

CNMI STANDARD PLAN MEDICAL Schedule of Benefits 2025

The medical services listed on these pages are medical benefits for the CNMI STANDARD Plan. This PPO Medical Plan is a summation of benefits. Detailed description of benefits, co-payments, deductibles & procedures are found in your Summary Plan Description, Summary of Benefit Coverage, or Uniform Glossary. A 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 at www.netcarelifeandhealth.com

BENEFIT DESCRIPTION			WHAT YOU PAY AT NON-	
			PARTICIPATING PROVIDERS	
DEDUCTIBLE (Subject to UCR)	NONE		\$300 Individual / \$900 Family	
PHYSICIAN & OUTPATIENT BENEFITS				
1. Primary Care Office Visit	10% of covered		30% of UCR	
2. Specialist Care Office Visit	10% of covered	Q	30% of UCR	
3. Second Surgical Opinion	10% of covered		30% of UCR	
4. Home Health Care	10% of covered	Q	30% of UCR	
5. Injections (Does not include Specialty and Orthopedic Injections)	10% of covered		30% of UCR	
6. Outpatient Laboratory Services	10% of covered		30% of UCR	
7. Outpatient X-ray Services		10% of covered charges		
8. Outpatient Surgery	10% of covered	charges	30% of UCR	
9. Private Duty Nursing	10% of covered	charges	30% of UCR	
URGENT CARE				
1. Clinic Setting	10% of covered	charges	30% of UCR	
2. Hospital Setting	10% of covered		30% of UCR	
HOSPITALIZATION (Inpatient Services) All inpatient admissions require			rs of admission.	
1. Room & board for semi-private room, intensive care, coronary care &	 Centers of Care & Philip 			
surgery; All other inpatient hospital services including laboratory, x-ray,	no charge for covered in		30% of UCR	
operating room, anesthesia, medication & physician's services	 CHC & other Hospit 	als - 20% of	30% of CER	
2. Inpatient Mental Health & Chemical/Substance Treatment	inpatient cha	arges.		
EMERGENCY SERVICES				
1. On or Off-island Emergency services (when not followed by admission)	10% of covered charges		10% of covered charges	
2. Ambulance Service (Limited to ground transportation for bona fide emerge	10% of covered charges		10% of UCR	
NON-EMERGENCY SERVICES (Non-emergency treatment in a hospital roc	50% of covered charges		50% of UCR	
ROUTINE ANNUAL EXAMS & IMMUNIZATIONS - Preventive guidelines established by U.S. Preventive Services Task Force, Grades A or B				
Preventive Care for Adults, Child & Baby				
1. Well-baby/Child Care	No Charge for covered charges		30% of UCR	
2. Routine Annual Physical Exam - Limited to one exam per contract period	No Charge for covered charges		30% of UCR	
3. Routine Annual Gynecological Exam - Limited to one exam per contract period	No Charge for covered charges		30% of UCR	
4. Routine Annual Mammograms - Age 40+	No Charge for covered charges		30% of UCR	
5. Routine Annual Eye Exam - Limited to one exam per contract period	No Charge for covered charges		Not Covered	
6. Routine Annual Immunizations - Per CDC Guidelines	No Charge for covered charges		30% of UCR	
7. Routine Annual Health Screening	No Charge for covered charges		30% of UCR	
8. Routine Annual Outpatient Laboratory	No Charge for covered charges		30% of UCR	
9. Routine Annual Outpatient X-ray	No Charge for covered charges		30% of UCR	
PRESCRIPTION DRUGS (www.optumrx.com)	Retail/Pharmacy	Mail Order	Out of Network	
1. Generic drugs	\$ 5 per unit	\$ 0 (90 days)	Not Covered	
2. Brand drugs	20% of covered charges	\$ 30 (90 days)	Not Covered	
3. Non-formulary drugs	30% of covered charges	\$ 60 (90 days)	Not Covered	
4. Injectables (includes specialty injectable drugs)	30% of covered charges	30%+shipping	Not Covered	
5. Specialty (excludes injectable drugs)	20% up to \$150 out of	Not Covered	Not Covered	
	pocket max			
	•			
AIDS COVERAGE	20% of covered charges		50% of UCR	
AUTISM SPECTRUM DISORDER	10% of covered charges		30% of UCR	
BLOOD, BLOOD PRODUCTS & DERIVATIVES	10% of covered	charges	30% of UCR	
Limited to cost of administration only	10% 01 covered	charges	30% OF BER	
CARDIAC CARE				
Limited to \$40,000 per Contract Period. Cardiac Implant is limited to cardiac	pacemaker and cardiac st	tent.		
1. Primary Office Visit	10% of covered charges		30% of UCR	
2. Specialist Office Visit	10% of covered charges		30% of UCR	
3. Cardiac Surgery (Limited to Centers of Care)	10% of covered charges		30% of UCR	
CHEMICAL DEPENDENCY/SUBSTANCE ABUSE (OUTPATIENT)	10% of covered charges		20% of UCR	
CHEMOTHERAPY Limited to \$20,000 per Contract Period	10% of covered charges		30% of UCR	
CHIROPRACTIC - Limited to \$250 per Contract Period	10% of covered charges		30% of UCR	
CHIRCH KACHC - Linned to \$250 per Contract renou	10 % of covered	charges	30 /0 01 UCK	

CHRONC CRETOPEDIC DEFORMITY & CONDITIONS 20% of covered charges 30% of UCR CONCENTIAL DESEASE Limited to 500.00 per Contract Period of all related services CONCENTIAL DESEASES Limited to 510.00 per Contract Period 10% of encend charges 30% of UCR 20% of the service 20% of encend charges 30% of UCR 20% of encend charges 30% of UC			CNMI Standard Plan	
CHRONC CRETOPEDIC DEFORMITY & CONDITIONS 20% of covered charges 30% of UCR CONCENTIAL DESCASES Limited to 5500, per Contract Period of all related services CONCENTIAL DESCASES Limited to 5500, per Contract Period Covered charges 30% of UCR 20% of covered charges 30% of UCR 20%	BENEFIT DESCRIPTION			
Linited to 5200 per Contract Period for all related services and of ONERG Charges 30% of UCR CONCENT LINES ASSES Linited to 150,000 per Contract Period 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 30% of UCR 2 Specialized Office Visit 10% of covered charges 10% of UCR 2 Specialized Office Visit 10% of covered charges 10% of UCR 2 Specialized Office Visit 10% of covered charges 10% of UCR 2 Specialized Office Visit 10% of covered charges 10% of UCR 2 Specialized Office Visit 10% of covered charges 10% of UCR 2 Specialized Office Visit 10% of covered charges 10% of UCR 2 Specialized Office Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Specialized Visit 10% of covered charges 10% of UCR 2 Spec	DEDUCTIBLE (Subject to UCR)	NONE	\$300 Individual / \$900 Family	
Limited 510000 per Canteral Period 1 Franzy Office Visit 2 specialist Office Visit 3 forgativitation (figurent Renefits apply) 10% of covered durges 30% of UCR 30% of UCR 30% of UCR 10% of covered durges 30% of UCR 10% of covered durges 30% of UCR 10% of covered durges 30% of UCR 10% of covered durges 10% of UCR 10% of covered du	CHRONIC ORTHOPEDIC DEFORMITY & CONDITIONS Limited to \$5,000 per Contract Period for all related services	20% of covered charges	30% of UCR	
1. Primary Office Visit 10% of covered charges 30% of UCR 2. Specialist Office Visit 20% of UCR 2. Specialist Office Visit 20% of UCR 20% of UC	CONGENITAL DISEASES			
2 Specialization (Dragenet Renearies apply) 10% of covered charges 30% of UCR Menginization (Cronnary Angiography, Bone Scan, Biopsy and any other diagnostic proceedure. Limited to one thet per anatomical region per contract period. Procentification reguined. Approval based on medical review. DURABLE MEDICAL IEQUIPMENT (DME) Includes standard boepial Hed, standard wheelchair, crutches portable commode, oxygen concentrato, Billin, Beabilizer, wigs after chemotherapy. Limited to neetal only. PTINESS INELFICAL IEQUIPMENT (DME) Para pays up to S20/mosh (up to S200 per Contract Period) for attendance themotherapy. Limited to revise on the foulth Risk Assessment. MATERNITY CARE I. Dronatal / Dronatal Care Visit (Includes one contine ultrasound) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Hospital Tacity and Todessional Fee (a separate copsyment will apply for newborn child) 2. Delivery: Cortact Period 2. Delivery: Cortact Period 2. Delivery: Cortact Period 2	Limited to \$10,000 per Contract Period			
3. Lingshiltration (Inpattent Benefits apply) 10% of covered charges 20% of UCR DIAGNOSTIC TESTING MILL Mammogram, CT Son, EKG, Ultrasound, Cardiac Stress Test, Cardiac Cardiac Cherication, Coronary Angiography, Beno Son, Berkoy and any other 10% of covered charges 20% of UCR 20% of UC	1. Primary Office Visit			
DIACNOSTIC TESTING Will, Mamnogram, CT Son, EKG, Ultrasound, Cardiac Stress Test, Cardiac Catherization, Coronay Anglography, Ison Scan, Biopey and any other lagowich provokure. Limited to next Isst per anatomical review. DURABLE MEDICAL EQUIPMENT (DMF) Includes standard hospital bed, intendited wheelshild, rentches, portable commode, oxygen concentrator, bill-like, nebulaer, vigo after Hendbersyn. Limited to next Isst per anatomical review. DURABLE MEDICAL EQUIPMENT (DMF) Includes standard hospital bed, intendited wheelshild, rentches, portable commode, oxygen concentrator, bill-like, nebulaer, vigo after Hang pays up to \$200 Cash Reward Stimes/month & completion of NeiCare's online Health Risk Assessment. MATENITY CARE 1. Pre-natal / Post-natal Care visit (Includes one routine ultrasound) 2. Delivery: Liopid Facility and Professional Fee (a separate copayment will apply for newborn child) 4. Circumcision: Within 30 days of date of birth 5. Inesstleeding Equipment (Imited to rental only) METAL HEALTH TREATMENT (OUTPATIENT) 10% of covered charges 30% of UCR 4. Circumcision: Within 30 days of date of birth 5. Inesstleeding Equipment (Imited to rental only) No Charge for covered charges 30% of UCR 4. Circumcision: Within 30 days of date of birth 10% of covered charges 30% of UCR METAL HEALTH TREATMENT (OUTPATIENT) 10% of covered charges 30% of UCR 10% of covered charges 30% of UCR				
MEL Mammagram, CT Son, EKG, Ultrasund, Cardia Stress Test, Cardiac Catherization. Convort Angiogram, None Son, Biops and any other diagnostic procedure. Limited to one test per anatomical region per contract period. Presentification reguined. Approval based on medical review. DURABLE MEDICAL EQUIPMENT (DMF) Includes standard hospital bed, standard wheekhair, crutches, portable commode, oxygen concentracts, Dille, nebuliner, vigo after sharotherapy. Limited to createl only. FTINESS BERLENTE & REWARD Flan pays up to 5200 Cash Reward stimes/month & completion of Neurosciences with the Risk Assessment. MATENTIY CARE In Pensatel / Personal Care Visit (Includes one routine ultrasound) 2. Delivery: Hospital Facility and Professional Tee (a separate copayment will apply for newborn child) 2. Delivery: Hospital Facility and Professional Tee (a separate copayment will apply for newborn child) 2. Delivery: Hospital Facility and Professional Tee (a separate copayment will apply for newborn child) 2. Delivery: Hospital Facility and Professional Tee (a separate copayment will apply for newborn child) 2. Delivery: Hospital Facility and Professional Tee (a separate copayment will apply for newborn child) 2. Delivery: Hospital Facility and Professional Tee (a separate copayment will apply for newborn child) 2. Delivery: Hospital Facility and Professional Tee (a separate copayment will apply for newborn child) 2. Delivery: Hospital Facility and Professional Tee (a separate copayment will apply for newborn child) 2. Delivery: Hospital Facility for Cortract Period 2. Delivery: No Charge for covered charges 3. 30% of UCR 2. Decompletion of New Period 2. Delivery: Appletion the period 2. Delivery: Appletion the period 2. Delivery: Appletion the period 2. Delivery: Appletion the period to rentatel Period 2. Delivery: Appletion the period to rentate Period 2. Delivery: Appletion the period to rest on the baset on which a Mattectory was performed due to career 3. Song of UCR 3. Defivered charges 3. Defivered charges 3. Defiver contract		10% of covered charges	30% 01 UCK	
DURABLE MEDICAL EQUIPMENT (DME) 10% of covered charges Not Covered Includes standard hespital bed, standard wheelchair, ruitches, portable chamotherapy. Lamited to crental only. 10% of covered charges Not Covered Plan pays up to \$20/month (up to \$200 per Contract Period) for attendance Simes/month & completion of Nuclear's online Health Risk Assessment. Plan pays up to \$200 Cash Reward MATERNITY CARE 1. Pre-ntal / Port-ntal Care Visit (Includes one routine ultrasound) No Charge for covered inpatient charges. 30% of UCR 1. Denotal / Port-ntal Care Visit (Includes one routine ultrasound) No Charge for covered inpatient charges. 0% of UCR 2. Delivery: Hospital Facility and Professional Fee (a separate copayment vill apply for newborn child) No Charge for covered inpatient charges. 0% of UCR 4. Circumcision: Within 30 days of date of birth 10% of covered charges 30% of UCR METAL HEALTH TREATMENT (OUTPATIENT) 10% of covered charges 30% of UCR MUCLIAK MEDICINE Limited to \$200.000 per Contract Period 10% of covered charges 30% of UCR COCUPATIONAL THERATY Maximum of 8 visits per Contract Period 10% of covered charges 30% of UCR REMOND Deficine for all related services 10% of covered charges 30% of UCR PHYSICAL THERAPY 10% of covered charges<	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	10% of covered charges	30% of UCR	
Includes standard hospital bod, standard vhoekhair, crutches, portable commode, oxygen concentrator, billike, nebuliker, wigs after commode oxygen concentrator, billike, nebuliker, wigs after contract Period for attendance concentrator, billike, nebuliker, wigs after contract Period for attendance concentrator, billiker, nebuliker, wigs after contract Period for attendance contine ultrasound). No Charge for covered charges contract Period contract Period for the contract Period cont				
FITNESS BENETT & REWARD Plan pays up to \$200 cash Reward Plan pays up to \$200 month (up to \$200 per Contract Period) for attendance Plan pays up to \$200 Cash Reward Stimes/month & completion of NetCare's online Health Risk Assessment. No Charge for covered charges 30% of UCR Delivery: Hospital Facility and Professional Fee No Charge for covered inpatient charges. • Centers of Care's Philippine Providers - no charge for covered inpatient charges. • CHC & other Hospitals - 20% of inpatient charges. 1. Circumstion: Within 30 days of date of birth 10% of covered charges 30% of UCR Streastleeding Equipment (limited to rental only) No Charge for covered charges 30% of UCR NUCLEAR MEDICINE 10% of covered charges 30% of UCR Contract Period 10% of covered charges 30% of UCR Cumited to \$200,000 per Contract Period 10% of covered charges 30% of UCR Cumited to \$200,000 per Contract Period 10% of covered charges 30% of UCR Cumited to \$200,000 per Contract Period 10% of covered charges 30% of UCR Cumited to \$200,000 per Contract Period 10% of covered charges 30% of UCR RADIATION THERAPY 10% of covered charges 30% of UCR RADIATION THERAPY 10% of covered charges 30%	Includes standard hospital bed, standard wheelchair, crutches, portable commode, oxygen concentrator, bili-lite, nebulizer, wigs after	10% of covered charges	Not Covered	
8 times/month & completion of NetCare's online Health Risk Assessment. MATENTIY CARE 1. Derivery: Hospital Facility and Professional Fee (a separate copayment will apply for newborn child) 2. Delivery: Hospital Facility and Professional Fee (a separate copayment will apply for newborn child) 4. Circurncision: Within 30 days of date of birth 5. ReasHeading Equipment (Imited to rental only) MENTAL HEALTH TREATMENT (OUTPATIENT) 10% of covered charges 30% of UCR 10% of covered charges 10% of UCR 10% of covered charges 10% of UCR 10% of covered charges	FITNESS BENEFIT & REWARD			
1. Pre-natal / Post-natal Care Visit (Includes one routine ultrasound) No Charge for covered charges 30% of UCR 2. Delivery: Hospital Facility and Professional Fee • Centers of Care & Philippine Providers - no charge for covered inpatient charges. • Others of Care & Philippine Providers - no charge for covered inpatient charges. 30% of UCR 4. Circumcision: Within 30 days of date of birth 10% of covered charges 30% of UCR Breastfiedding Equipment (Emined to rontal only) No Charge for covered charges 30% of UCR MENTAL HEALTH TREATMENT (OUTPATIENT) 10% of covered charges 30% of UCR NUCLEAR MEDICINE 10% of covered charges 30% of UCR NUCLEAR MEDICINE 10% of covered charges 30% of UCR NUCLEAR MEDICINE 10% of covered charges 30% of UCR NUCLEAR MEDICINE 10% of covered charges 30% of UCR NUCLEAR MEDICINE 10% of covered charges 30% of UCR NUMENTAL HERAPY 10% of covered charges 30% of UCR PHYSICAL THERAPY 10% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGEY 10% of covered charges 30% of UCR Emined to 520,000 Iret construct Period 10% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SUR	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	ash Reward	
2. Delivery: Hospital Facility and Professional Fee (a separate copayment will apply for newborn child) a separate copayment will apply for newborn child) CHC & other Hospitals - 20% of inpatient charges. - CHC & other Hospitals - 20% of UCR - Streastfeeding Equipment (limited to rental only) MENTAL HEALTH TREATMENT (OUTPATIENT) 10% of covered charges - 20% of UCR - NUCLEAR MEDICINE Limited to 520.000 per Contract Period OCCUPATIONAL THERAPY Limited to 520.000 per Contract Period - ORGAN TRANSPLANT COVERAGE Limited to 520.000 lifetime for all related services - PHYSICAL THERAPY - Limited to 520.000 per Contract Period - No Govered charges - 30% of UCR - Advantum of 8 visits per Contract Period - No G covered charges - 30% of UCR - Advantum of 8 visits per Contract Period - RADIATION THERAPY - Limited to 520.000 per Contract Period - SPEECLT THERAPY (OUTPATIENT) - Limited to 5 visits per Contract Period - SPEECLT THERAPY (OUTPATIENT) - Limited to 5 visits per Contract Period - SPEECLT THERAPY (OUTPATIENT) - Contract Period - Contract Period - Contract Period - Contract Period - Contract Period - Contract Period -	MATERNITY CARE			
CHC & other Hospitals - 20% of impatient charges 30% of UCR immed to State of the trental only) No Charge for covered charges 30% of UCR NUCLEAR MEDICINE 10% of covered charges 30% of UCR immed to State of the trental only 10% of covered charges 30% of UCR immed to State of the trental only 10% of covered charges 30% of UCR OCCUPATIONAL THERAPY 10% of covered charges 30% of UCR immed to State of the trental only 10% of covered charges 30% of UCR immed to State of the trental only 10% of covered charges 30% of UCR immed to State of the trental there of all related services 10% of covered charges 30% of UCR immed to \$20,000 lifetime for all related services 10% of covered charges 30% of UCR immed to \$20,000 per Contract Period 10% of covered charges 30% of UCR immed to \$20,000 per Contract Period 10% of covered charges 30% of UCR immed to \$20,000 per Contract Period 10% of covered charges 30% of UCR immed to \$20,000 per Contract Period 10% of covered charges 30% of UCR immed to \$20,000 per Contract Period 10% of covered charges 30% of UCR immed to \$20,000 per Contract Period 20% of covered charges 30% of UCR immed to \$20,000 per Contract Period 20% of covered charges 30% of UCR immed to \$20,000 per Contract Period 20% of covered charges 30% of UCR immed to \$20,000 per Contract Period 20% of covered charges 30% of UCR immed to the following in accordance with the Women's Health & Cancer is spirster and treatement of physical complication, including Lymphedemas & wigs SPECLH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR immed to \$visits per Contract Period 20% of covered charges 30% of UCR immed to \$visits per Contract Period 20% of covered charges 20% of covered charges 20% of covered charges 20% of covered charges 20% of UCR immed to \$visits per Contract Period 20% of covered	2. Delivery: Hospital Facility and Professional Fee •	Centers of Care & Philippine Providers -		
5. Breastfeeding Equipment (limited to rental only) No Charge for covered charges 30% of UCR MENTAL HEALTH TREATMENT (OUTPATIENT) 10% of covered charges 30% of UCR NUCLEAR MEDICINE Limited to \$20,000 per Contract Period 10% of covered charges 30% of UCR OCCUPATIONAL THERAPY 10% of covered charges 30% of UCR Limited to \$20,000 jefc time for all related services 10% of covered charges 30% of UCR PHYSICAL THERAPY 10% of covered charges 30% of UCR RADIATION THERAPY 10% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGERY 10% of covered charges 30% of UCR Limited to \$20,000 per Contract Period 10% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGERY 10% of covered charges 30% of UCR Limited to s00,000 per Contract Period 20% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGERY 20% of covered charges 30% of UCR Segregre and reconstruction of ther breast to produce symmetrical appearance 20% of covered charges 30% of UCR SPEECH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR STERILIZATION PROCEDURES 10% of covered charges 30% of UCR STERILIZATION PROCEDURES 20% of covered charges 30% of UCR Chinted to CNMI, Philippine & United		• CHC & other Hospitals - 20% of	30% of UCR	
MENTAL HEALTH TREATMENT (OUTPATIENT) 10% of covered charges 30% of UCR NUCLEAR MEDICINE Limited to \$20,000 per Contract Period 10% of covered charges 30% of UCR OCCUPATIONAL THERAPY Limited to 5 visits per Contract Period 10% of covered charges 30% of UCR ORGAN TRANSPLANT COVERAGE Limited to \$20,000 lifetime for all related services 10% of covered charges 30% of UCR Maximum of 8 visits per Contract Period 10% of covered charges 30% of UCR RADIATION THERAPY Limited to \$20,000 per Contract Period 10% of covered charges 30% of UCR RADIATION THERAPY Limited to be following in accordance with the Women's Health & Cancer 8 20% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGERY Limited to the following in accordance with the Women's Health & Cancer 20% of covered charges 30% of UCR •Reconstruction of the breast on which a Mastectomy was performed due to cancer •Weigrey and reconstruction of other breast to produce symmetrical appearance 10% of covered charges 30% of UCR •Prostheses and treatment of physical complication, including Lymphedemas & wigs 57EECH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR •Dutpatient Tubal Ligation or Vasectomy/pre-cert required No Charge for covered charges 30% of UCR TELHEALTH / TELEMEDICINE Limited to C	4. Circumcision: Within 30 days of date of birth			
NUCLEAR MEDICINE Limited to \$20,000 per Contract Period OCCUPATIONAL THERAPY Limited to \$50,000 per Contract Period ORGAN TRANSPLANT COVERAGE Limited to \$20,000 lifetime for all related services PHYSICAL THERAPY Maximum of \$ visits per Contract Period RADIATION THERAPY Limited to \$20,000 per Contract Period RADIATION THERAPY Limited to \$20,000 per Contract Period RECONSTRUCTIVE BREAST SURGERY Limited to \$20,000 per Contract Period RECONSTRUCTIVE BREAST SURGERY Limited to the following in accordance with the Women's Health & Cancer Signers van acconstruction 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 5 visits per Contract Period STERLIZATION PROCEDURES Dutpatient Tubal Ligation or Vasectomy/pre-cert required No Charge for covered charges Not Covered Limited to Cowred by represent required No Charge for covered charges Not Covered Meening S Not Covered Meening S Not Covered Member co-insurance may be reimbursed upon program completion ANNUAL PLAN MAXIMUM LIFETIME MAXIMUM	5. Breastfeeding Equipment (limited to rental only)	No Charge for covered charges	30% of UCR	
Limited to \$20,000 per Contract Period 10% of covered charges 30% of UCR DOCOPATIONAL THERAPY Limited to 5 visits per Contract Period 10% of covered charges 30% of UCR Limited to 5 visits per Contract Period 10% of covered charges 30% of UCR Limited to \$20,000 lifetime for all related services 10% of covered charges 30% of UCR RADIATION THERAPY Limited to \$20,000 per Contract Period 20% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGERY Limited to the following in accordance with the Women's Health & Cancer Rights Act of 1998 20% of covered charges 30% of UCR • Reconstruction of the breast to produce symmetrical appearance • Prostheses and treatment of physical complication, including Lymphedemas & wigs SFEECH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR STERLIZATION PROCEDURES Outpatient Tubal Ligation or Vasectomy/pre-cert required No Charge for covered charges 30% of UCR STERLIZATION PROCEDURES Outpatient Tubal Ligation or Vasectomy/pre-cert required 10% of covered charges Not Covered Limited to CNMI, Philippine & United Health Care provider networks 20% of covered charges Not Covered No Charge for covered charges Not Covered Charges Not Covered Charges 10% of UCR ANNUAL PLAN MAXIMUM Unlimited Unlimited ANNUAL PLAN MAXIMUM Unlimited ANNUAL OUT-OF-POCKET MAXIMUM Lineiton 10% of covered charges Not Covered Charges Not Covered Charges 10% of UCR ANNUAL OUT-OF-POCKET MAXIMUM Unlimited ANNUAL OUT-OF-POCKET MAXIMUM Lineiton 10% of covered charges Not Covered Member co-insurance may be reimbursed upon program completion Not covered Charges Not Covered Charges Not Covered Member co-insurance may be	MENTAL HEALTH TREATMENT (OUTPATIENT)	10% of covered charges	30% of UCR	
Limited to 5 visits per Contract Period 10% of Covered charges 30% of UCR 00% of covered charges 30% of UCR	NUCLEAR MEDICINE Limited to \$20,000 per Contract Period	10% of covered charges	30% of UCR	
Limited to \$20,000 lifetime for all related services 10% of covered charges 30% of UCR PHYSICAL THERAPY 10% of covered charges 30% of UCR RADIATION THERAPY 10% of covered charges 30% of UCR Imited to \$20,000 per Contract Period 10% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGERY 20% of covered charges 30% of UCR Limited to the following in accordance with the Women's Health & Cancer 20% of covered charges 30% of UCR •Reconstruction of the breast on which a Mastectomy was performed due to cancer •O% of covered charges 30% of UCR •Reconstruction of other breast to produce symmetrical appearance •Prostheses and treatment of physical complication, including Lymphedemas & wigs SPEECH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR •Prostheses and treatment of physical complication, including Lymphedemas & wigs SPEECH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR •Dutpatient Tubal Ligation or Vasectomy/pre-cert required No Charge for covered charges 30% of UCR TELEHEALTH / TELEMEDICINE 10% of covered charges Not Covered Limited to CNMI, Philippine & United Health Care provider networks 20% of covered charges Not Covered Member co-insurance may be reimbursed upon	OCCUPATIONAL THERAPY Limited to 5 visits per Contract Period	10% of covered charges	30% of UCR	
PHYSICAL THERAPY 10% of covered charges 30% of UCR Maximum of 8 visits per Contract Period 10% of covered charges 30% of UCR RADIATION THERAPY 10% of covered charges 30% of UCR Limited to \$20,000 per Contract Period 10% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGERY 20% of covered charges 30% of UCR Limited to the following in accordance with the Women's Health & Cancer 20% of covered charges 30% of UCR Neconstruction of the breast on which a Mastectomy was performed due to cancer 90% of covered charges 30% of UCR •Prostheses and treatment of physical complication, including Lymphedemas & wigs 90% of covered charges 30% of UCR STERILIZATION PROCEDURES 10% of covered charges 30% of UCR Outpatient Tubal Ligation or Vasectomy/pre-cert required No Charge for covered charges 30% of UCR ELEHEALTH / TELEMEDICINE 10% of covered charges 30% of UCR Limited to CNMI, Philippine & United Health Care provider networks 20% of covered charges Not Covered WELLNESS 20% of covered charges Not Covered Not Covered Member co-insurance may be reimbursed upon program completion 20% of covered charges Not Covered	ORGAN TRANSPLANT COVERAGE	10% of covered charges	30% of UCR	
Maximum of 8 visits per Contract Period 10% of covered charges 30% of UCK RADIATION THERAPY 10% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGERY 10% of covered charges 30% of UCR Rights Act of 1998 20% of covered charges 30% of UCR •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 10% of covered charges 30% of UCR SPEECH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR Limited to 5 visits per Contract Period 10% of covered charges 30% of UCR STERILIZATION PROCEDURES No Charge for covered charges 30% of UCR Outpatient Tubal Ligation or Vasectomy/pre-cert required 10% of covered charges 30% of UCR TELEHEALTH / TELEMEDICINE 10% of covered charges Not Covered Limited to CNMI, Philippine & United Health Care provider networks 20% of covered charges Not Covered Member co-insurance may be reimbursed upon program completion 20% of covered charges Not Covered ANNUAL PLAN MAXIMUM Unlimited ANNUAL CUT-OF-POCKET MAXIMUM Unlimite				
RADIATION THERAPY 10% of covered charges 30% of UCR Limited to \$20,000 per Contract Period 10% of covered charges 30% of UCR RECONSTRUCTIVE BREAST SURGERY 20% of covered charges 30% of UCR Limited to the following in accordance with the Women's Health & Cancer 20% of covered charges 30% of UCR •Reconstruction of the breast on which a Mastectomy was performed due to cancer 20% of covered charges 30% of UCR •Surgery and reconstruction of other breast to produce symmetrical appearance • • • •Prostheses and treatment of physical complication, including Lymphedemas & wigs 30% of UCR • SPEECH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR Limited to 5 visits per Contract Period 10% of covered charges 30% of UCR STERILIZATION PROCEDURES No Charge for covered charges 30% of UCR Outpatient Tubal Ligation or Vasectomy/pre-cert required 10% of covered charges Not Covered Elimited to CNMI, Philippine & United Health Care provider networks 10% of covered charges Not Covered WELLNESS 20% of covered charges Not Covered Member co-insurance may be reimbursed upon program completion Unlimited ANNUAL PLAN MAXIMUM Unl		10% of covered charges	30% of UCR	
Limited to \$20,000 per Contract Period 0 RECONSTRUCTIVE BREAST SURGERY Imited to the following in accordance with the Women's Health & Cancer Reights Act of 1998 20% of covered charges 30% of UCR eReconstruction of the breast on which a Mastectomy was performed due to cancer 9 30% of UCR •Reconstruction of other breast to produce symmetrical appearance 9 7 •Prostheses and treatment of physical complication, including Lymphedemas & wigs 30% of UCR STEECH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR Limited to 5 visits per Contract Period No Charge for covered charges 30% of UCR Outpatient Tubal Ligation or Vasectomy/pre-cert required 10% of covered charges 30% of UCR TELEHEALTH/TELEMEDICINE 10% of covered charges Not Covered Limited to CNMI, Philippine & United Health Care provider networks 20% of covered charges Not Covered Member co-insurance may be reimbursed upon program completion 20% of covered charges Not Covered ANNUAL PLAN MAXIMUM Unlimited Unlimited LIFETIME MAXIMUM Unlimited Inlimited ANNUAL OUT-OF-POCKET MAXIMUM \$2,000 Not Applicable	RADIATION THERAPY		209/ - (LICD	
Limited to the following in accordance with the Women's Health & Cancer Rights Act of 1998 20% of covered charges 30% of UCR •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 5 visits per Contract Period STERILIZATION PROCEDURES Outpatient Tubal Ligation or Vasectomy/pre-cert required TELEHEALTH/TELEMEDICINE Limited to CNMI, Philippine & United Health Care provider networks Member co-insurance may be reimbursed upon program completion ANNUAL PLAN MAXIMUM United Unlimited LIFETIME MAXIMUM Unimited LIFETIME MAXIMUM Unimited ANNUAL OUT-OF-POCKET MAXIMUM 1. Per Individual Per Contract Period \$2,000 Not Applicable	Limited to \$20,000 per Contract Period	10% of covered charges	30% 01 UCK	
SPEECH THERAPY (OUTPATIENT) 10% of covered charges 30% of UCR Limited to 5 visits per Contract Period No Charge for covered charges 30% of UCR STERILIZATION PROCEDURES No Charge for covered charges 30% of UCR Outpatient Tubal Ligation or Vasectomy/pre-cert required 10% of covered charges 30% of UCR TELEHEALTH/TELEMEDICINE 10% of covered charges Not Covered Limited to CNMI, Philippine & United Health Care provider networks 20% of covered charges Not Covered WELLNESS 20% of covered charges Not Covered Member co-insurance may be reimbursed upon program completion Unlimited Unlimited ANNUAL PLAN MAXIMUM Unlimited Unlimited LIFETIME MAXIMUM Unlimited Unlimited I. Per Individual Per Contract Period \$2,000 Not Applicable	RECONSTRUCTIVE BREAST SURGERY Limited to the following in accordance with the Women's Health & Cancer Rights Act of 1998 •Reconstruction of the breast on which a Mastectomy was performed due to cancer •Surgery and reconstruction of other breast to produce symmetrical appearance		30% of UCR	
Limited to 5 visits per Contract Period 10% of covered charges 30% of UCR STERILIZATION PROCEDURES No Charge for covered charges 30% of UCR Outpatient Tubal Ligation or Vasectomy/pre-cert required 10% of covered charges Not Covered TELEHEALTH/TELEMEDICINE 10% of covered charges Not Covered Limited to CNMI, Philippine & United Health Care provider networks 20% of covered charges Not Covered WELLNESS 20% of covered charges Not Covered Member co-insurance may be reimbursed upon program completion Unlimited Unlimited ANNUAL PLAN MAXIMUM Unlimited Mot Covered LIFETIME MAXIMUM Unlimited Mot Applicable			200% of LICP	
Outpatient Tubal Ligation or Vasectomy/pre-cert required Not Covered tharges 50% of OCK TELEHEALTH / TELEMEDICINE 10% of covered charges Not Covered Limited to CNMI, Philippine & United Health Care provider networks 20% of covered charges Not Covered WELLNESS 20% of covered charges Not Covered Member co-insurance may be reimbursed upon program completion Unlimited Unlimited ANNUAL PLAN MAXIMUM Unlimited Mot Covered LIFETIME MAXIMUM Unlimited Mot Covered ANNUAL OUT-OF-POCKET MAXIMUM \$2,000 Not Applicable	Limited to 5 visits per Contract Period	10 % or covered charges	50 % 01 UCK	
Limited to CNMI, Philippine & United Health Care provider networks 10% of covered charges Not Covered WELLNESS 20% of covered charges Not Covered Member co-insurance may be reimbursed upon program completion Unlimited ANNUAL PLAN MAXIMUM Unlimited LIFETIME MAXIMUM Unlimited ANNUAL OUT-OF-POCKET MAXIMUM \$2,000 1. Per Individual Per Contract Period \$2,000 Not Applicable	STERILIZATION PROCEDURES Outpatient Tubal Ligation or Vasectomy/pre-cert required	No Charge for covered charges	30% of UCR	
WELLNESS 20% of covered charges Not Covered Member co-insurance may be reimbursed upon program completion Unlimited Inlimited ANNUAL PLAN MAXIMUM Unlimited Unlimited LIFETIME MAXIMUM Unlimited Inlimited ANNUAL OUT-OF-POCKET MAXIMUM 1. Per Individual Per Contract Period \$2,000 Not Applicable	TELEHEALTH / TELEMEDICINE Limited to CNML Philippine & United Health Care provider networks	10% of covered charges	Not Covered	
ANNUAL PLAN MAXIMUM Unlimited LIFETIME MAXIMUM Unlimited ANNUAL OUT-OF-POCKET MAXIMUM 1. Per Individual Per Contract Period \$2,000 Not Applicable	WELLNESS	20% of covered charges	Not Covered	
LIFETIME MAXIMUM Unlimited ANNUAL OUT-OF-POCKET MAXIMUM 1. Per Individual Per Contract Period \$2,000 Not Applicable		¥¥ ¥• •.	<u>,</u>	
ANNUAL OUT-OF-POCKET MAXIMUM 1. Per Individual Per Contract Period \$2,000 Not Applicable				
1. Per Individual Per Contract Period \$2,000 Not Applicable		Giannite	u	
	1. Per Individual Per Contract Period 2. Per Family Per Contract Period			

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

COVERED CHARGES for Participating Providers are charges determined by NetCare to be the maximum amount that it will pay for a covered service to a health care provider. Any applicable co-payment will apply to the Eligible Charge. Covered Charges or Eligible Charges shall be defined as the reimbursement amounts agreed between the Company and the Participating Provider.

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

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

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

PRESCRIPTION DRUGS - NetCare adopted a mandatory generic program, which means prescription drugs are limited to covered generic drugs. Additional charges will apply for non-generic prescription drugs that include copayment of the non-generic drug plus the ingredient cost difference of the non-generic and generic drug. Contraceptives, including injectable contraceptives, are covered at no charge for generic retail & generic mail order at participating providers. Brand & non-formulary contraceptives at participating providers are subject to Plan benefits. Speciatly 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 rendered outside CNMI are limited to Guam, Asia, Philippines, Hawaii and the Continental U.S. or through NetCare's direct contracted providers and NetCare's Centers of Care with a NetCare approved referral.

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

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

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

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

MEDICAL EXCLUSIONS

Medical services listed below are NOT covered by NetCare

- Acupuncture care & services.
- Airfare (unless criteria as set forth by the Plan has been met).
- Allergy testing & treatment.
- Biofeedback and other forms of self-care or self-help training.
- Blood derivatives for experiemental purposes.
- Care for military service connected disabilities to which a member is legally entitled.
- Care and services normally covered by Medicare Parts A & B for which Medicare is is or would be primary for a member who is eligible and entitled to at no cost and declined to enroll.
- Care or services rendered by immediate relatives or members of the enrollee's household, rendered as a duly licensed medical practitioner employed by a healthcare providers.
- 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.

MEDICAL EXCLUSIONS (continued)

Medical services listed below are NOT covered by NetCare

- Elective cosmetic treatment including but not limited to breast implants (unless after mastectomy due to cancer) cosmetic eye surgery (i.e., Lasik), etc.
- Emergency treatment provided outside the service area if the need for care could have been foreseen before departing the service area.
- Executive Physical Exams/Executive Check-up (Inpatient Physical Exam).
- Experimental medical, surgical and other health-care procedures.
- Gastric Bypass, stapling or reversal, surgical correction (except as approved by the Plan).
- Hearing Aids.
- 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.
- Injury or illness incurred as a result of attempted suicide.
- Interrupted pregnancy (non-medically necessary), non-life threatening abortions unless medically necessary.
- Living expenses including meals, hotel rooms, transportation, etc.
- Long term rehabilitation including but not limited to physical therapy, speech therapy, hand therapy, and occupational therapy.
- Medical treatment and services related to End Stage Renal Disease, including Dialysis
- Nasal reconstruction except to correct a deformity as a result of an accidental injury which occurred within 90-days of the date of surgery, or the removal or treatment of cancer of the nose.
- Non-medical treatment of obesity (except as approved by the Plan).
- Orthopedic and external prosthetic devices including but not limited to shoes, orthotics, artificial limbs, etc.
- Over-the-counter drugs or drugs for which a prescription from a licensed physician is not required under federal law, inclusive of OTC contraceptives and devices and all non FDA approved drugs.
- Personal comfort items, such as but not limited to telephone, television, guest trays, electrical power, water and disposal systems, baths and pools at their installation, hospital room installation, hospital room upgrades & surcharges.
- Physical examinations and all services related thereto when required for obtaining or
- continuing employment, insurance, schooling, governmental licensing or sports activities.
- Pre-existing conditions and medical conditions excluded and noted on the policy.
- Prenatal ultrasound (except as approved by the Plan). Routine ultrasounds are limited to one per pregnancy term. Subsequent ultrasounds are not covered unless medically necessary and approved by the Plan.
- Services provided by the covered person's spouse, child, brother, sister or parents whether by blood or by law.
- Services rendered outside CNMI without a NetCare approved referral.
- 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 for hepatitis, including drugs, without a NetCare approved prior authorization and strict criteria satisfaction.
- Treatment and services related to sleeping disorders.
- Treatment of acne related services, including prescription drugs.
- Treatment for adult circumcision procedures, if provided solely for cosmetic or religious purposes.
- Treatment for services and supplies related to sexual dysfunction (i.e., Viagra)
- Treatment and services 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 for injuries sustained in the commission of an illegal act including but not limited to drunk driving (driving while intoxicated, or with an alcohol level of .08 or greater on the Draeger Alco Test, or blood alcohol level of 100-250 MG/DL).
- Treatment of injuries or illnesses sustained as a result of war or any acts of war, declared or undeclared.
- Treatment of injuries while participating in hazardous sports, such as but not limited to off-road, skydiving, etc.
- Whole blood 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.