasonable charges of the geographical location where service was rendered based on the current Medicare RBRVS/DRG. Charges in excess of UCR are not payable by the plan.

MEDICAL EXCLUSIONS

Medical services listed below are NOT covered by NetCare

- Airfare (unless criteria as set forth by the Plan has been met).
- Acupuncture.
- Biofeedback and other forms of self-care or self-help training.
- Blood derivatives used 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 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 healthcare providers.
- 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 no include 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 (i.e. Lasik), etc.

MEDICAL EXCLUSIONS (continued)

Medical services listed below are NOT covered by NetCare

- 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.
- All Hip Joint Arthroplasties to include but not limited to hip arthroplasty (replacement), resurfacing arthroplasty, hip arthroscopy and related treatment and services.
- Hyperbaric Oxygen Treatment (HBO).
- 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.
- 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.
- Prescription drugs not included in NetCare's mandatory generic drug program, unless approved by the Plan.
- Preventive care & services rendered at participating specialist providers, except for OB/GYN related services.
- Services provided by the covered person's spouse, child, brother, sister or parents whether by blood or by law.
- Services rendered by a non-participating provider, except for emergency care & services.
- Services rendered outside Guam other than at NetCare's direct contracted providers and NetCare's Centers of Care.
- Services rendered outside Guam without a NetCare approved referral.
- Services rendered for pre-certified benefits not approved by NetCare.
- Specialty drugs purchased at pharmacies other than participating retail providers.
- 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 from intentionally self-induced or self-inflicted injuries from attempted suicide.
- Treatment and services for Adoptive Cell Therapy to include but not limited to Gene Therapy, Immunotherapy, CAR T Cell Therapy TIL Therapy, TCR Therapy, NK Cell Therapy.
- Treatment & services for Massage Therapy other than for therapeutic techniques defined by AMA guidelines.
- Treatment & services for hepatitis drugs without a NetCare approved prior authorization and strict criteria satisfaction.
- Treatment and services related to Organ Transplant.
- Treatment and services related to sleeping disorders, sleep evaluation & diagnosis.
- 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.
- 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.