NetCare
Life & Health Insurance

CNMI PRIME PLAN

MEDICAL

BENEFITS & TERMS

The medical services listed on these two pages are your benefits for the CNMI Prime Plan. For a detailed description of your benefits, co-payments, deductibles and procedures, please refer to your Group Service Agreement or Member Handbook. For a listing of participating providers within our network, please refer to NetCare's Provider Directory or log on to www.netcarelifeandhealth.com

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS		NON-PARTICIPATING PROVIDERS
ANNUAL DEDUCTIBLE (subject to UCR)	**None**		**$500 Individual / $1,500 Family**
PHYSICIAN & OUTPATIENT BENEFITS			
1. Primary Care Office Visit	80% of covered charges		70% of UCR
2. Specialist Care Office Visit	80% of covered charges		70% of UCR
3. Second Surgical Opinion	80% of covered charges		70% of UCR
4. Home Health Care	80% of covered charges		70% of UCR
6. Outpatient Laboratory Services	80% of covered charges		70% of UCR
7. Outpatient X-ray Services	80% of covered charges		70% of UCR
8. Outpatient Surgery	80% of covered charges		70% of UCR
9. Urgent Care Visit	80% of covered charges		70% of UCR
HOSPITALIZATION & INPATIENT BENEFITS			
1. Room & board for semi-private room, intensive care, coronary care & surgery	80% of covered charges		70% of UCR
2. All other inpatient hospital services including laboratory, x-ray physician services, operating room, anesthesia & medication	80% of covered charges		70% of UCR
MATERNITY CARE			
1. Pre-natal & Post-natal Care (Includes routine ultrasound)	100% of covered charges		70% of UCR
2. Delivery			
Hospital Facility	80% of covered charges		70% of UCR
3. Circumcision (covered within 30 days from date of birth)	80% of covered charges		70% of UCR
EMERGENCY BENEFITS			
1. On & Off-island emergency facility, physician services, laboratory, x-rays	80% of covered charges		80% of UCR
2. Ambulance Service (Limited to ground transportation)	80% of covered charges		80% of UCR
NON-EMERGENCY BENEFITS			
Non-emergency treatment in a hospital emergency room	50% of covered charges		50% of UCR
ROUTINE ANNUAL EXAM/PREVENTIVE CARE			
1. Well-Baby Care (Up to age 2; Limited to 5 visit per Contract Period)	80% of covered charges		70% of UCR
2. Annual Physical Exam	80% of covered charges		70% of UCR
3. Anuual Gynecological Exam	80% of covered charges		70% of UCR
4. Annual Mammogram (over 40 years of age)	80% of covered charges		70% of UCR
5. Annual Eye Exam (maximum of $50 per contract period)	80% of covered charges		Not Covered
6. Routine Immunizations	80% of covered charges		70% of UCR
6. Health Screening/Out-patient Laboratory/Out-patient X-ray	80% of covered charges		70% of UCR
PRESCRIPTION DRUGS			
Limited to generics unless specified by physician (additional co-pay may apply)	**Retail**	**Mail**	**Out of Network**
1. Generic drugs	$ 0.00 co-payment	$ 0.00 for 90-days	50% of AWP
2. Brand name drugs	$15.00 co-payment	$30.00 for 90-days	50% of AWP
3. Non-Formulary drugs	$30.00 co-payment	$60.00 for 90-days	50% of AWP
4. Injectable drugs	15% per unit	15% plus shipping	50% of AWP
DIAGNOSTIC TESTING			
MRI, CT Scan, Ultrasound, Cardiac Stress Test, Cardiac Catheterization, Coronary Angiography, Bone Scan, Biopsy and any other diagnostic procedures. Limited to one test per contract period per anatomical region. Pre-certification required.	80% of covered charges		70% of UCR
CARDIAC CARE			
1. Primary & Specialty Care Office Visit	80% of covered charges		70% of UCR
2. Cardiac Surgery (Limited to Centers of Care)	80% of covered charges		70% of UCR
CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE (Limited to $20,000 per contract period)	80% of covered charges		70% of UCR
CONGENITAL DISEASES (Limited to $10,000 per Contract Period)			
1. Primary & Specialty Care Office Visit	80% of covered charges		70% of UCR
2. Hospitalization	80% of covered charges		70% of UCR
STERILIZATION PROCEDURES (Outpatient Tubal Ligation or Vasectomy)	80% of covered charges		70% of UCR
BLOOD & BLOOD DERIVATIVES (Limited to cost of administration only)	80% of covered charges		70% of UCR
ORGAN TRANSPLANT COVERAGE (Limited to $20,000 Lifetime)	80% of covered charges		70% of UCR
AIDS COVERAGE	80% of covered charges		50% of UCR
CHIROPRACTIC (Limited to $250 per Contract Period)	80% of covered charges		70% of UCR
PHYSICAL THERAPY (Limited to $400 per Contract Period)	80% of covered charges		70% of UCR
SPEECH THERAPY (Limited to $200 per Contract Period/50 2-hr sessions lifetime)	80% of covered charges		70% of UCR
MENTAL HEALTH (Limited to 10 Outpatient Visits)	80% of covered charges		70% of UCR
DURABLE MEDICAL EQUIPMENT (DME) Includes standard hospital bed, standard wheelchair, crutches, oxygen concentrator, bili-lite., nebulizer. Limited to rental only.	80% of covered charges		Not Covered

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
CHRONIC ORTHOPEDIC CONDITION (Limited to $5,000 per Contract Period)		
1. Primary & Specialty Care Office Visit	80% of covered charges	70% of UCR
2. Hospitalization	80% of covered charges	70% of UCR
ALCOHOL/SUBSTANCE ABUSE TREATMENT (Limited to 10 Outpatient Visits)	80% of covered charges	70% of UCR
RECONSTRUCTIVE BREAST SURGERY		
1. Primary & Specialty Care Office Visit	80% of covered charges	70% of UCR
2. Hospitalization/Surgery	80% of covered charges	70% of UCR
Limited to the following:		
●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 physcial complication, including Lymphedemas		
ANNUAL PLAN MAXIMUM		
1. Individual Lifetime Maximum	$1,000,000.00	
2. Individual Annual Maximum	$30,000.00	
ANNUAL CO-PAYMENT MAXIMUM		
1. Per individual per contract period	$2,000.00	None
2. Per family per contract period	$6,000.00	None

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

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

REFERRALS - are not required for primary or specialty care at approved providers in CNMI, Guam, Asia, Philippines. Referrals are required for all services in Hawaii and the Continental United States. Please refer to the CNMI Provider Listing for approved providers for referrals.

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

Medical Exclusions: *Services NOT covered by NetCare.*

- Accupuncture care & services.
- Airfare.
- Allergy testing and treatment.
- Biofeedback and other forms of self-care or self-help training.
- Care for military service connected disabilities to which a member is legally entitled.
- Care and services normally covered by Medicare Parts A & B for which the member is eligible and entitle to at no cost, but declined to enroll.
- Care or services rendered by immediate relatives or members of the enrollee's household, rendered as a duly licensed medical practitioner employed by a health care provider.
- Chronic Brain Sydrome, or custodial care charges resulting from senile deterioration.
- Cost of care and services related to or for replacement of joints and use of prosthetic devices and artificial limbs.
- Cost of care or treatment related to diseases, illness, or injuries where payment is provided for under local laws or programs, federal acts, industrial insurance, automobile insurance or Worker's Compensation programs.
- Custodial care, domiciliary or convalescent care, or rest cures.
- Dental services except for surgical procedures as a result of accidental injury to natural teeth or jaw. Such services do not include capping, bridges or retainers as benefits.
- Elective cosmetic treatment including but not limited to breast implants (unless after mastectomy due to cancer) cosmetic eye surgery (ie. Lasik), etc.
- Emergency treatment provided outside the service area if the need for care could have been foreseen before departing the service area.
- Experimental medical, surgical and other health-care procedures.
- Gastric Bypass, stapling or reversal, surgical correction (except as approved by the Plan).
- Hearing Aids.
- Hip & Joint replacement surgery and all related treatment and services.
- Implants including a non-human artificial or mechanical organ, breast implants, penile prosthesis, cornea, intra-ocular lenses, artificial joints and limbs, etc. except for cardiac pacemakers and stents.
- Infertility services and care related to conception by artificial means, including artificial insemination, in-vitro fertilization and embryo transfers, sterilization unless medically necessary, cost of care and treatment for reversal of sterilization and treatment or correction of infertility.
- Inpatient Mental Health Care.
- Intentionally self-inflicted injury, while sane or insane unless or from a domestic violence dispute.
- Injury or illness incurred as a result of attempted suicide.
- Interrupted pregnancy (non-medically necessary), non-life threatening abortions unless medicall necessary.
- Living expenses including meals, hotel rooms, transportation, etc.
- Long term rehabilitation and physical therapy.
- Maternity care for non-spouse dependent.
- Medical treatment and services related to dialysis.
- Nasal reconstruction except to correct a deformity as a result of an accidental injury which occurred within 90-days of the date of surgery, or the removal or treatment of cancer of the nose.
- Non-medical treatment of obesity (except as approved by the Plan).
- Organ Transplants.
- Orthopedic and external prosthetic devices including but not limited to shoes, orthotics, artificial limbs, etc.
- Over-the-counter drugs or drugs for which a prescription from a licensed physician is not required under federal law.
- Personal comfort items, such as but not limited to telephone, television, guest trays, electrical power, water and disposal systems, baths and pools at their installation, hospital room upgrades & surcharges.
- Physical examinations and all services related thereto when required for obtaining or continuing employment, insurance, schooling, governmental licensing or sports activities.
- Pre-existing conditions and medical conditions excluded and noted on the policy.
- Prenatal ultrasound (except as approved by the Plan). Routine ultrasounds are limited to one per pregnancy term. Subsequent ultrasounds are not covered unless medically necessary and approved by the Plan.
- Services provided by the covered person's spouse, child, brother, sister or parents whether by blood or by law.
- 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 of acne related services, including prescription drugs.
- Treatment for adult circumcision procedures, if provided solely for cosmetic or religious purposes.
- Treatment for services and supplies related to sexual dysfunction (ie. Viagra)
- Treatment for injuries sustained in the commission of an illegal act including but not limited to drunk driving (driving while intoxicated, or with an alcohol level of .08 or greater on the Draeger Alco Test, or blood alcohol level of 100-250 MG/DL).
- Treatment of injuries or illnesses sustained as a result of war or any acts of war, declared or undeclared.
- Treatment of injuries while participating in hazardous sports, such as but not limited to off-road, skydiving, etc.
- Treatment and services related to Occupational therapy, including hand therapy.
- Treatment and services related to sleeping disorders.
- Whole blood and blood derivatives.
- Any portion of an expense, charge or fee that exceeds the eligible charges and the Usual, Customary and Reasonable charge.
- Benefits and services not specified as covered.