The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage call at 1-671-472-7FLY (7359). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.netcarelifeandhealth.com or call 1-671-472-7FLY (7359) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at network providers; $200 Individual/ $600 Family at out-of-network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No. A deductible apply only to services at out-of-network providers.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $1,000 individual / $3,000 family; for out-of-network providers a limit does not apply.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.netcarelifeandhealth.com or call 1-671-472-3610 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/office visit at CMI/FHP clinics; $15 copay/office visit at Other Providers	30% coinsurance of UCR	COVID19 testing for work or school related services are covered. Cost sharing will apply to all other COVID19 related services.
	Specialist visit	$25 copay/office visit at CMI/FHP clinics; $25 copay/office visit at Other Providers	30% coinsurance of UCR	None
	Preventive care/screening/ immunization	No charge	30% coinsurance of UCR	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. No charge expense is limited to U.S. Preventive Services Task Force guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test at CMI/ FHP clinics; $15 copay/test at Other Providers	30% coinsurance of UCR	A plan approved written pre-certification is required, base on medical necessity. A 50% disallowance of eligible charges will be applied for non-approved pre-certification.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance of UCR	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.netcarelifeandhealth.com or www.optumrx.com	Generic drugs (Tier 1)	$10 copay/prescription at retail. $20 copay/ prescription for mail order, No charge for prescribed contraceptives	Not Covered	▪ Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription) of FDA approved drugs. ▪ 10% coinsurance for all Injectable drugs. ▪ No charge will apply for Diabetic insulin filled at Guam Kmart pharmacy. Your injectable coinsurance, no greater than $50, will apply for Diabetic insulin filled at other participating pharmacy providers.
	Preferred brand drugs (Tier 2)	$20 copay/prescription at retail. $40 copay/ prescription for mail order.	Not Covered	
	Non-preferred brand drugs (Tier 3)	$40 copay/prescription at retail; $80 copay/ prescription for mail	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		order.		
	Specialty drugs (Tier 4)	$40 copay/prescription at retail; $80 copay/ prescription for mail order.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit at CMI/FHP clinics; $100 copay/visit at Other Providers	30% coinsurance of UCR	None
	Physician/surgeon fees	No charge	30% coinsurance of UCR	None
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	Non emergency treatment at a participating hospital emergency room is 30% coinsurance; no coverage at Out-of-Network Provider. Medical transportation is limited to ground ambulance for bonafide emergencies.
	Emergency medical transportation	$50 copay/ transportation	$50/transportation	
	Urgent care	$10 copay/visit at CMI/FHP clinics; $15 copay/visit at Other Providers	30% coinsurance of UCR	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay plus 10% coinsurance/admission	30% coinsurance of UCR	No charge for inpatient services at NetCare Centers of Care facilities.
	Physician/surgeon fees	10% coinsurance	30% coinsurance of UCR	No charge for inpatient services at NetCare Centers of Care facilities.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit at CMI/FHP clinics; $25 copay/office visit at Other Providers	30% coinsurance of UCR	No charge for inpatient services at NetCare Centers of Care facilities.
	Inpatient services	$100 copay plus 10% coinsurance/admission	30% coinsurance of UCR	
If you are pregnant	Office visits	$10 copay/office visit at CMI/FHP clinics; $15 copay/office visit at Other providers to determine pregnancy. No charge/office visits thereafter.	30% coinsurance of UCR	▪ Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). ▪ Prenatal ultrasound is limited to one routine per pregnancy term.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance of UCR	▪ Service at a Birthing Center is limited to Guam. No charge for inpatient delivery at NetCare Centers of Care.
	Childbirth/delivery facility services	$100 copay plus 10% coinsurance/admission $100 copay/admission at Birthing Center.	30% coinsurance of UCR	
If you need help recovering or have other special health needs	Home health care	$10 copay/visit from CMI/FHP clinics; $15 copay/visit from Other Providers	30% coinsurance of UCR	None
	Rehabilitation services	$25 copay/visit	30% coinsurance of UCR	20 visits/year; Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$25 copay/visit	30% coinsurance of UCR	
	Skilled nursing care	$100 copay plus 10% coinsurance/admission	30% coinsurance of UCR	30 visits/contract period
	Durable medical equipment	20% coinsurance	30% coinsurance of UCR	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	$25 copay/visit	Not Covered	Limited to $50/day up to 90 days/contract period; 180 days lifetime
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Coverage limited to 1 exam/contract period
	Children's glasses	No charge	No charge	Coverage limited to $100/contract period
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Birthing Center services other than on Guam
- Cosmetic Surgery
- Dental Care (Adults)
- Eye refraction beyond 1 routine visit
- Eye glass hardware beyond the dollar limit
- Hearing Aids
- Infertility Treatment
- Long Term Care, which includes rehabilitative & habilitative services
- Medical transportation other than ground transportation
- Over the counter and non-FDA approved drugs, contraceptives and devices
- Prenatal ultrasound in excess of one routine per pregnancy term
- Prescription drugs in excess of 30-days for retail and 90-days for mail order, unless approved by the Plan
- Preventive and immunization services beyond U.S. Preventive Services Task Force guidelines
- Treatment & services for all non-approved Plan pre-certification and referrals. A 50% disallowance will be applied toward charges

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic Care
- Most coverage provided outside the United States. See www.netcarelifeandhealth,.com for provider network
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: NetCare at 671-472-3610, Guam Department of Revenue and Taxation, Office of the Insurance Commissioner at 1240 Army Drive, Barrigada Guam 96921 or 671-635-1844, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: NetCare at 1-671-472-3610 or 1-888-966-9526 toll free or www.netcarelifeandhealth.com

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-671-472-3610

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-671-472-3610

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-671-472-3610

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-671-472-3610

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$100 plus 10%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,900**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$100 plus 10%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$100 plus 10%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$470**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: NetCare at 1-671-475-7FLY (7359).
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.