

GOVERNMENT OF GUAM
and

GROUP HEALTH CERTIFICATE

GOVGUAM RETIREE SUPPLEMENT INSURANCE

This Certificate, including Exhibits, describes the retiree supplement group health insurance benefits that shall be provided to each Covered Person, the circumstances under which the benefits shall be provided, limitations on and exclusions from benefits, and provisions for termination of benefits. No benefits are available under the Plan, except as set forth herein. In the event of a conflict between the provisions of this Certificate and those of the Exhibits, the provisions of this Certificate shall govern.

This Additional Insurance Benefits plan provides coverage to covered Persons in the Philippines, Korea, Japan, or other Pacific-Asian locations at Participating Providers, and when pre-authorized by the Company, for services not covered by Medicare, consistent with the extent of services and subject to the exclusions set out herein on a first dollar basis without deductible, and without co-payment.

ARTICLE 2

Medical Benefits

Medical Benefits. Subject to the terms and conditions of this Agreement, payment for the Covered Services contained in this Article 2 (“Medical Benefits”) shall be paid by Company when provided in accordance with this Agreement.

§2.1 **Physician Services.** Visits to or by a Physician for a non-Surgical health Services as a Covered Person may require in the treatment of an Injury or Illness.

2.1.1 **Primary Care Services.** As required by Section 2719A of the PHSA, as added by PPACA, each Covered Person shall be entitled to designate any Participating Provider who is a Primary Care Physician and who is available to accept the Covered Person as the Primary Care Physician for that Covered Person.

- Office visits with your Primary Care Physician during office hours
- Treatment for illness and injury
- Routine physical examinations
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40
- Routine gynecological examinations and Pap smears for females, performed by your Primary Care Physician or a participating gynecologist. No referral to a gynecologist is required for a female to obtain covered gynecological care from a gynecologist.
- Annual mammography screening for asymptomatic women age 40 and older

Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.

- Routine immunizations (except those required for travel work)
- Annual eye examinations without a referral to a participating provider
- Routine hearing screenings

2.1.2 **Specialist Care Services.** Services provided by a medical specialist to whom a patient has been referred, usually by a primary care provider.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by the Company.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Hearing Aids - Coverage will be provided for medically necessary expenses incurred in the purchase of a hearing aid for Covered Persons. Hearing aid replacement when it is medically necessary and prescribed by a licensed physician or audiologist. Coverage is limited to \$500 per covered person per plan year. Replacement once every twenty four months.

2.1.3 Home or office visit. Each home or office visit, including charges for injections, inclusive of materials.

2.1.4 Hospital or Skilled Nursing Facility visit. Visit to a Covered Person who is a Registered Bed Patient at a Hospital or Skilled Nursing Facility.

2.1.5 Intensive Care Unit visit. A visit for a critical Injury or Illness provided that the Covered Person is a Registered Bed Patient.

§2.2 Preventive Physical Exam. A routine preventive physical examination (including limited hearing testing and mammograms in accordance with the U.S. Preventive Services Task Force Recommendations with a Grade A or B only). Physical examinations required for obtaining or continuing any employment, insurance, schooling or licensing are excluded from this benefit. Coverage for routine preventive physical exam is limited to one exam per plan year

2.2.1 PPACA Preventive Care Services (with no Deductibles, Co-Payments or Co-Insurance) when provided by Participating Providers.

2.2.2 Routine preventive physical examination coverage at a Participating Provider in the Philippines with no maximum.

§2.3 Preventive Lab Services. Preventive Lab Services is covered at One Hundred percent (100%) with no co-payments, co-insurance, or deductibles in accordance with PPACA.

§2.4 Immunizations. Charges incurred in connection with immunizations in accordance with the guidelines provided by the United States Preventive Services Task Force. See Exhibit ____, 'Schedule of Covered Immunizations.'

§2.5 Injections. Other than immunizations, an infusion method of putting fluid into the body, usually with a hollow needle and a syringe which is pierced through the skin to a sufficient depth for the material to be forced into the body. There are several methods of injection or infusion, including intradermal, subcutaneous, intramuscular, intravenous, intraosseous, and intraperitoneal.

§2.6 **Allergy testing** A maximum benefit of One Thousand Dollars (1000) per Plan Year per Covered Person for charges for allergy testing.

§2.7 **Basic Hospital benefits.** The Hospital benefits to which a Covered Person is entitled while medically necessary and reasonably confined as a Registered Bed Patient are limited to a maximum of three hundred and sixty-five (365) days of confinement during a Plan Year, in accordance with evidence based medical guidelines. If necessarily incurred during said period, the following Services shall be Covered Services:

2.7.1 Hospital Room and Board. Coverage is provided at the Hospital's most common Semi-Private room rate, or at the Hospital's daily average private or single room rate if there are no Semi-Private accommodations or if a private room is Medically Necessary.

2.7.2 Intensive Care Unit. Room and Board charges for a stay in an intensive care unit which is equipped and operated according to generally recognized Hospital standards.

2.7.3 Cardiac room. Charges for a stay in a cardiac room which is equipped and operated according to generally recognized Hospital standards.

2.7.4 Surgery. Charges for the operating room, surgical supplies, Hospital Anesthesia Services, drugs, dressings, oxygen and antibiotics.

2.7.5 Diagnostics. Charges for diagnostics to the extent the same are not provided under Article 2.9.

2.7.6 Outpatient Hospital benefits. Hospital charges incurred by a Covered Person for use of a Hospital's outpatient facilities in connection with an Injury or Illness as follows:

2.7.6.1 Emergency medical Services within twenty-four (24) hours of a serious Injury or the sudden onset of an acute Illness, or such longer time as may be necessary to stabilize a covered individual in accordance with the emergency definitions and requirements of PPACA in the case of PPACA Emergencies.

2.7.6.2 Medical Services received on the day of and in connection with Surgery.

2.7.6.3 Pre-admission tests and/or examinations.

2.7.6.4 Medical Services which cannot be rendered in a Physician's office.

2.7.6.5 Non-Emergency. Company shall not pay for charges incurred for use of a Hospital's outpatient facilities, supplies and equipment in connection with elective minor Surgical Services, non-Emergency Services or health Services that could be received in a Physician's office. Services in the emergency setting must meet the definition of Emergency. The Company reserves the right to audit and review the claim retrospectively to validate the nature of the condition for which services were provided. The Company shall not pay for non-Emergency use of the Hospital's emergency facilities, unless the condition is urgent and treatment is unavailable elsewhere at the time.

2.7.7 Ambulatory Surgical Center benefits. Charges for Outpatient Surgery.

§2.8 **Basic Surgical benefits.** The Surgical benefits to which a Covered Person is entitled are as follows:

2.8.1 Surgical Services. Charges for Surgical Services the Covered Person may require in the treatment of an Injury or Illness, including charges for such Medically Necessary after visits in connection with the particular Surgical Services performed. Any charges for non-Medically Necessary after Service visits shall not be paid.

2.8.2 Anesthesiology. Charges of a private anesthesiologist or Hospital anesthesiologist when the Services of an anesthesiologist are Medically Necessary.

2.8.3 Gastric Banding and Bariatric Surgery. Gastric banding and bariatric surgery will only be covered if such treatment is in accordance with the following:

- Company covers bariatric surgery using a covered procedure outlined below as medically necessary when ALL of the following criteria are met:
 - The individual has reached full expected skeletal growth AND has evidence of EITHER of the following:
 - a BMI (Body Mass Index) ≥ 40
 - a BMI (Body Mass Index) 35-39.9 with at least one clinically significant comorbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease, or pulmonary hypertension
 - Failure of medical management including evidence of active participation within the last two years in a weight-management program that is supervised either by a physician or a registered dietician for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of ALL of the following components:
 - weight
 - current dietary program
 - physical activity (e.g., exercise program)

Programs such as Weight Watchers®, Jenny Craig® and Optifast® are acceptable alternatives if done in conjunction with the supervision of a physician or registered dietician and detailed documentation of participation is available for review. For individuals with long-standing, morbid obesity, participation in a program within the last five years is sufficient if reasonable attendance in the weight-management program over an extended period of time of at least six months can be demonstrated. However, physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

- A thorough multidisciplinary evaluation within the previous 12 months which includes the following:
 - an evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure(s) and all of the associated current CPT codes
 - a separate medical evaluation from a physician other than the surgeon recommending surgery, that includes a medical clearance for bariatric surgery
 - unequivocal clearance for bariatric surgery by a mental health provider
 - a nutritional evaluation by a physician or registered dietician

2.8.4 Elective Surgery. Covered by plan in accordance with the Schedule of Benefits and must be pre-certified and approved by plan.

2.8.5 Robotic Surgery/Robotics Suite. Covered in accordance with basic surgical procedure benefits as indicated on the Schedule of Benefits. Robotic surgery/Robotics Suite must be pre-certified and approved by the plan.

2.8.6 Organ Transplant. Covered in accordance with basic surgical procedure benefits as indicated on the Schedule of Benefits. Transplant must be pre-certified and approved by the plan. Only the services, care and treatment received for, or in connection with, the pre-approved transplant of organs, which are determined by the Plan to be medically necessary services and which are not experimental, investigational or for research purposes except as permitted through approved clinical trials will be covered by this Plan. Coverage for the organ donor is included.

§2.9 Basic diagnostic and therapy benefits.

2.9.1 Provider Services. Charges for the following Services when ordered by a Physician for the treatment of an Injury or Illness.

2.9.1.1 Laboratory Services. Charges for laboratory Services.

- 2.9.1.2 X-ray Services. Charges for diagnostic X-ray procedures.
- 2.9.1.3 Electrocardiograms. Charges for EKG procedures.
- 2.9.1.4 Radiotherapy. Charges for radiotherapy.
- 2.9.1.5 Inhalation Therapy. Charges for Inhalation Therapy provided as an Outpatient Service.
- 2.9.1.6 Sleep Apnea Studies/Polysomnograph. Charges for sleep apnea studies/polysomnograph - diagnostic and therapeutic procedures.

§2.10 Medical-related Dental Benefits. The following dental benefits are Covered Services:

2.10.1 Services rendered by a Dentist or Physician, and Hospital or Ambulatory surgi-center services related thereto, when required to treat traumatic injury to sound, natural teeth or jaw. Coverage is limited to palliative care to alleviate pain and other acute symptoms resulting from the Injury. Such may include debridement of wounds, suturing, extraction of broken teeth, splinting of loose teeth, wiring of jaws, smoothing jagged edges of broken teeth. Services must be completed within 12 months following the injury. Fillings, crowns, bridges, dentures, bonding and similar permanent restorations are excluded.

2.10.2 If a Participating Physician certifies, in advance, that a non-dental, medical condition makes admission necessary to safeguard the Covered Person in connection with Dental Services rendered by a Dentist, Hospital and Ambulatory Surgi-center Services rendered in connection therewith are covered.

§2.11 Home Health Care. Home Health Care, provided by allied health care professionals, is covered according to the schedule of benefits.

§2.12 Basic Skilled Nursing Facility benefits. The following Skilled Nursing Facility benefits are provided:

2.12.1 Skilled Nursing Facility benefits. If a Covered Person is confined as a Registered Bed Patient in a Skilled Nursing Facility, the Covered Person shall be eligible for benefits as if confined in a Hospital, except that the eligible period of confinement shall be limited to a maximum of sixty (60) days per Plan Year and payment for such benefits shall be the rates applicable for such Skilled Nursing Facility. To be eligible for these benefits, each of the following requirements must be met:

2.12.2 The admission to the Skilled Nursing Facility must be approved in advance by Company.

2.12.3 The Covered Person must be admitted on the authorization of a Physician and must continue to be attended by a Physician while confined.

2.12.4 Confinement in the Skilled Nursing Facility must not be primarily for comfort, convenience, rest cure or domiciliary care.

2.12.5 If a Covered Person remains in a Skilled Nursing Facility more than thirty (30) days, the attending Physician must submit to Company an evaluation report reviewing the thirty (30) day period of confinement and addressing the specific need for continued confinement.

§2.13 Hospice Care. Charges for a maximum of one hundred eighty (180) days per lifetime. The attending Physician must determine limited life expectancy of six (6) months or less. The Covered Person shall not be entitled to benefits for any Services for the Terminal Illness except for palliative care. Services must be provided through a bona fide Hospice. Coverage for Hospice Services shall be limited to One Hundred Fifty Dollars (\$150) per day.

2.13.1 Palliation Therapy is covered under the Hospice Care Benefit.

2.14.1A Palliation Therapy: Shall be defined as patient and family centered care that optimizes the quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice. Palliative care should be covered on an outpatient basis only.

2.13.2 At least one of the treating Physicians must determine limited life expectancy of six months or less and certifies terminal illness of a Covered Person.

2.13.3 There must have been agreement by the Covered Person or the Covered Person's authorized representative to begin Hospice care as palliative and/or support only; and

The Hospice level of benefits begins on the date the above conditions are met. The Covered Person shall not be entitled to any care for the terminal illness except for palliative care. Medically necessary care for unrelated conditions shall continue as covered benefits, subject to plan benefits, deductibles, exclusions and limitations, medically necessity determinations and eligibility. Benefits for conditions normally covered, and not directly or indirectly related to the terminal condition are covered for inpatient, outpatient and emergency care in accordance with the schedule of benefits.

§2.14 Prescription Drugs

2.14.1 Charges for Prescription Drugs, including insulin and syringes, when prescribed by a Physician. Charges for Medically Necessary prescription drugs not contained on the Company's Preferred Drug Formulary shall be covered provided the Physician certifies to the Company that the non-formulary drug is Medically Necessary for the Covered Person, and that no formulary drug was appropriate.

2.14.2 Prescription Drugs shall be limited to a thirty (30) day supply except for birth control pills and mail order Prescription Drugs which may be issued in a ninety (90) day prescription.

2.14.3 Prescriptions may be refilled for a period up to six (6) months from the original date of prescription, if so specified by a Physician in writing on the prescription.

2.14.4 Prescription Unit represents the maximum amount of outpatient prescription medication that can be obtained at one time for a single co-payment. For most oral medications, a prescription unit is up to a 30-day supply of medication.

2.14.5 For other medications, a Unit represents a single container, inhaler unit, package or course of therapy. For habit-forming medication, a unit may be set at a smaller quantity for the covered person's protection and safety.

2.14.6 Participating Mail Order Pharmacy. A pharmacy which has contracted with Company's Pharmacy Benefits Manager to provide covered outpatient prescription drugs or medicines and insulin to Members by mail or other carrier.

2.14.7 Participating Retail Pharmacy. A community pharmacy which has contracted with Company's Pharmacy Benefits Manager to provide covered outpatient prescription drugs to Members.

2.14.8 Benefits for outpatient prescription Drug Products dispensed by a mail service Network Pharmacy. The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

2.14.9 Prescribed drugs in countries outside of the United States (U.S.) may differ from those that require a prescription in the U.S. Drugs purchased outside the U.S. must be an equivalent product of one approved by U.S. federal law or there must be clinical evidence that prescribing the drug is consistent with the standard of medical practice in the Country where the prescription is issued.

§2.15 Specialty Drugs: Charges for medications used to treat certain complex and rare medical conditions. Specialty drugs are often self-injected or self-administered. Many grow out of biotech research and may require refrigeration or special handling.

§2.16 Health education. Charges for health education classes and materials in accordance with Exhibit ___ herein provided.

§2.17 Durable Medical Equipment. The rental cost of: standard hospital bed, cane single tip, cane quad tip, crutches (forearm, aluminum OR forearm, wood), walker (folding, adjustable with wheels OR folding, adjustable without wheels), oxygen refill, oxygen concentrator, oxygen portable with regulator, suction pump with supplies, suction tubing (replaceable every 3 months), yankauer oral suction catheter, tracheostomy care kits (for new and established tracheostomies), continuous positive airway pressure (CPAP) machine, and standard wheelchairs (to include extra-wide sizes), when prescribed by a Physician and then only at the prescribed level. If the total rental cost exceeds the purchase price, Company may, at its discretion, either rent or purchase the item for the Covered Person. This benefit is limited to one rental or purchase every three (3) years and is limited to standard equipment only, unless subject to a treatment plan.

§2.14 Mental health benefits. The charges for the diagnosis and treatment of mental illness, as that term is defined in Title 22, Guam Code Annotated, Section 28103, subject to the same conditions and restrictions applicable to physical illness.

§2.15 Ambulance Services. If a Covered Person is transported to a Hospital by ground ambulance from the place where an Injury occurred, or when prescribed by a Physician, eighty percent (80%) of the charges for such ground ambulance Services are payable if: (i) the Services are provided by a licensed ambulance service; and (ii) the transportation is to a Hospital capable of treating the Covered Person and which Hospital is nearest to the place of Injury or place of entering the ambulance.

§2.16 Tubal ligation. The charges for tubal ligations.

§2.17 Vasectomy. The charges for vasectomies on an outpatient basis only.

§2.18 Breast reconstruction. Reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all states of mastectomy, including lymphedemas, are covered. Such re-constructive procedures are not limited to re-constructive procedures necessitated by mastectomies performed while covered under this Plan.

§2.19 Blood products. Charges for blood and blood products and their administration.

§2.20 Preventive Care. To the extent required by PPACA, preventive care (with no cost-sharing) when preventive care is provided by Participating Providers.

§2.21 Preferred Provider(s) The following sections refer to charges incurred by a Covered Person for Covered Services provided by Preferred Providers:

2.21.1 The Covered Person has obtained written Prior Authorization from Company or Company's agent to receive Services from a Preferred Provider and has agreed to receive Services from such Preferred Provider chosen by Company or Company's agent. No Prior Authorization shall be required for Emergency or PPACA Emergency cases and the Covered Person may select the Preferred Provider where Emergency or PPACA Emergency Services shall be rendered.

2.21.2 Company is the primary payor based on the coordination of benefits provisions of this Certificate, unless the primary payor is Medicare for those Centers of Excellence located in the United States; provided, however, the Company shall be the primary payor for Preferred Providers outside of the United States and located in the Philippines, Korea, Japan, or other Pacific-Asian locations.

2.21.3 For Inpatient Services which are unavailable in Guam and rendered by the Preferred Providers.

2.21.3.1 Company shall pay 100% of these services.

2.21.3.2 Company shall waive any co-insurance for such Services.

2.21.3.3 Company shall only provide airfare for the Covered Person for the most direct route to and from the location of the Covered Person and the Preferred Providers as determined by Company.

Regardless of the location of the Covered Person, or if it is Medically Necessary to provide for a break in the trip, Company shall provide the lesser of the lowest applicable economy airfare or the lowest economy, round-trip airfare on a commercial direct flight between Guam and the Preferred Providers. In no event shall Company provide an air ambulance.

2.21.3.4 If the Service is one of the following specific procedures or conditions: open heart surgery, oncology surgery to include but not limited to the following cancers brain, lung, liver, kidney, adrenal, nasopharyngeal, tongue, prostate, colon, genito-urinary, breast and gynecological oncology, aneurysmectomy, pneumonectomy, intra cranial surgery, acute leukemia, gamma knife, or if the expected cost to the Company for off-island Covered Services exceeds \$25,000.00, Company shall pay the air fare of one companion of the Covered Person to the Center of Excellence [Preferred Providers] under the terms set forth in §2.21.3.3.

2.21.3.5 If it is Medically Necessary that a licensed medical attendant be with the Covered Person, Company shall provide for one airline seat for such attendant under the same terms set forth in §2.21.3.3.

2.21.3.6 If the Covered Person is unable to self-care, Company shall provide for one airline seat for a qualified assistant under the same terms as §2.21.3.3

2.21.3.7 Company may, at its option, make the travel arrangements for the Covered Person and his or her companion, attendant or assistant (if any) and purchase the airline tickets.

2.21.3.8 Company shall facilitate the Hospital/Physician arrangements for the Covered Person.

2.21.3.9 For Company to be liable to pay any airfare, the proposed Service to be performed at the Preferred Provider must be a specific procedure and not merely a diagnostic work-up or to confirm or rule out the diagnosis of another Physician. In the event the covered person/attendant purchases the seat(s), the Company will reimburse for actual expenses incurred in purchasing Medically Necessary seat(s), but not more than the Company would have paid had it purchased the seat(s) for the companion in advance. In no event will company reimburse for any seat(s) purchased with frequent flyer miles.

2.21.4 For Ambulatory Surgical Center Services which are unavailable in Guam and rendered by Preferred Providers:

2.21.4.1 Company shall waive the twenty percent (20%) Co-Insurance.

2.21.4.2 Company shall facilitate the Surgicenter/Physician arrangements for the Covered Person.

2.21.5 Inpatient and Ambulatory Surgical Center Services which are unavailable in Guam and rendered by Preferred Providers:

2.21.5.1 Company shall waive the twenty percent (20%) Co-Insurance.

2.21.5.2 Company shall facilitate the Surgicenter/Physician arrangements for the Covered Person.

2.21.6 Only those facilities identified as Preferred Providers in the Company's most recently updated Provider Directory will qualify for the airfare benefit.

§2.22 If no Participating Provider available. If there is no Participating Provider available, within the United States, to provide necessary Covered Services to a Covered Person, Company will cover those services at a Non-Participating Provider, within

the United States, unless otherwise agreed by the Covered Person, such that the Covered Person will have no greater out-of-pocket cost than he or she would have had had the Services been rendered by a Participating Provider.

§2.23 If not able to travel. In case Emergency medical care is needed off-island, and it is medically imprudent for the Covered Person to be transported to a Participating Provider, Company will cover Services rendered to the Covered Person at a Non-Participating Provider such that the Covered Person will have no greater out-of-pocket cost than he or she would have had had the Services been rendered by a Participating Provider.

ARTICLE 3

Specific Limitations on Benefits

§3.1 **Dollar limitations.** The medical benefits available under this Agreement are subject to the following specific dollar limitations per Covered Person, in addition to all other exclusions and limitations set forth in the Agreement and this Certificate:

3.1.1 **Maximum Annual Benefit.** The total benefits payable to or on behalf of a Covered Person shall be unlimited per Plan Year.

3.1.2 **Cardiac surgery.** Benefits for cardiac surgery, including, but not limited to catheterization, angioplasty, valve replacement/repair, bypass and pacemaker are included.

3.1.3 **Nuclear medicine.** Coverage for nuclear medicine and all Covered Services related thereto are included.

3.1.4 **Orthopedic conditions.** Coverage for orthopedic conditions and related internal and external prosthetic devices, are included.

3.1.4.1 Except as specifically limited under this Agreement, Services, supplies and devices related to the treatment of chronic or acute orthopedic conditions are covered. This includes, but is not limited to:

3.1.4.1.1 Prosthetic devices. Devices, including artificial joints, limbs and spinal segments.

3.1.4.1.2 Orthotic devices. Orthotic devices, which are defined as appliances or apparatus that support or align movable parts of the body, correct deformities or improve the functioning of movable parts of the body.

3.1.5 **Radiation therapy.** Coverage for radiation therapy and all Services related thereto shall be included.

3.1.6 **Allergy testing.** A maximum benefit of One Thousand Dollars (1000) per Plan Year for charges for allergy testing that are not considered essential benefits under PPACA. Benefits for Allergy testing and treatment that constitute essential benefits under PPACA are subject only to the PPACA Annual Limit.

3.1.7 **Annual refraction eye examination.** Coverage for annual eye examination is once per member per Plan Year and up to \$150 per member per Plan Year for "hardware" (frames, lenses, contacts, etc.).

3.1.8 **Blood and blood products and derivatives.** Coverage for blood and blood products/derivatives and services related thereto shall be included.

3.1.9 **Hearing aids.** Coverage for hearing aids is limited to Five Hundred Dollars (\$500) per Plan Year. Replacements for hearing aids are allowed once every two years.

3.1.10 **Acupuncture.** Coverage for acupuncture services are up to the Annual Maximum Benefit per Plan Year as stated in the Schedule of Benefits marked as Exhibit A.

3.1.11 **Chemical dependency treatment.** Coverage for the diagnosis and necessary treatment of chemical dependency shall not be subject to a dollar limit other than being included under the PPACA Annual Limit.

3.1.12 Chiropractic. Coverage for chiropractic Services are up to the Annual Maximum Benefit per Plan Year as stated in the Schedule of Benefits marked as Exhibit A.

3.1.13 Occupational Therapy. Coverage for Occupational therapy is up to the Annual Maximum Benefit per Plan Year as stated in the Schedule of Benefits marked as Exhibit A.

3.1.14 Respiratory Assist Devices. Coverage for Respiratory Assist Devices (RAD) is based upon medical necessity and will be in accordance with published Medicare Guidelines of coverage at the time of service.

§3.2 Other benefit limitations. The medical benefits available under this Agreement are subject to the following other benefit limitations, in addition to all other exclusions and limitations set forth in the Agreement and this Certificate, Per Covered Person:

3.2.1 Emergency Services. Coverage for Emergency Services is generally limited to those Services required for diagnosis and treatment of an Emergency immediately after onset, no later than twenty-four (24) hours. PPACA Emergency Services shall be provided as necessary to stabilize the Covered Person, without regard to such time limit.

3.2.2 Hospital and Surgical authorization. Prior Authorization must be obtained from the Company before a Covered Person is admitted to a Hospital or has one of the Surgeries or Medical Procedures listed in §3.2.2.2. Prior Authorization will be handled in accordance to the Milliman Healthcare Guidelines.

3.2.2.1 Responsibility for Prior Authorization. The Participating Provider ordering the hospitalization or Surgery for a Covered Person shall obtain Prior Authorization. The Covered Person shall not be responsible for obtaining Prior Authorization and shall not be liable for any penalty.

The Non-Participating Provider or the Covered Person shall be responsible for obtaining Prior Authorization required by the Company prior to the hospitalization or Surgery. In the event a Covered Person is admitted to a Hospital for an Emergency, required authorization consists of notifying Company (i) within forty eight (48) hours of the admission if it occurs on a day other than a Saturday, Sunday or holiday; or (ii) within seventy-two (72) hours if it occurs on a Saturday, Sunday or holiday, and, in either case, receiving Company's authorization for the admission. PPACA Emergency Services shall not require Prior Authorization, and such services provided by Non-Participating Providers shall not require any notification or other administrative requirement other than what is required when provided by Participating Providers.

Prior Authorization denials shall be handled pursuant to the PPACA Claims Procedure Requirements provided in §5.19, to the extent required by PPACA.

3.2.2.2 Reduced benefit without Prior Authorization. If a required Prior Authorization is not obtained in accordance with this §3.2.2, Company shall pay fifty percent (50%) of the Eligible Charges incurred in connection with the confinement or Surgery. If the Participating Provider is the person required to obtain the Prior Authorization, the reduction in benefits shall not be charged to the Covered Person. No penalty for failure to obtain Prior Authorization shall be imposed for a PPACA Emergency, whether Participating or Non-Participating Providers are utilized.

List of outpatient and inpatient procedures requiring authorization (unless a PPACA Emergency). If the following procedures are not pre-certified by plan, payment may be denied.

- All elective outpatient surgical procedures requiring use of surgical facilities
- Any and all diagnostics and surgical procedures in excess of \$300.00 including specialty laboratory
- Any back or disc surgery
- Any knee surgery
- Any varicose veins surgery
- Carpal Tunnel Release
- Durable Medical Equipment: Standard hospital bed, wheelchairs, walkers, crutches, oxygen, suction machine
- EMG/NCT (upper extremities)
- Gall Bladder Surgery
- Heart By-Pass Surgery
- Heart catheterization
- Hernia surgery
- Hysterectomy
- Mastectomy
- MIBI Scan, Thallium Stress Test, Exercise Stress Test
- MRI (All)
- Non-Routine Endoscopies and Colonoscopies
- Pain Management Studies
- Physical Therapy requiring more than five (5) out-patient visits
- Prostatetectomy
- Radiological and nuclear diagnostic procedures performed or ordered by the same provider on any one patient two or more time
- Robotic Suite and Robotic Surgery
- Ultrasounds (All with the exception of the first OB ultrasound & first FNST)
- Upper GI Endoscopy
- **Prosthetic & Orthotic devices as covered by Medicare**

3.2.3 Excess Non-Participating Provider charges. The Covered Person shall be responsible for charges by a Non-Participating Provider in excess of Eligible Charges, except (a) Out-Of-Service Area emergency, or (b) when the Non-Participating Provider is a Sole Source Provider as defined in §7.9 of the Agreement. A Covered Person using a Non-Participating Provider for a PPACA Emergency shall not be liable for Co-Payments or Co-Insurance in excess of Co-Payments and Co-Insurance that would have been charged if Participating Providers had been used. The Company shall pay an amount for PPACA Emergency Services computed as provided in this Agreement.

3.2.4 Excessive Participating Provider charges. The Covered Person shall not be liable for charges by a Participating Provider in excess of the Eligible Charges.

3.2.5 Physical therapy. Charges for the first twenty (20) visits to a licensed physical therapist for physical therapy, including neuromuscular rehabilitation. After twenty (20) visits in a Plan Year, Company shall pay fifty percent (50%) of Eligible Charges.

3.2.6 Skilled Nursing Facility care. Coverage for Skilled Nursing Facility Services is limited to sixty (60) days maximum per Plan Year.

3.2.7 Case Management. Company may, in its discretion, assign Nurses or other qualified health professionals for the purpose of Case Management. Payment for alternative Services in one instance does not obligate the Company to provide the same or similar benefits for the same or any other Covered Person in any other instance. Payment of these alternative benefits is made as an exception and in no way changes or voids the benefits, terms or conditions of this Agreement.

ARTICLE 4

Specific Exclusions from Benefits

§4.1 No benefits will be paid for Injury or Illness, (a) when the Covered Person is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such Injury or Illness or (b) when Services for an Injury or Illness are rendered to the Covered Person by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (c) when such Services would have been rendered without charge but for the fact that the person is a Covered Person under the Plan.

§4.2 No benefits will be paid if any material statement made in an application for coverage, enrollment of any Dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall give the Covered Person at least 30 days notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage shall be effective no earlier than the date of the suspension. The Covered Person may dispute any termination of coverage by filing a claim under the PPACA Claims Procedure for internal or external appeals, set out in §6.7 of this Certificate. If an appeal under §6.7 is filed, the resolution of the matter shall be in accordance with the outcome of the appeal proceedings. If no appeal is filed for any retroactive termination and the Company paid benefits prior to learning of any such false statement, the Subscriber must reimburse the Company for such payment. Terminations of coverage shall be handled in accordance with the applicable claims procedure requirements of Section 2719 of the PHSA, as added by PPACA. Retroactive terminations of coverage shall not violate the applicable prohibitions on rescissions of Section 2712 of

the PHSA, as added by PPACA, and recissions shall be handled in compliance with PPACA's applicable claim denial requirements.

§4.3 No benefits will be paid for confinement in a Hospital or in a Skilled Nursing Facility if such confinement is primarily for custodial or domiciliary care. (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self care. Custodial or domiciliary care also includes supervisory services by a Physician or Nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.) Company and not Covered Person shall be liable if the Company approves the confinement, regardless of who orders the service.

§4.4 No benefits will be paid for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)

§4.5 No benefits will be paid for private Duty Nursing. This provision does not apply to Home Health Care.

§4.6 No benefits will be paid for special medical reports, including those not directly related to treatment of the Member. (e.g., Employment or insurance physicals, and reports prepared in connection with litigation.)

§4.7 No benefits will be paid for services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

§4.8 No benefits will be paid for court ordered services, or those required by court order as a condition of parole or probation.

§4.9 No benefits will be paid for Services and supplies provided to a Covered Person for an Injury or Illness resulting from an attempted suicide by that Covered Person unless resulting from a medical condition (including physical or mental health conditions) or from domestic violence.

§4.10 No benefits will be paid for Services and supplies provided in connection with intentionally self-induced or intentionally self-inflicted injuries or illnesses unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.

§4.11 No benefits will be paid for Services and supplies provided to a Covered Person for Injuries incurred while the person was committing a criminal act.

§4.12 Unless otherwise specifically provided in the Agreement, no benefit will be paid for, or in connection with, airfare and the Company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person.

§4.13 No benefits will be paid for living expenses for Covered Persons who require, or who of their own accord seek, treatment in locations removed from their home.

§4.14 No benefits will be paid for home uterine activity monitoring.

§4.15 No benefits will be paid for services performed by an immediate family member for which, in the absence of any health benefits coverage, no charge would be made. Immediate family member is defined as parents, spouses, siblings, or children of the insured member.

§4.16 No benefits will be paid for treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a Member is covered under a Workers' Compensation law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered "nonoccupational" regardless of cause. The Covered Benefits under the Group Health Insurance Certificate for Members eligible for Workers' Compensation are not designed to duplicate any benefit to which they are entitled under Workers' Compensation Law. All sums payable for Workers' Compensation services provided under the Group Health Insurance Certificate shall be payable to, and retained by Company. Each Member shall complete and submit to Company such consents, releases, assignments and other documents reasonably requested by Company in order to obtain or assure reimbursement under the Workers' Compensation Law

§4.17 No benefits will be paid for:

- 4.17.1 Drugs or substances not approved by the Food and Drug Administration (FDA), or
- 4.17.2 Drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury, or
- 4.17.3 Drugs or substances labeled "Caution: limited by federal law to investigational use."
- 4.17.4 Any drug or substance which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC drug).

§4.18 No benefits will be paid for experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes, unless deemed medically necessary by the patient's physician, are associated with a qualifying clinical trial per PPACA regulations, and pre-authorized by the Company.

Per PHSA sec. 2709(a)(2), added by PPACA sec 10103(c), the plan must pay for items and services furnished in connection with approved clinical trials, and cannot exclude such items and services based on an exclusion for experimental or investigational treatments. The requirement mandates coverage of all medically necessary charges associated with the clinical trial, such as physician charges, labs, X-rays, professional fees and other routine medical costs.

An approved clinical trial is defined as:

- Phase I, Phase II, Phase III, or Phase IV clinical trial,
- Being conducted in relation to the prevention, detection or treatment for Cancer or other life threatening disease or condition, and
- Is one of the following:
 1. A federally funded or approved trial.
 2. A clinical trial conducted under an FDA investigational new drug application.
 3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

§4.19 No benefits will be paid for services or supplies related to Genetic Testing except as may be required by PPACA.

§4.20 No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care.

§4.21 No benefits will be paid for Services and supplies provided to perform transsexual surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and Services necessary to maintain transsexual status are also excluded from coverage, as are complications or medical sequela of such surgery or treatment.

§4.22 No benefits will be paid for injuries incurred by the operator of a motorized vehicle while such operator is under the influence of intoxicating alcoholic beverage, controlled drugs, or substances. If a blood alcohol level or the DRAEGER ALCO TEST is available and shows levels that are equal to or exceed 0.08 grams percent (gms%) or that exceed the amount allowed by law as constituting legal intoxication, no benefits will be paid.

§4.23 No benefits will be paid for any medical Service or supply which is available to the Covered Person on Guam and which is paid by or reimbursable through a governmental agency or institution that provides medical and healthcare services to low-income or indigent persons, provided, however, this exclusion *shall* not apply to the treatment of any communicable disease as defined in Article 3 of Chapter 3, Title 10, Guam Code Annotated, and for which the Company *shall* pay for medical services and supplies as is medically necessary for the treatment of Covered Person. However, notwithstanding the aforesaid, in no event will the Company consider the availability of benefits under Medicaid or Medically Indigent Program when paying benefits under this Agreement.

§4.24 No benefits will be paid for dental services including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, dental splint and other dental appliances, root canal treatment, soft tissue impactions, alveolectomy, augmentation, and vestibuloplasty, treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, maxillary and mandible implants (osseointegration) and all related services, removal of impacted teeth, bite plates, orthognathic surgery to correct a bit defect. This exclusion does not apply to:

4.24.1 Removal of bony impacted teeth, bone fractures, removal of tumors, and biopsy or excision of oral cysts.

4.24.2 Emergency Services to stabilize an acute injury to sound natural teeth, the jawbone or surrounding structures, if provided within 48 hours of the injury or as required by PPACA to stabilize and treat a PPACA Emergency.

4.24.3 Surgical treatment of TMJ as described in the Covered Benefits Section "Temporomandibular Joint Syndrome (TMJ) Services".

4.24.4 Dental anesthesia when provided according to the conditions described in the Covered Benefits Section, "Limited General Anesthesia for Dental Procedures".

4.24.5 Procedures deemed medically necessary by patient's physician and pre-authorized by Company.

§4.25 No benefits will be paid for vision care services, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision), lasik, keratoplasty, and

radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the Covered Benefits section of the Group Health Insurance Certificate.

§4.26 No benefits will be paid for Services in connection with surgery for the purpose of diagnosing or correcting errors in refraction

§4.27 No benefits will be paid in connection with any injuries sustained while the Covered Person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.

§4.28 No benefits will be paid for personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies.

§4.29 No benefits will be paid for hypnotherapy.

§4.30 No benefits will be paid for religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

§4.31 No benefits will be paid for cosmetic Surgery, or other services intended primarily to improve the Member's appearance or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion does not apply to:

4.31.1 Medically Necessary reconstructive surgery as described in the Covered Benefits sections Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery.

4.31.2 surgery to correct the results of injuries causing an impairment;

4.31.3 surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;

4.31.4 surgery to correct congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

§4.32 Except as otherwise provided in this agreement, no benefit will be paid for specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

§4.33 No benefits will be paid for Services and supplies associated with growth hormone treatment unless the Covered Person is proven to have growth hormone deficiency using accepted stimulated growth hormone analyses and also shows an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency.

§4.34 No benefits will be paid for Services and supplies provided for liposuction.

§4.35 No benefits will be paid for weight reduction programs, or dietary supplements, except as pre-authorized by Company for the Medically Necessary treatment of morbid obesity.

§4.36 No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction unless medically necessary.

§4.37 Except as provided in this Agreement, or unless medically necessary for the treatment of Morbid Obesity or other disease, no benefit will be paid for gastric bypass, stapling or reversal if for the purpose of weight reduction or aesthetic purposes.

§4.38 No benefits will be paid for surgical operations, procedures or treatment of obesity, except when pre-authorized by Company.

§4.39 No benefits will be paid for the treatment of male or female Infertility, including but not limited to:

4.39.1 The purchase of donor sperm and any charges for the storage of sperm;

4.39.2 The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;

4.39.3 Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, hospital, ultrasounds, laboratory tests, etc.);

4.39.4 Home ovulation prediction kits;

4.39.5 Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;

4.39.6 Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any advanced reproductive technology ("ART") procedures or services related to such procedures;

4.39.7 Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);

4.39.8 Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

4.39.9 Any charge associated with a frozen embryo transfer including but not limited to thawing charges;

4.39.10 Reversal of sterilization surgery; and

4.39.11 Any charges associated with obtaining sperm for ART procedures.

§4.40 Except as provided in this Agreement, no benefits will be paid for the purchase or rental of durable or disposable medical equipment and supplies, other than for equipment and supplies used in a Hospital or Skilled Nursing Facility, or in conjunction with an approved Hospital or Skilled Nursing Facility confinement, or items covered as preventive care under well-women coverage in accordance with reasonable medical management techniques, or as otherwise noted in the Agreement.

§4.41 No benefits will be paid for household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member's house or place of business, and adjustments to vehicles.

§4.42 No benefits will be paid for outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, and elastic stockings.

§4.43 No benefits will be paid for Services and supplies provided for penile implants of any type.

§4.44 No benefits will be paid for Services and supplies to correct sexual dysfunction.

§4.45 Except as specifically provided, if a benefit is excluded, all Hospital, surgical, medical treatments, prescription drugs, laboratory services, and x-rays in relation to the excluded benefits are also excluded as of the time it is determined that the benefit is excluded.

§4.46 Except as specifically provided in this Agreement, no benefits will be provided for Services and supplies not ordered by a Physician or not Medically Necessary.

§4.47 No benefits will be paid for temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the Covered Benefits Section

§4.48 Except as specifically provided in this Agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment.

§4.49 No benefits will be paid for Services for which the Covered Person or Subscriber is not legally obligated to pay.

§4.50 No benefit will be paid for ambulance services when used for routine and convenience transportation to receive outpatient or inpatient services, unless deemed medically necessary with prior authorization obtained from Company.

§4.51 **No benefits will be paid for** elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a Physician.

§4.52 No benefits will be paid for hospital take-home drugs.

§4.53 No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the Covered Person.

§4.54 No benefits will be paid for educational services. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

§4.55 No benefits will be paid for Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.

§4.56 No benefits will be paid for Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms or whether providing or receiving the Service.

§4.57 No benefits will be paid for non-medically necessary services, including but not limited to, those services and supplies:

4.57.1 Which are not Medically Necessary, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

4.57.2 That do not require the technical skills of a medical, mental health or a dental professional;

4.57.3 Furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member's family, or any Provider;

4.57.4 Furnished solely because the Member is an inpatient on any day in which the Member's disease or injury could safely and adequately be diagnosed or treated while not confined;

4.57.5 Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.

§4.58 As required by HIPAA, no source-of-injury exclusion, such as exclusion 4.28 for off-road sporting events, will apply if the accident resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Article V.

General Terms and Conditions

§5.1 **Eligibility.** An individual is eligible for Enrollment and benefits only if he or she satisfies the definition of Covered Person and has not previously had coverage under the Plan which was terminated for cause.

§5.2 **Dependent.** A Dependent is either a:

5.2.1 **Spouse.** The Spouse of the Subscriber includes (i) a lawful wedded spouse; or (ii) a divorced spouse where there is an order issued by a court having jurisdiction over the parties that the Subscriber continue to provide such spouse coverage under this Plan, provided that no Subscriber can enroll more than one (1) person as a spouse at a time unless one spouse is covered pursuant to a court order.

5.2.2 **Domestic Partner.** The Domestic Partner of the Subscriber shall be defined as a person who: (1) is 18 years of age or older; (2) is of the same or opposite sex as Subscriber; (3) is in an exclusive mutually committed relationship with the Subscriber and intends to remain the Subscriber's sole domestic partner; (4) is not married to any other person; (5) is not related to the Subscriber by blood to a degree that would prohibit marriage; and (6) has cohabitated with the Subscriber for the two (2) consecutive years immediately preceding the proposed Enrollment.

§5.3 **Residency Requirement.** Except as otherwise specifically stated in this Agreement, Enrollment in the Plan shall be limited to only those Covered Persons who are Domiciled in the Service Area and do not reside out of the Service Area for more than 182 days per Plan Year. Company shall be entitled to prior notice from the Covered Person concerning his/her residency status and the failure of the Covered Person to provide this prior notice may result in a denial of benefits under this Agreement. Company shall also be entitled to require substantiation from a Covered Person to determine the Covered Person's Domicile and may deny benefits under this Agreement for lack thereof. Covered Persons outside the Service Area must coordinate their care and obtain Prior Authorization from the Company for Services, excluding Emergency services. For a Covered Person who is Domiciled in the Service Area, time spent receiving continuous medical Services out of the Service Area shall not count toward the 182 day maximum provided the receipt of such Services precludes returning to the Service Area. Further, time spent by a parent or spouse of such Covered Person shall not count toward the 182 day maximum, provided the parent or spouse is providing necessary assistance to the Covered Person and further provided that under no circumstance

can there be more than one such caregiver hereunder for any incident out of the Service Area. Company shall use its best efforts, to include making available written forms and materials, to inform Subscribers of the requirements of this Section during enrollment period, in its marketing materials and on its website.

§5.4 **Institutionalized applicant.** Any individual shall be entitled to the full benefits of this Plan beginning on his or her effective date regardless of any pre-existing medical condition and regardless of whether he or she is confined as an inpatient in any institution. In the event the individual is confined in an inpatient facility covered under this Agreement and incurring costs covered under this Plan, Company will make best efforts to coordinate with the individual's prior carrier, if any, to minimize disruption in the individual's medical care and to minimize cost to the Plan.

§5.5 **Enrollment.**

5.5.1 **Enrollment During an Open Enrollment Period.** An eligible individual may enroll in the Plan during an open Enrollment period, or as proscribed by federal or local law to include Section 1882 of the Social Security Act, 42 USC §1395ss.

5.5.2 **Enrollment After Open Enrollment Period.** Persons becoming eligible for Enrollment after completion of Open Enrollment period under this Agreement may elect to enroll within thirty (30) days of the date of first becoming eligible.

5.5.3 **After Thirty (30) Day Enrollment**

5.5.3.1 **Subscriber.** Subject to §5.4.3.3, an individual eligible to enroll as a Subscriber who does not make written election for Enrollment within thirty (30) days after first becoming eligible shall not be permitted to enroll hereunder until the next Open Enrollment period unless entitled to special enrollment rights under federal or local law.

5.5.3.2 **Dependents.** Subject to §5.4.3.3, a Subscriber with Dependents eligible for Enrollment who does not make written election for Enrollment of such Dependents within thirty (30) days after their first becoming eligible shall not be permitted to enroll such Dependents hereunder until the next Open Enrollment period unless entitled to special enrollment rights under federal or local law.

5.5.3.3 **HIPAA and PPACA Enrollment Requirements.** If an individual eligible to enroll as a Subscriber loses other employer coverage or acquires a Dependent through marriage, then the special enrollment requirements of HIPAA may be applicable. If a Subscriber becomes eligible for a HIPAA special enrollment, such Subscriber and Spouse, if applicable, shall be entitled to change from Class I to Class II during such special enrollment.

§5.6 **Commencement of coverage.** After fulfilling all conditions of Enrollment as set out in this Agreement, coverage under the Plan shall commence:

5.5.1 **Previously Enrolled.** As of the Effective Date of this Agreement, for a Subscriber and his or her **Covered Dependents** who are Enrolled on such Effective Date.

5.5.2 **Not Yet Enrolled.** As of the first day following the pay period in which the individual satisfies the Enrollment requirements as set forth in this Agreement and Company becomes entitled to receive the appropriate Premium for a Subscriber and his or her Covered Dependents who become Enrolled subsequent to the Effective Date of this Agreement.

5.5.3 Except as provided in §5.6, coverage of a Dependent of a Subscriber who become eligible after such Subscriber has been Enrolled hereunder shall commence as of the first day of the pay period following the timely filing of an application for Enrollment and liability for the appropriate Premium accrues.

5.5.4 Open Enrollment Period. For any eligible individual and his or her eligible Dependent who applies for Enrollment or re-Enrollment during GovGuam's open Enrollment period, coverage shall commence as of the Plan effective date first following the open Enrollment.

§5.7 **Continuing Enrollment.** Subscribers and Covered Dependents enrolled under this Plan on the last day of a Plan Year shall be automatically enrolled for the following Plan Year unless they change to some Other Plan during open Enrollment or unless this Plan is not renewed.

§5.8 **Medical Term.** Covered Persons must continue medical coverage under this Agreement for a minimum of twelve (12) months or for the balance of the Plan Year, except when termination of Enrollment is approved by GovGuam's Director of Administration and by Company. A rate increase during the Plan Year is not grounds for disenrollment.

§5.9 **Dental eligibility and term.** Covered Persons may enroll in the Company's dental plan only if they are enrolled in Company's Retiree Supplement Insurance Plan. Covered Persons in the medical and dental Plan must continue their medical and dental coverage under this Agreement for a minimum of twelve (12) months or for the balance of the Plan Year, except when termination of Enrollment is approved by GovGuam's Director of Administration and by Company. A rate increase during the Plan Year is not grounds for disenrollment.

§5.10 **Release of medical information.** As a condition to the receipt of Plan benefits, each Covered Person authorizes Company to use and obtain information about his or her medical history, medical condition and the Services provided to him or her as may be necessary in connection with the administration of this Agreement. Information from medical records of Covered Persons and information received from Physicians or Hospitals arising from the Physician-patient relationship shall be kept confidential and shall only be disclosed with the consent of the Covered Person and in accordance with applicable law.

§5.11 **Termination for cause.** Company may terminate a Covered Person from the Plan for:

5.11.1 Misuse of card. A Covered Person knowingly allowing his or her Plan identity card to be used by another person or falsely representing the relation between himself or herself and another in order that the other person can obtain Services hereunder; or

5.11.2 To the extent required by PPACA, terminations for cause (other than for non-payment of premiums) shall be handled as required by the applicable PPACA Claims Procedure Requirements provided in §5.19 and as reflected in the Company's Appeal Procedures.

§5.12 **Termination other than for cause.** Except as otherwise provided in this Agreement or applicable law, if the Covered Person terminates his or her rights under this Agreement then all rights to benefits shall cease as of the effective date of such termination. However, Company shall pay Eligible Charges for all Covered Services incurred prior to the date of termination.

§5.13 **Rebate of Premium.** In the event of termination of coverage, GovGuam or the Subscriber, as applicable, shall receive a pro rata rebate of the Premium paid to Company for such Covered Person.

§5.14 Effective date of termination. Except as otherwise provided herein, termination of coverage shall take effect on the first (1st) day of the pay period following the event causing termination.

§5.15 To the extent required by PPACA, disputed terminations (other than for non-payment of premiums) shall be handled as required by the applicable PPACA claims procedure rules for external review process that provides the right to appeal within four (4) months after you receive notice of termination. A Covered Person can appeal a disputed termination pursuant to the PPACA Claims Procedure for internal and external review appeals provided in §5.19.

§5.16 HIPAA compliance. Company shall provide the certifications required by HIPAA for terminated Subscribers upon notification by GovGuam of the Subscriber's termination.

§5.17 Grievance Procedures. The Grievance Procedure is not applicable to adverse benefit determinations, including rescission of coverage, and their appeals which are subject to PPACA Claims Procedure Requirements provided in §5.20 and reflected in the Company's Appeal Procedures. A grievance is a formal complaint or dissatisfaction with the service received by a Covered Person. Grievance includes complaints about the quality of care or non-quality of care services at any of the Company's contracted network facilities, providers or with any administration provider/behavioral services and access to care. Non-quality of care services includes complaints about administrative services, sales processes or other marketing issues. A Covered Person and/or his or her representative may file a written grievance claim, including all relevant documentation, with the Company. The Covered Person and Company shall provide additional information or documentation, as applicable, if requested in writing.

5.17.1 Within sixty (60) days after a grievance is received by the Company, the Covered Person shall be notified in writing of the denial, partial denial or approval of the grievance.

5.17.2 If a Covered Person does not agree with the decision, then the Covered Person or the Covered Person's authorized representative may file a grievance appeal as follows:

5.17.2.1 A written grievance appeal request must be directed to the Grievance Coordinator. The request shall state all bases for the grievance appeal and be supported by all relevant information and documentation.

5.17.2.2 The Grievance Coordinator may refer grievance appeals to the medical society, the utilization department, peer review committee, or a medical specialty organization for an opinion to assist in the resolution of the grievance appeal.

5.17.2.3 Within ten (10) working days of the receipt of a grievance appeal, the Grievance Coordinator shall be available to meet with the Covered Person to discuss possible resolution of the matter and establish the time frame for review of the grievance appeal, which shall not exceed thirty (30) days.

§5.18 **Notice.** For purposes of service of any notice or other document under this Agreement, a Covered Person's address shall be that stated in the Enrollment materials, unless the Covered Person designates a new address by providing written notice to the Company. The address of the Company is: _____ unless the Company designates a new address in writing served on the Covered Person.

§5.19 **Cooperation Regarding Federal Law.** Company and the Government of Guam shall fully cooperate in implementing any Qualified Medical Child Support Order as defined and required by federal law.

§5.20 **PPACA Claims Procedure Requirements.** Adverse benefit determinations, including rescissions of coverage, and their appeals are subject to the requirements of Section 2719 of the PHSa, as added by PPACA, and applicable regulations to include 45 CFR 147.136 and 29 CFR 2560.503-1. The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan (e.g., a rescission of coverage), and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The Company's PPACA Claims Procedure is reflected in Exhibit ____.

5.20.1 As required by PPACA, the Company shall comply with U.S. Department of Labor claims regulations applicable to health plans under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as set forth at Section 2560.503-1 of Title 29, Code of Federal Regulations, as such regulations may be updated from time to time by the Secretary of Labor (the "ERISA Claims Regulations"). These ERISA Claims Regulations shall apply notwithstanding that the Plan is a government plan, previously not subject to ERISA's requirements, but shall be modified as follows:

5.20.1.1 An adverse benefit decision, to which the ERISA Claims Regulations shall apply, shall include a rescission, whether or not the rescission has an adverse effect on any particular benefit at that time.

5.20.1.2 In the case of a claim determination (whether adverse or not) involving urgent care, the claimant shall be notified as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.

5.20.2 On appeal, the claimant must be allowed to review the claim file and to present evidence and testimony.

5.20.3 Other aspects of the PPACA Claims Procedure regulations shall be followed including the right of a Covered Person to file an external review within four (4) months after the Covered Person receives notice of adverse benefit determination or denial of an internal appeal from the Company.

Article VI.

Dental Benefits

6.1 Dental Benefits Available. This Article contains the Dental Benefits available to Covered Persons in the optional dental plan.

6.2 Definitions. The definitions contained herein are supplemental to those contained elsewhere in this Agreement and apply only to Dental Benefits in the dental plan. The definitions contained elsewhere in this Agreement are applicable to this Article.

6.2.1 Treatment Plan. Treatment Plan means a Dentist's report of the Covered Person's dental defects, prescribing a program of treatment for the identified defects, including applicable charges.

6.3 Maximum Allowances. The maximum dental benefit payable by the Company for each Covered Person shall be One Thousand Dollars (\$1,000) per Plan Year.

6.4 Co-Payments for Diagnostic and Preventive Services.

6.4.1 For any Diagnostic and Preventive Services which are covered under §7.7.1 of this Agreement, Company will pay 100% of Eligible Charges if the Services are rendered by a Participating Provider.

6.4.2 For any Diagnostic and Preventive Services which are covered under §7.7.1 of this Agreement, Company will pay 70% of Eligible Charges if the Services are rendered by a Non-Participating Provider.

6.5 Payments for Basic and Restorative Services.

6.5.1 For any Basic and Restorative Services which are covered under §7.7.2 of this Agreement, Company will pay 80% of Eligible Charges if the Services are rendered by a Participating Provider.

6.5.2 For any Basic and Restorative Services which are covered under §7.7.2 of this Agreement, Company will pay 70% of Eligible Charges if the Services are rendered by a Non-Participating Provider.

6.6 Payments for Major and Replacement Services.

6.6.1 For any Major and Replacement Services which are covered under §7.7.3 of this Agreement, Company will pay 50% of Eligible Charges if the Services are rendered by a Participating Provider.

6.6.2 For any Major and Replacement Services, which are covered under §7.7.3 of this Agreement, Company will pay 35% of Eligible Charges if the Services are rendered by a Non-Participating Provider.

6.7 Services Available. Subject to the other conditions contained in this Agreement, Covered Persons choosing the optional dental plan for whom Premiums have been paid shall be entitled to the following Dental Benefits:

6.7.1 Diagnostic and Preventive Services.

6.7.1.1 Examinations (including Treatment Plan) limited to once every six (6) months.

- 6.7.1.2 Radiographs (X-rays).
 - 6.7.1.2.1 Full mouth series (once per 36 months).
 - 6.7.1.2.2 Bite-wings. Maximum of four per Plan Year.
- 6.7.1.3 Prophylaxis (cleaning and polishing) limited to twice per Plan Year.
- 6.7.1.4 Topical application of fluoride (once every Plan Year for Covered Persons under the age of 19);
- 6.7.1.5 Study models.
- 6.7.1.6 Space maintainers (for Covered Persons age 15 and under). This includes adjustments within 6 months of installation.
- 6.7.1.7 Caries susceptibility test.
- 6.7.1.8 Sealants (for permanent molars of Covered Persons age 15 and under).
- 6.7.2 Basic and Restorative Services.
 - 6.7.2.1 Emergency Services (during office hours).
 - 6.7.2.2 Pulp treatment.
 - 6.7.3.3 Routine fillings (amalgam and composite resin).
 - 6.7.3.4 Simple extractions.
 - 6.7.3.5 Complicated extractions.
 - 6.7.3.6 Extraction of impacted teeth.
 - 6.7.3.7 Periodontal prophylaxis (cleaning and polishing once every six months).
 - 6.7.3.8 Periodontal treatment.
 - 6.7.3.9 Pulpotomy and root canals (endodontic surgery and care).
 - 6.7.3.10 Conscious sedation and nitrous oxide for Covered Persons under the age of 13.
- 6.7.3 Major Dental Services and Replacement Services.
 - 6.7.3.1 Fixed prosthetics.
 - 6.7.3.1.1 Crowns and bridges.
 - 6.7.3.1.2 Gold inlays and onlays.
 - 6.7.3.1.3 Repairs of crowns and bridges.

6.7.3.1.4 Replacement of crown or bridge (limited to once every five years)

6.7.3.2 Removable prosthetics.

6.7.3.2.1 Full and partial dentures. Replacements limited to once every five years.

6.7.3.2.2 Denture repair and relines.

6.7.3.3 General anesthesia, but only if medically or dentally necessary.

6.8 Claims and Payment for Services. The procedures, requirements and conditions applicable to the processing and payment of claims for Medical Benefits contained in Article 6 shall apply to claims for Dental Services under this Agreement, except the Deductible amount does not apply to the Dental Benefits.

6.9 Reasonableness and necessity of Services and charges.

6.9.1 Company shall not be required to pay any claim unless and until Company has determined that the Covered Person received Covered Services and that the charges for the Dental Services are reasonable. No payment shall be made for: (i) Dental Services not actually rendered; or (ii) Dental Services which are not Covered Services. No payment shall be made for any portion of a charge determined by Company to be unnecessary, unreasonable or excessive. In the case of a Participating Provider, when a Covered Person receives Covered Services, Company guarantees the Covered Person shall not be responsible for payment of any charges in excess of the Eligible Charges

6.9.2 Preliminary determination that any Dental Service or charge is unnecessary or unreasonable or otherwise not payable shall, at the Dentist's or Covered Person's request, be reviewed through Company's grievance procedure. The determination made through the grievance procedure shall be conclusive upon all parties in interest, subject, however to the parties' right to arbitration.

6.10 Prior Authorization of Services. Prior Authorization by Company for Dental Services shall be required when any Treatment Plan and/or treatments exceed Five Hundred Dollars (\$500).

6.11 General Provisions.

6.11.1 Dental Exclusions. No benefits will be paid for:

6.11.1.1 Work in progress on the effective date of coverage. Work in progress is defined as:

6.11.1.1.1 A prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered.

6.11.1.1.2 A crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered.

6.11.1.1.3 Root canal therapy, if the pump chamber was opened before the patient was covered.

6.11.1.2 Services not specifically listed in the Agreement, Services not prescribed, performed or supervised by a Dentist, Services which are not medically or dentally necessary or customarily

performed, Services that are not indicated because they have a limited or poor prognosis, or Services for which there is a less expensive, professionally acceptable alternative.

- 6.11.1.3 Any Service unless required and rendered in accordance with accepted standards of dental practice.
- 6.11.1.4 A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement or modification of a crown, cast restoration, denture or bridge installed less than five years ago or one that replaces a tooth that was missing before the date of the Covered Person became eligible for Services under the plan (including previously extracted missing teeth).
- 6.11.1.5 Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable
- 6.11.1.6 Precision attachments, Interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.
- 6.11.1.7 Replacement of any lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.
- 6.11.1.8 Any Service for which the Covered Person received benefits under any other coverage offered by the Company.
- 6.11.1.9 Spare or duplicate prosthetic devices.
- 6.11.1.10 Services included, related to, or required for:
 - 6.11.1.10.1 Implants;
 - 6.11.1.10.2 Cosmetic purposes;
 - 6.11.1.10.3 Services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to, equilibrium, full mouth rehabilitation and restoration for malalignment of teeth;
 - 6.11.1.10.4 Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction of harmful habits;
 - 6.11.1.10.5 Experimental procedures; and
 - 6.11.1.10.6 Intentionally self inflicted injury unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.
- 6.11.1.11 Any over the counter drugs or medicine.
- 6.11.1.12 Fluoride varnish.

- 6.11.1.13 Charges for finance charges, broken appointments, completion of insurance forms or reports, providing records, oral hygiene instruction, pit and fissure sealants and dietary instruction, or lack of cooperation on the part of the patient.
- 6.11.1.14 Charges in excess of the amount allowed by the Plan for a Covered Service.
- 6.11.1.15 Any treatment, material, or supplies which are for orthodontic treatment, including extractions for orthodontics.
- 6.11.1.16 Services for which no charge would have been made had the Agreement not been in effect.
- 6.11.1.17 All treatments not specifically stated as being covered.
- 6.11.1.18 Surgical grafting procedures.
- 6.11.1.19 General anesthetic, conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein.
- 6.11.1.20 Services paid for by Workers' Compensation.
 - 6.11.1.21 Charges incurred while confined as an inpatient in a Hospital unless such charges would have been covered had treatment been rendered in a dental office.
 - 6.11.1.22 Treatment and/or removal of oral tumors.
 - 6.11.1.23 All surgical procedures except for surgical extractions of teeth and periodontal surgeries Performed by a Dentist. Surgical procedure is defined as the surgical and adjunctive treatment of diseases, injuries, and deformities of the oral and maxillofacial region.
 - 6.11.1.24 Panoramic x-ray if provided less than three (3) years from the Covered Person's last full mouth x-rays; and full mouth x-rays if provided less than three (3) years from the Covered Person's last panoramic x-ray.

6.11.2 Issuance of this Agreement. This Article 7 shall take effect, and coverage for the Subscriber and Dependents initially listed on the Enrollment form shall commence as of the Subscriber's Effective Date if the Enrollment form is accepted by Company.

6.11.3 DENTAL COVERAGE SPECIAL CONDITIONS OF ENROLLMENT. EMPLOYEES MAY ELECT TO ENROLL IN THE MEDICAL PLAN ONLY BENEFIT LEVEL OR IN THE MEDICAL AND DENTAL PLAN BENEFIT LEVEL. MEMBERS ENROLLED IN THE MEDICAL PLAN ONLY BENEFIT LEVEL MAY ELECT TO ENROLL IN THE MEDICAL AND DENTAL PLAN DURING ANY OPEN ENROLLMENT PERIOD. ANY COVERED PERSON SELECTING THE MEDICAL AND DENTAL PLAN BENEFIT LEVEL SHALL ENROLL IN THE SAME CLASS FOR THE MEDICAL PLAN AND THE DENTAL PLAN.

Article VII.

Rate.

The Rate for this GovGuam Retiree Supplement Insurance Plan to include the services and benefits set out in Exhibit A and Exhibit B shall be for the semi-monthly rate of \$_____ for

Class I and \$_____ for Class II effective October 1, 2016 through September 30, 2017, and the optional Dental Plan shall be for the semi-monthly rate of \$_____ for Class I and \$_____ for Class II effective October 1, 2016 through September 30, 2017.