NetCare
Life & Health Insurance

PALAU PREFERRED PLAN

MEDICAL

BENEFITS & TERMS

The medical services listed on these two pages are your benefits for the Palau Preferred Plan. For a detailed description of your benefits, co-payments, and procedures, please refer 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	
ANNUAL DEDUCTIBLE	**None**	
PHYSICIAN & OUTPATIENT BENEFITS		
1. Primary Care Office Visit	100% of covered charges	
2. Specialist Care Office Visit	100% of covered charges	
3. Second Surgical Opinion	100% of covered charges	
4. Home Health Care	100% of covered charges	
6. Outpatient Laboratory Services	100% of covered charges	
7. Outpatient X-ray Services	100% of covered charges	
8. Outpatient Surgery	100% of covered charges	
9. Urgent Care Visit	100% of covered charges	
HOSPITALIZATION & INPATIENT BENEFITS		
1. Room & board for semi-private room, intensive care, coronary care & surgery	100% of covered charges	
2. All other inpatient hospital services including laboratory, x-ray physician services, operating room, anesthesia & medication	100% of covered charges	
MATERNITY CARE		
1. Pre-natal & Post-natal Care (Includes routine ultrasound)	100% of covered charges	
2. Delivery		
Hospital Facility	100% of covered charges	
3. Circumcision (covered within 30 days from date of birth)	100% of covered charges	
EMERGENCY BENEFITS		
1. On & Off-island emergency facility, physician services, laboratory, x-rays	100% of covered charges	
2. Ambulance Service (Limited to ground transportation)	100% of covered charges	
ROUTINE ANNUAL EXAM/PREVENTIVE CARE		
1. Well-Baby Care (Up to age 2; Limited to 5 visits per Contract Period)	100% of covered charges	
2. Annual Physical Exam	100% of covered charges	
3. Anuual Gynecological Exam	100% of covered charges	
4. Annual Mammogram (over 40 years of age)	100% of covered charges	
5. Annual Eye Exam (maximum of $50 per contract period)	100% of covered charges	
6. Routine Immunizations	100% of covered charges	
7. Health Screening/Out-patient Laboratory/Out-patient X-ray	100% of covered charges	
PRESCRIPTION DRUGS		
(Limited to generics unless specified by physician (additional co-pay may apply)	**Retail**	**Mail**
1. Generic drugs	$ 0.00 co-payment	$ 0.00 for 90-days
2. Brand name drugs	$15.00 co-payment	$30.00 for 90-days
3. Non-Formulary drugs	$30.00 co-payment	$60.00 for 90-days
4. Injectable drugs	15% per unit	15% plus shipping
DIAGNOSTIC TESTING		
MRI, CT Scan, Ultrasound, Cardiac Stress Test, Cardiac Catheterization, Coronary Angiography, Bone Scan, Biopsy and any other diagnostic procedures. Limited to one test per contract period per anatomical region. Pre-certification required.	100% of covered charges	
CARDIAC CARE		
1. Primary & Specialty Care Office Visit	100% of covered charges	
2. Cardiac Surgery (Limited to Centers of Care in the Philippines)	100% of covered charges	
CHEMOTHERAPY, RADIATION THERAPY, NUCLEAR MEDICINE	100% of covered charges	
BLOOD & BLOOD DERIVATIVES (Limited to cost of administration only)	100% of covered charges	
PHYSICAL THERAPY (Limited to $200 per Contract Period)	100% of covered charges	
CHRONIC ORTHOPEDIC CONDITION (Limited to $5,000 per Contract Period)		
1. Primary & Specialty Care Office Visit	80% of covered charges	
2. Hospitalization	80% of covered charges	
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	None	
2. Per family per contract period	None	

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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.
REFERRALS - are not required for primary or specialty care at approved providers in Palau. Services rendered outside of Palau without an approved NetCare referral are not covered by the Plan. Services rendered at non-participating providers are not covered by the Plan.
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.

- Acupuncture care & Chiropractic services.
- Airfare (unless criteria as set forth by the Plan has been met).
- 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.
- Cost of services for Sterilization (Tubal Ligation, Vasectomy)
- Custodial care, domiciliary or convalescent care, or rest cures.
- Dental services except for surgical procedures as a result of accidental injury to natural teeth or jaw. Such services do not include capping, bridges or retainers as benefits.
- Durable Medical Equipment.
- Elective cosmetic treatment including but not limited to breast implants (unless after mastectomy due to cancer) cosmetic eye surgery (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.
- Executive Physical Exam/ECU (inpatient physical exam).
- Gastric Bypass, stapling or reversal, surgical correction (except as approved by the Plan).
- Hearing Aids.
- Hip & Joint replacement surgery and all related treatment and services.
- Hyperbaric Oxygen Treatment (HBO).
- Implants including a non-human artificial or mechanical organ, breast implants, penile prosthesis, cornea, intra-ocular lenses, artificial joints and limbs, etc. except for cardiac pacemakers and stents.
- Infertility services and care related to conception by artificial means, including artificial insemination, in-vitro fertilization and embryo transfers, sterilization unless medically necessary, cost of care and treatment for reversal of sterilization and treatment or correction of infertility.
- Inpatient Mental Health Care.
- Intentionally self-inflicted injury, while sane or insane unless or from a domestic violence dispute.
- Injury or illness incurred as a result of attempted suicide.
- Interrupted pregnancy (non-medically necessary), non-life threatening abortions unless medicall necessary.
- Living expenses including meals, hotel rooms, transportation, etc.
- Long term rehabilitation and physical therapy.
- Maternity care for non-spouse dependent including but not limited to ectopic pregnancy, antepartum hemorrhage.
- Mental Health treatment and services.
- 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.
- Speech related services.
- State & local taxes, administrative fees and handling/shipping charges.
- Temporomandibular (jaw) joint disorders and related diseases (TMJ).
- The purchases and/or fitting of eyeglasses or contact lenses (unless Vision Care Rider is elected), radical keratotomy or lasik.
- Transsexual surgery and related services.
- Treatment and services related to Dialysis.
- Treatment and services related to Organ Transplants.
- Treatment and services related to Congenital abnormalities.
- Treatment of acne related services, including prescription drugs.
- Treatment for adult circumcision procedures, if provided solely for cosmetic or religious purposes.
- Treatment for services and supplies related to sexual dysfunction (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.