BENEFITS PROVIDED BY
HEALTH INSURANCE - GUAM, FY 2006

BENEFITS	MEDICAID	MIP	STAYWELL SILVER	STAYWELL BRONZE 500	STAYWELL BRONZE 1000	SELECT CARE 1500, SELECTCARE HSA 1500,
ACUPUNCTURE	Not covered	10 visits per contract period; $50:00 per visit No coinsurance	$50.00 per visit, 10 visits maximum. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% Coinsurance member after deductible.	$50.00 per visit, 10 visits maximum. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50.00 per visit, 10 visits maximum. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** Not covered
AIDS TREATMENT	100% covered benefits	100% covered benefits	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** Not covered
AIRFARE BENEFITS	Round trip air transportation if the treatment is not available on Guam to an eligible patient One (1) parent if the patient is minor or one medical escort when medically necessary	Round trip air transportation if the treatment is not available on Guam to an eligible patient One (1) parent if the patient is minor or one medical escort when medically necessary	To Center of Excellence. Round trip air transportation to an eligible member only when the following qualifications are met: has received precertification from STWL, has been a member for a minimum of 6 months, has STWL as primary carrier or is an enrolled Medicare eligible retiree and inpt tx is not available on Guam.	To Center of Excellence. Round trip air transportation to an eligible member only when the following qualifications are met: has received precertification from STWL, has been a member for a minimum of 6 months, has STWL as primary carrier or is an enrolled Medicare eligible retiree and inpt tx is not available on Guam.	Non-covered benefit	Plan pays 100% to centers of excellence only for members who meet qualifying conditions, Selectcare provides roundtrip airfare.

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ALLERGY TESTING/TREATMENT	100% covered.	100% covered.	$500.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% Coinsurance member after deductible.	$500.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% Coinsurance member after deductible.	$500.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% Coinsurance member after deductible.	$500.00 maximum per contract period. **PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% Coinsurance member after deductible.
AMBULATORY SURGICENTER GUAM	Covered benefit. Prior -authorization required	Covered benefit. Prior -authorization required	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. Precertification required.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. Precertification required.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. Precertification required.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible. Precertification required.
ANNUAL MEDICAL EXAM (ROUTINE)	100% covered benefits. Prior authorization is required.	Covered benefit $5.00 co-payment for each PE related services.	$200.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$200.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$200.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$200.00 maximum per contract period. **PP** $10.00 member co-pay **NPP** Not covered
ANNUAL EYE EXAM	Eye refractive examination every two years except for EPSDT clients	$50:00 maximum per year.	$50.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50.00 maximum per contract period. **PP** $10.00 member co-pay **NPP** Not covered

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BLOOD AND BLOOD DERIVATIVES	100% covered.	$50,000.00 maximum per year except hemophilia or hemophilia related conditions.	$50,000.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50,000.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50,000.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50,000.00 maximum per contract period. **PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible.
BREAST RECONSTRUCTIVE SURGERY	100% covered.	100% covered.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible.
CARDIAC SURGERY	100% covered.	10% CO-INSURANCE	$50,000.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50,000.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. 100% at Center of Excellence	$50,000.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. 100% at Center of Excellence	$50,000.00 maximum per contract period. **PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible.
CHEMICAL DEPENDENCY	Not covered benefit.	$10,000.00 per year	$8,000.00 maximum per contract period, $16,000.00 lifetime maximum. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$8,000.00 maximum per contract period, $16,000.00 lifetime maximum. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$8,000.00 maximum per contract period, $16,000.00 lifetime maximum. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$8,000.00 maximum per contract period, $16,000.00 lifetime maximum. **PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible.

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CHIROPRACTIC CARE	Not covered	10 visits per contract year; $25.00 per visit.	20 visits per contract year; $25.00 per visit. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	20 visits per contract year; $25.00 per visit. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	20 visits per contract year; $25.00 per visit. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	20 visits per contract year; $25.00 per visit. **PP** 80% SC 20% coinsurance member after deductible. **NPP** Not covered
CONGENITAL ANOMALY DISEASES COVERAGE	100% covered	100% coverage on-island $175, 000.00 limit including airfare for off-island treatment 10% co-insurance on selective services	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** Not covered
DIAGNOSTIC, LABS, X-RAY RADIOTHERAPY	100% covered	100% coverage on Laboratory 10% co-insurance on all radiology services and radiotherapy	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible.
DURABLE MEDICAL EQUIPMENT	100% covered	100% covered	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** Not covered

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ELECTIVE SURGERY	100% covered	100% covered	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC, 30% coninsurance member after deductible.
EMERGENCY BENEFITS	100% covered	100% covered	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC, 30% coninsurance member after deductible.
HEARING AIDS	100% covered Hearing evaluation and hearing aids every three years	$500.00 maximum per hearing aid.	$500.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% Coinsurance member after deductible.	$500.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% Coinsurance member after deductible.	$500.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% Coinsurance member after deductible.	$500.00 maximum per contract period. **PP** 80% SC 20% coinsurance member after deductible. **NPP** Not covered
HOSPITALIZATION AND INPATIENT BENEFITS	100% covered	100% covered	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC, 30% coninsurance member after deductible.
IMMUNIZATIONS (ROUTINE)	100% covered	100% covered	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** $10.00 CO-PAY **NPP** 70% SC, 30% coninsurance member after deductible.

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IMPLANTS	100% covered. (limited to cardiac artificial valves, pacemakers and intraocular lens for cataract patients.	Cardiac implant 10% coinsurance , all others 100% covered subject to benefit limitation on condition.	Limited to cardiac pacemakers, valves, stents, intraocular lenses. Orthopedic internal prosthetic device. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	Limited to cardiac pacemakers, valves, stents, intraocular lenses. Orthopedic internal prosthetic device. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	Limited to cardiac pacemakers, valves, stents, intraocular lenses. Orthopedic internal prosthetic device. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	Limited to cardiac pacemakers, valves, stents, intraocular lenses. Orthopedic internal prosthetic device. **PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible.
MATERNITY CARE	100% covered benefits.	100% covered benefits.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC, 30% coninsurance member after deductible.
MATERNITY CARE FOR NON-SPOUSE DEPENDENTS	100% covered benefits.	100% covered benefits.	Dependent $500.00 maximum. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. Outpatient care only,	Dependent $500.00 maximum. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. Outpatient care only,	Dependent $500.00 maximum. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. Outpatient care only,	Dependent $500.00 maximum. **PP** 80% STWL 20% coinsurance member after deductible. Outpatient care only, **NPP** Not covered

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MENTAL HEALTH SERVICES	Out-patient mental disorders and psychiatric services for up to 20 sessions for EPSDT clients only	100% covered 30 days inpatient hospitalization 100% covered outpatient services	Outpatient care only **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	Outpatient care only **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	Outpatient care only **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	Outpatient care only **PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC, 30% coninsurance member after deductible.
NUCLEAR MEDICINE	100% covered benefits	100% covered benefits	$30,000 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$25,000 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$25,000 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$25,000 maximum per contract period. **PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible.
ORTHOPEDIC CONDITIONS	100% Covered Orthotic devices covered for persons below 21 years of age.	$50,000.00 maximum per year; 10% co-insurance on all services	$50,000.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50,000.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50,000.00 maximum per contract period. **PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	$50,000.00 maximum per contract period. **PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible.

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PHYSICAL THERAPY	Physical, occupational and inhalation therapy. Prior authorization required	Physical, occupational and inhalation therapy. Prior authorization required. Out-patient PT and OT is 100^ covered for the 1st 20 visits and %0% thereafter.	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. For 20 visits 50% thereafter	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. For 20 visits 50% thereafter	**PP** 80% STWL 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible. For 20 visits 50% thereafter	**PP** 80% SC 20% coinsurance member after deductible. **NPP** 70% SC 30% coninsurance member after deductible. For 20 visits 50% thereafter
PHYSICIAN CARE AND OUTPATIENT BENEFITS	100% covered benefit on outpatient hospital and clinic services	100% covered benefit on outpatient hospital and clinic services	**PP** 80% STWL, 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL, 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL, 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** $10.00 Co-pay **PP** 80% SC 20% coinsurance member after deductible on outptient hospital services **NPP** 70% SC 30% coninsurance member after deductible.
PRESCRIPTION DRUGS	100% covered benefits	100% covered benefits for generic drugs and brand name drugs for sole mode of treatment with $2.50 co-pay per prescrition	**PP** 80% STWL, 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL, 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** 80% STWL, 20% coinsurance member after deductible. **NPP** 70% STWL, 30% coninsurance member after deductible.	**PP** $10 co- payment for Formulary generic drugs per prescription unit $20 co-payment for Formulary brand name drugs $5 co-payment for Mail order formulary drugs $20 member co-ayment for non-formulary medically necessary drugs **NPP** 70% SC 30% coninsurance member after deductible.

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RADIATION THERAPY	100% covered benefit	10% co-insurance on all services	$30,000 maximum per contract period. **PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	$25,000 maximum per contract period. **PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	$25,000 maximum per contract period. **PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	$25,000 maximum per contract period. **PP** 80% SC, 20% member after deductible. **NPP** 70% SC, 30% member after deductible.
SKILLED NURSING FACILITY	180 days maximum per year for all ages	180 days maximum per year	60 days maximum per contract year **PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	60 days maximum per contract year **PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	60 days maximum per contract year **PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	60 days maximum per contract year **PP** 80% SC, 20% member after deductible. **NPP** 70% SC, 30% member after deductible.
STERILIZATION PROCEDURES	100% covered benefit	100% covered benefit	**PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	**PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	**PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	**PP** 80% SC, 20% member after deductible. **NPP** 70% SC, 30% member after deductible.

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WELL BABY CARE	six (6) visits per year up to age two (2) excluding visits for immunization	six (6) visits per year up to age two (2) excluding visits for immunization	5 visits per child under 2 years old. **PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	5 visits per child under 2 years old. **PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	5 visits per child under 2 years old. **PP** 80% STWL, 20% member after deductible. **NPP** 70% STWL, 30% member after deductible.	5 visits per child under 2 years old. **PP** 80% STWL, 20% member **NPP** 70% STWL, 30% member
WELLNESS BENEFIT AT SDA WELLNESS CENTER	Not covered benefit.	Not covered benefit.	**PP** 80% STWL, 20% member up to $200.00 , 50% STWL, 50% member thereafter after deductible **NPP** Not covered	**PP** 80% STWL, 20% member up to $200.00 , 50% STWL, 50% member thereafter after deductible **NPP** Not covered	**PP** 80% STWL, 20% member up to $200.00 , 50% STWL, 50% member thereafter after deductible **NPP** Not covered	**PP** 80% SC20% member up to $200.00 , 50% SC, 50% member thereafter after deductible **NPP** Not covered
COVERAGE MAXIMUMS	No limit.	No limit for on -island services $175, 000.00 limit including airfare for off-island services.	1. Individual Lifetime maximum for care on Guam - $1 million 2. Individual Annual Maximum for care off-island $ 100,000	1. Individual Lifetime maximum for care on Guam - $1 million 2. Individual Annual Maximum for care off-island $ 100,000	1. Individual Lifetime maximum for care on Guam - $1 million 2. Individual Annual Maximum for care off-island $ 100,000	1. Individual Lifetime maximum for care on Guam - $1 million 2. Individual Annual Maximum for care off-island $ 100,000
OUT OF POCKET MAXIMUMS	None	Personal liability or cost sharing ranging from 7 to 45 percent depending on income and resources. Co-payment on selective services.	Prefunded deductible: Individual : $464 Family: $1604.00 Co-insurance and Co-payment Individual : $1,500.00 Family : $4,500.00 Note: No maximum out of pocket for NPP	Deductible, co-payment, and coinsurance Individual : $2,000.00 Family: $6000.00 Note: No maximum out of pocket for NPP	Deductible, co-payment, and coinsurance Individual : $2,500.00 Family: $7,500.00 Note: No maximum out of pocket for NPP	Deductible, co-payment, and coinsurance $2,500 per covered person, $7,500 per family Note: No maximum out of pocket for NPP

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