GOVERNMENT OF GUAM

and

NETCARE LIFE & HEALTH INSURANCE COMPANY

GOVGUAM RETIREE SUPPLEMENT PLAN

FOR THE PERIOD OF:

OCTOBER 1, 2017 – SEPTEMBER 30, 2018

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Bureau of Budget and
Management Research

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GOVERNMENT OF GUAM

And

NETCARE LIFE & HEALTH INSURANCE

GOVGUAM RETIREE SUPPLEMENT INSURANCE AGREEMENT

October 1, 2017 – September 30, 2018

Preamble

This Agreement is made effective by and between the GOVERNMENT OF GUAM ("GovGuam") and NetCare Life & Health Insurance Company ("Company"). The effective date of this Agreement is October 01, 2017.

Recitals

WHEREAS, Company is an insurance company duly licensed to do business in Guam; and

WHEREAS, Company is qualified to provide an insurance program designed for eligible GovGuam retirees spouses and survivors to supplement Medicare; and

WHEREAS, GovGuam selected Company to provide this insurance program to eligible GovGuam retired employees, spouses and survivors of retired employees who receive annuity benefits; and

WHEREAS, Company agrees to administer this insurance program, as hereinafter set forth, under a health insurance plan known as the "GovGuam Retiree Supplement Plan", and

WHEREAS, the parties wish to enter into an agreement defining their mutual rights and obligations.

NOW, THEREFORE, in consideration of the premises, mutual promises and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE 1

Preamble and Recitals

The preamble and recitals set forth above are hereby incorporated into and made a part of this Agreement.

ARTICLE 2

General Provisions

§2.1 **Definitions:** The following words and phrases shall have the following meanings, unless a different meaning is required by the context. Words in the singular shall include the plural unless the context indicates otherwise. These are general definitions and are not an indication of the existence of a benefit. The definitions shall control the interpretation of this Agreement, Enrollment forms, any identification cards, any supplements and the performance hereunder, unless the term is otherwise specifically defined or modified within a particular section of this Agreement, or defined in the attached Exhibits hereto.

2.1.1 **Accident:** Shall be defined as an event that is sudden and not foreseen, is exact as to time and place and which results in bodily injury.

2.1.2 **Agreement:** Shall be defined as the GovGuam Retiree Supplement Plan Agreement, an employee-sponsored plan, including the attached Group Health Certificate and Exhibits made a

part hereof.

2.1.3 **Ambulatory Surgical Center and/or Surgicenter:** Shall be defined as a legally operated institution or facility, either freestanding or part of a Hospital with permanent facilities, which a patient is admitted to and discharged from within a 24-hour period and which:

2.1.3.1 has continuous Physician and Nursing services whenever a patient is in the facility; and

2.1.3.2 has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and

2.1.3.3 is not a private office or clinic maintained by a Physician for the practice of medicine or dentistry or for the primary purpose of performing terminations of Pregnancy.

2.1.4 **Anesthesia Services:** Shall be defined as the administration of anesthetics to achieve general or regional anesthesia and related resuscitative procedures.

2.1.5 **Case Management:** Shall be defined as a process directed at coordinating resources and creating flexible, cost-effective options for catastrophically or chronically ill or injured individuals on a case by case basis to facilitate quality individualized treatment goals and improve functional outcomes. Case Management also includes providing any alternative medical or non-medical benefits to a Covered Person that are expected to be medically beneficial for the Covered Person but which may not be Covered Services under this Agreement. Services should be cost-effective and generally follow acceptable standards of evidence based medical practice. The Company may, in its discretion, provide said alternative benefits for a Covered Person's Illness or Injury in lieu of, or in addition to, Covered Services if:

2.1.5.1 The total cost of said alternative benefits does not exceed the total benefits payable for Covered Services;

2.1.5.2 The Covered Person's Physician recommends that the Covered Person receive said alternative benefits;

2.1.5.3 The Covered Person's Physician agrees that the recommended alternative benefits are expected to be beneficial for the treatment of the Illness or Injury; and

2.1.5.4 The services are prior authorized by the Company's Medical Management Department.

2.1.6 **Certificate:** Shall be defined as the GovGuam Retiree Supplement Plan Certificate attached hereto.

2.1.7 **Chemotherapy:** Shall be defined as remedial Services of a euplastic Illness or tumor by means of systemic cytotoxic agents or systemic hormonal agents.

2.1.8 **Chemical Dependency:** The pathological use or abuse of alcohol or other drugs in a manner, or to a degree, that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

2.1.9 **Cosmetic Procedure or Surgery:** Shall be defined as Services performed solely for the improvement of a Covered Person's appearance rather than for the improvement, restoration or correction of normal body functions.

2.1.10 **Covered Dependent:** Shall be defined as a Dependent eligible to receive benefits under the terms of this Plan.

2.1.11 **Covered Person:** Shall be defined as a person entitled to receive Covered Services pursuant to the Retiree Supplement Insurance Plan. A Covered Person shall reside in the Service Area, shall be a retiree of the Government of Guam, or a spouse of a retiree of the Government of Guam or a survivor of a retiree of the Government of Guam, and enrolled in Medicare Parts A & B, and eligible for Retiree Supplement Insurance Plan.

2.1.12 **Covered Services:** Shall be defined as Medically Necessary Services that are not specificallyexcluded from coverage by this Agreement and other Services which are specifically included.

2.1.13 **Dental Service:** Shall be defined as the act of:

2.1.13.1 adjusting, removing, or replacing teeth. The removing of wholly or partly unerupted impacted wisdom teeth shall be considered an oral surgical procedure; or

2.1.13.2 providing Services for teeth, gums, and related parts of the oral cavity; or

2.1.13.3 performing any other Services normally rendered by a Dentist.

2.1.14 **Dentist:** Dentist means a doctor of medical dentistry or dental surgery who is currently licensed to practice by the appropriate authority of the jurisdiction in which the person practices and who renders Services within the lawful scope of such license.

2.1.15 **Domicile:** Shall be defined as the place where a person has his or her true, fixed, and permanent home and principal establishment, and to which whenever that person is absent that person has the intention of returning. A person shall have only one domicile at a time.

2.1.16 **Durable Medical Equipment:** Shall be defined as equipment which is:

2.1.16.1 Able to withstand repeated use; and

2.1.16.2 Primarily and customarily used to serve an Illness or Injury; and

2.1.16.3 Not generally useful for a person in the absence of Illness or Injury.

2.1.17 **Eligible Charge(s):** Shall be defined as the portion of charges made to a Covered Person for Covered Services rendered which are payable to the Provider under this Agreement. For a Participating Provider, the Eligible Charges shall be the reimbursement amounts agreed to between the Company and the Participating Provider.

2.1.18 **Emergency:**

2.1.18.1 In general, an Emergency shall be defined as an Accidental Injury or an acute or serious medical condition of sudden or unexpected onset requiring immediate medical attention because any delay in treatment, in the opinion of the Physician, would seriously impair future treatment or result in permanent disability, a serious worsening of the condition, or irreparable harm to the Covered Person's health or endanger his or her life. Examples of Emergencies include, but are not limited to heart attack, severe hemorrhaging, loss of consciousness, convulsions and loss of respiration.

2.1.18.2 For purposes of compliance with the requirements of Section 2719A(b) of the PHSA,

as added by PPACA, a PPACA Emergency shall mean an injury or medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of an individual (including the health of a pregnant woman or her unborn child) in serious jeopardy, or to result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

2.1.18.3 PPACA Emergency Services shall mean services provided by the emergency department of a Hospital, including a medical screening examination, and also including ancillary services routinely available to the emergency department to evaluate such condition, and such further medical examination and treatment to stabilize the Covered Person as are within the capabilities of the staff and facilities available at the hospital.

2.1.18.4 Co-Insurance percentages and Co-Payment amounts for any PPACA Emergency Services provided by Non-Participating Providers shall not be greater than such percentages or amounts that would be applied to Participating Providers. The Company's payments for any PPACA Emergency Service shall not be more than the greater of:

2.1.18.4.1 The amount negotiated with Participating Providers for the PPACA Emergency Service (excluding any Co-Insurance or Co-Payment normally charged the Covered Person for such service when provided by Participating Providers); or

2.1.18.4.2 The amount calculated using the same method the Company generally uses under this Agreement to determine payments for such services when provided by Non-Participating Providers, but excluding any Co-Insurance or Co-Payment normally charged the Covered Person for such service when provided by Participating Providers; or

2.1.18.4.3 The amount that would be paid under Medicare (Part A or Part B) for the PPACA Emergency service, excluding any Co-Insurance or Co-Payment normally charged the Covered Person for such service when provided by Participating Providers.

2.1.19 **Enrollment:** Shall be defined as the acceptance, as of a specified date, of a written application for coverage under the Plan on forms provided by the Company.

2.1.20 **Experimental:** Shall be defined as all procedures and treatments not covered under the Medicare Program (Title XVIII of Social Security Act of 1965, as amended), unless otherwise specifically included or excluded under this Agreement.

2.1.21 **HIPAA:** Shall be defined as the Health Insurance Portability and Accountability Act of 1996, as amended (including amendments by PPACA), including all provisions codified at 42 U.S.C. §300gg, and the regulations promulgated thereunder.

2.1.22 **Home Health Care Agency:** Shall be defined as a public or private agency or organization, or part of one, that primarily provides Home Health Care Services and complies with the following requirements:

2.1.22.1 Is legally qualified in the state or locality in which it operates;

2.1.22.2 Keeps clinical records on all patients;

2.1.22.3 Services are supervised by a Physician or Nurse; and

2.1.22.4 Services provided by the Home Health Care Agency are based on policies established by associated professionals, which include at least one Physician and one Nurse.

2.1.23 **Home Health Care Plan:** Shall be defined as a program of Home Health Care established and approved in writing by the Covered Person's Physician for the provision of Home Health Care Services. The Physician shall state that confinement to a Hospital or Skilled Nursing Facility would be Medically Necessary for the treatment of the Covered Person's Injury or Illness if the Home Health Care Plan is not provided.

2.1.24 **Home Health Care:** Shall be defined as the Services set forth below, subject to all other exclusions and limitations set forth in this Agreement:

2.1.24.1 Part-time or intermittent home nursing Services from or supervised by a registered Nurse or a licensed practical Nurse;

2.1.24.2 Part-time or intermittent home health aide Services;

2.1.24.3 Physical therapy; and

2.1.24.4 Medical supplies, drugs and medications prescribed by a Physician, and laboratory Services to the extent that they would have been covered if provided or performed in a Hospital or Skilled Nursing Facility.

2.1.24.5 be a Covered Service, Home Health Service shall:

2.1.24.5.1 replace a needed Hospital or Skilled Nursing Facility stay;

2.1.24.5.2 be for the care or treatment of a Covered Person's illness or injury;

2.1.24.5.3 be ordered in writing by the Covered Person's Physician; and

2.1.24.5.4 be provided in the Covered Person's home (permanent or temporary) by a properly licensed Home Health Care Agency.

2.1.25 **Hospice:** Shall be defined as a coordinated plan of home and/or Inpatient Services, which treats a Terminally Ill patient and his or her family as a unit, focusing on providing comfort rather than on curing an illness. The plan provides Services to meet the special needs of the family unit during the final stages of a Terminal Illness and during bereavement. These services may include physical care, counseling, drugs, equipment and supplies for the terminal illness and related condition(s). Services are provided by a team made up of trained medical personnel, homemakers and counselors. The team acts under an independent hospice administration and helps the family unit cope with physical, psychological, spiritual, social and economic stress. Hospice is generally provided in the home, is not limited to people with cancer, and must be approved as meeting established standards, including but not limited to compliance with any licensing requirements of Guam, and the benefit period begins on the date the attending physician certifies that a covered member is terminally ill.

2.1.26 **Hospital:** Shall be defined as a medical institution which is operated in accordance with the laws of the jurisdiction in which the Hospital is located. The Hospital must, on an Inpatient basis, be primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, and treatment of injured and sick persons. These Services must be

provided by or under the supervision of Physicians and the institution must continuously provide twenty-four (24) hours a day Nursing Service by Nurses.

2.1.26.1 A Hospital may include a psychiatric or tuberculosis facility which satisfies the above requirements.

2.1.26.2 Any institution which is, primarily, a place for rest, a place for the aged, or a nursing home shall not be considered a Hospital for purposes of this Agreement.

2.1.27 **Injury:** Shall be defined as a condition caused by Accidental means that results in damage to the Person's body independently of Illness and is a result of an unexpected slip, fall, blow or other violent external force. Injury shall also include a scenario that is not unexpected or not Accidental if it constitutes a PPACA Emergency.

2.1.28 **Illness:** Shall be defined as a bodily disorder, disease, physical sickness, Pregnancy, Mental or Nervous Condition or congenital abnormality.

2.1.29 **Inhalation Therapy:** Shall be defined as remedial Services for an Illness or Injury by means of intermittent positive pressure breathing equipment.

2.1.30 **Inpatient:** Shall be defined as a Covered Person admitted to a Hospital, Skilled Nursing Facility or Hospice for a condition requiring confinement.

2.1.31 **Care Unit:** Shall be defined as a section, unit or area of a Hospital that is designated as an intensive care unit by the Hospital and is reserved and operated exclusively for the purpose of providing Services for critically ill patients.

2.1.32 **Maximum Annual Benefit:** Shall be defined as those benefits payable under this Agreement that have annual maximum limits for each Covered Person as shown in Exhibit A and B.

2.1.33 **Medically Necessary or Medical Necessity:** Shall mean services or supplies which, under the provisions of this Agreement, are determined to be:

2.1.33.1 appropriate and necessary for the symptoms, diagnosis or treatment of the Injury or Illness or dental condition;

2.1.33.2 provided for the diagnosis or direct care and treatment of the Injury or Illness or dental condition;

2.1.33.3 within standards of good medical or dental practice within the organized medical or dental community;

2.1.33.4 not primarily for the convenience of the Covered Person or of any Provider providing Covered Services to the Covered Person;

2.1.33.5 an appropriate supply or level of service needed to provide safe and adequate care;

2.1.33.6 within the scope of the medical or dental specialty, education and training of the Provider;

2.1.33.7 provided in a setting consistent with the required level of care; or

2.1.33.8 preventative Services as provided in the Plan.

2.1.34 **Medicare:** Shall be defined as Title XVIII (Health Insurance for the Aged) of the Federal Social Security Act, which includes Part A, Hospital Insurance Benefits for the Aged; Part B, Supplementary Medical Insurance Benefits for the Aged; and Part C, miscellaneous provisions regarding both programs, and also including any subsequent changes or additions to those programs.

2.1.35 **Medicare Supplement Insurance:** Shall mean private health insurance designed to supplement Medicare, which is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare, and meeting standards established by Section 1882 of the Social Security Act (42 USC §1395ss).

2.1.36 **Mental or Nervous Condition:** Shall be defined as a condition which includes neurosis, psychoneurosis, psychopathy, or psychosis or disease of any kind, in a degree which subsequently impairs the Covered Person's economic or social functioning; and shall, as required by the Parity In Health Insurance For Mental Illness and Chemical Dependency Act, Title 22, Guam Code Annotated, Chapter 28, include the definition of Mental Illness contained in said Act; and shall include, as required, relevant definitions found in the Mental Health Parity Act of 1996, Public Law 104-204.

2.1.37 **Network:** Shall be defined as the network of Participating Providers. Network may also be referred to as Plan Network.

2.1.38 **Nurse, Nursing, Nursing Services:** Shall be defined as a registered graduate nurse (RN), a licensed vocational nurse (LVN), or licensed practical nurse (LPN) who has received specialized Nursing training and experience and is duly licensed to perform such Nursing Services by the state or regulatory agency responsible for such licensing in the jurisdiction in which the individual performs such Services.

2.1.39 **Occupational Injury:** Shall be defined as an Injury arising out of, or in the course of, employment.

2.1.40 **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.

2.1.41 **Participating Providers, Non-Participating Providers, Providers and Network:**

2.1.41.1 Providers shall be defined as health care providers who are duly licensed in their jurisdiction and acting within the scope of their license. Such term shall include, without limitation, Physicians, Hospitals, ancillary health Services facilities and ancillary health care providers.

2.1.41.2 Participating Providers shall be defined as Providers who: (i) have directly, or indirectly through Company's agreements with other networks, entered into an agreement with the Company to provide the Covered Services; and (ii) are assigned from time to time by the Company to participate in the Network or any other network of Company pursuant to this Agreement.

2.1.41.3 Payment of claims to Providers: Claims shall be paid based on the agreements that Company has with its providers whenever the services are rendered by a participating provider.

2.1.42 **PHSA:** Shall mean the Public Health Service Act provisions that are part of HIPAA (as

defined above), some of which have been added to the PHSA by PPACA.

2.1.43 **Physician:** Shall be defined as a legally licensed medical doctor, Dentist, surgeon, chiropractor, osteopath, podiatrist (chiropodist), optometrist, or clinical Psychologist acting within the scope of his or her license. A Physician shall not include a medical resident, intern, fellow, Physician's assistant, social worker or master prepared therapist.

2.1.44 **Physician's Services:** Shall be defined as Medically Necessary professional Services provided by duly licensed Physicians including diagnosis, consultation, medical treatment, surgery, anesthesia, physical therapy, x-ray and laboratory services, diagnostic procedures such as electrocardiograms, electroencephalograms, and other services customarily provided by Physicians for patients. Experimental Services shall not be included within the scope of Physicians' Services.

2.1.44.1 Primary Care Services. Basic, routine or general health care services of individuals with common health problems and chronic illnesses that can be managed on an outpatient basis. Primary care is provided by primary care physicians, nurse practitioners, physician assistants and other mid-level practitioners.

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

2.1.45 **Physical Therapy:** Shall be defined as remedial Services for the treatment of an Injury or Illness by means of therapeutic massage and exercise; heat, light and sound waves; electrical stimulation; hydrotherapy; and manual traction.

2.1.46 **Plan:** Shall be defined as the GovGuam Retiree Supplement Insurance benefits provided in accordance with this Agreement.

2.1.47 **Plan Year:** Shall be defined as the twelve (12) month period during which GovGuam Retiree Supplement Insurance benefits are provided under this Agreement.

2.1.48 **PPACA:** Shall mean the Patient Protection and Affordable Care Act of 2010, as amended.

2.1.49 **PPACA Preventative Care Services:** Shall mean care required by Section 2713 of the PHSA, as added by PPACA, to be provided without cost-sharing.

2.1.49.1 Care considered PPACA Preventative Care shall be:

2.1.49.1.1 Evidence-based items or services that have in effect a rating of A or B in the most recently updated recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except that 2009 USPSTF recommendations regarding breast cancer screening, mammography, and prevention issued in or around November 2009 shall not be considered current for purposes of this provision; and

2.1.49.1.2 With respect to women, any additional evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

2.1.50 **Preferred Drug Formulary:** Shall be defined as those medications chosen by the Company for their safety, effectiveness and affordability. The Preferred Drug Formulary is subject to change during the Plan Year.

2.1.51 **Preferred Provider (Center of Excellence):** Preferred Provider shall be defined as a Participating Provider that is a Hospital or Ambulatory Surgical Center located outside of the Service Area. The Hospital or Ambulatory Surgical Center shall be a Participating Provider at the time Services are rendered to the Covered Person and shall be specifically designated by name as a Preferred Provider in the more recent of Company's most current member brochure or Company's most current updated provider directory.

2.1.52 **Premium:** Shall be defined as the dollar amount paid to the Company for the provision of this Plan to Covered Persons.

2.1.53 **Psychiatric Services or Psychoanalytical Care:** Shall be defined as Services provided for the treatment of a Mental or Nervous Condition.

2.1.54 **Psychologist:** Shall be defined as an individual holding the degree of Ph.D., licensed as a psychologist in the jurisdiction in which services are provided, and acting within the scope of his or her license.

2.1.55 **Registered Bed Patient:** Shall be defined as a Covered Person who has been admitted to a Hospital or a Skilled Nursing Facility or a Hospice upon the recommendation of a Physician for any Injury or Illness covered by this Agreement and who is confined by the Hospital, Skilled Nursing Facility or Hospice as an Inpatient.

2.1.56 **Room and Board:** Shall be defined as all charges, by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of providing Inpatient Services. Such charges do not include the professional Services of Physicians nor intensive, private duty Nursing Services by whatever name called.

2.1.57 **Semi-Private:** Shall be defined as a class of accommodations in a Hospital or Skilled Nursing Facility in which at least two (2) patient beds are available per room.

2.1.58 **Services:** Shall be defined as medical, dental or other health care services, treatments, supplies, medications and equipment.

2.1.59 **Service Area:** Shall be defined as Guam and the Commonwealth of the Northern Mariana Islands. Enrollment to this Plan is limited to individuals residing in the Service Area.

2.1.60 **Skilled Nursing Facility:** Shall be defined as a specially qualified and licensed facility that:

2.1.60.1 For a fee and on an Inpatient basis, provides 24 hour per day skilled Nursing services under the full-time supervision of a Physician or Nurse and provides physical restoration services for persons convalescing from an Injury or Illness; and

2.1.60.2 maintains daily clinical records; and

2.1.60.3 complies with legal requirements applicable to the operation of a skilled nursing institution; and

2.1.60.4 has transfer arrangements with one or more Hospitals; and

2.1.60.5 has an effective utilization review plan; and

2.1.60.6 is approved and licensed by the jurisdiction in which it operates.

2.1.61 **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.

2.1.62 **Subscriber:** Shall be defined as a Covered Person.

2.1.63 **Surgery and Surgical Services:** Shall be defined as Medically Necessary Services directly performed by a Physician in the treatment of an Injury or Illness which requires one or more of the following: cutting; suturing; diagnostic or therapeutic endoscopic procedures; debridement of wounds, including burns; surgical management or reduction of fractures or dislocation; orthopedic casting; manipulation of joints under general anesthesia; or destruction of localized lesions, cryotherapy or electrosurgery. The term "Surgery" does not include Dental Services, routine venipuncture or minor endoscopic examinations.

2.1.64 **Terminally Ill:** Shall be defined as a medical prognosis of limited expected survival of six (6) months or less at the time of referral to a Hospice of a Covered Person with a chronic, progressive Illness which has been designated by the Covered Person's attending Physician as incurable.

2.1.65 **Urgent Care:** Shall be defined as the delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis, without a scheduled appointment. Urgent care centers treat many problems that can be seen in a primary care physician's office, but urgent care centers offer some services that are generally not available in primary care physician's offices such as x-rays and minor trauma treatment.

§2.2 **PPACA Requirements:** It is the intent of this Agreement to provide, at a minimum, all of the benefits, rights and responsibilities afforded as a result of the Patient Protection and Affordable Care Act (Public Law 111-148), and the regulations promulgated under the authority of this Act, except for the benefits, rights and responsibilities as specifically excluded by GovGuam.

§2.3 **Guaranteed Renewability of Health Insurance Coverage:** In the event that GovGuam invokes the protection afforded by the Health Insurance Portability and Accountability Act of 1996, as amended, found at Section 2712 of the Public Health Services Act, and its regulations, for the guaranteed renewability of health insurance coverage the parties agree that coverage would be continued until a new contract is in place with the first ninety (90) days of coverage guaranteed at the same rate and plan designs.

ARTICLE 3

Services

§3.1 Company shall provide Covered Persons with the GovGuam Retiree Supplement Plan, subject to the applicable limitations and conditions, set forth in this Agreement and the attached Exhibits incorporated herein.

§3.2 Company shall provide Covered Persons with Additional Insurance Benefits coverage in the Philippines, 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 in the Group Health Certificate, incorporated herein, on a first dollar basis without deductible, and without co-payment.

§3.3 Company shall provide Covered Persons an Optional Dental Benefits Plan subject to the applicable limitations and conditions set forth in this Agreement and the Optional Dental Benefits Plan incorporated in the Group Health Certificate.

§3.4 Company shall pay the co-payments, deductibles, and co-insurance required by Medicare and treat Covered Person as having met the Out-of-Pocket maximum under the plan for purposes of receiving benefits under this Agreement.

ARTICLE 4

Rates and Premiums and Experience Participation

§4.1 **Rates.** Company shall provide the GovGuam Retiree Supplement Insurance benefits set forth in §3.1 and the Additional Insurance benefits set forth in §3.2 for the semi-monthly rate of $210.64 for Class I and $448.20 for Class II effective October 1, 2017 through September 30, 2018, and the optional Dental Plan set forth in §3.3 for the semi-monthly rate of $17.04 for Class I and $38.74 for Class II effective October 1, 2017 through September 30, 2018.

§4.2 **Premium Payment.** GovGuam shall pay the Premium due under this Agreement to Company within fifteen (15) business days after the close of each GovGuam pay period. Each such Premium payment shall be for the preceding pay period. Payment in full of all Premiums due constitutes a discharge of GovGuam's responsibility for the cost of benefits and administration provided under this Agreement. Should GovGuam fail to pay any Premium when due under this Agreement, Company shall have the right to suspend performance under this Agreement with respect to any Covered Person whose Premium payments have not been paid by GovGuam, in addition to the right of termination under Article 5.2.1 and Article 5.3. However, such suspension may only take place after Company provides written notice to GovGuam at least ten (10) days prior to the suspension stating the names of the Covered Persons at risk of suspension and the amount of Premium owed for each. Further, Company shall retroactively reinstate a Covered Person's right to benefits upon full payment of the past due Premiums only if the premiums are paid within 120 days after the notification of the suspension.

§4.3 **Experience Participation.** No later than January 31, 2019, the Company shall present to GovGuam an annual experience participation accounting, which will produce either a positive or negative balance after accounting for all incurred claims and the 14% of premium guaranteed retention for the Company, such experience participation to be determined as follows,

4.3.1 The term "Target Experience" shall mean the amount calculated by multiplying (a) the total Premiums earned by the Company for the full 12-month Plan Year ending September 30, 2018 under the HSA $2,000 deductible policy and the PPO $1,500 deductible policy issued to GovGuam with respect to such Plan Year (such two separate policies being referred to, collectively, as the "Participating Policies"), by (b) eighty-six percent (86%).

4.3.2 The "Actual Experience" shall be an amount calculated by subtracting from the Target Experience all claims incurred during such Plan Year under both the Participating Policies (i.e., Actual Experience = Target Experience (Total Premiums x 86%) minus incurred claims, the PPACA Insurance Company Fee or Tax and the PCORI fee).

4.3.3 To the extent the Actual Experience is positive (i.e., an amount greater than zero), such amount will be called an "Experience Refund," and the Company shall remit such amount to GovGuam for placement into the "Section 2718 Fund" established by Title 4, Guam Code Annotated, Section 4302.3 (P.L. 31-233:XII:18).

4.3.4 To the extent the Actual Experience is negative (i.e., an amount less than zero), the Company may add this amount to the premium needed for the Plan Year beginning on October 1, 2019, but only if the Company is the health insurance provider during such Plan Year.

4.3.5 This Experience Participation provision determines the combined Actual Experience of both the Participating Policies. Identical provisions, describing the combined calculation, are included in each of the Participating Policies for convenience, but the result of the combined calculation shall be applied only once. If necessary to determine the distribution of any positive or negative amount of Actual Experience between the two Participating Policies, such amount may be allocated between the two policies in any share, at the discretion of GovGuam, as long as the total of the shares is equal to the combined amount of the Actual Experience.

4.3.6 If PPACA's Minimum Loss Ratio ("MLR") requirements result in payment, from the Company to GovGuam, of a refund for either the 2017 or 2018 calendar year MLR calculations, any Experience Refund calculated above in section 4.3.3, will be reduced by the portion of the MLR refund payable to GovGuam and

applicable to the Participating Policies. The portion applicable to the Participating Policies is determined by multiplying the MLR refund by the ratio of the Participating Policies' earned premium in the calendar year to the total of the GovGuam earned premium in that calendar year. A hypothetical illustration is included in this agreement as Exhibit D.

ARTICLE 5

Term and Termination

§5.1 **Term.** The Agreement is for a one year term beginning October 1, 2017 and ending September 30, 2018, unless terminated for major default in services, given by written notice from GovGuam to Company not less than ninety (90) calendar days or unless modified by mutual agreement.

§5.2 **Termination.**

5.2.1 **By Company.** If GovGuam fails to make any Premium payment within fifteen (15) days after receipt of a written notice of non-payment from Company, Company may terminate this Agreement by providing at least fifteen (15) days prior written notice of termination to GovGuam and all Subscribers under this Agreement.

§5.3 **Individual termination.**

5.3.1 **Non-payment of Premium.** Company may, in accordance with the notice provisions contained in §5.2.1, terminate the coverage of one or more individual Covered Persons for non-payment of Premium without terminating this Agreement as to other Covered Persons for whom Premiums have been received by Company.

5.3.2 **Other Reasons.** Except for non-payment of Premiums, Company may only terminate a Covered Person as provided in Article 5 of the Group Health Certificate attached hereto.

5.3.3 **Review of Termination.** Any Covered Person whose coverage is terminated pursuant to this Section 5.3 shall be entitled to a review through the PPACA Claims Procedure set forth in this Agreement, if so requested.

§5.4 **Effect of Termination.** In the event of termination of this Agreement for a Covered Person, Company shall be responsible for providing the benefits contained in this Agreement up to the effective date of termination and GovGuam shall be responsible for payment of the Premiums up to said effective date.

ARTICLE 6

Enrollment

§6.1 **Regular Open Enrollment.** The parties to this Agreement shall establish one (1) open Enrollment period, which shall be the same period as for all Other Plans offering health insurance and/or health benefits programs to GovGuam. During such period GovGuam shall provide Company with the assistance and cooperation detailed in Article 8. Except as provided in §6.1.1, §6.2 and §6.3 below, the open Enrollment period is the only time during which current and potential Covered Persons shall be allowed to enroll in this Plan or to disenroll from this Plan. The effective date of such Enrollment or disenrollment shall be the effective date of this Agreement, unless otherwise specified by GovGuam in accordance with this Agreement, or unless otherwise required under HIPAA or Social Security Act of 1882.

6.1.1 **Special Open Enrollments.** If GovGuam holds a special open Enrollment during the Plan Year, Company shall participate in such special open Enrollment, unless otherwise agreed by the parties, or unless the Plan is no longer to be offered as of the entry date of the special open Enrollment period. If the special open Enrollment shall impact on rates, the parties shall negotiate an appropriate change prior to the participation of Company in such special open Enrollment.

§6.2 **Newly Eligible Persons.** Subject to §6.3, any individual who first becomes eligible to be a Covered Person outside the open Enrollment period, shall have thirty (30) days after the date on which he/she became eligible to become a Covered Person. The effective date of such Enrollment shall be as specified in §5.5 of the Certificate.

§6.3 **Otherwise Eligible.** Enrollment shall be restricted to only those occasions provided for in this Article 6 unless an individual is eligible for Enrollment under the HIPAA provisions allowing special enrollment rights. Enrollment shall be in accordance with HIPAA and PPACA requirements.

ARTICLE 7

Company's Responsibilities

§7.1 **Marketing.** Company shall print and provide necessary brochures, announcements, instructions, Enrollment forms, and certificates for Enrollment purposes and for distribution to potential Covered Persons. Company shall be responsible for the dissemination of information to potential Covered Persons regarding the Plan. Company shall provide agreed upon quarterly communication to members clearly defining the benefits of the current plans in place. Company will work directly with the Government of Guam to determine their needs in distribution, and type of communication desired.

§7.2 **Benefits to be Provided.** Company shall, in consideration of receipt of applicable Premiums, provide the benefits contained in this Agreement through the earlier of the effective date of a Covered Person's termination or the termination of this Agreement.

§7.3 **Financial and Medical Cost Information.** In accordance with Title 4 GCA, Section 4302 (b) and (g), Company shall provide GovGuam detailed claims utilization and cost information, and shall provide upon reasonable request, the most recent audited financial statements, experience data, and any other information pertaining to this Agreement. GovGuam may, upon reasonable notice of no less than fifteen (15) working days, audit Company to confirm the accuracy of the information provided specifically to the government of Guam book of business.

§7.4 **Confidential Information.** The parties hereto shall maintain the confidentiality of any and all medical records which shall be in their possession and control, and such information shall only be released or disseminated pursuant to the valid authorization of the Covered Person whose medical condition is reflected in such medical records or as shall be otherwise permitted under applicable law. Upon request and subject to applicable law, Company shall make available to GovGuam medical records to assure Covered Persons are receiving adequate and appropriate benefits in accordance with the Certificate.

§7.5 **Errors and Omission Insurance.** The Company shall use all reasonable efforts to secure and maintain current errors and omission liability insurance of at least One Million Dollars ($1,000,000) during the term of this Agreement.

§7.6 **Payment of Claims.** Company shall pay claims in accordance with the Guam Health Care Prompt Payment Act of 2000 and the applicable claims payment requirements of PPACA. Appeals of claim denials shall comply with applicable requirements of PPACA claim and external review requirements.

§7.7 **Notification.** Company shall fulfill the notice requirements of the Women's Health and Cancer Rights Act of 1998, and the Newborns' and Mothers' Health Protection Act of 1996, and shall be responsible for notice requirements applicable to PPACA requirements.

§7.8 **Termination Notification.** If the Company terminates this Agreement, Company shall provide notice announcing its termination at least fifteen (15) days prior to the date of termination on the Company's website, an ad in any of the local newspaper publications, and email to subscribers of the Company's Plan. Further, Company shall fully cooperate with GovGuam in transitioning Covered Persons to Other Plans.

§7.9 **Sole Source Provider.** If there is a Covered Service which is provided on Guam by only one provider who is not a Participating Provider, the eligible Charges for such services shall be as if the sole source provider were a participating provider.

§7.10 **Performance Guarantees.** Performance guarantees have the appropriate annual penalties listed by each guarantee as stated in Exhibit E with a maximum amount of $105,000 annually. The penalties, if any, are to be paid annually upon an annual review meeting within thirty (30) days after the end of the plan year.

§7.11 **Online Access Capabilities.** The Company shall provide, for the benefit of the Covered Person and GovGuam, the following online access capabilities:

7.11.1 Online access is available twenty-four (24) hours a day, seven (7) days a week in accordance with Section 508 standards of the Rehabilitation Act of 1973 as amended.

7.11.2 For the Covered Person, access to Personal Health Record ("PHR") to include historical health conditions, prescription medications, office visit summary and procedures where a medical claim has been filed.

7.11.3 For the Covered Person, access to record of medical and drug claims.

7.11.4 For the Covered Person, ability to verify eligibility.

7.11.5 Ability of Providers to submit claims through a separate portal rather than through Company's website for payment.

7.11.6 For the Covered Person, GovGuam, and Providers access to Schedule of Benefits, Member Handbooks and Provider Network Information.

7.11.7 For the Covered Person, ability to print PHR to federal compliance standard file formats or plain text file.

7.11.8 For the Covered Person, ability to print online membership cards.

7.11.9 For the Covered Person, access to interactive tools for researching health issues, treatments, and risk assessment tools for health conditions.

ARTICLE 8

GovGuam's Responsibilities

§8.1 **Marketing.** GovGuam shall give Company reasonable assistance and cooperation to enable Company to contact all sources of Enrollment, to disseminate all information, to distribute and post literature, to provide access to employees during working hours, to provide all employees' names and addresses, and to instruct department heads to provide Company's representatives reasonable opportunity for personal contact with employees, consistent with that given other GovGuam contracted health plans, for the purpose of explaining Company's Plan to GovGuam employees.

§8.2 **Responsible Persons.** GovGuam shall designate persons within each agency, department and branch, who shall be responsible for the handling of health insurance problems, Enrollment, and cancellations within their particular department. These designated persons shall be available to attend meetings on government time for the purpose of reviewing administrative procedures, and to assist in problem solving relating to this Agreement.

§8.3 **Personnel Changes.** GovGuam shall provide written notice to Company of terminations, resignations, department transfers, and the like, so that coverage can be terminated at the appropriate time.

GovGuam shall make available to Company a computer listing of each employee receiving an applicable payroll deduction for Premiums no later than fifteen (15) working days following each pay period.

8.3.1 **Individual with Questionable Status.** If GovGuam does not provide the list of employees as required in §8.3, Company shall have the right to charge an individual whose Enrollment is in question for any Covered Services rendered prior to receipt of written verification of eligibility and Enrollment by GovGuam. If such individual is subsequently determined to be a Covered Person, and GovGuam remits a Premium payment for the Covered Person for the period for which the Covered Services were rendered, Company shall cancel all charges to the Covered Person and return any amounts collected. If Company files a written objection to an Enrollment list forwarded by GovGuam, then within thirty (30) days after the filing, GovGuam shall provide Company with the applicable change of status forms, Enrollment cards, and other documentation substantiating the accuracy of the Enrollment records and meet with Company to reconcile any differences. Evaluation of such individual's entitlement shall be handled in accordance with PPACA's applicable Claims Procedure requirements, taking into account any applicable PPACA prohibition on rescissions and any applicable PPACA requirement that costs of care be provided or continued during evaluation period

§8.4 **No restrictions on Enrollment.** GovGuam shall place no restriction or limitation on the percentage or number of Enrollments in the Plan.

ARTICLE 9

Covered Person's Responsibilities

§9.1 **Acceptance.** By Enrolling in the Plan, all Covered Persons agree to the terms, provisions and conditions of this Agreement.

§9.2 **Continued Residency.** Except as specifically stated in this Agreement, Enrollment in the Plan shall be limited to Covered Persons domiciled in the Service Area, and who do not reside outside the service area for more than one hundred eighty-two (182) days per plan year, Company shall 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. For a Covered Person Domiciled in the Service Area, time spent receiving continuous medical Services out of the Service Area shall not count toward the one hundred eighty-two (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 one hundred eighty-two (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 of care out of the Service Area.

§9.3 **Continued Enrollment in Medicare.** Covered Person agrees to be continuously enrolled in Medicare Parts A (Hospital) & B (Medical) for the entire benefit year (Oct. 1, 2017 - Sept. 30, 2018).

ARTICLE 10

Notices

§10.1 **Address of Record.** For the purpose of communication and services of notice under this Agreement, the parties' addresses are as follows:

To: NetCare Life & Health Ins. Co.
424 W. O'Brien Dr., Ste. 200
Hagatna, Guam 96910

To: GovGuam
Director
Department of Administration
Government of Guam
590 S. Marine Corps Dr., Ste. 224
Tamuning, Guam 96913

ARTICLE 11

Dispute Resolution

§11.1 **Mandatory Disputes Resolution Clause (As amended but consistent with 2 GAR Div. 4 § 9103(g) and applicable law).** GovGuam and the Company agree to attempt resolution of all controversies which arise under, or are by virtue of, this Agreement through mutual agreement. If the controversy is not resolved by mutual agreement, then the Company shall request GovGuam in writing to issue a final decision within sixty days after receipt of the written request. If GovGuam does not issue a written decision within sixty days after written request for a final decision, or within such longer period as may be agreed upon by the parties, then the Company may proceed as though GovGuam had issued a decision adverse to the Company. GovGuam shall immediately furnish a copy of the decision to the Company, by certified mail with a return receipt requested, or by any other method that provides evidence of receipt. GovGuam's decision shall be final and conclusive, unless fraudulent or unless the Company appeals the decision. This subsection applies to appeals of GovGuam's decision on a dispute. For money owed by or to GovGuam under this Agreement, the Company shall appeal the decision in accordance with the Government Claims Act by initially filing a claim with the Office of the Attorney General no later than eighteen months after the decision is rendered by GovGuam or from the date when a decision should have been rendered. For all other claims by or against GovGuam arising under this Agreement, the Office of the Public Auditor has jurisdiction over the appeal from the decision of GovGuam. Appeals to the Office of the Public Auditor must be made within sixty days of GovGuam's decision or from the date the decision should have been made. The Company shall exhaust all administrative remedies before filing an action in the Superior Court of Guam in accordance with applicable laws. The Company shall comply with GovGuam's decision and proceed diligently with performance of this Agreement pending final resolution by the Superior Court of Guam of any controversy arising under, or by virtue of, this Agreement, except where the Company claims a material breach of this Agreement by GovGuam. However, if GovGuam determines in writing that continuation of services under this Agreement is essential to the public's health or safety, then the Company shall proceed diligently with performance of the Agreement notwithstanding any claim of material breach by GovGuam.

ARTICLE 12

Governing Law

The rights and responsibilities of the parties and their respective officers, directors, employees, agents and representatives under this Agreement and their performance hereunder shall be governed by the laws of Guam.

ARTICLE 13

Miscellaneous

§13.1 **Government Laws and Regulation.** Company guarantees the negotiated rates shall remain in effect for the Plan Year. However, if during such year the Government of the United States or GovGuam enacts statutes or promulgates regulations which (i) require that the Company offer different coverage to Covered Persons than that specifically provided in this Agreement; or (ii) causes an increase or decrease in Provider rates or other costs, the parties reserve the right on thirty (30) days written notice to the other to adjust the Premiums if the parties mutually determine that such mandate or law shall change Company's costs under this Agreement by more than five percent (5%). Where the Agreement indicates that a PPACA requirement might override a specific limitation, this section 13.1 shall apply if it is determined that a PPACA override is in fact required.

§13.2 **Contingent Fee Warranty.** Company warrants that it has not retained anyone to solicit or secure this Agreement for payment of a commission, percentage, brokerage, or contingent fee, except for Company's bona fide employees or any bona fide established commercial selling agencies which Company may disclose to GovGuam.

§13.3 **Gratuity Warranty.** Company warrants that it has not violated, is not violating, and promises it shall not violate the prohibition against gratuities and kickbacks set forth in Guam Procurement Regulations at Title 2, GAR, Div. 4 §11107.

§13.4 **Personal Interest Disclaimer.** Company warrants that no member of any governing body of any agency of GovGuam and no officer, employee, or agent of GovGuam who exercises any functions or responsibilities in connection with the work to which this Agreement pertains has or shall have any personal interest, direct or indirect, in this Agreement, except that such members, officers or employees may be Covered Persons under the Plan. Company further warrants that no member of the Guam Legislature and no other official of GovGuam who exercises functions and responsibilities in connection with the work to which this Agreement pertains has or shall have any personal interest, direct or indirect, in this Agreement except as possible Covered Persons under the Plan.

§13.5 **Captions.** The captions, section numbers and article numbers and marginal notes appearing in this Agreement or in any copies of this Agreement are placed there only as a matter of convenience and in no way define, limit, or describe the scope or intent of this Agreement.

§13.6 **Waiver.** The waiver of any breach of this Agreement by either party shall not be deemed a waiver of any other breach or a waiver of any subsequent breach of the same nature.

§13.7 **Excused Non-Performance.** The parties' performance hereunder shall be excused when the failure of performance is caused by fire, explosion, acts of God, civil disorder, war, riot or other event not reasonably within the control of the party.

§13.8 **Entire Agreement.** This Agreement, including the Group Health Certificate and Exhibits, is the entire Agreement between the parties. There are no terms or obligations other than those contained herein applicable to this Agreement. This instrument shall supersede all previous communications or representations, whether verbal or written between the parties.

§13.9 **Amendment.** This Agreement may only be amended upon the written consent of both parties.

§13.10 **Time of Essence.** Time is expressly made of the essence in this Agreement and for performance hereunder.

§13.11 **Limitation of Actions.** Any action in relation to this Agreement must be brought no later than one (1) year from the time such claim arises or should have been reasonably discovered.

§13.12 **Third Party Rights.** Nothing in this Agreement, whether expressed or implied, is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the parties to this Agreement and their respective successors and assigns.

§13.13 **Successors in Interest.** Each and all of the covenants, conditions, and restrictions in this Agreement shall inure to the benefit of and shall be binding upon the assignees and successors in interest of Company. However, Company shall not be entitled to assign its interest in this Agreement, or any prior or future agreement with GovGuam, without the express written consent of GovGuam.

§13.14 **Severability.** If any term or provision of this Agreement or the application thereof shall to any extent be determined to be invalid or unenforceable, the remainder of this Agreement or the application of such remainder, other than as held invalid or unenforceable, shall not be affected and each term and condition of this Agreement shall be valid and be enforceable to the fullest extent permitted by law.

§13.15 **Counterparts.** This Agreement, including the Group Health Certificate and Exhibits may be executed by the parties in several counterparts, each of which shall be deemed to be an original copy.

§13.16 **Legal Compliance.** Company shall comply with applicable federal and local statutes and regulations, including the certification requirements of HIPAA and applicable requirements of PPACA and the PHSA. To the extent not preempted by the laws of the United States, this Agreement will be construed in accordance with and governed by the laws of Guam. In the event of conflict between any provision of this Agreement and applicable law, the law shall govern.

§13.17 **Determination of Currency Exchange Payments.** When a service is rendered outside of the United States, the claims shall be paid in accordance with Company's agreements with its participating providers. Claims for nonparticipating providers will be reimbursed using the Philippines fees as a reference. Additionally, claims incurred outside of the United States will be based on the date of service and will be converted according to the conversion rate, for cash transactions, against the U.S. Dollar as found in XE.com and for credit card transactions, against the utilized specific conversion rate for the card used. For multiple dates of service, the rate will be calculated based on the last date of service or payment, whichever is earlier in time.

§13.18 **Restriction Against Contractor Employing Sex Offenders to Work at Government of Guam Venues**. The Company warrants that no person convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated, or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated, in Guam, or an offense in any jurisdiction which includes, at a minimum, all of the elements of said offenses, or who is listed on the Sex Offender Registry, shall work for the Company on property of the government of Guam other than a public highway. Further, the Company warrants that if any person providing services on behalf of the Company is convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated or an offense in another jurisdiction with, at a minimum, the same elements as such offenses, or who is listed on the Sex Offender Registry, that such person will be immediately removed from working at such agency and that the administrator of said agency be informed of such within twenty-four (24) hours of such conviction.

§13.19 **Ethical Standards.** With respect to this Agreement and any other contract the Company may have, or wish to enter into, with any government of Guam agency, Company represents that it has not knowingly influenced, and promises that it will not knowingly influence, any government employee to breach any of the ethical standards set forth in the Guam Procurement Law and in any of the Guam Procurement Regulations.

§13.20 **Minimum Wages As Determined by U.S. Government.** Company agrees to comply with Title 5, Guam Code Annotated, Sections 5801 and 5802. In the event that Company employs persons whose purpose, in whole or in part, is the direct delivery of service contracted by the Government, then the Company shall pay such employees, at a minimum, in accordance with the U.S. Department of Labor Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands in effect on the date of this Agreement. In the event that this Agreement is renewed by the Government and the Contractor, at the time of the renewal, Company shall pay such employees in accordance with the Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands promulgated on a date most recent to the renewal date. Company agrees to provide employees whose purpose, in whole or in part, is the direct delivery of service contracted by the Government those mandated health and similar benefits having a minimal value as detailed in the U.S. Department of Labor Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands, and guarantee such employees a minimum of ten (10) paid holidays per annum per employee.

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*****SIGNATURE PAGE FOLLOWS*****

18-0367

IN WITNESS WHEREOF, GovGuam and Company have signed this Agreement on the aforementioned date.

NetCare Life & Health Insurance Co.

By: _____
Troy K. Moylan
VP & Director

Date: 8/15/18

Government of Guam

By: _____
Director, Department of Administration

Date: 8/16/18

By: _____
Acting Insurance Commissioner,
Department of Revenue & Taxation

Date: 8/20/18

Effective Date:

October 1, 2017

8/23/18

CLEARED PER BBMR'S REVIEW

By: _____
LESTER L. CARLSON, JR.
Deputy Director BBMR

VS 8/23/18

Date: AUG 24 2018

Approved as to Legality and Form:

By: _____
Attorney General

Date: 8/31/18

DOA 18-0367

By: _____
The Honorable Raymond S. Tenorio
Lieutenant Governor of Guam

Date: 9/21/2018

DEPARTMENT OF ADMINISTRATION
DIVISION OF ACCOUNTS
Registration Date 09/21/2018
Registration No. C18DGU019
Vendor No. N0018481
Registered By: 10/08/2018

RECEIVED
AUG 21 2018
Bureau of Budget and Management Research

GOVERNMENT OF GUAM

and

NETCARE LIFE & HEALTH INSURANCE

GROUP HEALTH CERTIFICATE

GOVGUAM RETIREE SUPPLEMENT INSURANCE

This Certificate, including Exhibits, describes the retiree supplemental 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 D, '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 intraperiotoneal.

§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.

§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.

2.13.1A 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 on 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 wit 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.

- Prescribed specialty medications purchased at retail pharmacies are limited to Kmart Pharmacies on Guam and Hawaii.

§2.16 **Health education.** Charges for health education classes and materials in accordance with Exhibit C 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.

§2.18 **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.

§2.19 **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.

§2.20 **Tubal ligation.** The charges for tubal ligations.

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

§2.22 **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.

§2.23 **Blood products.** Charges for blood and blood products and their administration.

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

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

2.25.1 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.

2.25.2 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.

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

2.25.3.1 Company shall pay 100% of these services.

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

2.25.3.3 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

2.25.3.4 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 level of care required is NICU Level III, 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

2.25.3.5 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.

2.25.3.6 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

2.25.3.7 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.

2.25.3.8 Company shall facilitate the Hospital/Physician arrangements for the covered Person.

2.25.3.9 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.

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

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

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

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

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

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

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

§2.26 **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.

§2.27 **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 §6.7, 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 catherization
- 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 grievance procedure provided in the Agreement. If a grievance is filed, the resolution of the matter shall be in accordance with the outcome of the grievance proceedings. If no grievance 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 will be paid for Services and supplies provided to a dependent of a non-Spouse Dependent. Dependents of non-Spouse Dependents are not eligible for coverage. For example, when a Dependent other than a Spouse of the Subscriber, has a child, that child is a dependent of a non-Spouse Dependent and is not eligible to become covered under the Plan, unless such child otherwise becomes eligible for enrollment.

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

§4.16 No benefits will be paid for services performed by an immediate family member for whom, 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.

§4.17 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

§4.18 No benefits will be paid for:

4.18.1 Drugs or substances not approved by the Food and Drug Administration (FDA), or

4.18.2 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

§4.19 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 treatments and procedures or pharmacological regimes, unless deemed medically necessary by the patient's physician, and pre-authorized by the Company.

Experimental and investigational treatments and procedures are those medical treatments and procedures that have not successfully completed a Phase III trial, have not been approved by the FDA and are not generally recognized as the accepted standard treatment for the disease or condition from which the patient suffers.

Experimental and investigational treatments include off label therapies. Off-label therapies are those medical therapies that use a FDA approved drug or procedure for a non-indicated use. Also, these Experimental or investigational medical and surgical procedures, equipment, and items or medications, are otherwise not covered by Medicare or covered under qualifying clinical trials.

§4.20 No benefits will be paid for services or supplies related to Genetic Testing. 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 sequelae of such surgery or treatment.

§4.21 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.

§4.22 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.

§4.23 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 (Osseo integration) and all related services, removal of impacted teeth, bite plates, orthognathic surgery to correct a bit defect. This exclusion does not apply to:

4.23.1 To procedures deemed medically necessary by patient's physician and pre-authorized by Company.

4.23.2 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.

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

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

§4.24 No benefits will be paid in connection with elective abortions unless Medically Necessary.

§4.25 No benefits will be paid for vision care services and supplies, 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 in connection with any injuries sustained while the Covered Person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.

§4.27 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.

§4.28 No benefits will be paid for hypnotherapy.

§4.29 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.

§4.30 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:

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

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

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

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

§4.31 No benefits will be paid for routine foot/hand care, including routine reduction of nails, calluses and corns.

§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 in connection with 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

4.39.11Any 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:

4.40.1 equipment and supplies used in a Hospital or Skilled Nursing Facility, or in conjunction with an approved Hospital or Skilled Nursing Facility confinement, or as otherwise noted in the Agreement.

4.40.2 items covered as preventive care under well-women coverage such as breastfeeding supplies in accordance with reasonable medical management techniques

§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 husband or wife; 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 the 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.** 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.

5.5.1 Enrollment During an Open Enrollment Period. An eligible individual may enroll in the Plan and may cause his or her Dependents to become Enrolled, during an open Enrollment period.

5.5.2 Enrollment After Open Enrollment Period. Persons becoming eligible for Enrollment after completion of the 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 §5.6.3.3, 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 §5.6.3.3, 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 or 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

5.6.1 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.

5.6.2 Not yet Enrolled. As of the first day following the pay period in which the individual satisfies the Enrollment requirements 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.

5.6.3 Except as provided in §5.6, coverage of a Dependent of a Subscriber who becomes 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. applicable Premium is paid.

5.6.4. Open Enrollment period. For any eligible individual and his or her eligible Dependents who apply 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 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 terminating GovGuam employment, or 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 Medicare 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.** 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 §5.19 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: NetCare Life & Health Insurance, 424 West O'Brien Drive, Ste. 200, Hagatna, Guam 96910 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 & Appeal Procedure is reflected in Exhibit F.

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.

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

5.20.1.4 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 form 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 optional 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 §6.7.1 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 §6.7.1 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 §6.7.2 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 §6.7.2 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 §6.7.3 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 §6.7.3 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.

6.7.2.3 Routine fillings (amalgam and composite resin).

6.7.2.4 Simple extractions.

6.7.2.5 Complicated extractions.

6.7.2.6 Extraction of impacted teeth.

6.7.2.7 Periodontal prophylaxis (cleaning and polishing once every six months).

6.7.2.8 Periodontal treatment.

6.7.2.9 Pulpotomy and root canals (endodontic surgery and care).

6.7.2.10 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.

6.7.3.2.3 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 the enrollee 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 stress.

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 enrollee 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, unless prescribed by a dentist or physician.

6.11.1.12 Fluoride varnish.

6.11.1.13 Charges for finance charge, 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 Surgical grafting procedures.

6.11.1.18 General anesthetic, conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein., unless deemed medically necessary by patient's dentist or physician and pre-authorized by Company.

6.11.1.19 Services paid for by Workers' Compensation.

6.11.1.20 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.

6.11.1.21 Treatment and/or removal of oral tumors.

6.11.1.22 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.

6.11.1.23 Panoramic x-ray or full mouth 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.

Rates

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 $210.64 for Class I and $448.20 for Class II effective October 1, 2017 through September 30, 2018, and the optional Dental Plan shall be for the semi-monthly rate of $17.04 for Class I and $38.74 for Class II effective October 1, 2017 through September 20, 2018.

EXHIBIT A
RETIREE SUPPLEMENTAL PLAN

GOVGUAM RSP

WHEN YOU GO TO A PARTICIPATING PROVIDER		
YOUR BENEFITS: WHAT NETCARE COVERS	**RETIREE SUPPLEMENTAL PLAN (RSP) PAYS[1]**	**MEMBER PAYS AT PARTICIPATING PROVIDER**
OUT OF AREA SERVICES Covered services outside Guam include but not limited to Philippines, Hawaii, Japan, Taiwan, U.S. Mainland and other foreign participating providers. Pre-Certification required.	A NetCare approved pre-certification is required for all services outside Guam.	
PLAN MAXIMUM	Unlimited	

PREVENTIVE SERVICES	RSP PAYS	MEMBER PAYS
PREVENTIVE SERVICES (Outpatient Only) In accordance with guidelines established by the USPSTF Grades A & B, and PPACA. 1. Annual Routine Physical Exam 2. Preventive Laboratory Service 3. Counseling and Health Screenings 4. Philippine Annual Routine Physical Exam • May choose age appropriate physical exam with no dollar limit • Includes preventive lab tests	Nothing	Nothing
IMMUNIZATIONS/VACCINATIONS In accordance with guidelines established by the Advisory Committee on Immunization Practices	Nothing	Nothing
WELL-WOMAN CARE In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA) and the Women's Health and Cancer Act	Nothing	Nothing

BENEFITS & SERVICES	RETIREE SUPPLEMENTAL PLAN (RSP) PAYS[1]	MEMBER PAYS AT PARTICIPATING PROVIDER
ANNUAL EYE EXAM One Exam per Member per Plan Year	Plan Pays 100% Covered on Guam only	Nothing
OUTPATIENT PHYSICIAN CARE & SERVICES		
1. Primary Care Visit	20% co-insurance	Nothing
2. Specialist Care Visit	20% co-insurance	Nothing
3. Voluntary Second Surgical Opinion	20% co-insurance	Nothing
4. Home Health Care Visit	Nothing	Nothing
5. Hospice (Pre-Certification Required) • Guam only • Maximum 180 days • Maximum $150/day	80% co-insurance	20% co-insurance
6. Outpatient Laboratory (diagnostic or non-preventive labs)	Nothing	Nothing
7. X-ray Services	Medicare Part B deductible then 20% co-insurance	Nothing
8. Injections (Does not include those on the Specialty Drug List and Orthopedic Injections)	20% co-insurance	Nothing
9. Urgent Care Visit	Medicare Part B deductible then 20% co-insurance	Nothing
PRESCRIPTION DRUGS		
1. Formulary Generic Drugs (per prescription unit)	Plan Pays 100% after member co-pay	$15 Co-Pay (30 day supply)
2. Formulary Brand Name Drugs (per prescription unit)	Plan Pays 100% after member co-pay	$30 Co-Pay (30 day supply)
3. Mail Order Drugs	Plan Pays 100% after member co-pay	$0 Co-Pay (90 day supply)
4. Non-Formulary Drugs (Medically Necessary and Pre-Certification Required)	Plan Pays 100% after member co-pay	$60 Co-Pay (30 day supply)
5. Specialty Drugs[1] (Medically Necessary and Pre-Certification Required)	Plan Pays 100% after member co-pay	$100 Co-Pay (30 day supply)
ACUPUNCTURE 30 visits per member per plan year	Plan pays 80%	Member pays 20%
AIDS TREATMENT Exclusive of Experimental drugs	Plan pays 80%	Member pays 20%

		GOVGUAM RSP
BENEFITS & SERVICES	**RETIREE SUPPLEMENTAL PLAN (RSP) PAYS[1]**	**MEMBER PAYS AT PARTICIPATING PROVIDER**
AIRFARE BENEFIT TO CENTERS OF CARE Members must meet qualifying conditions. The Plan provides roundtrip airfare upon required Plan approval.	Plan Pays 100%	Nothing
ALLERGY TESTING $1,000 per member per plan year	Plan pays 80%	Member pays 20%
AMBULATORY SURGI-CENTER CARE (Pre-Certification Required)	Plan pays 80%	Member pays 20%
BLOOD & BLOOD DERIVATIVES	Plan pays 80%	Member pays 20%
BREAST RECONSTRUCTIVE SURGERY In accordance with 1998 W.H.C.R.A. (Pre-Certification Required)	Plan pays 80%	Member pays 20%
CARDIAC SURGERY (Pre-Certification Required)	Plan pays 80%	Member pays 20%
CATARACT SURGERY (OUTPATIENT) Includes Conventional Lens	Plan pays 80%	Member pays 20%
CHEMICAL DEPENDENCY	Plan pays 80%	Member pays 20%
CHEMOTHERAPY BENEFIT (Pre-Certification Required)	Plan pays 80%	Member pays 20%
CHIROPRACTIC CARE 30 Visits per Member per plan year	Plan pays 80%	Member pays 20%
CLINICAL TRIALS Routine costs in relation to treatment of cancer or other life-threatening disease or condition as approved by the National Institute of Health or in case of cancer, the National Cancer Institute. (Pre-Certification Required)	Plan Pays 80%	Nothing
CONGENITAL ANOMALY DISEASES COVERAGE (Pre-Certification Required)	Plan pays 80%	Member pays 20%
DIAGNOSTIC TESTING (Pre-Certification Required) MRI, CT Scan, Ultrasound and other diagnostic procedures	Plan pays 80%	Member pays 20%
DURABLE MEDICAL EQUIPMENT (DME) The lesser amount between the purchase or rental when prescribed by a Physician. (Pre-Certification Required) • Crutches • Suction Machine • Walker • CPAP Machine • Nebulizer Machine • Wheelchair • Hospital Beds • Oxygen (includes accessories)	Plan pays 80%	Member pays 20% of the total rental cost or purchase
ELECTIVE SURGERY (Pre-Certification Required)	Plan pays 80%	Member pays 20%
EMERGENCY CARE Plan must be contacted and advised within 48 hours for off-island emergencies 1. On/Off Island emergency facility, physician services, laboratory, x-rays 2. Ambulance Services (Ground Transportation Only)	Plan pays 80%	Member pays 20%
END STAGE RENAL DISEASE / HEMODIALYSIS (Pre-Certification Required)	Plan pays 80%	Member pays 20%
HEARING AIDS Maximum $500 per member per plan year	Plan pays 80%	Member pays 20%
HOSPITALIZATION & INPATIENT BENEFITS 1. Room & Board for semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room anesthesia and medication. 3. Physician's Hospital Services	Plan pays 80%	Member pays 20%
HYPERBARIC OXYGEN THERAPY & WOUND CARE Medically necessary. (Pre-Certification Required)	Plan pays 80%	Member pays 20%
IMPLANTS (Pre-Certification Required) Limitations apply, please refer to contract. Limited to the following: • Cardiac Pacemakers • Intraocular Lens • Heart Valves • Orthopedic Internal Prosthetic Devices • Stents	Plan pays 80%	Member pays 20%

BENEFITS & SERVICES	RETIREE SUPPLEMENTAL PLAN (RSP) PAYS[1]	GOVGUAM RSP MEMBER PAYS AT PARTICIPATING PROVIDER
INHALATION THERAPY	Plan pays 80%	Member pays 20%
MENTAL HEALTH CARE (OUTPATIENT)	Plan Pays 100% after member co-pay	Member pays $20
NUCLEAR MEDICINE (Pre-Certification Required)	Plan pays 80%	Member pays 20%
OCCUPATIONAL THERAPY 20 visits per member per plan year (Pre-Certification Required)	Plan pays 80%	Member pays 20%
ORGAN TRANSPLANT (Pre-Certification Required) Coverage includes but not limited to: • Heart • Kidney • Bone Marrow • Lung • Pancreas • Cornea • Liver • Intestine Benefits include coverage for the organ donor	Plan pays 80%	Member pays 20%
ORTHOPEDIC CONDITIONS Internal and External Prosthesis (Pre-Certification Required)	Plan pays 80%	Member pays 20%
PHYSICAL THERAPY (Pre-Certification Required)	Plan pays 80% for the first 20 visits and 50% thereafter	Member pays 20% for the first 20 visits and 50% thereafter
RADIATION THERAPY (Pre-Certification Required)	Plan pays 80%	Member pays 20%
ROBOTIC SURGERY/ROBOTICS SUITE (Pre-Certification Required)	Plan pays 80%	Member pays 20%
SKILLED NURSING FACILITY Maximum 60 Days per Member per plan year (Pre-Certification Required)	Plan pays 80%	Member pays 20%
SLEEP APNEA Diagnostics and Therapeutic Procedure (Pre-Certification Required)	Plan pays 80%	Member pays 20%
SPEECH THERAPY 20 visits per member per plan year. (Pre-Certification Required)	Plan pays 80%	Not Covered
STERILIZATION PROCEDURES Vasectomy (Outpatient Only)	Plan pays 80%	Member pays 20%
VISION HARDWARE • Eye Glasses/Lenses • Contact Lenses	Plan pays 100% up to $150 per Contract Period	

ADDITIONAL BENEFITS: What the Plan Covers	RETIREE SUPP PLAN PAYS	MEMBER PAYS
WELLNESS AND FITNESS BENEFITS Limited to Employee & dependent ages 18 years above. 1. Wellness Benefit at a Wellness Center Member co-insurance may be reimbursed upon program completion (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Not Covered
2. Healthy Fit • Gym Enrollment • Plan pays a monthly reward based on gym attendance of eight (8) monthly required visits, any gym anywhere	Plan pays 100% only at Participating Facilities Plan pays up to $360 Cash Reward per Contract Period	
3. Healthy Actions Rewards • Completion of NetCare's Health Risk Assessment - $25 • Completion of an Annual Physical Exam/Health Screening - $25 • Completion of a Smoking Cessation Program or Wellness Program - $25 • Completion & attendance at a GovGuam sponsored Health Fair - $25 • Monthly participation in an organized sporting or fitness event, activity, class or program as defined by NetCare at a minimum participation of three (3) times per month within the Contract Period.	Plan pays up to $200 Cash Reward per member per Contract Period	
4. Healthy Outcome Rewards (Know Your Numbers)[2] • Blood Pressure reading must be no greater than 120 over 80 • Hemoglobin A1c Test for diabetes - level between 4.0% -6.4% • Body Mass Index (BMI) between 18.5 - 24.9 based on height and weight • Cholesterol Screening with LDL of less than 100-130 mg/dL or Triglycerides less than 150 mg/dL	Plan pays $200 Cash Reward per member per Contract Period when all criteria's are met	Not Covered
TRAVEL ALLOWANCE Members must meet qualifying criteria for Airfare Benefits. Travel Allowance is limited to Philippine travel, one allowance per member per Contract Period.	Plan pays $500	Not Covered

ADDITIONAL INFORMATION

* ELIGIBLE CHARGE Shall be defined as the portion of charges made to a Covered Person for Covered Services rendered which are payable to the Provider under this Agreement. For a Participating Provider, the Eligible Charges shall be the reimbursement amounts agreed to between NetCare and the Participating Provider. For a Non-Participating Provider, Eligible Charges for covered medical services rendered by a physician, who is not a Participating Provider, shall be based on the Usual, Customary and Reasonable (UCR) charge that is limited to the lesser of: (a) the actual charge made by the provider, or (b) in the United States, Context 4 Fee Schedule based on the geographic area where the service was rendered; or (c) in Asia, the lesser of the amount billed or the fees most recently contracted by NetCare at St. Lukes Medical Center, Manila, Philippines, or (d) elsewhere, the Medicare National Standard Fee.

** AVERAGE WHOLESALE PRICE (AWP) is widely accepted as a basis for determining drug reimbursement and pricing. It is defined as the most common price that a pharmacy would pay a wholesale to purchase a specified quantity of a product.

[1] If a benefit is covered by Medicare, this RSP will cover your Part A and Part B deductible plus the 20% coinsurance. If a benefit is NOT COVERED by Medicare for services at a Medicare participating provider, this RSP will cover the coinsurance listed in the column "Retiree Supplemental Plan Pays" of this Schedule of Benefits upon receipt of a Medicare Explanation of Benefits (EOB). Once you satisfy your deductible for Medicare Part A or Part B, your member share will be considered satisfied for the calendar year. Coverage for this RSP is limited to services at Medicare participating providers. No benefits are payable for services rendered at non-Medicare participating providers, except at Philippine participating providers. This RSP will pay covered benefits as the primary payer for amounts listed in this Schedule of Benefits.

[2] PRESCRIPTION DRUG - Retail Specialty drugs filled on Guam & Hawaii are limited to Kmart pharmacy. No co-pay shall apply to retail diabetic insulin filled at Kmart pharmacy. A co-payment no greater than $50 will apply for prescribed diabetic insulin filled at retail pharmacy provider on Guam

[3] HEALTHY OUTCOME REWARDS are dollar rewards focused on specific health benchmarks from biometric screenings. Eligible members must satisfy all Health Outcome benchmarks for three (3) quarters within the Contract Period. Members who do not or are unable to attain or achieve health benchmarks must enroll & complete a bonifide NetCare Wellness Program showing progress of all biometric benchmarks. Upon completion of a bonafide Wellness Program, members also qualify for their co-insurance reimbursement of the Wellness Program.

PHILIPPINE CARE - The RSP will pay primary for Covered Charges at NetCare's Philippine Centers of Care and at Participating Providers. No deductible will apply for Covered Charges. A NetCare approved pre-certification is required prior to services rendered.

PRE-CERTIFICATION for covered benefits are required for all services outside Guam and for covered benefits defined in this Schedule of Benefits. A pre-certification from a physician must be approved by NetCare prior to services rendered.

SERVICE AREA: You must continuously reside in the Service Area to remain eligible for coverage under this Plan. If you are absent from the Service Area for more than one hundred eighty-two (182) consecutive days during the Contract Period, you will no longer be eligible for benefits and that your coverage may be terminated under the Plan.

ENROLLMENT

1. This is a supplemental plan for retirees and survivors who are insured with Medicare Parts A & B.
2. To enroll in Class I of the RSP, a Retiree must be 65 years of age or older, and MUST be continuously enrolled in Medicare Parts A (Hospital) and B (Medical) for the entire benefit year (Oct 1, 2017 - Sep 30, 2018).
3. To enroll in Class II of the RSP, both the Member and the spouse must be 65 years of age or older, and MUST be continuously enrolled in Medicare Parts A & B for the entire benefit year (Oct 1, 2017 - Sep 30, 2018).
4. Retirees who enroll in the RSP CANNOT enroll in the PPO1500 or HSA2000 plans during the benefit year (Oct 1, 2017 - Sep 30, 2018).
5. Retirees MUST provide proof of enrollment (i.e. beneficiary card for Medicare Parts A & B) upon submission of the RSP Enrollment Form.

NOTES

1. To ensure continuous Medicare coverage, please pay your Parts A & B premiums on time. Your premium payments can be 100% reimbursed by submitting proof of payment to the Retirement Fund for processing of your reimbursement. Your Part D (Prescription) premiums are also 100% reimbursable by the Retirement Fund. Medicare premium reimbursements are available to GovGuam retirees or their survivor domiciled on Guam.
2. Benefits under the RSP are age-appropriate and DO NOT cover persons under age 65 years. The benefits offered under the RSP are the same benefits offered under the PPO1500 or the HSA2000 Plans.
3. The RSP offers a Vision Benefit Coverage of up to $150 for eyeglasses, contact lenses and other eyeglass hardware. Members are eligible to elect dental coverage when enrolling in the RSP. Also available to RSP members is access to health care in the Philippines.
4. Please verify if your Provider(s) is listed in our Provider Network before election of our RSP or before services are rendered.
5. RSP coverage begins after the Retiree and spouse, if applicable, have met the deductible under the primary payer.
6. RSP is a secondary payer and will use the Medicare reimbursement fee schedule when processing claims.
7. Contact the following agencies for additional RSP information. Government of Guam Retirement Fund Benefits section at (671) 475-8902/25 or (671) 475-8903/21 and the Guam Medicare Assistance Program, within the Division of Senior Citizens, DPHSS at (671) 735-7421 or (671) 735-7415 for Medicare information or assistance.

EXHIBIT B
DENTAL SCHEDULE OF BENEFITS

GOVGUAM DENTAL1000

YOUR BENEFITS (Subject to the specific limitations which are contained in the Group Health Certificate)	What NetCare Covers at PARTICIPATING PROVIDERS	What NetCare Covers at NON-PARTICIPATING PROVIDERS
DIAGNOSTIC & PREVENTIVE CARE 1. Caries Susceptibility Test 2. Exams • Includes Treatment Plan • Once every 6 months 3. Fluoride Treatment • Annually for children age 19 years & under 4. Prophylaxis • Cleaning and polishing of teeth • Once every 6 months 5. Sealants • For permanent & pre-molars of children age 15 years & und 6. Space Maintainers • For children age 15 years & under • Includes adjustments within 6 months of installation 7. Study Models 8. X-rays (Bite Wing) • Maximum of 4 per Plan Year 9. X-rays (Full Mouth) • Once every 3 years	100% of Eligible Expenses	70% of Eligible Expenses
BASIC & RESTORATIVE CARE General Services 1. Emergency Services (during office hours) 2. Pulp Treatment 3. Routine Fillings • Amalgam and Composite Resin 4. Simple Extractions 5. Complicated Extractions 6. Extraction of Impacted Teeth 7. Periodontal Prophylaxis • Cleaning and polishing once every six months 8. Periodontal Treatment 9. Pulpotomy & Root Canals/Endodontic Surgery & Care & Care 10. Conscious Sedation and Nitrous Oxide • For children under the age 13 years	80% of Eligible Expenses	70% of Eligible Expenses
MAJOR & REPLACEMENT CARE Fixed Prosthetics 1. Crowns and Bridges 2. Gold Inlays & Onlays 3. Replacement of Crown Restoration • Limited once every 5 years Removable Prosthetics 1. Full Dentures • Once every 5 years 2. Partial Dentures • Once every 5 years 3. Each Anesthesia • Only if medically or dentally necessary 4. Relines 5. Denture Repair	50% of Eligible Expenses	35% of Eligible Expenses
DEDUCTIBLE	None	
REGISTRATION FEE per Visit to Dentist	None	
COVERAGE MAXIMUMS per Member per Plan Year	$1,000	

TERMS:
1. Unused balances are not transferable to the following year.
2. Charges for Non-participating Providers are limited to the lesser or actual charges or NetCare's determination of the Usual, Customary and reasonable charge in the geographic location where the service was rendered, unless otherwise provided in the agreement.
3. The covered member pays any excess above Eligible Charges.

EXHIBIT C

WELLNESS & FITNESS BENEFIT

PREVENTIVE CARE

NetCare covers 100% of outpatient annual examination and preventative care screenings in compliance with the Affordable Care Act (ACA). NetCare complies with the U.S. Preventive Services Task Force Guidelines, with Grade A & B Rating. In addition, NetCare fully complies with the Women's Health Care Act and covers 100% of the benefits and services stipulated under this law. These include the following services:

- Abdominal Aortic Aneurysm Screening for men ages 65-75
- Anemic Screening for iron deficiency and pregnant women
- Bacteriuria Screening with urine culture and pregnant women at 12-16 weeks gestation
- Breast Cancer Screening for women 40 years of age and older
- Cervical Cancer Screening for women 21-65 years of age every three years; and HPV DNA test in combination with pap smear
- Chlamydial Infection Screening for all sexually active women age 24 and younger and older if at increased risk
- Cholesterol Screening (Dyslipidemia) for children at risk due to known family history
- Cholesterol Screening (Dyslipidemia) for adults for men age 35 years and older or age20 -35 if risk factors for coronary heart disease are present; women age 45 years and older or age 20-45 if risk factors for coronary heart disease are present
- Colorectal Cancer Screening beginning at age 50 years by any of the following methods:
  -Fecal Occult blood testing
  -Sigmoidoscopy every five years
  -Colonoscopy every 10 years
  -Double Contrast Barium Enema every 5 years
- Congenital Hypothyroidism Screening for newborns
- Diabetes Screening for adults with sustained blood pressure greater than 135/80
- Gestational Diabetes for pregnant women at first prenatal visit and all women at 24-28 weeks of gestation
- Gonorrhea Screening for sexually active women including pregnant women if they are at risk for infection
- Hearing Screening for infants, children through age 10 years
- Hemoglobin or Hematocrit
- Hemoglobinopathy Screening
- Hepatitis B Screening
- HIV Screening
- Hypothyroidism, Congenital for newborns
- Lead Screening
- Newborn metabolic Screening Panel
- Nutrition Counseling
- Osteoporosis Screening
- Ovarian Cancer and Breast Cancer Risk Counseling
- Phenylketonuria Screening for newborns
- RH Incompatibility Screening
- Prostate Cancer Screening
- Tobacco Use Counseling and Intervention
- Tuberculin Testing

DISEASE MANAGEMENT

NetCare covers a variety of programs and activities focused on Disease and Case Management. NetCare's Medical Management Department is staffed with medically trained professionals who are responsible for coordinating programs and member referrals to various contracted wellness providers both on-island and off-island.

The following is the current Disease and Case Management criteria:

- Plan covers 80% of charges and the member pays the remaining 20% of charges. This applies to clinic visits, laboratory procedures and medications.
- Deductible does not apply to the Disease and Case Management programs
- After the member has successfully completed the program, NetCare will reimburse the member for the 20% co-payment once a reimbursement from the member is filed and processed.
- NetCare provides 100% coverage for wellness services provided through, RGA's Rosebud Program for complicated pregnancies; and activities through American Health Holdings.

Other Disease Management Programs include the following programs:

Asthma Care Management – members diagnosed with asthma will likely trigger or open a case management program which includes providing a member with a nebulizer to be used for home treatment. In addition, NetCare works closely with Optum Rx, our pharmacy benefit manager to identify and monitor members who have been prescribed with beta agonist (inhaler). NetCare's Case Management Specialists will routinely review on a weekly and monthly basis all medication refills for compliance and non-compliance. Members who have been determined to be non-compliant with their medications are telephoned to remind them to fill out their prescription medications and/or to determine why they have not filled their prescriptions and determine if proper intervention can be implemented with the member's primary care physician.

Cancer Care Management – NetCare has implemented case management programs with American Health Holdings (AHH) for those members who have opted to receive cancer treatment in the U.S. Mainland. AAH assigns a specific case manager who is a registered nurse with specialty in oncology services and treatment. AHH works closely with NetCare's Medical Management Department to provide updates and address any issues that the member may be encountering. For members receiving cancer treatment and services on island, NetCare's Medical Management Department closely monitors all cases to ensure proper intervention that may be impeding on ongoing treatment. NetCare works to ensure that there are little to no delays in a member's treatment. All pre-certification requests including medications and appointments are facilitated in an expeditious manner. NetCare also works closely with the member in recommending and/or approving any necessary referrals to off-island facilities.

Congestive Heart Failure Care Management – A hospital admission to the hospital automatically triggers case management review. During an inpatient stay, NetCare's Case Management Specialist will provide necessary counseling and resources available for the member and the family in order for them to fully understand the disease process and encourage health risk modification behavior. In addition, NetCare will facilitate the necessary referrals to specialists both on-island and off-island.

Diabetes Care Management- NetCare's In-Control Diabetes Care Management Program is designed to provide members with knowledge and resources about the importance of keeping their blood sugar levels under control. NetCare provides a free Accu-Chek Advantage Meter and Diabetic Care Kit for eligible members. This program includes the monitoring meter, test strips, lancets etc...required for blood glucose monitoring. NetCare currently contracts with Health Services of the Pacific, SDA Wellness Center, and Horinuchi Wellness Clinic to provide on-going referrals for wellness treatment and services for diabetic members.

Hypertension Care Management – NetCare's Hypertension Care Management Program is an integrated lifestyle therapy program that is available as a wellness program through our wellness partners including the SDA Wellness Center, Horinuchi Wellness Clinic and Dr. Lombard's Weight Management Program. Members will be engaged on how to naturally lower their cholesterol by 40 to 100 points. In addition, members will participate in informative health lectures and presentations on the latest scientific based evidence, health screenings to measure blood sugar, blood pressure levels, weight control, proper meal planning, and stress management through exercise and lifestyle modification.

Neonatal Intensive Care Management- NetCare utilizes and contracts with ROSEBUD, a national high risk pregnancy program to manage and handle neonatal case management. The ROSEBUD Program is staffed with experienced neonatal nurse consultants as well as board certified OB/Gyn physicians, Neonatologist and Pediatric physicians who work in collaboration with NetCare's Medical Management Department, the member and the member's physician in order to provide support and guidance for the member's plan of care. The goal of the program is to manage any possible complicated issues and needs.

Pre-Natal Care Management- NetCare utilizes and contracts with the ROSEBUD Program to handle and manage pre-natal and prenatal case management issues. The ROSEBUD Program which is facilitated and coordinated by a registered nurse

provides educational resources to promote healthy lifestyles in low risk pregnancies. This is accomplished through a comprehensive risk screening assessment. For prenatal cases, the goal is to bring high risk pregnancies closer to term and decrease neonatal intensive care unit days.

Smoking Cessation Program – NetCare's Smoking Cessation Program is available as a wellness program through our wellness partners including the SDA Wellness Center, Horinuchi Wellness Clinic. The program includes a stop smoking class which utilizes effective lifestyle and nutritional approach to break the addiction to nicotine and smoking habit.

WELLNESS & FITNESS

NetCare offers a myriad of wellness and fitness benefits focused on promoting healthier lifestyles. NetCare's wellness partners include the following providers:

- SDA Wellness Center
- Horinuchi Wellness Clinic
- Dr. Lombard's Supervised Weight Management Therapy
- Lohas Chiropractic & Nutrition
- Health Services of the Pacific
- Guam Running Club

The above listed wellness partners provide nutritional classes and counseling. In addition, a multitude of informational materials and resources are available for review and information.

In addition, NetCare offers and routinely schedules weekly and monthly work site health fairs directly at the employer work site. NetCare contracts with trained and licensed professionals affiliated with our wellness partners and participating providers to provide risk screening for hypertension, diabetes, heart disease, obesity etc... The following measurements are taken including blood glucose, blood pressure, body mass index and body fat composition.

NetCare also offers and provides for a Health Risk Assessment (HRA) tool that is completed on-line at NetCare's website as www.netcarelifeandhealth.com/wellness suite. The HRA is also available on paper format as well. A report and a Certificate of Completion is immediately generated from the HRA providing advice and resources pertaining to the results of the completed HRA.

Under this proposal, NetCare pays 100% of the gym or fitness membership fee for eligible members at one of NetCare's Participating Fitness Providers listed below. In addition, NetCare offers and provides up to $400 fitness reward if the member participates or attends a minimum of eight (8) visits per month at either a participating fitness provider or non-participating fitness

-Hilton Wellness Center (Limited Availability)
-The Gym Guahan
-Urban Fitness & Dance Studios
-Custom Fitness
-International Sports Center
-CrossFit Hita
-CrossFit Latte Stone

New valued added features, which will be offered for FY 2018:

- Enhanced ***Fitness Rewards*** of up to $400 when members meet a minimum of eight (8) visits at either a participating or non-participating fitness or gym provider...***any gym any where***

- Expanded Provider Network that now includes the ***FHP Health Center*** for medical, dental, vision, cancer, radiology, pharmacy, urgent care, OB/GYN etc...

- NetCare's ***Healthy Outcomes Reward*** is a health-contingent wellness program focused on members achieving a specific health benchmark for key biometric screening on cholesterol, blood pressure reading, body mass index

(BMI), HB A1C screening, cancer preventive screening and coronary risk analysis. Members can earn up to $200 per contract period if they attain a specific health outcome. The program also provides alternative activities for those members who are unable to attain or achieve the specific health benchmark and still receive a Healthy Outcome Reward.

- NetCare's ***HealthyFit*** Program provides members with free weekly wellness classes that motivate members to get and stay in shape. Classes include pilates, water aerobics, zumba and running programs.

COST MANAGEMENT PROGRAMS

NETCARE CASE MANAGEMENT PROGRAM

NetCare has in-house Case Management program, which was designed for members diagnosed with catastrophic illness including but not limited to cancer and those high risk cases or members who will undergo complicated surgery.

Main objective includes timely intervention and faster coordination of much needed services,
thus avoiding any delay, which can add cost in the treatment and making sure members will be referred to the best providers who can provide high quality of care at the best possible cost, Include the following:

- Coordination of off-island referral (e.g. MEDIVAC cases)
- Precertification of procedures/ services
- Arrangement with Home Care providers
- Arrangement with DME (wheelchair, hospital beds, Nebulizers, Crutches)

Rosebud Program - a program of RGA, which was designed to assist health plans, with improving outcomes and reducing costs associated with high risk pregnancies, and infants. Their experienced perinatal and neonatal nurse consultants work in collaboration with the health plan to support the member's plan of care.

Med-Rehab Consultants - NetCare members who are being referred to U.S. and was diagnosed with a complicated medical condition will be referred to Med-Rehab. Medical Rehabilitation Consultants provide case management service, which supplements the professional staff with a dedicated and highly respected advisory team of medical consultants in multiple specialties.

The benefits to our NetCare members, who are being referred in U.S Mainland, and under MedRehab Consultants Case Management:

- Fast and efficient treatment
- Prevention of delay in service
- Prevention of over utilization of service
- Educational resources

EuroAssist/Global Corporate Solutions - Combine with their hundreds to millionss of direct network, along with access to best-in-class HMO and PPO networks, and refined cost-based negotiations for a solution that will help reduce healthcare costs.

Capabilities and performance in the U.S. market include:

- Highest net savings in the industry
- Broad access
- Best in class discounts with key Centers of Excellence

OptumRx NetCare PBM. As a pharmacy care services company, OptumRx® goes beyond traditional pharmacy benefit management. They leverage analytics and the most frequent health care touch point, to impact overall health, especially where it matters most within complex conditions.
PBM Features which are sources of Client Savings:

- Mail Service
- Promoting Generic Equivalent
- Lower Cost Alternative Medication
- Pharmacist Medical Consults
- Provider Decision Support

- Care and Disease Management

Equian /ClinAssist - NetCare also is contracted with Equian (formerly ClinAssist), which provide forensic review on large claims. Overpayment on healthcare claims can cost millions of dollars, making Claim Overpayment & Recovery solutions critical to a company's financial health. Equian identify, eliminate, and recover overpayments. They also qualify your specific overpayment errors and work with NetCare to determine the root cause, with a focus on situations that can be changed or eliminated. Equian's Claim Overpayment & Recovery solutions use advanced statistical techniques, including custom data mapping, pattern detection, and regression analysis, to identify situations that are hard to spot at the transactional level, and provide significant recovery and prevention opportunities

INFORMATION FOR ADULT PATIENTS

2017 Recommended Immunizations for Adults: **By Age**

If you are this age, talk to your healthcare professional about these vaccines →

	Flu *Influenza*	Td/Tdap Tetanus, diphtheria, pertussis	Shingles *Zoster*	Pneumococcal		Meningococcal		MMR Measles, mumps, rubella	HPV *Human papillomavirus*		Chickenpox *Varicella*	Hepatitis A	Hepatitis B	Hib *Haemophilus influenzae* type b
				PCV13	PPSV23	MenACWY or MPSV4	MenB		for women	for men				
19 - 21 years														
22 - 26 years														
27 - 59 years														
60 - 64 years														
65+ year														

More Information:

- Flu: You should get flu vaccine every year.
- Td/Tdap: You should get a Td booster every 10 years. You also need 1 dose of Tdap. Women should get a Tdap vaccine during every pregnancy to help protect the baby.
- Shingles: You should get shingles vaccine even if you have had shingles before.
- Pneumococcal: You should get 1 dose of PCV13 and at least 1 dose of PPSV23 depending on your age and health condition.
- MMR, HPV, Chickenpox, Hepatitis A, Hepatitis B, Hib: You should get this vaccine if you did not get it when you were a child.
- HPV: You should get HPV vaccine if you are a woman through age 26 years or a man through age 21 years and did not already complete the series.

Recommended For You: This vaccine is recommended for you *unless* your healthcare professional tells you that you do not need it or should not get it.

May Be Recommended For You: This vaccine is recommended for you if you have certain risk factors due to your health condition or other. Talk to your healthcare professional to see if you need this vaccine.

If you are traveling outside the United States, you may need additional vaccines.
Ask your healthcare professional about which vaccines you may need at least 6 weeks before you travel.

For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit www.cdc.gov/vaccines

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CS272886-G

INFORMATION FOR ADULT PATIENTS

2017 Recommended Immunizations for Adults: **By Health Condition**

If you have this health condition, talk to your healthcare professional about these vaccines

	Flu *Influenza*	Td/Tdap Tetanus, diphtheria, pertussis	Shingles *Zoster*	Pneumococcal		Meningococcal		MMR Measles, mumps, rubella	HPV *Human papillomavirus*		Chickenpox *Varicella*	Hepatitis A	Hepatitis B	Hib *Haemophilus influenzae* type b
				PCV13	PPSV23	MenACWY or MPSV4	MenB		for women	for men				
Pregnancy														
Weakened Immune System			SHOULD NOT GET VACCINE					SHOULD NOT GET VACCINE			SHOULD NOT GET VACCINE			
HIV: CD4 count less than 200														
HIV: CD4 count 200 or greater														
Kidney disease or poor kidney function														
Asplenia (if you do not have a spleen or if it does not work well)														
Heart disease Chronic lung disease Chronic alcoholism														
Diabetes (Type 1 or Type 2)														
Chronic Liver Disease														
More Information:	You should get flu vaccine every year.	You should get a Td booster every 10 years. You also need 1 dose of Tdap vaccine. Women should get Tdap vaccine during every pregnancy.	You should get shingles vaccine if you are age 60 years or older, even if you have had shingles before.	You should get 1 dose of PCV13 and at least 1 dose of PPSV23 depending on your age and health condition.				You should get this vaccine if you did not get it when you were a child.	You should get HPV vaccine if you are a woman through age 26 years or a man through age 21 years and did not already complete the series.					You should get Hib vaccine If you do not have a spleen, have sickle cell disease, or received a bone marrow transplant.

For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit www.cdc.gov/vaccines

Recommended For You: This vaccine is recommended for you *unless* your healthcare professional tells you that you do not need it or should not get it.

May Be Recommended For You: This vaccine is recommended for you if you have certain other risk factors due to your age, health condition or other. Talk to your healthcare professional to see if you need this vaccine.

YOU SHOULD NOT GET THIS VACCINE

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CS272886-G

2017 Recommended Immunizations for Children from Birth Through 6 Years Old

Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
HepB	HepB			HepB	HepB	HepB	HepB	HepB	HepB	HepB
		RV	RV	RV						
		DTaP	DTaP	DTaP		DTaP	DTaP			DTaP
		Hib	Hib	Hib	Hib	Hib				
		PCV	PCV	PCV	PCV	PCV				
		IPV	IPV	IPV	IPV	IPV	IPV	IPV	IPV	IPV
				Influenza (Yearly)*	Influenza (Yearly)*	Influenza (Yearly)*	Influenza (Yearly)*	Influenza (Yearly)*	Influenza (Yearly)*	Influenza (Yearly)*
					MMR	MMR	MMR			MMR
					Varicella	Varicella	Varicella			Varicella
					HepA§	HepA§	HepA§	HepA§	HepA§	

Is your family growing? To protect your new baby and yourself against whooping cough, get a Tdap vaccine. The recommended time is the 27th through 36th week of pregnancy. Talk to your doctor for more details.

Shaded boxes indicate the vaccine can be given during shown age range.

NOTE:
If your child misses a shot, you don't need to start over, just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

FOOTNOTES:

- Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.
- § Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.

SEE BACK PAGE FOR MORE INFORMATION ON VACCINE-PREVENTABLE DISEASES AND THE VACCINES THAT PREVENT THEM.

For more information, call toll free
1-800-CDC-INFO (1-800-232-4636)
or visit
www.cdc.gov/vaccines/parents

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Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	**Varicella vaccine** protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	**DTaP*** vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	**Hib** vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	**HepA** vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic, and blood disorders
Hepatitis B	**HepB** vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Influenza (Flu)	**Flu vaccine** protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	**MMR**** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	**MMR****vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	**DTaP*** vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	**IPV** vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	**PCV** vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	**RV** vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	**MMR**** vaccine protects against rubella.	Air, direct contact	Children infected with rubella virus sometimes have a rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	**DTaP*** vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.

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INFORMATION FOR PARENTS

2017 Recommended Immunizations for Children 7-18 Years Old

Talk to your child's doctor or nurse about the vaccines recommended for their age.

	Flu *Influenza*	Tdap Tetanus, diphtheria, pertussis	HPV Human papillomavirus	Meningococcal		Pneumococcal	Hepatitis B	Hepatitis A	Inactivated Polio	MMR Measles, mumps, rubella	Chickenpox *Varicella*
				MenACWY	MenB						
7-8 Years											
9-10 Years											
11-12 Years											
13-15 Years											
16-18 Years											
More Information:	Preteens and teens should get a flu vaccine every year.	Preteens and teens should get one shot of Tdap at age 11 or 12 years.	All 11-12 year olds should get a 2-shot series of HPV vaccine at least 6 months apart. A 3-shot series is needed for those with weakened immune systems and those age 15 or older.	All 11-12 year olds should get a single shot of a quadrivalent meningococcal conjugate vaccine (MenACWY). A booster shot is recommended at age 16.	Teens, 16-18 years old, may be vaccinated with a MenB vaccine.						

These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine should be given if a child is catching-up on missed vaccines.

These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at www.cdc.gov/vaccines/pubs/ACIP-list.htm.

This shaded box indicates the vaccine is recommended for children not at increased risk but who wish to get the vaccine after speaking to a provider.

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Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Diphtheria (Can be prevented by Tdap vaccination)

Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be passed from person to person by direct contact with droplets from an infected person's cough or sneeze. When people are infected, the bacteria can produce a toxin (poison) in the body that can cause a thick coating in the back of the nose or throat that makes it hard to breathe or swallow. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In serious cases, the illness can cause coma, paralysis, and even death.

Hepatitis A (Can be prevented by HepA vaccination)

Hepatitis A is an infection in the liver caused by hepatitis A virus. The virus is spread primarily person-to-person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms can include fever, tiredness, poor appetite, vomiting, stomach pain, and sometimes jaundice (when skin and eyes turn yellow). An infected person may have no symptoms, may have mild illness for a week or two, may have severe illness for several months, or may rarely develop liver failure and die from the infection. In the U.S., about 100 people a year die from hepatitis A.

Hepatitis B (Can be prevented by HepB vaccination)

Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rashes, joint pain, and jaundice. Symptoms of acute hepatitis B include fever, fatigue, loss of appetite, nausea, vomiting, pain in joints and stomach, dark urine, grey-colored stools, and jaundice (when skin and eyes turn yellow).

Human Papillomavirus (Can be prevented by HPV vaccination)

Human papillomavirus is a common virus. HPV is most common in people in their teens and early 20s. It is the major cause of cervical cancer in women and genital warts in women and men. The strains of HPV that cause cervical cancer and genital warts are spread during sex.

Influenza (Can be prevented by annual flu vaccination)

Influenza is a highly contagious viral infection of the nose, throat, and lungs. The virus spreads easily through droplets when an infected person coughs or sneezes and can cause mild to severe illness. Typical symptoms include a sudden high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Extreme fatigue can last from several days to weeks. Influenza may lead to hospitalization or even death, even among previously healthy children.

Measles (Can be prevented by MMR vaccination)

Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever can persist, rash can last for up to a week, and coughing can last about 10 days. Measles can also cause pneumonia, seizures, brain damage, or death.

Meningococcal Disease (Can be prevented by meningococcal vaccination)

Meningococcal disease is caused by bacteria and is a leading cause of bacterial meningitis (infection around the brain and spinal cord) in children. The bacteria are spread through the exchange of nose and throat droplets, such as when coughing, sneezing or kissing. Symptoms include sudden onset of fever, headache, and stiff neck. Meningococcal bacteria also cause blood infections. About one of every ten people who get the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous systems, become developmentally disabled, or suffer seizures or strokes.

Mumps (Can be prevented by MMR vaccination)

Mumps is an infectious disease caused by the mumps virus, which is spread in the air by a cough or sneeze from an infected person. A child can also get infected with mumps by coming in contact with a contaminated object, like a toy. The mumps virus causes swollen salivary glands under the ears or jaw, fever, muscle aches, tiredness, abdominal pain, and loss of appetite. Severe complications for children who get mumps are uncommon, but can include meningitis (infection of the covering of the brain and spinal cord), encephalitis (inflammation of the brain), permanent hearing loss, or swelling of the testes, which rarely results in decreased fertility.

Pertussis (Whooping Cough) (Can be prevented by Tdap vaccination)

Pertussis is caused by bacteria spread through direct contact with respiratory droplets when an infected person coughs or sneezes. In the beginning, symptoms of pertussis are similar to the common cold, including runny nose, sneezing, and cough. After 1-2 weeks, pertussis can cause spells of violent coughing and choking, making it hard to breathe, drink, or eat. This cough can last for weeks. Pertussis is most serious for babies, who can get pneumonia, have seizures, become brain damaged, or even die. About half of children under 1 year of age who get pertussis must be hospitalized.

Pneumococcal Disease (Can be prevented by pneumococcal vaccination)

Pneumonia is an infection of the lungs that can be caused by the bacteria called pneumococcus. This bacteria can cause other types of infections too, such as ear infections, sinus infections, meningitis (infection of the covering around the brain and spinal cord), and bacteremia (bloodstream infection). Sinus and ear infections are usually mild and are much more common than the more serious forms of pneumococcal disease. However, in some cases pneumococcal disease can be fatal or result in long-term problems, like brain damage and hearing loss. Pneumococcal disease spreads when people cough or sneeze. Many people have the bacteria in their nose or throat at one time or another without being ill—this is known as being a carrier.

Polio (Can be prevented by IPV vaccination)

Polio is caused by a virus that lives in an infected person's throat and intestines. It spreads through contact with the stool of an infected person and through droplets from a sneeze or cough. Symptoms typically include sore throat, fever, tiredness, nausea, headache, or stomach pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, About 2 to 10 children out of 100 die because the virus affects the muscles that help them breathe.

Rubella (German Measles) (Can be prevented by MMR vaccination)

Rubella is caused by a virus that is spread through coughing and sneezing. In children rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but can be very serious to a baby in the womb. If a pregnant woman is infected, the result to the baby can be devastating, including miscarriage, serious heart defects, mental retardation and loss of hearing and eye sight.

Tetanus (Lockjaw) (Can be prevented by Tdap vaccination)

Tetanus is caused by bacteria found in soil, dust, and manure. The bacteria enters the body through a puncture, cut, or sore on the skin. When people are infected, the bacteria produce a toxin (poison) that causes muscles to become tight, which is very painful. Tetanus mainly affects the neck and belly. This can lead to "locking" of the jaw so a person cannot open his or her mouth, swallow, or breathe. Complete recovery from tetanus can take months. One to two out of 10 people people who get tetanus die from the disease.

Varicella (Chickenpox) (Can be prevented by varicella vaccination)

Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough, sneeze. It can also spread from the blisters on the skin, either by touching them or by breathing in these viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache and fever. Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), or even death.

If you have any questions about your child's vaccines, talk to your healthcare provider.

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American Academy of Pediatrics
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Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
promotion and health promotion for infants, children, adolescents, and their families

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	←	→	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←		●[10]	→	←	●	→	←		●	→
DEVELOPMENTAL/BEHAVIORAL HEALTH																																
Developmental Screening[11]								●			●		●																			
Autism Spectrum Disorder Screening[12]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		■	●		●		●	●	●	●	■	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	■	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																									
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	■	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															■
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	★	←			●	→
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←		●	→	★	★	★
Cervical Dyplasia[31]																																●
ORAL HEALTH[32]							●[33]	●[34]	★		★	★	★	★	★	★	★															
Fluoride Varnish[35]							←				●				→																	
Fluoride Supplementation[36]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★						
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months. In addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← ● → = range during which a service may be provided

(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0–3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
25. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017.
For updates, visit www.aap.org/periodicityschedule.
For further information, see the *Bright Futures Guidelines*, 4th Edition, *Evidence and Rationale chapter* (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per 'Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs' (http://pediatrics.aappublications.org/content/120/4/898.full)."
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See 'The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies' (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext)."

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (http://pediatrics.aappublications.org/content/135/2/384) and 'Poverty and Child Health in the United States' (http://pediatrics.aappublications.org/content/137/4/e20160339)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications' (http://pediatrics.aappublications.org/content/124/4/1193)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (http://pediatrics.aappublications.org/content/134/3/626)."

Final FY2018 Performance Guarantees

	Fees At Risk		Metric	FY18 Guam
Claim Adjudication / Administration				
1.b	$	5,000	Clean Claim Timeliness - 45 Calendar Days	99% in 45 days
1.c	$	5,000	Claims Financial Accuracy	≥ 98%
1.d	$	15,000	Claims Payment Accuracy	≥ 98%
Total	**$**	**25,000**		
Client/Member Service				
2.a	$	5,000	Average Speed to Answer	100% of calls within 30 seconds
2.b	$	10,000	Ongoing ID Cards Issuance	99% will be mailed within 15 business days
2.c	$	10,000	Member Satisfaction	≥ 85% based on Unit Level
2.d	$	5,000	Call Abandonment Rate	≤ 2%
2.e	$	5,000	First Call Resolution	≥ 90%
2.f	$	10,000	Processing of Ongoing Eligibility Information	100% within 3 business days
2.g	$	5,000	Participant Email Response Performance	90% of emails will be responded within 3 days
Total	**$**	**50,000**		
Account Management				
3.a	$	10,000	Account Management Satisfaction	Average score of 3 or higher out of 5
3.b	$	10,000	Account Management Reporting	< 15 business days
3.c	$	10,000	Account Management Issues Resolution	< 1 business days
Total	**$**	**30,000**		
Total	**$**	**105,000**		

EXHIBIT F

CLAIMS AND APPEALS PROCEDURES

The Affordable Care Act ensures a member's right to an internal appeal or asks NetCare to reconsider its decision to deny payment for a service or treatment. The law also permits the member to have an independent review organization (an external review) decide whether to uphold or overturn NetCare's internal appeal decision. NetCare uses guidelines from the Uniform Health Carrier External Review Act to assure a member has the opportunity for an independent review of an adverse determination or final adverse determination.

If a claim is denied, in whole or in part, NetCare will furnish notice to the member specifying reason or describe any additional information required in perfecting the claim and the member's right to file an internal appeal. If the member wishes to review and discuss the reason for the denial, a request must be made in writing to NetCare within **one-hundred eighty (180) days** of receipt of a denial notice. NetCare will re-evaluate the claim in question and give a final written decision on the re-evaluation within sixty (60) days for services already incurred, thirty (30) days for non-urgent care not yet received, or seventy-two (72) hours for urgent care, after such request is received.

NOTICE OF APPEAL RIGHTS

A member has the right to appeal any decision we make that denies payment on a claim or a request for coverage of a health care service or treatment.

A member may request more explanation when a claim or request for coverage of a health care service or treatment is denied or the health care service or treatment a member received was not fully covered. A member can contact our office at 671-472-3610 when the following is applicable or occurs:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Policy Specification;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If a claim was denied due to missing or incomplete information, a member or his/her health care provider may resubmit the claim to us with the necessary information to complete the claim.

Appeals

All appeals for claim denials (or any decision that does not cover expenses a member believes should have been covered) must be sent in writing to our office at 424 W. O'Brien Drive, Suite 200, Hagatna, Guam 96910 within 180 days of the date you receive our denial. We will provide a full and fair review of the claim by individuals associated with us, but who were not involved in making the initial denial of the claim. A member may provide us with additional information that relates to a claim and a member may request copies of information that we have pertaining to his/her claim. We will notify the member of our decision in writing within **60 days** of receiving your appeal. If a member does not receive our decision within **60 days** of receiving the appeal, a member may be entitled to file a request for an external review.

When a member appeals a claim, NetCare must give you its decision within:

1. Urgent Care Claims – 72 Hours Reply Time
A special kind of pre-service claim that requires a quick decision due to a health condition that may be threatened. If your appeal concerns urgent care, you may be able to have the internal appeal and external review take place at the same time.

2. Pre-Service Claims – 30 Days Reply Time
Denials of non-urgent care you have not yet received.

3. Post-Service Claims – 60 Days Reply Time
Claims for benefits under NetCare, including claims after medical care have been provided, such as reimbursement or payment of the costs of the services provided.

External Review
If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review within **four (4) months** after the date you receive our denial to Guam Department of Revenue and Taxation, Office of the Insurance Commissioner, 1240 Army Drive Barrigada, GU 96921, telephone 671-635-1844. For standard external review, a decision will be made within **forty-five (45) days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an expedited external review of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document or contact our office at 671-472-3610, 424 W. O'Brien Drive, Julale Center Ste 200, Hagatna, GU 96910.

Expedited External Review - An expedited process if you have a medical condition where the timeframe for completion of a standard external review, pursuant to the Uniform Health Carrier External Review Act, would seriously jeopardize your life or health or ability to regain maximum function. A decision will be made expeditiously as your medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of your request.

EXHIBIT G

MEDICAL LOSS RATIO

Hypothetical Illustration

This Exhibit serves as a hypothetical illustration for the purposes of illustrating how the formula might work based on hypothetical numbers.
ASSUMPTIONS:

1. Fiscal Year 2016 earned premiums are 60,000,000 from October 2015 through September 2016 (level 5,000,000 per month)

2. Fiscal Year 2017 earned premiums are 72,000,000 from October 2016 through September 2017. (Level 6,000,000 per month)

3. Assume the commercial block of business earned premium is $20,000,000 for each of Fiscal Year 2016 and 2017

4. Assume the calendar 2016 MLR refund (based upon aggregate commercial and GovGuam experience) is 2% of premium

5. Assume the calendar year 2017 MLR refund (based upon aggregate commercial and GovGuam experience) is 1% of premium

6. Assume the GGFY17 loss ratio is 80% for the fiscal year October 2016 through September 2017

Then, the GGFY16 premium earned in calendar 2016 is 45,000,000 and the GGFY17 premium earned in calendar year 2016 is 18,000,000 for a total of 63,000,000

Assume there is no renewal of the GGFY18. Then GovGuam will earn a MLR refund for calendar 2016 of 2% of 63,000,000, or 1,260,000. GG will earn a MLR refund for calendar 2017 of 1 % of 54,000,000, or 540,000.

The participation contract refund for GGFY17 is 3,600,000 (5% of 72,000,000) before adjustment for MLR refunds.

The calendar 2016 MLR refund applicable to GGFY17 is 18,000,000 (3 months of GGFY17 premium) divided by 63,000,000 (9 months of GGFY16 premium plus three months of GGFY17 premium). This becomes 360,000, which is 28.57143% of the 1,260,000 2016 refund to GovGuam.

The calendar, 2017 MLR refund in this illustration which is applicable to GGFY17 is 100% of the 540,000, because for the sake of this illustration we assume no renewal.

Therefore, the participation refund is reduced by 900,000 (360,000 + 540,000)

This process removes the duplication of the MLR refund and the participation refund and keeps the GGFY17 refund plus incurred claims equal to 85%.

In this situation, GG gets 100% of both the 2016 and 2017 MLR refunds and an additional refund from the Participation agreement.

The above numbers are hypothetical and for illustration purposes only.

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TIME 9:15 DATE 9.12.18

Office of the Governor
Central Files
By: 10:10 Date: 6.8.18
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