

Government of Guam
And
****COMPANY****

Third Party Administration Services Contract (V14)
October 1, 2024 – September 30, 2025

Preamble

This Third Party Administration Services Contract (Contract) is made by and between the Government of Guam ("GovGuam") and **COMPANY** effective October 1, 2024 through September 30, 2025 under which the Contractor agrees to provide administration services to the Government of Guam Employees and retirees for the Health and Pharmacy Insurance Plans (Plan), subject to the following terms and conditions:

1. Identity of and Relationship between the Parties

- A. **COMPANY**, a corporation organized under the laws of the Guam is an organization capable of providing third party member administration, medical claims administration and related services as herein described, including provider network access. This service is provided through its managing general agent **COMPANY**
- B. The TPA administers the Plan on behalf of GovGuam acting administratively through the Department of Administration (DOA), an agency of the Government of Guam.
- C. The TPA and GovGuam are independent legal entities. Nothing in this Contract shall be construed to create the relationship of employer and employee or principal and agent or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the terms of this Contract.
- D. Neither the TPA, GovGuam, nor any of their respective agents or employees shall control or have any right to control the activities of the other party in carrying out the terms of this Contract, nor shall either party, its respective agents or employees, be liable to third parties for any act or omission of the other party.
- E. Nothing in this Contract is intended to be construed, nor shall it be deemed to create, any right or remedy in any third party.
- F. This Contract includes the following Exhibits:
 - 1. Exhibit A – Fee Schedule for Third Party Administration Services
 - 2. Exhibit B – Performance Guarantees
 - 3. Exhibit C – TPA Services Contractor Reports
 - 4. Exhibit D – Stoploss Insurance Agreement

2. Definitions

- A. "Allowable Charge" means the lesser of the submitted charge or the amount established by the TPA, as provided through network contract(s) with a participating Provider or based on analysis of Provider charges for non-participating Providers, as the maximum amount for all such Provider services covered under the terms of the Plan.
- B. "Third Party Administrator" or "TPA" means the organization under contract to GovGuam responsible for

providing member services, claims administration and Provider network services.

- C. "Complete Claim" means all the necessary information required by the TPA to adjudicate the claim.
- D. "Confidential Business Information" of a party means all information concerning such party's properties, products, services, employees, finances, businesses and operations, including, without limitation, all information, in whatever form embodied, relating to such party's Creations, but excluding information which (i) is already known to the receiving party or is publicly available at the time of disclosure; (ii) is disclosed to the receiving party by a third party who is not in breach of an obligation of confidentiality; or (iii) becomes publicly available after disclosure through no act of the receiving party.
- E. "Covered Services" means Gym Services, Hospital Services, Medical Services, and Pharmacy Services as defined in the Plan Document.
- F. "Department of Administration" (DOA). Shall be defined as the Department of Administration. DOA shall be responsible for payment and administration of line agencies, agencies whom the DOA administers payroll, and the Foster program.
- G. "Foster Child or Foster Children" shall be defined as a Foster child under the legal custody of the Child Protective Services Division of the Department of Public Health and Social Services as defined in 4 G.C.A §4301.1(h).
- H. "Gym Services" means gym membership only at participating gym facilities in Guam. This benefit only provides coverage for the monthly membership fee per the agreement between the TPA and the Gym.
- I. "Health Information Technology for Economic and Clinical Health Act" (HITECH) shall refer to the portion of the "American Recovery and Reinvestment Act" (ARRA) of 2009 that addresses the privacy and security concerns associated with the electronic transmission of Protected Health Information.
- J. "Health Insurance Portability and Accountability Act (HIPAA)" shall refer to the Health Insurance Portability and Accountability Act of 1996, as amended.
- K. "Utilization Management" or "UM" means the provision of utilization review, including, but not limited to, hospital management services, continued stay management, discharge planning, retrospective review, outpatient diagnostic test review, pre-admission and post-discharge outreach, and medical review to determine medical necessity for specified medical services, the most appropriate setting, appropriate treatment and, where applicable, an appropriate length of stay. "UM" also means the provision of wellness/health promotion, medical case management, disease management, and out-of-network review.
- L. "Hospital Services" means acute care inpatient and hospital outpatient services or supplies for which payment may be sought under the terms of the Plan. "Hospital Services" do not include long-term, non-acute care inpatient services.
- M. "Medical Services" means patient care services or supplies for which payment may be sought under the terms of the Plan, other than Hospital Services.
- N. "Network" refers to the TPA's responsibility for direct network contracting services for the development and maintenance of a Provider network.

- O. "Participant" is a person entitled to receive Covered Services pursuant to the Plan. A Participant shall reside in the Service Area and shall be a subscriber or dependent of the Plan and shall include a Foster Child under the legal custody of the DPHSS CPS as defined in 4 G.C.A 4301.1(h)
- P. "Pharmacy Benefit Manager" (PBM) is the organization which provides the administration of Pharmacy Services to Participants on behalf of the TPA and GovGuam.
- Q. "Pharmacy Services" means those outpatient drugs, products, services, testing and/or diagnostics, or supplies that are prescribed by a prescriber and/or covered for which payment may be sought under the terms of the Plan.
- R. "Plan" means the benefit plans(s) pursuant to which Covered Services are provided to Participants.
- S. "Plan Document" (PD) is the document that states the benefits and eligibility terms of the Plan. This document is published and maintained by the GovGuam.
- T. "Provider" means a physician or other medical practitioner, health care professional, or facility as defined in the Plan Document.
- U. "Service Area" shall be defined as Guam and the Commonwealth of the Northern Mariana Islands.
- V. Subscriber: Shall be defined as a bona fide employee of GovGuam who is working 30 hours per week; or
 - 1. Voluntarily working under the "Quality Time" program and classified as such by GovGuam pursuant to P.L. 25-72; or working under any GovGuam sponsored program that ensures continuity of health insurance benefits.
 - 2. Classified as a Retiree of GovGuam by GovGuam; or
 - 3. Classified as a Survivor of a Retiree of GovGuam by GovGuam; or
 - 4. A Foster Child under the legal custody of the Child Protective Services Division of the Department of Public Health.
- W. "Retiree" shall be a qualified GovGuam Retiree as defined by 4 GCA Chapter 8 §8104;
 - 1. A qualified retiree, who is age 65 and older and who is enrolled in Medicare Parts A & B Primary;
 - 2. A qualified retiree, who is under age 65 years of age with a disability or ESRD under Medicare
- X. "Survivor" shall be defined as the survivor of a qualified GovGuam Retiree

3. **Responsibilities of the TPA**

This section contains information on services and procedures the TPA should provide, or adhere to, in servicing the Plan, either directly or through identified subcontractors. The applicable Plan Document provides specific details of the Plan. The TPA shall be responsible for the complete performance of all work; for the methods, means, and equipment used; and for furnishing all materials, tools, apparatus, and property of every description used in connection therewith. No statement within this Contract shall negate compliance with any applicable governing regulation. The absence of detail specifications or the omission of detail description shall be recognized as meaning that only the best commercial practices are to prevail and that only first quality materials and workmanship are to be used.

The TPA shall provide the following services:

A. Dedicated Account Service

A Service Center must be located in Guam to serve GovGuam, employer units and health plan participants.

When GovGuam provides the TPA with written notification of a significant issue, the TPA will respond in writing to GovGuam with the resolution of the issue or an explanation of when the issue can be resolved, with a defined timetable, within five (5) business days.

B. Account Manager

The TPA must assign a dedicated (but not necessarily exclusive) account manager to participate in activities relative to all aspects of the contract between GovGuam and the TPA.

Additionally, TPA must assign at least one full-time, licensed, on-site (DOA offices or other departments) individual to support new hires, open enrollment, forms processing, enrollment processing, communicating plan benefits, answering questions about the Plan, resolving claim issues, and other medical, and pharmacy administrative tasks for Participants, Retirees, and Foster Children, per contract year.

C. Welcome Packets & Identification (ID) Card

GovGuam requires custom welcome packets and ID cards to identify participants. The TPA is responsible for producing electronic welcome packets and ID cards and for e-mailing or mailing these items to the participant's e-mail address or home address at no charge to GovGuam. Participants have the ability to print temporary ID cards. The TPA is responsible for mailing, within ten (10) business days of receipt of eligibility, the welcome packets and ID cards under the following circumstances:

1. Initial enrollment in the Plan
2. New hires
3. Newly retired

Each Participant will receive their own ID Cards. The information to be printed on each ID card must be according to GovGuam's specifications and satisfy all regulatory requirements. The ID card will include, at a minimum, the participant's name and identification number, plan name, applicable deductibles, any applicable out-of-pocket maximum limitations, the TPA name and contact information, and website address for individuals to seek consumer assistance.

D. Online Access for Participants

The TPA must provide, at no additional cost to Participant direct online access to claim information and claim/membership/eligibility information. Online access must allow for viewable inquiry only including historical eligibility and claims information.

E. Claims Administration

The TPA is responsible for maintaining a system for timely and accurate processing, adjudicating, and recording of claims for benefits in accordance with the current Plan Document, any applicable requirements established by GovGuam and any modifications or changes as communicated by GovGuam or as required by federal or state law. The TPA should maintain the resources, flexibility, and innovation to update and change the claims processing system as required by GovGuam. The TPA is responsible for reviewing submitted claims information for completeness and requesting any additional information necessary for proper adjudication of the claim in a timely manner. The claims processing system must be capable of accepting both electronic and paper submitted claims.

The TPA must have the capabilities to issue prior authorizations, verify medical necessity, detect and report potential fraud and abuse cases; cross-reference family deductible accumulations when employees and their dependents are all participants of the Plan; compare total charges against total payments; identify duplicate charges; compare number of inpatient hospital days on each claim against admission and discharge dates; verify services are provided within the employee's eligibility date and maintain breaks in active service; recognize historical benefit maximums; verify Provider license to the type of

procedure billed; reconcile the diagnosis code to the procedure and gender and age codes for consistency; compute benefit year deductibles; integrate in network deductible accumulations with out of-network deductible requirements; ensure high-deductible health plan (HDHP) participants are not over-charged deductible by monitoring pharmacy deductible applications and adjusting medical claims, when necessary; identify and maintain information on potential coordination of benefits, subrogation, and other party liability situations; verify out-of-pocket amounts; review age limits for eligibility or coverage limits; determine coinsurance levels; identify unbundling of services, up coding of services, obsolete or invalid codes; identify ineligible services; apply multiple surgery guidelines; receive and process claims from other payers for secondary coverage payments to ensure the total combined payments from all payers do not exceed the maximum amount allowed by the Plan for covered expenses; track and process network provider fee schedules to include percentage of charge (POC), per diem rates, Ambulatory Payment Group (APG), Ambulatory Payment Classification (APC), and Diagnosis Related Group (DRG) reimbursements.

Additional TPA services relative to claims administration include, but are not limited to, the following: preparing and distributing 1099 Forms (as may be required) for Providers, filing of reports on the behalf of GovGuam as required by federal and Guam law, producing and distributing claim forms, communicating in a timely manner to all participants and employer units procedures for filing claims, interpreting explanation of benefits (EOB), filing appeals, making changes in eligibility, handling claims from Providers who have a prompt-pay agreement, investigating returned checks for updated addresses, and related actions.

The TPA must maintain the following information for all claims: employee name, employee identification number, patient name or other specific identifier, claim number, Provider number, Provider name, service date, type of service, amount of charges, co-payment amount, amount allowed, and reason codes that specify the reason for claim payment/nonpayment. The information contained in the explanation of benefits must be available for inspection upon request.

For claims in which GovGuam is primary, the TPA shall process and pay claims within 90 days of receipt from the Provider. (Prompt Payment Act of Guam requires clean claims to be processed within 45 days. The TPA confirms to pay all other claims within 2x that requirement).

The TPA shall process and pay reimbursements to members within 90 days of receipt of a claim for any incorrect out-of-pocket expenses paid by the member.

On a monthly basis, or upon request by GovGuam, the TPA will provide the Specialty Drug List in Excel format including the following fields: GPI, NDC, Label Name, Member / PDL Drug Class, Drug Short Name, B/G, Access, LDD, and AWP Discount.

F. Run-Out Claims Administration

Upon termination of the Contract, the TPA is responsible for adjudicating and processing all claims with service dates prior to the termination date of the contract that are received by the TPA for one (1) year after the termination date. GovGuam will fund claim payments in accordance with the terms and conditions of this Contract.

G. Data Security

The TPA shall provide a high level of data security and protection, including cyber security controls, including:

1. A data center facility to meet the needs of the business areas, participants, and Provider network.
2. A business recovery model to support critical needs during a disaster.

3. Technology practices to support critical needs during a disaster.

H. Quality Control

The TPA will maintain formal policies and procedures regarding quality control. Quality control processes will be applied to regularly evaluate and ensure that the performance and accuracy of all areas of administration including, but not limited to, claims processing, customer service, and enrollment/eligibility, meet the performance measures established by GovGuam.

I. Provider Coding Accuracy

The TPA should utilize a system designed to evaluate coding accuracy and appropriateness relative to International Classification of Disease (ICD) and Physicians Current Procedural Terminology (CPT) coding and other coding references.

J. Hospital DRG Validations and Bill Audits

The TPA is responsible for initiating hospital DRG validations, charge/bill audits, and professional bill audits.

K. Credit Balance Recovery

The TPA is responsible for performing credit balance and overpayment recovery services, and will provide to GovGuam reports upon request of its findings to include, at a minimum, the following details:

1. Overpaid Entity/Individual;
2. Provider Tax ID, if applicable;
3. Overpayment Amount;
4. Overpayment Reason;
5. Date Overpayment Identified;
6. Collection Activity, including letter and phone date(s); and
7. Date Debt Discharged.

L. Out of Network Review and Price Negotiation

The TPA is responsible for completing out-of-network request for services and, if necessary, negotiates the allowed amount of these services.

M. National Provider Indicator

The TPA's claims processing system must be capable of maintaining standard unique identifiers for health care Providers in accordance with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

N. National Drug Codes

The TPA's claims processing system must be capable of capturing, storing and pricing claims based on National Drug Codes.

O. Prior Authorization of Benefits

The TPA is responsible for reviewing requests for prior authorization of benefits for physician and outpatient services based on the medical necessity of a particular case. The participant and {Provider must be notified of the determination of denial or approval in accordance with all applicable federal requirements and Plan requirements. In compliance with the No Surprises Act, the TPA must assure that the Plan will pay for emergency services without prior authorization, without additional administrative requirements for nonparticipating providers and facilities, and without being solely based on diagnostic codes.

P. Participant and Provider Customer Service

The TPA is responsible for responding to inquiries from participants, Providers, and DOA regarding the services provided by the TPA during normal service hours of 8:30 AM to 5:30 PM Monday through Friday.

The TPA is responsible for maintaining a separate participant customer service with a well-trained exclusive customer service department for participants capable of addressing all benefit and procedure questions. GovGuam members shall have a dedicated toll free member services telephone number to call for questions and issues. The member services call center shall be available 24 hours a day, 7 days a week, 365 days a year for all GovGuam members, Providers, and pharmacies. The TPA shall provide translation services and member materials for all languages, including Braille, as required by GovGuam, and text telephone (TTY) or telecommunication device for the deaf (TDD) services for hearing impaired members.

The TPA shall provide GovGuam specific training procedures for member service representatives.

The TPA is responsible for maintaining a separate provider customer service area for verification of participant eligibility, benefit questions, and claims status, and if requested, an estimate of allowable charges.

The TPA is required to participate in activities with DOA in responding to participant or Provider inquiries or complaints relating to TPA services.

The TPA is responsible for responding to inquiries from GovGuam agencies concerning administrative procedures and benefits.

Q. Participant Website and Mobile App

The TPA provides a website that enables participants the ability to access important information online at any time including, but not limited to, viewing claim information including deductible and out of pocket accumulations, viewing benefit information, accessing a virtual ID Card, ordering ID Cards, viewing articles on various health topics, and updating personal information.

The TPA shall have a mobile app that enables participants to obtain important information from a mobile device. Information available through this app should include, but is not limited to, locating a provider, accessing a virtual ID Card, viewing benefit information, viewing claim information, viewing articles on various health topics, updating personal information.

R. Enrollment and Eligibility

The TPA maintain enrollment and eligibility information on all participants. The TPA will receive enrollment and eligibility information from each GovGuam agency. The TPA should be able to receive and process enrollment data in electronic and paper formats. The TPA must have the capability of electronic scanning, storage, and retrieval of enrollment forms submitted for initial enrollment and enrollment/status changes. The Plan Document outlines the enrollment guidelines and provides a detailed explanation for the administration of the Plan.

S. Premium Billing and Reconciliation

The TPA is required to provide reconciliation services to the GovGuam payroll / Human Resources agencies. In addition to the requirements contained under Section C.- Eligibility under Item 4.- GovGuam's Responsibilities, GovGuam, through their agencies, will provide the TPA with their respective employee/retiree participant list for every Pay-Period-End (PPE). Each agency is required to provide their participant list no later than fifteen (15) days after the PPE. The information transmitted to the TPA must be sufficient for the TPA to fulfill this requirement; the detail of this information will be agreed between GovGuam and the TPA.

The TPA will maintain a premium billing and accounts receivable system for each PPE. The TPA will compare the information provided by each agency against its records for each PPE. The TPA will provide each agency and/or DOA information which will highlight discrepancies between the submitted participant listing and the TPA's record with regard to each participant's health plan choice and premium billing class. The TPA is required to submit such discrepancy report no later than fifteen (15) days after receipt of a GovGuam agency's participant listing. GovGuam and each agency is required to assist the TPA in resolving discrepancies in a timely manner. The TPA will not be held financially responsible for any unrecoverable amount of premium or claims due to any unresolved participant enrollment discrepancies.

T. Coordination of Benefits (COB) Administration

The TPA is responsible for providing COB services. The necessary information concerning primary coverage for participants and their dependents and other coverage extended via other carriers or benefits systems must be encoded into the TPA's claims processing system and tracked and managed via the system. To administer the coordination of benefits, the TPA must exchange information with other plans involved in paying claims, request that the participant/provider furnish any necessary COB information, reimburse any plan that made payments that this Plan should have made, and recover any overpayment from health care Providers and other insurance companies as necessary. If this Plan should have paid benefits that were paid by any other plan, the TPA will pay the plan that made the other payments in the amount the Plan determines to be proper under COB provisions.

U. Subrogation Administration (Third Party Liability and Work-Related)

As a condition to receiving medical benefits under the Plan, participants agree to transfer to the Plan their rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person. Benefits for work-related injuries or illnesses may be extended by the Plan where (1) liability is being controverted by the employer in a proceeding before the particular worker's compensation agency with jurisdiction and participant's related claims are unpaid; or (2) claims payments were made prior to notification to the Plan of their work-related nature. The TPA is responsible for full subrogation administration, including, but not limited to, efficiently identifying those cases that qualify for subrogation and the legal pursuit thereof.

V. Overpayment/Recovery Administration

The TPA shall identify, collect and post overpayments from participants and Providers in a timely manner. Overpayments will be posted to the participant's individual claims account.

W. Medicare Secondary Payer (MSP)

The TPA is responsible for all functions related to MSP post-payment recoveries. The Plan is not liable for interest accrued as the result of untimely or unaccepted defenses. In these instances, the TPA will be responsible for any and all interest accrued.

X. Satisfaction Surveys

The TPA must conduct at least one (1) participant satisfaction and one (1) network provider survey annually. The contents and process of the satisfaction surveys must be agreed upon by GovGuam and the TPA.

Y. Appeal and Grievance Procedures

The TPA must administer appeal and grievance procedures in accordance with all regulations required by Affordable Care Act. A participant has the right to appeal any decision that denies payment of a claim or a request for coverage of a health care service or treatment. If a participant believes that the TPA incorrectly denied all or part of a claim, he has the right to obtain a full and fair review. A request for a review must be made in writing to the TPA. TPA is to adhere to the appeal procedures as described in the Plan Document.

Z. Utilization Review and Medical Director

The TPA must provide a well-staffed utilization review department to administer the functions listed hereunder. The TPA must employ or contract with a full-time Medical Director to support the claims management of the Plan. The medical director will be required to provide support in participant benefit appeals and benefit determinations, ensuring accurate processing of claims which require review, consult on prior approvals, etc. Support functions may include, but are not limited to: pre determination of benefits, medical necessity, and experimental or investigative procedures.

AA. Medical Policy

The TPA is responsible for establishing and maintaining medical policies on medical services/procedures. Medical policy must be based on scientifically based evidence provided through research for a particular medical technology. Medical policy must also be based on data from peer-reviewed scientific literature from criteria developed by specialty societies and from guidelines adopted by other health care organizations such as the MCG guidelines and/or the Medicare payment policy guidelines for applicable benefits at the time of service.

BB. Training Personnel

Upon request, the TPA is required to conduct training sessions relative to enrollment/eligibility policies and procedures for GovGuam agencies. The number of training sessions is dependent on many factors including payroll/personnel, staff turnover, changes to enrollment/eligibility requirements, updates /changes in eligibility system, etc. The TPA must provide field representative personnel to conduct such employer/employee training sessions, including individual meeting with employers as needed.

CC. Benefit Fairs

The TPA agrees to participate in benefit fairs as requested by employer units to educate participants.

DD. Explanation of Benefits (EOB)

The TPA's EOB form and Provider payment voucher must facilitate the separation of non-covered amounts, Provider discounts, and the patient's financial responsibility amount. The TPA must issue EOBs and must accurately reflect patient responsibility, Provider discounts, non-covered services, explanation codes, etc. The TPA must also provide the capability for participants and Providers to access, download, and print EOBs and Provider payment vouchers online. The TPA must monitor replies to EOB notifications and respond accordingly to participant inquiries received.

EE. Claims and Performance Reviews

GovGuam, at its own expense, contracts with an independent third party vendor to conduct annual claims and performance reviews of the TPA. In addition, the operations of the TPA relative to the Plan are included in annual audits conducted by the State Auditor's Office or its designee. GovGuam maintains the right to perform financial, performance and other special audits on records maintained by the TPA during regular business hours. The TPA will make available all records, as defined by the selected auditor, for review at no cost to GovGuam. This does not preclude the auditing of other services or additional claims. Any errors detected via the audit will be addressed and corrected in a timely manner by the TPA. Any claim processing error will be adjusted to the proper account.

FF. Standard and Ad Hoc Reporting

The TPA must furnish standard reports in a form and content approved by GovGuam as stated in Exhibit C, TPA Services Contractor Reports. Additionally, the TPA will provide ad hoc reports at GovGuam's request. The TPA shall provide for GovGuam the time and cost for the development of ad hoc reports prior to the development of the report.

GG. Transition of Services

Upon termination of this contract, the TPA is responsible for coordinating with the succeeding TPA to transition services performed by the TPA.

HH. Cost of Doing Business

The TPA shall be solely responsible for all applicable taxes, insurance, licensing, and other costs of doing business. Should TPA default in these or other responsibilities, jeopardizing TPA's ability to perform services effectively, this Contract may be terminated for default.

II. Informational Materials

The TPA, at its own cost, shall provide and maintain a supply of the TPA's informational materials to GovGuam. The TPA, at its own cost, shall provide a supply of the TPA's informational materials to GovGuam agencies throughout the terms of the Contract when requested. Participants will receive informational materials from the participant's GovGuam agency offices.

The TPA shall obtain GovGuam's approval for all member communication materials before distribution to members. The TPA will not automatically enroll GovGuam in any programs that involve any type of communications with members or alterations without express written consent from GovGuam.

JJ. GovGuam Approval

The TPA is required to notify GovGuam prior to (1) using GovGuam's or the Plan's name or Plan benefit information in any social media, publications or printed material or (2) any publications or printed material mailed or provided directly to participants or (3) any change in the core services to be provided by the TPA.

KK. Network

The TPA will develop and manage a network of health care providers to meet the health care needs of the participants. The TPA will be responsible for contacting, negotiating, and contracting with hospitals, Providers, and other health care professionals. The TPA will be responsible for credentialing the Providers, managing the network including monitoring access, cost and quality, and providing related customer service to the participants and to the Providers.

Network adequacy will be determined by a number of factors, including the types of Providers available by discipline, geographic accessibility, and travel distance. The Provider network must be adequate to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, specialized hospital care, both on-island and off-island, along with all other health care services included under the terms of the contract.

The network of Providers on Guam should include most of the Providers on Guam and must be sufficient in numbers and types of Providers and facilities to ensure that all services will be accessible without unreasonable delay.

Healthcare from off-island Providers is an important component of Guam's overall health care system. The TPA is expected to contract with Providers in the U.S. and other countries where airline service is frequent. The off-island Provider network must contain multi-specialty hospital facilities to accommodate the health care needs which are unable to be performed locally. This may be accomplished by providing access to a comprehensive network of providers such as a Preferred Provider Organization (PPO) in the mainland U.S. or other countries, which not necessarily exclusive to the Plan.

The TPA is expected to designate Centers of Excellence (COE) that include providers who specialize in particular medical services. Any designation of an institution as a COE must be based on objective measures for which there is clear evidence of improved outcomes and/or cost efficiency. COEs may include, but are

not limited to, facilities that specialize in procedures such as bariatric surgery, hip and knee replacements, cardiac procedures, and back surgeries. GovGuam anticipates savings will result from improvements to quality of care and outcomes for services that are performed at a COE.

The TPA shall also contract with a PBM for the administration of pharmacy benefits, pharmacy claims, and comprehensive network of pharmacies.

LL. Off-island Services

The TPA is expected to coordinate off-island medical services for participants upon request or referrals.

MM. Contract Provisions

The TPA will maintain contracts with network providers that contain acceptable language relating to those contract requirements as required by GovGuam.

NN. Provider Resolution

The TPA agrees to cooperate with DOA in resolving any provider issues brought forth to them including, but not limited to, contracting terms, pricing disputes, claims issues, providers not accepting new patients, lengthy waits for appointments, or lack of specialty provider coverage.

OO. Provider Audit

The TPA should contractually require each participating provider to cooperate with any reasonable audit program implemented by GovGuam, including, but not limited to, hospital bill audit, DRG validation, and provider bill audit, and to provide, without charge, all necessary information for the completion of such audits.

PP. Cooperation with Other GovGuam Vendors

The TPA will cooperate as required with GovGuam's other contracted vendors.

QQ. Provider Directory

The TPA will maintain a Provider Directory for the participating providers within their network, including name, billing address, physical address, telephone number, provider number, area(s) of practice or specialty. The TPA agrees to provide access to updated provider information via their website.

RR. Network Provider Requirements

The TPA shall require that all network providers adhere to the following:

1. To not discriminate in the treatment of participants on the basis of race, color, creed, sex, age, national origin, physical handicap, disability, religion, place of residence, source of payment or any other consideration made unlawful by federal and state laws;
2. To comply with Guam and federal laws and regulations relating to the confidentiality of protected health information of participants;
3. To adhere to the medical/utilization management program requirements;
4. To not bill participants or the Plan for services that are not medically necessary as determined by the medical management/utilization program vendor or the claims administrator. Such services shall include those services that are not covered under the Plan's wellness/preventive services benefit. Covered wellness services are listed on the Plan's website at: ****COMPANY WEBSITE****;
5. To file claims with other carriers when the Plan is secondary in coordination of benefits. Under such circumstances, the Plan will provide benefits for the patient's liability amount, as defined by the primary payor, not to exceed the allowable charge;
6. To accept, as the allowable charge, the lesser of covered charges, or the amount established by the TPA;
7. For claims in which the Plan is a participant's primary coverage, to file claims within ninety (90) days

of the date on which the services were performed. For claims in which the Plan is considered a participant's secondary coverage, to file claims within twelve (12) months of the date on which the services were performed. The network provider will hold the participant and the Plan harmless for any charges for which a claim is not filed within the timeframe above;

8. To comply with the Healthcare Effectiveness Data and Information Set (HEDIS) measures, where applicable;
9. To submit biometric data on participants as requested to the claims administrator; and
10. To adhere to the requirements of the pharmacy clinical programs such as prior authorization, step therapy, and quantity limits.

SS. Plan Communication

The TPA will develop a system for regularly communicating the Plan's benefits, medical management requirements, and billing procedures to network providers which will include written communications as well as annual workshops.

TT. Provider Website

The TPA must provide a secure provider service website where routine provider service inquiries can be handled. Information available through this website must include a self-serve system to providers for verification of participant eligibility, benefit summaries, deductible and co-insurance maximum accumulation amounts and claims status. This self-serve system must be available twenty-four (24) hours, seven (7) days a week.

UU. Provider Manuals

The TPA shall develop, distribute, and maintain provider manuals. In addition, the TPA will be expected to notify network providers of subsequent contract clarifications and procedural changes. The provider manual will include at least the following information:

1. An introduction to the Plan which explains the TPA's organization and administrative structure;
2. A description of the Plan's case management process;
3. A description of covered medical services, excluded medical services, and benefit limitations;
4. Billing and encounter submission information indicating which form (e.g. UB92, HCFA 1500) is to be used for services and which fields and codes are required for a claim to be considered acceptable by the TPA, or the necessary protocol and procedural information for a Provider to submit claims electronically in accordance with HIPAA and HITECH EDI standards;
5. Provider performance expectations including disclosure of medical management and quality assurance criteria and processes;
6. Emergency room utilization (appropriate and non-appropriate use of the emergency room);
7. Claim filing procedures (paper and electronic)
8. A listing of key contacts and telephone numbers at the TPA;
9. Prior authorization requirements, including rules for referrals for specialty care and use of non-participating providers; and
10. How to register a complaint or grievance with the TPA.

VV. Provider Credentialing

The TPA will be responsible for credentialing all providers prior to their acceptance into the provider network of the Plan. Additionally, the TPA will be responsible for re-credentialing the providers. This can be delegated to Provider Sponsored Organizations for those providers in a Provider Sponsored Organization. The TPA will utilize credentialing and re-credentialing standards that meet or exceed National Committee for Quality Assurance (NCQA) standards for credentialing providers.

WW. Corrective Action

The TPA will notify GovGuam of any corrective action taken against a participating provider, which would

materially limit the participating provider's admitting privileges at a participating hospital. The TPA will notify GovGuam of any corrective action taken against a participating hospital or other provider and the reason for such action.

XX. Other Provider Requirements

1. The TPA shall develop, implement, and maintain grievance and appeal procedures related to credentialing and pricing.
2. The TPA shall not prohibit or otherwise restrict a covered provider or other health care professional from advising a participant about their health situation or medical care or treatment for the participant's condition or disease, regardless of whether benefits for such care or treatment are provided under the Plan, if the professional is acting within his lawful scope of practice.
3. The TPA shall not prohibit a network provider from advocating on behalf of the participant within the medical management or grievance and appeal processes established by the TPA.
4. The TPA shall notify network providers of their responsibilities with respect to the Plan's applicable administrative policies and programs, including, but not limited to, payment terms, medical management, quality assessment and improvement programs, credentialing, grievance and appeal procedures, data reporting requirements, and any applicable federal and state programs.
5. Neither the TPA nor any subcontractor shall offer any inducement to any providers to provide less than standard quality medical care to participants than is medically necessary.
6. The TPA shall be responsible for notifying participants of any material changes in the network.

YY. Quality

The TPA will cooperate with any quality initiatives including, but not limited to, provider profiling and outcome measurements established by GovGuam.

ZZ. Customer Service

The TPA will be available for provider, participant, and employer unit inquiries and complaints. Customer service standards are outlined in **Exhibit B, Performance Guarantees**, of this Contract.

AAA. Complaint Resolution Process

The TPA is responsible for responding to and documenting resolution of provider and participant complaints. The TPA will fully respond to all participant and provider complaints within ten (10) business days after receiving the complaint.

BBB. Rebates

The Plan shall receive 100% of pharmacy rebates received by the TPA attributable to GovGuam's pharmacy utilization.

CCC. Other Services

The TPA shall provide other services for which the TPA has the technical capability to render, as requested by GovGuam and agreed to in writing by GovGuam and the TPA.

DDD. Audits

The TPA shall pay all monies owed as a result of any audit and such payment will be made within 30 calendar days after the parties' agreement to the specific audit item. Both parties agree to respond to audit findings in a timely manner.

The TPA confirms that if it utilizes the services of a rebate aggregator, group purchasing organization, or other entity to administer rebate contracts or collect rebates, the same audit provisions that apply to the TPA would apply to the rebate aggregator, regardless of ownership or affiliation.

EEE. Direct Contracted Provider Claims

TPA will reimburse DOA direct contracted providers at the agreed upon rates. TPA agrees to pay claims to providers currently contracted with the TPA at the rates agreed upon between DOA & the direct contracted provider.

FFF. IBNP Reporting

TPA will provide quarterly incurred but not paid (IBNP) estimates by plan to GovGuam separately for medical and pharmacy claims, within 3 months after the end of each quarter.

GGG. Pharmacy Formulary

TPA to provide any proposed formulary change, by NDC, to GovGuam at least ninety (90) days in advance of the effective date for GovGuam's approval prior to implementation.

4. GovGuam Responsibilities

A. Benefit Funding

GovGuam shall open an account through which Plan benefit payments, Service Fees and Plan benefit related charges will be made. GovGuam shall grant TPA access to the funds contained in the account. GovGuam will initially fund the account with an amount equal to one (1) month of estimated benefit payments and Service Fees.

The TPA, typically on a weekly basis, will withdraw funds from the account to fund the "Weekly Payments" to providers for covered services and applicable Service Fees under the Plan. Prior to the withdrawal of funds, the TPA will notify DOA, and obtain approval of the withdrawal with an accompanying detailed report to be agreed between GovGuam and TPA.

GovGuam shall replenish the account within ten (10) days after each Weekly Payment in an amount at least equal to the last Weekly Payment. The TPA will not make payment nor release payments to providers unless adequate funds are contained in the account. The funding of Weekly Payments by GovGuam shall be made in chronological order. The lack of adequate funds is subject to the Termination section of this contract.

- B. Plan Document Review** – GovGuam shall provide TPA with the Plan Document at least thirty (30) days prior to the Effective Date of this contract. The TPA will need adequate time to review the Plan Document to determine any potential differences that may exist between the Plan Document and the TPA's current administrative systems and internal policies and procedures to make the necessary changes.

The TPA agrees to compose or aide in the creation of the Plan Document and any accompanying Summary of Benefits and Coverage (SBC), Summary Plan Description (SPD), Schedule of Benefits (SOB) or other accompanying documents to aide participants or for compliance with applicable law. However, the TPA shall not be held responsible for satisfying any and all Plan reporting and disclosure requirements imposed by law.

- C. Eligibility** – The Plan Document shall contain the eligibility requirements for participation under the plan including any required documentation from participants as proof of eligibility. GovGuam, directly or through its agencies, shall notify the TPA of any and all participant changes under the Plan within fifteen (15) days after the Pay Period End Date (PPE) for such pay period the change was effective. The notification of changes will include all the necessary participant information and documentation listed below. Such notification will be submitted via a standard medium (paper form, electronic enrollment, etc.) to be agreed between GovGuam and TPA. Aside from new and terminating participants, participant changes also include any changes to the required participant information listed below:
- a. Participant's health plan choice;
 - b. Participant's name, social security number, date of employment, date of birth, mailing address, phone

- numbers and email address;
- c. Participant's unique identification number;
- d. Participant's and any covered dependents' Social Security numbers;
- e. Dependent's address (if different than subscriber);
- f. Effective dates of coverage;
- g. Participant's marital status;
- h. Participant's GovGuam payroll agency;
- i. Retiree participant's retirement plan and retiring agency;
- j. Other insurance information (Medicare A,B,D; other)
- k. Disabled Dependent Status Indicator – The TPA is responsible for verifying that the dependent qualifies for continued coverage as a disabled dependent;
- l. Changes in Subscriber Premium Class;
- m. Changes from one agency to another;
- n. Mandatory health plan choice changes for retirees as required under the Plan;
- o. Changes or corrections to participant's personal information.

GovGuam through its agencies, are responsible for requesting and acquiring any required documentation from subscribers for submission to the TPA.

- D. **Notice of Plan or Benefit Change** – GovGuam shall notify the TPA in writing of any changes in the Plan Document or Plan benefits (including changes in eligibility requirements) at least 30 days prior to the effective date of such changes. The TPA will have 30 days following receipt of such notice to inform GovGuam whether TPA will agree to administer the proposed changes. If the proposed changes increase the TPA's costs or alter its ability to meet any performance guarantees or otherwise impose substantial operational challenges, TPA may require an adjustment to the Service Fees or other financial terms.
- E. **Employee Notices** – GovGuam shall furnish each Employee covered by the Plan written notice that GovGuam has complete financial liability for the payment of Plan benefits. GovGuam shall inform its Plan participants, in a manner that satisfies applicable law, that confidential information relating to their benefit claims may be disclosed to third parties in connection with plan administration.
- F. **Third Party Consents** – GovGuam shall obtain any consents, authorizations or other permissions from Employees or relevant third parties, which may be required under law or otherwise necessary in order for TPA to access, use or disclose information and data for the purposes of providing Services under this contract.
- G. **Audits** - GovGuam has audit rights into any and all delegated functions and contractual components.

5. Termination of Contract

- A. The effective date of this Contract is October 1, 2024. The term of the Contract will be for one (1) year.
- B. This Contract may be terminated by either party, with or without cause, upon at least ninety (90) days prior written notice of intent to terminate is provided to the other party.
- C. If either party to this contract refuses or fails to perform any of the provisions of this Contract with such diligence as to disrupt its continuous and efficient administration, or any extension thereof, or otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of this Contract, one party of this contract may terminate this contract by providing at least a thirty (30) day notice of termination to the other party.

However, if GovGuam fails to adequately fund the account made available to the TPA for Weekly

Payments, the TPA has the right to immediately suspend Services by providing written notice to GovGuam of such suspension until the funds have been provided. Should funding adequacy remain unresolved, the TPA has to right to terminate this contract under the provisions above.

- D. If Guam enacts a law to prohibit the continuance of the Agreement or some portion thereof, the Agreement or that portion shall terminate automatically as to such jurisdiction on the effective date of such law or interpretation; provided, however, if only a portion of the Agreement is impacted, the Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.
- E. Upon termination of this Contract, for any reason other than funding inadequacy or default of payment by GovGuam, the TPA will continue to process runoff claims for Plan benefits that were incurred prior to the termination date, which are received by the TPA within 6 months following the termination date. The Service Fee for such activity is included in the Service Fees described in Exhibit A – Fee Schedule. Runoff claims will be processed and paid in accordance with the terms of this Contract. New requests for benefit payments received after the-6-month runoff period will be returned to GovGuam or to a successor administrator at GovGuam's expense. Claims which were pending or disputed prior to the start of the runoff period will be handled to their conclusion by the TPA, as well as provider performance or incentive payments paid for prior period provider performance, and GovGuam agrees to fund such claims or payments when requested by the TPA.
- F. GovGuam shall continue to fund Plan benefit payments and agrees to instruct its bank to continue to make funds available until all outstanding Plan benefit payments have been paid or until such time as mutually agreed upon by TPA and GovGuam. GovGuam's wire line and bank account from which funds are requested must remain open for one year after runoff processing ends, or two years after termination.
- G. Upon termination of the Agreement and provided all Service Fees have been paid, the TPA will release to GovGuam, or its successor administrator, all claim data in TPA's standard format, within a reasonable time period following the termination date. All costs associated with the release of such data shall be paid by GovGuam.

6. Termination of Agencies and Participants

A. Termination of Participants

Under the direction of DOA, upon completion of the reconciliation process for an agency for a PPE, the TPA will immediately suspend the coverage of those individual participants for non-payment of premium effective on the last day for which premium was paid. The TPA must provide direct written notice of coverage suspension to subscribers who have outstanding premium payments due and after fifteen (15) days if premium payment remains unresolved, provide notice of termination from the Plan. The TPA will provide each agency and DOA accompanying lists of those subscribers under coverage suspension and to be terminated by the Plan.

Except for non-payment of Premiums, the TPA may only terminate a participant as provided under the Plan.

B. Termination of GovGuam Agencies

If any GovGuam agency refuses or fails to perform any of the provisions required of such agency by this Contract including but not limited to the payment of premiums, the TPA, only under the specific direction of DOA, may terminate from the Plan, all participants from within such agency.

7. Consideration

- A. GovGuam agrees to compensate the TPA for services approved by GovGuam and performed by the TPA under the terms of this Contract. As illustrated under Exhibit A, Fee Schedule for Third Party Administration Services, the TPA fee is based on the number of subscribers per Pay-Period-End. As required, each GovGuam agency will be submitting employer participant listings each PPE during the duration of this contract. Using this information, the TPA will withdraw its calculated Fees from the GovGuam bank account made available to the TPA. Any withdrawal payment by the TPA shall be adjusted for prior PPE overpayments or underpayments after PPE reconciliation is completed as outlined in this contract.

8. Record Retention and Access to Records

The TPA agrees that GovGuam or any of its duly authorized representatives at any time during the term of this Contract shall have unimpeded, prompt access to and the right to audit and examine any pertinent books, documents, papers, and records of the TPA related to the TPA's charges and performance under this Contract. GovGuam agrees to provide the TPA with reasonable advance notice for any standard audits or reviews, with the expectation that such reviews shall be made during normal business hours of the TPA. The parties shall cooperate to schedule and conduct such audit or inspection to prevent disruption to TPA's performance of the services hereunder and for TPA's other customers. All records related to this Contract shall be retained by the TPA for a period of six (6) years after final payment under this Contract and all pending matters are closed unless GovGuam authorizes their earlier disposition. However, if any litigation, claim, negotiation, audit or other action arising out of or related in any way to this Contract has been started before the expiration of the six (6) year period, the records shall be retained for one (1) year after all issues arising out of the action are finally resolved or until the end of the six (6) year period, whichever is later. The TPA agrees to refund to GovGuam, any overpayment disclosed by any such audit arising out of or related in any way to this Contract.

9. Right to Audit

TPA shall maintain such financial records and other records as may be prescribed by GovGuam or by applicable federal and state laws, rules, and regulations. TPA shall retain these records for a period of three years after final payment, or until they are audited by GovGuam, whichever event occurs first. These records shall be made available for inspection during regular business hours and with reasonable advance notice during the term of the Contract and the subsequent three-year period for examination, transcription, and audit by GovGuam or its designees or other authorized bodies.

10. Right to Inspect

GovGuam or any other auditing agency or their authorized representative shall, at all reasonable times, have the right to enter onto the TPA's premises, or such other places where duties under this Contract are being performed, to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. The TPA shall provide access to all facilities and assistance to GovGuam's representatives. All inspections and evaluations shall be performed in such a manner as to not delay work.

11. Applicable Law

The Contract shall be governed by and construed in accordance with the laws of Guam and Federal Laws as applicable, excluding its conflicts of law provisions, and any litigation with respect thereto shall be brought in the courts of Guam. The TPA shall comply with applicable federal and local laws and regulations.

12. Severability

If any part of this Contract is declared to be invalid or unenforceable, such invalidity or unenforceability shall not

affect any other provision of the Contract, and to this end the provisions hereof are severable. In such event, the parties shall amend the Contract as necessary to reflect the original intent of the parties and to bring any invalid or unenforceable provisions in compliance with applicable law.

13. Anti-Assignment/Subcontracting

TPA acknowledges that it was selected by GovGuam to perform the services required hereunder based, in part, upon TPA's special skills and expertise. TPA shall not assign, subcontract, or otherwise transfer this Contract, in whole or in part, without the prior written consent of GovGuam.

14. Information Designated by Contractor as Confidential

Confidential Information as earlier defined under this contract, each party to this agreement agrees to the following:

- A. To protect all confidential information provided by one party to the other to the extent allowed under Guam and/or federal law; and,
- B. To treat all such confidential information as confidential to the extent that confidential treatment is allowed under Guam and/or federal law; and,
- C. Any disclosure of those materials, documents, data, and other information which TPA has designated in writing as proprietary and confidential shall be subject to the provisions of any governing law. As provided in the Contract, the personal or professional services to be provided, the price to be paid, and the term of the Contract shall not be deemed to be a trade secret, or confidential commercial or financial information.

15. Disclosure of Confidential Information

In the event that either party to this Contract receives notice that a third party requests divulgence of confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of confidential or otherwise protected information that party shall promptly inform the other party and thereafter respond in conformity with such subpoena to the extent mandated by law. This section shall survive the termination or completion of this Contract.

16. Confidentiality

Notwithstanding any provision to the contrary contained herein, it is recognized that GovGuam and/or DOA is a public entity and is subject to the 5 GCA Chapter 10, also known as the Sunshine Reform Ac. If a public records request is made for any information provided to GovGuam pursuant to the Contract and designated by the TPA in writing as trade secrets or other proprietary confidential information, DOA and GovGuam shall follow the provisions of the Act. DOA or GovGuam shall not be liable to the TPA for disclosure of information required by court order or required by law.

17. Independent Contractor Status

The TPA shall perform all services as an Independent Contractor and shall at no time act as an agent for GovGuam. Nothing contained herein shall be deemed or construed by GovGuam, the TPA, or any third party as creating the relationship of principal and agent, master and servant, partners, joint ventures, employer and employee, or any similar such relationship between GovGuam and the TPA. Neither the method of computation of fees or other charges, nor any other provision contained herein, nor any acts of GovGuam or the TPA hereunder creates, or shall be deemed to create a relationship other than the independent relationship of

GovGuam and Contractor. The TPA's personnel shall not be deemed in any way, directly or indirectly, expressly or by implication, to be employees of GovGuam. No act performed or representation made, whether oral or written, by the TPA with respect to third parties shall be binding on GovGuam. Neither the TPA nor its employees shall, under any circumstances, be considered servants, agents, or employees of GovGuam; and GovGuam shall at no time be legally responsible for any negligence or other wrongdoing by the TPA, its servants, agents, or employees. GovGuam shall not withhold from the Contract payments to the TPA, any federal or local unemployment taxes, federal or state income taxes, Social Security tax, or any other amounts for benefits to the TPA. Further, GovGuam shall not provide to the TPA any insurance coverage or other benefits, including Worker's Compensation, normally provided by GovGuam for its employees.

18. Force Majeure

Except for GovGuam's obligation under Section 4.A and payment of the Service Fee to TPA, each party shall be excused from performance for any period and to the extent that it is prevented from performing any obligation or service, in whole or in part, as a result of causes beyond the reasonable control and without the fault or negligence of such party and/or its subcontractors. Such acts shall include without limitation acts of God, typhoons, earthquakes, floods, strikes, riots, acts of war, epidemics, governmental regulations superimposed after the fact, fire, or other natural disasters ("force majeure events"). When such a cause arises, the TPA shall notify GovGuam immediately regarding the anticipated duration of the inability to perform. Delays in delivery or in meeting completion dates due to force majeure events shall automatically extend such dates for a period equal to the duration of the delay caused by such events, unless GovGuam determines it to be in its best interest to terminate the Contract.

19. Modification or Renegotiation

This Contract may be modified, altered or changed only by written agreement signed by the parties hereto. The parties agree to renegotiate the Contract if federal, or Guam revisions of any applicable laws or regulations make changes in this Contract necessary.

20. Oral Statements

No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this Contract. All modifications to the Contract shall be made in writing by GovGuam and agreed to by the TPA.

21. Indemnification

To the fullest extent allowed by law, GovGuam shall indemnify, defend, save and hold harmless, protect, and exonerate the TPA, its owners, Board Members, officers, employees, agents, and representatives from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever, including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of or caused by GovGuam and/or its partners, principals, agents, employees, and/or subcontractors in the performance of or failure to perform this Contract.

22. Insurance or Other Sureties

The TPA shall maintain, throughout the term of this Contract, at its own expense,

- A. **Professional and comprehensive general or commercial liability insurance** coverage in an amount no less than One Million Dollars (\$1,000,000) per occurrence and Three Million Dollars (\$3,000,000) annual aggregate.

23. Third Party Action Notification

The TPA shall give GovGuam prompt notice in writing of any action or suit filed, and prompt notice of any claim made against the TPA by any entity that may result in litigation related in any way to this Contract. GovGuam shall give the TPA prompt notice in writing of any action or suit filed, and prompt notice of any claim made against GovGuam by any entity that may result in litigation related in any way to this Contract.

24. Disputes

Any dispute between the parties whether in tort, this Contract, or otherwise which is not disposed of by agreement shall be submitted to binding arbitration pursuant to arbitration process as outlined in the Guam Code Annotated (Title 10, Chapter 10).

25. Failure to Enforce

Failure by GovGuam or the TPA at any time to enforce the provisions of the Contract shall not be construed as a waiver of any such provisions. Such failure to enforce shall not affect the validity of the Contract or any part thereof or the right of GovGuam to enforce any provision at any time in accordance with its terms.

26. Business Associate Statement

In the paragraphs that follow under this section, the term "BA Statement" shall refer to this section of the Contract, the term "Business Associate" shall refer to the GovGuam, and the term "Covered Entity" shall refer to the TPA. The purpose of this BA Statement is to satisfy certain standards and requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) and regulations promulgated there under by the U.S. Department of Health and Human Services (HHS) (the HIPAA Regulations) and other applicable laws, including the American Recovery and Reinvestment Act (ARRA) of 2009, as applicable. The Covered Entity wishes to disclose certain information (Information) to Business Associate pursuant to the terms of the Contract, some of which may constitute Protected Health Information (PHI). The Covered Entity desires and directs Business Associate to share PHI with other Business Associates of the Covered Entity. In consideration of mutual promises below and exchange of information pursuant to this BA Statement, the parties agree as follows:

A. Definitions

Terms used, but not otherwise defined, in this BA Statement shall have the same meaning as those terms in the Standards for Privacy of Individually Identifiable Information (the Privacy Rule) and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In the event of an inconsistency between the provisions of this BA Statement and mandatory provisions of the Privacy Rule and or the Security Standards, as amended, the Privacy Rule and/or the Security Standards shall control. Where provisions of this BA Statement are different than those mandated in the Privacy Rule and/or the Security Standards, but are nonetheless permitted by the Privacy Rule and/or the Security Standards, the provisions of this BA Statement shall control.

1. Breach. Breach shall be as defined in HITECH and the HIPAA regulations at 45 CFR §164.402.
2. Business Associate. Business Associate shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.
3. Covered Entity. Covered Entity shall have the same meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.
4. Designated Record Set. Designated Record Set shall have the same meaning given to such term under 45 CFR § 164.501 and shall mean a group of records maintained by or for the Covered Entity that is the payment, enrollment, claims adjudication and case or health management record systems maintained

by or for the Covered Entity, or used, in whole or in part, by or for the Covered Entity, to make decisions about Individuals.

5. **Electronic Media.** Electronic Media has the same meaning as the term “electronic media” in 45 CFR § 160.103, which is:
 - a. Electronic storage material on which data is or may be recorded electronically, including for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
 - b. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.
6. **Electronic Protected Health Care Information or (EPHI).** EPHI has the same meaning as the term ‘electronic protected health care information’ in 45 CFR § 160.103, and is defined as that PHI that is transmitted by or maintained in electronic media.
7. **Individual.** Individual shall have the same meaning as the term “individual” in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
8. **Privacy Rule.** Privacy Rule shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, subparts A and E.
9. **Protected Health Information or (PHI).** PHI shall have the same meaning as the term “protected health information” in 45 CFR § 164.103, limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of Covered Entity.
10. **Required By Law.** Required By Law shall have the same meaning as the defined term “required by law” in 45 CFR § 164.103.
11. **Security Incident** has the meaning in 45 CFR § 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
12. **Security Standards** shall mean the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) codified at 45 CFR Parts 160 and 164, subpart C (Security Rule).
13. **Unsecured PHI** as defined in HIPAA and the HIPAA regulations at 45 CFR § 164.402, means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in guidance issued under 13402(h)(2) of Public Law 111-5 on HHS website.

B. Obligations and Activities of Business Associate

1. **Compliance with Applicable Laws.** Business Associate shall fully comply with the standards and requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the American Recovery and Reinvestment Act of 2009, Public Law 111- 5 (ARRA) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the HIPAA Regulations) and other applicable laws as of the date(s) the requirements under these laws become effective for Business Associates. This compliance shall include all requirements noted in Section 13404(a), (b) and (c) of the HITECH Act.
2. **Business Associate directly subject to certain HIPAA provisions.** Under HITECH, Business Associate acknowledges that it is directly subject to certain HIPAA provisions including, but not limited to, Sections 13401, 13404, 13405 of HITECH.
3. **Use and Disclosure of Protected Health Information.** Business Associate may use and/or disclose the Covered Entity’s PHI received by Business Associate pursuant to this BA Statement, the Contract, or as required by law, or as permitted under 45 CFR §164.512, subject to the provisions set forth in this BA

Statement. Business Associate may use PHI in its possession for its proper management and administration or to fulfill any of its legal responsibilities. The Covered Entity specifically requests that Business Associate disclose PHI to other Business Associates of the Covered Entity for Health Care Operations of the Covered Entity. The Covered Entity shall provide a list of the affected Business Associates and shall request specific disclosures in written format. If any affected Business Associate is no longer under a BA Statement with the Covered Entity, the Covered Entity shall promptly inform Business Associate of such change.

4. **Safeguards Against Misuse of Information.** Business Associate shall use appropriate safeguards to prevent the use or disclosure of the Covered Entity's PHI in any manner other than as required by this BA Statement or as required by law. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.
5. **Reporting of Disclosures.** Business Associate shall report to the Covered Entity any use or disclosure of the Covered Entity's PHI in violation of this BA Statement or as required by law of which the Business Associate is aware, including Breaches of Unsecured PHI as required by 45 CFR §164.410, and agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of the Covered Entity's PHI by Business Associate in violation of this BA Statement.
6. **Business Associate's Agents.** Business Associate shall ensure that any agents, including subcontractors, to whom it provides PHI received from (or created or received by Business Associate on behalf of) the Covered Entity agree to be bound to by restrictions and conditions on the use or disclosure of PHI that are no less protective than those that apply to Business Associate with respect to such PHI. Business Associate represents that in the event of a disclosure of PHI to any third party, the information disclosed shall be in a limited data set if practicable and in all other cases the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.
7. **Nondisclosure.** Business Associate shall not use or further disclose the Covered Entity's PHI otherwise than as permitted or required by this BA Statement, the Contract, or as required by law.
8. **Availability of Information to the Covered Entity and Provision of Access and Accountings.** Business Associate shall make available to the Covered Entity such Protected Health Information maintained by the Business Associate in a Designated Record Set as the Covered Entity may require to fulfill the Covered Entity's obligations to provide access to, or provide a copy of, such Designated Record Set as necessary to satisfy the Covered Entity's obligations under 45 CFR § 164.524. Business Associate shall also maintain and make available the information required to provide an accounting of disclosures of Protected Health Information to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR § 164.528.
9. **Amendment of PHI.** Business Associate shall make the Covered Entity's PHI available to the Covered Entity as the Covered Entity may require to fulfill the Covered Entity's obligations to amend PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR § 164.526 and Business Associate shall, as directed by the Covered Entity, incorporate any amendments to the Covered Entity's PHI into copies of such PHI maintained by Business Associate. Business Associate agrees to make any amendment(s) to Protected Health Information that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of the Covered Entity or an Individual, and in the time and manner designated by the Covered Entity. [45 CFR § 164.504(e)(2)(F)]
10. **Internal Practices.** Business Associate agrees to make its internal practices, policies, procedures, books, and records relating to the use and disclosure of PHI received from the Covered Entity (or received by Business Associate on behalf of the Covered Entity) available to the Secretary of the U.S. Department of Health and Human Services for inspection and copying for purposes of determining the Covered Entity's compliance with HIPAA and the HIPAA Regulations.
11. **Notification of Breach.** During the term of this BA Statement, Business Associate shall notify the Covered Entity following discovery and without unreasonable delay (but in no case later than 60 days)

- any Breach of Unsecured PHI. Business Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.
12. **Safeguard of EPHI.** The Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.
 13. **Subcontractors.** The Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI agrees to implement reasonable and appropriate safeguards to protect it.
 14. **Notification.** The Business Associate shall report to the Covered Entity through the Office of Insurance any Breach of Unsecured PHI of which it becomes aware, without unreasonable delay, in the following time and manner:
 - a. any actual, successful Security Incident shall be reported to the Covered Entity in writing, without unreasonable delay; and
 - b. Any attempted, unsuccessful Security Incident, of which Business Associate becomes aware, shall be reported to the Covered Entity in writing, on a reasonable basis, at the written request of the Covered Entity. If the Security Rule is amended to remove the requirement to report unsuccessful attempts at unauthorized access, this subsection (ii) shall no longer apply as of the effective date of the amendment of the Security Rule.
 15. Business Associate shall maintain and provide to the Covered Entity without unreasonable delay and in no case later than 60 days of discovery of a Breach of Unsecured PHI, (as these terms are defined in the HIPAA Regulations), the appropriate information to allow the Covered Entity to adhere to Breach notification.
 16. The information provided to the Covered Entity shall include, at a minimum and to the extent possible, the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used, or disclosed during the Breach, and the Business Associate shall provide the Covered Entity with any other available information that the Covered Entity is required to include in its notification to the Individual following discovery of a Breach and without unreasonable delay or promptly thereafter as information becomes available, including:
 - a. A brief description of what happened, including the date of the breach, if known, and the date of the discovery of the breach.
 - b. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).
 - c. The steps individuals should take to protect themselves from potential harm resulting from the breach.
 - d. A brief description of what the Business Associate involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.
 17. **Minimum Necessary.** Business Associate shall limit its uses and disclosures of, and requests for, PHI (a) when practical, to the information making up a Limited Data Set; and (b) in all other cases subject to the requirements of 45 CFR § 164.502(b), to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.
 18. **Marketing.** Business Associate shall not sell PHI or use or disclose PHI for purposes of marketing, as defined and proscribed in the Regulations.
 19. **Data Aggregation.** Business Associate may use PHI in its possession to provide data aggregation services relating to the health care operations of the Covered Entity, as provided for in 45 CFR §164.501.
 20. **De-identification of PHI.** Business Associate may de-identify any and all PHI, provided that the de-identification conforms to the requirements of 45 CFR § 164.514(b), and further provided that Business Associate maintains the documentation required by 45 CFR § 164.514(b), which may be in the form of a written assurance from Business Associate. Pursuant to 45 CFR § 164.502(d), de-

identified information does not constitute PHI and is not subject to the terms of the BA Statement.

C. Obligations of the Covered Entity

1. Covered Entity's Representatives. The Covered Entity shall designate, in writing to Business Associate, individuals to be regarded as the Covered Entity's representatives, so that in reliance upon such designation Business Associate is authorized to make disclosures of PHI to such individuals or to their designee(s).
2. Restrictions on Use or Disclosure of PHI. If the Covered Entity agrees to restrictions on use or disclosure, as provided for in 45 CFR § 164.522 and the HITECH Act, of PHI received or created by Business Associate regarding an Individual, the Covered Entity agrees to pay Business Associate the actual costs incurred by Business Associate in accommodating such voluntary restrictions.
3. Limitation on Requests. The Covered Entity shall not request or require that Business Associate make any use or alteration of PHI that would violate HIPAA or HIPAA Regulations if done by the Covered Entity.

D. Audits, Inspection, and Enforcement

Upon reasonable notice, upon a reasonable determination by the Covered Entity that Business Associate has breached this BA Statement; the Covered Entity may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this BA Statement. Business Associate shall promptly remedy any violation of any term of this BA Statement and shall certify the same to the Covered Entity in writing. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this BA Statement, nor does the Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this BA Statement. Business Associate shall fully cooperate with the U.S. Department of Health and Human Services, as the primary enforcer of the HIPAA, who shall conduct periodic compliance audits to ensure that both Business Associate and the Covered Entity are compliant.

E. Termination

1. Material Breach. A breach by Business Associate of any provision of this BA Statement, as determined by the Covered Entity, shall constitute a material breach of the BA Statement and shall provide grounds for immediate termination of the BA Statement by TPA pursuant to Section E.2. of this BA Statement. [45 CFR § 164.504(e)(3)]
2. Reasonable Steps to Cure Breach. If either Party knows of a pattern of activity or practice of the other that constitutes a material breach or violation of that Party's obligations under the provisions of this BA Statement or another arrangement and does not terminate this BA Statement pursuant to Section E.1., then that Party shall take reasonable steps to cure such breach or end such violation, as applicable. If the Party's efforts to cure such breach or end such violation are unsuccessful, that Party shall either (i) terminate this BA Statement if feasible; or (ii) If termination of this BA Statement is not feasible, the non-breaching Party shall report the other Party's breach or violation to the Secretary of the Department of Health and Human Services. [45 CFR § 164.504(e)(1)(ii)]
3. Judicial or Administrative Proceedings. Either party may terminate this BA Statement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.
4. Effect of Termination. Upon termination of this BA Statement for any reason, Business Associate shall return or destroy PHI received from the Covered Entity (or created or received by Business Associate on behalf of the Covered Entity) that Business Associate still maintains in any form, and shall retain no

copies of such PHI except for one copy that Business Associate shall use solely for archival purposes and to defend its work product, provided that documents and data remain confidential and subject to this BA Statement, or if return or destruction is not feasible, it shall continue to extend the protections of this BA Statement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. [45 CFR § 164.504(e)(2)(I)]

F. Disclaimer

The Covered Entity makes no warranty or representation that compliance by Business Associate with this BA Statement, HIPAA or the HIPAA Regulations shall be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or shall be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

G. Amendment

Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this BA Statement and the Contract may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that the Covered Entity shall receive satisfactory written assurance from Business Associate that Business Associate shall adequately safeguard all PHI that it receives or creates pursuant to this BA Statement. Upon the Covered Entity's request, Business Associate agrees to promptly enter into negotiations with the Covered Entity concerning the terms of an amendment to this BA Statement and the Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Regulations or other applicable laws. The Covered Entity may terminate this BA Statement upon 90 days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this BA Statement and the Contract when requested by the Covered Entity pursuant to this Section; or (ii) Business Associate does not enter into an amendment to this BA Statement and the Contract providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations.

H. Assistance in Litigation or Administrative Proceedings

Business Associate shall make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this BA Statement, available to the Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party. No Third Party Beneficiaries

Nothing expressed or implied in this BA Statement is intended to confer, nor shall anything herein confer, upon any person other than the Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

I. Effect on Contract

Except as specifically required to implement the purposes of this BA Statement, or to the extent inconsistent with this BA Statement, all other terms of the Contract shall remain in force and effect.

J. Electronic Health Records (EHR)

If electronic health records are used or maintained with respect to PHI, individuals shall have the right to obtain a copy of such information in "electronic format".

K. No Remuneration for PHI

Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI, unless it first obtains a valid authorization from the individual whose PHI is being disclosed.

L. Interpretation

This BA Statement shall be interpreted as broadly as necessary to implement and comply with HIPAA, HIPAA Regulations and applicable state laws. The parties agree that any ambiguity in this BA Statement shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations.

27. Notices

All notices required or permitted to be given under this Contract shall be in writing and personally delivered or sent by certified United States mail, postage prepaid, return receipt requested, to the party to whom the notice should be given at the address set forth below. Notice shall be deemed given when actually received or when refused. The parties agree to promptly notify each other in writing of any change of address.

If to GovGuam:

Edward M. Birn
Director - Department of Administration
Government of Guam
ITC, 590 S Marine Corps Dr Bldg, Suite 224, Tamuning,
96913, Guam

With a copy of any notice to:

If to the TPA:

****COMPANY****
COMPANY ADDRESS

****COMPANY****
COMPANY ADDRESS

28. Incorporation of Documents

This Contract consists of and precedence is hereby established by the order of the following documents incorporated herein:

- A. This Contract signed by the parties including **Exhibit A, Fee Schedule for Third Party Administration Services; Exhibit B, Performance Guarantees; and Exhibit C, TPA Services Contractor Reports;**

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

COMPANY

Government of Guam

By: _____
COMPANY

By: _____
Edward M. Birn, Director
Department of Administration

Date: _____

Date: _____

By: _____
Insurance Commissioner
Department of Revenue & Taxation

Date: _____

Effective Date
October 1, 2025 [OBJ]

By: _____
Lester L. Carlson Jr
Director
Bureau of Budget and Management Research

Date: _____

Approved as to Legality and Form:

By: _____
Attorney General

Date: _____

By: _____
Lourdes Leon Guerrero
Governor of Guam

Date: _____

Exhibit A - Fee Schedule for Third Party Administration Services

All fees are guaranteed throughout the term of the Contract. The bundled administration fee will be calculated and paid every pay period as stipulated under this contract. The bundled fees rates are on a Per Employee/Retiree Per Pay Period (PEPPP) basis as provided below.

Active Employees: To be confirmed shortly

Retirees: To be confirmed shortly

The fees listed above are firm for the duration of the Contract and are not subject to escalation for any reason unless the Contract is duly amended. No additional compensation shall be provided by GovGuam for any expense, cost, or fee not specifically authorized by this Contract, or by written authorization from GovGuam.

Exhibit B - Performance Guarantees

1. Performance Objectives

The TPA provides health benefits administration and other services for GovGuam's Self Insured medical plan. The services set forth in this document will be provided by the TPA.

The TPA, in measuring the activities described below, feel they are important Indicators of how it services GovGuam participants. To reinforce confidence in the TPA's ability to administer the Plan, the TPA is subject to the following performance guarantees in the following areas:

- A. Claims Adjudication
 - 1. Turnaround Time
 - 2. Financial Accuracy
 - 3. Payment Incidence Accuracy
- B. Member Services
 - 1. Average Speed to Answer
 - 2. Ongoing ID Cards Issuance
 - 3. Call Abandonment Rate
 - 4. First Call Resolution Rate
 - 5. Participant Email Response Performance
 - 6. Member Satisfaction
- C. Administration and Account Management
 - 1. Processing of Ongoing Eligibility Information
 - 2. Account Management Reporting
 - 3. Overall Account Management Issues Resolution /Client Satisfaction

2. Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **October 1, 2024 through September 30, 2025** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the Self Insured medical plan administered under the Self Insured contract. These guarantees do not apply to non-TPA benefits or networks.

If the TPA processes runoff claims from a prior carrier or administrator, the performance guarantees described herein (other than Account Management Guarantees) will begin 3 months after the guarantee period effective date.

If the TPA processes runoff claims upon termination, performance guarantees of Turnaround Time, Financial Accuracy, Payment Incidence Accuracy, and/or Total Claim Accuracy will not apply to such claims. Further, performance guarantees described herein will not apply to the guarantee period claims if termination is prior to the end of the guarantee period. In addition, performance guarantees will not be reconciled, and payouts will not occur until the full guarantee period premium has been paid. Failure to remit applicable premium within the grace period may invalidate certain guarantees listed below.

3. Aggregate Maximum

In total, TPA agrees to place \$75,000.00 (seventy-five thousand) of its applicable guarantee period administrative fees at risk through the Performance Guarantees outlined in this document. The guarantee period administrative fees will be calculated at the end of the guarantee period and will be based on the total number of employees actually enrolled in the Self Insured medical plan throughout the guarantee period.

4. Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by the TPA in the event of the occurrence of (1), (2) or (3) below:

- A. a material change in the plan initiated by GovGuam or by legislative action that impacts the claim adjudication process, member service functions, or network management;
- B. failure of GovGuam to meet its obligations to remit premium;
- C. failure of GovGuam to meet its administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the contract is terminated by GovGuam or by the TPA.

5. Refund Process

At the end of each guarantee period, the TPA will compile its Performance Guarantees results. If necessary, it will provide a "lump sum" refund for any penalties it has incurred. Any penalty payments as a result of a missed performance guarantee will be paid or credited to GovGuam within ninety (90) days at the end of the reporting year.

6. Measurement Criteria

Results for the processing of Government of Guam's claims will be used to determine guarantee compliance for any Financial Accuracy, Payment Incidence Accuracy, and/or Total Claim Accuracy Guarantees. The results for these guarantees will be calculated using industry accepted stratified audit methodologies. A performance guarantee report, with supporting documentation including detailed calculation methodology, will be provided to GovGuam within ninety (90) days from the end of the reported quarter and ninety (90) days from the end of the reporting year.

7. Performance Guarantee Details

A. Turnaround Time

Guarantee: The TPA will guarantee that the claim turnaround time during the guarantee period will not exceed forty-five (45) calendar days for 99% of the processed claims.

Definition: We measure turnaround time from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied, or pending). Weekends and holidays are included in turnaround time.

Penalty and Measurement Criteria: If the cumulative guarantee period turnaround time (TAT) exceeds the day guarantee as stated above, the TPA will reduce its compensation by an amount equal to \$10,000.00 (ten-thousand).

B. Financial Accuracy

Guarantee: The TPA will guarantee that the guarantee period dollar accuracy of the claim payment dollars will be 98.0% or higher.

Definition: Financial accuracy is measured using industry accepted stratified audit methodology. The results are calculated by calculating the financial accuracy for a subset of claims (a stratum) and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata. Each overpayment and underpayment is considered an error; they do not offset each other. Includes both manual and auto adjudicated claims.

Penalty and Measurement Criteria: The TPA will reduce its compensation by an amount equal to \$10,000.00 (ten-thousand).

The TPA's overall audit results for the units processing GovGuam's claims will be used. Those results include the performance in processing all customers' claims handled by the units in question during the Guarantee period, not just the Plan's claims. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.

C. Payment Incidence Accuracy

Guarantee: The TPA will guarantee that the guarantee period payment incidence accuracy will be 97.0% or higher.

Definition: Payment incidence accuracy is measured by industry accepted stratified audit methodology. Accuracy in each stratum (a subset of the claim population) is calculated by dividing the number of claims paid correctly by the total number of claims audited and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata.

Penalty and Measurement Criteria: The TPA will reduce its compensation by \$10,000.00 (ten-thousand). The results include the TPA's performance in processing all customers' claims in question during the Guarantee period, and the results for these guarantees will be calculated using industry accepted stratified audit methodologies.

D. Average Speed to Answer

Guarantee: We will guarantee that the average speed of answer results for the units that will be handling Government of Guam's member services will not exceed 30 seconds. Those results include our performance for all customers' calls handled by the units in question during the Guarantee period, not just your plans'.

Definition: On an ongoing basis, we measure telephone response time through monitoring equipment that produces a report on the average speed of answer. Average speed of answer is defined as the amount of time that elapses between the time a call is received into the telephone system and the time a representative responds to the call. The result expresses the sum of all waiting times for all calls answered by the queue divided by the number of incoming calls answered.

Penalty and Measurement Criteria: We will reduce our compensation by \$5,000.00 (five-thousand).

E. Ongoing ID Cards Issuance

Guarantee: We will guarantee that we ship ID cards to ninety (90) percent of plan participants within 15 days of notification of new member coverage or a valid Enrollment Form. Cards will be also made available electronically to members within the aforementioned notification of enrollment. The electronic cards issuance will qualify as meeting the requirement.

Definition: For all complete enrollment/eligibility data provided by Government of Guam and accepted by the eligibility system, we agree to ship ID cards to plan participants within 15 days of new member coverage or a valid Enrollment Form.

Penalty and Measurement Criteria: We will reduce our compensation by an amount equal to \$5,000.00 (five-thousand).

F. Call Abandonment Rate

Guarantee: We will guarantee that the average rate of telephone abandonment results for the units that will be handling Government of Guam's member services will not exceed 2.0%. Those results include our performance for all customers' calls handled by the units in question during the Guarantee period, not just your plans'.

Definition; On an ongoing basis, we measure telephone response time through monitoring equipment that produces a report on the average abandonment rate. The abandonment rate measures the total number of calls abandoned greater than 10 seconds and divided by the number of calls offered into the member service phone queue.

Penalty and Measurement Criteria: We will reduce our compensation by \$5,000 (five-thousand).

G. First Call Resolution Rate

Guarantee: the TPA will guarantee that the First Call Resolution rate will be 90.0% or higher.

Definition: On an annual basis, the TPA will share with Government of Guam the First Call Resolution results from the accountable unit that services Government of Guam. We define the first call resolution rate as the percentage of telephone calls resolved at the time of initial contact of the member. The rate will be calculated based upon first calls where the issue was within the TPA's control to resolve.

Penalty and Measurement Criteria: the TPA will reduce its compensation by \$5,000.00 (five-thousand). The first call resolution rate is defined as the percentage of calls resolved without the need for follow-up. The rate will be calculated based upon first calls where the issue was within the TPA control to resolve

H. Participant Email Response Performance

Guarantee: the TPA will guarantee that 90.0% of member emails will be responded to within 3 business days.

Definition: On an ongoing basis, we monitor email responses and measure email response time through monitoring equipment that produces a report on the average abandonment rate. The abandonment rate measures the total number of calls abandoned divided by the number of calls accepted into the skill.

Penalty and Measurement Criteria: We will reduce our compensation by an amount equal to \$5,000.00 (five-thousand).

I. Member Satisfaction

Guarantee: We will guarantee member satisfaction is 85.0% with a minimum participation rate of 15.0%

Definition: We measure member satisfaction within our customer service units via a short survey offered at the end of every phone call. 15% of Government of Guam members must participate in this survey for valid satisfaction scores.

Penalty and Measurement Criteria: We will reduce our compensation by an amount equal to \$10,000.00 (ten-thousand).

J. Processing of Ongoing Eligibility Information

Guarantee: We guarantee to process 90.0% of eligibility updates within three (3) business days of receiving a clean submission.

Definition: For online and email enrollment requests, "clean" is defined as: All required fields entered and in format acceptable to the TPA.

Penalty and Measurement Criteria: We will reduce our compensation by an amount equal to \$5,000.00 (five-thousand).

K. Account Management Reporting

Guarantee: We will guarantee that a standard report including customer premium and plan enrollment data will be provided on a monthly basis. More detailed customer specific plan experience and utilization reports will be provided on a quarterly basis.

Definition: On an ongoing basis, a report detailing premium received and plan enrollment will be provided by the 25th day following the end of the prior month. A more detailed report including plan experience and member utilization data will also be provided on a quarterly basis by the 25th day following the end of each quarterly period.

Penalty and Measurement Criteria: Monthly and quarterly reports not delivered by the 25th day following the reporting period will be subject to \$5,000 (five-thousand).

L. Overall Account Management Issues Resolution /Client Satisfaction

Guarantee: We will guarantee that the services (i.e., on-going financial, eligibility, drafting, and benefit administration, acknowledgement and resolution of plan management issues and overall continued customer support) provided by the Account Management Staff during the guarantee period will be satisfactory to Government of Guam.

Exhibit C - TPA Services Contractor Reports

TPA will provide reporting. The report list and frequency will include the following. The specific details and format will be agreed between GovGuam and the TPA:

- A. Detailed Medical and Pharmacy Claims Data**
- B. Enrollment and Premium Data**
- C. Claims Lag Triangles**
- D. High Cost Claimants**
- E. Quarterly IBNP Reporting (as described earlier in this document)**

STOP LOSS INSURANCE AGREEMENT

Agreement No.: ***

(hereinafter referred to as the “Agreement”)

Between

****COMPANY****

Hagatna, Guam

(hereinafter referred to as the “Company”)

And

GOVERNMENT OF GUAM

Hagatna, Guam

(hereinafter referred to as the “Insured”)

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SCHEDULE OF COVERAGE

Risk Details:

TYPE: Medical Risk Excess of Loss Insurance Agreement

INSURED: Government of Guam (Insured)

INSURER: **COMPANY**

PERIOD: Losses occurring during the period of 1st October 2025 both days inclusive, Local Standard Time and paid through September 30, 2026.

CLASS OF BUSINESS: Excess of Loss Insurance protecting the Insured against Medical Expenses of Insured Persons, on the Group Health Insurance for the Employees and Dependents of Government of Guam under its Self-Insured Benefit Plan, to include covered medical benefits, and Prescription Drugs, in accordance with the Schedule of Benefits inforce at the effective date hereof or issued or renewed on or after that date, subject to the terms, conditions and limitations hereinafter set forth.

EFFECTIVE DATE: October 1, 2025

CLAIMS BASIS: Losses that are:

- Incurred from October 1, 2025 through September 30, 2026
- Paid by March 31, 2026
- Reported and submitted by June 30, 2026
- All checks issued by March 31, 2026

CLAIM PAYOR: Third Party Administrator

COINSURANCE: All eligible services, including Retail Pharmacy
100% (Insured Retains 0%) – Layer 1
100% (Insured Retains 0%) – Layer 2

EXCESS OF
LOSS COVERAGE: Covered medical and pharmacy claims in excess of \$1,000,000 per covered member.

EXCLUSIONS: The following shall be excluded from the cover under this Agreement

- Medical expenses recoverable under the provisions of a Workers' Compensation or Employer's Liability policy.
- War, whether declared or undeclared.
- Items excluded under the Insured's original benefit plans.
- Loss in excess of the Insured's annual policy limits, if applicable.
- Loss in excess of Insured's liability.
- Medical Plans not specified in the Classes of Business Article.
- Benefit Plans issued to cover active military personnel.
- Losses related to Terrorism events.
- Losses related to Nuclear, Biological and Chemical events.
- Regenerative or Advanced Therapies.
- Vision and Dental benefits
- Accidents caused directly or indirectly by war, invasion, hostilities or warlike operation (whether war be declared or not), civil war, revolution, rebellion, insurrection, military or usurped power, martial law, strike, riot or civil commotion;
- Accidents caused by any sudden failure of nuclear technology, nuclear radiation or radioactive contamination (whether controlled or uncontrolled);
- Gene and Car T Therapy and any related services to both therapies.

TERRITORIAL

SCOPE: Guam

LIMITS: Unlimited

INSURANCE

CONDITIONS: This insurance is subject to the same terms and conditions as stated in the Insured's plan documents covering Government of Guam employees and dependents. Insurer hereby agrees to follow the settlements of the benefits as stated in the plan coverage documents.

ORIGINAL

CONDITIONS: As per wording

CHOICE OF LAW AND

JURISDICTION: This insurance will be governed by and interpreted pursuant to the laws of the Territory of Guam and laws of Guam applicable therein, and any dispute arising hereunder shall be submitted to the exclusive jurisdiction of the courts of the Territory of Guam.

ARBITRATION: Seat of Arbitration: Territory of

Guam PREMIUM: Government of Guam Employees

\$17.34 per employee per month all plans

PREMIUM PAYMENT

TERMS: Premium to be paid within 30 days.

RETENTION & LIMITS: Government of Guam Employees

Unlimited xs \$1,000,000 per Covered Person per Coverage Period

Member Number: ***** has an alternated deductible of \$ 2.5 million. High-Cost Rx Claimant 1 in GovGuam data for stop

INSURER CONTRACT

DOCUMENTATION: This document details the contract terms entered by the insurer(s), and constitutes the contract document loss quote; Member with 1.5M of Nuwiq claims in 2022-2023 year

ARTICLE I

DEFINITIONS

The following definitions apply to the terms used in this Agreement. In the event of conflict in the meaning of the terms or the content of provisions between this Agreement and the Company's Original Policies, provider contracts or management service contracts, the definitions herein and the provisions of this Agreement will govern.

"Insured Retention" means the amount of Losses retained by the Insured without reimbursement by the Company, as set forth in the Schedule of Coverage.

"Coverage Period" means the period of time beginning on the first date and ending at midnight (Central Time) on the last date shown in the Coverage Period on the Schedule of Coverage.

"Covered Person" means a person who is eligible to receive benefits and/or services within the terms and provisions of the self-funded employee benefit plans covered under this Agreement.

"Incurred" refers to the date services are rendered or supplies are provided.

"Insurance Limits" means the amount of insurance coverage provided under this Agreement for Incurred Losses in respect of any one Covered Person in excess of the Insured Retention, as set forth in the Schedule of Coverage.

"Loss" or "Losses" means eligible expenses Incurred during the Coverage Period by a Covered Person in the course of treatment for an injury or sickness as defined in the Policies.

"Premium" as used herein shall be the amount to be remitted to the Company as set forth in the Schedule of Coverage.

"Regenerative or Advanced Therapies" are products designed to cure disease, transform disease treatment and restore functionality. These include cell and gene therapies approved by the U.S. Food and Drug Administration and related agencies.

"Schedule of Coverage" means the page or pages attached to this Agreement, as may be amended from time to time on renewal or otherwise. The Schedule of Coverage is a part of this Agreement.

ARTICLE II

UTMOST GOOD FAITH

The Company and the Insured agree that this Agreement is entered into with the understanding that the principles of utmost good faith traditional to insurance will be adhered to in the formation and performance of this Agreement and will govern the parties' rights and obligations.

ARTICLE III

CLASSES OF BUSINESS

The classes of business are set forth in the attached Schedule of Coverage and are limited to those Medical and Prescription Drugs plans issued to employees of the Government of Guam.

ARTICLE IV

LIABILITY OF THE COMPANY

The Company agrees to indemnify the Insured for the Losses within the Insurance Limits that may accrue to the Insured during a Coverage Period.

ARTICLE V

COMPANY RETENTION AND INSURANCE LIMITS

During the Coverage Period, the Company shall not be liable for any Losses within the Insured Retention amount. The Company shall indemnify the Insured for the amount by which such Loss or Losses exceed the Insured Retention during said Coverage Period not to exceed the Limits as shown in the Schedule of Coverage.

ARTICLE VI

EXCLUSIONS

This Agreement does not apply to and specifically excludes the following:

1. Medical expenses recoverable under the provisions of a Workers' Compensation or Employer's Liability policy.
2. War, whether declared or undeclared.

3. Items excluded under the Insured's original benefit plans.
4. Loss in excess of the Insured's annual policy limits, if applicable.
5. Loss in excess of Insured's liability.
6. Medical Plans not specified in the Classes of Business Article.
7. Benefit Plans issued to cover active military personnel.
8. Losses related to Terrorism events.
9. Losses related to Nuclear, Biological and Chemical events.
10. Regenerative or Advanced Therapies.
11. Vision and Dental Benefits.
12. Accidents caused directly or indirectly by war, invasion, hostilities or warlike operation (whether war be declared or not), civil war, revolution, rebellion, insurrection, military or usurped power, martial law, strike, riot or civil commotion.
13. Accidents caused by any sudden failure of nuclear technology, nuclear radiation or radioactive contamination (whether controlled or uncontrolled).
14. Gene and Car T Therapy and any related services to both therapies.

ARTICLE VII

PREMIUM

Condition Precedent. The payment of Premiums is a condition precedent to the liability of the Company for insurance covered by this Agreement.

Premium Due. During the Coverage Period, the Insured shall remit to the Company the Premium as set forth in the Schedule of Coverage. Premiums are due on the first day of each month during the Coverage Period, and must be received by the Company within thirty (30) days thereafter, or this Agreement will terminate, as set forth in Article XI, "Renewal/Termination."

Premium Basis. Premiums shall be based on an estimate of the number of Employees covered by

this Agreement for the upcoming month, and an adjustment for the previous months' actual number of Employees. Monthly adjustments will not be made more than six (6) months after the month for which the adjustment applies. Company shall have the right to adjust the premium for any Material Changes as set forth in Article XII - Material Change.

ARTICLE VIII

LOSS NOTICES AND SETTLEMENTS

1. **Loss Payments.** All Loss payments made by the Insured that are within the terms of this Agreement and within the terms and conditions of the Policies, shall be binding upon the Company, who agrees to pay all amounts for which it may be liable upon reasonable evidence of the amount due or to be due being furnished by the Insured.
2. **Pre-Notification of Certain Losses.** Whenever the Insured's aggregate payments for Losses Incurred by any one Covered Person exceed 50% of the Insured's Retention or involves any diagnoses listed below, the Insured shall notify the Company no later than thirty (30) days from the date on which the Insured learns of such potential liability. The Insured agrees to use its best efforts to provide this notification and the Company reserves the right to deny payment for Losses not reported in accordance with the provisions of this Paragraph 2.
 - a. Head injuries;
 - b. Spinal injuries resulting in real or suspected paralysis of the limbs (paraplegia or quadriplegia);
 - c. Burns if 20% or more of the body is covered with second or third degree burns;
 - d. Multiple fractures;
 - e. Crushing or massive internal injuries;
 - f. Continuous hospitalization for more than three months;
 - g. Acquired Immune Deficiency Syndrome (AIDS), where confidentiality or other laws do not prohibit disclosure;
 - h. Children weighing less than three pounds at birth, or children born with major abnormalities; or
 - i. Organ transplants.
3. **Notification of Losses Generally.** In no event shall the Company be liable to the Insured for Losses unless the following conditions are met:
 - a. The Losses are Incurred, paid and reported by the Insured, in writing, to the Company within the time period stipulated in the Claims Basis section of the Schedule of

Coverage.

- b. A complete request for medical insurance reimbursement, including all required back-up supporting data, has been submitted by the Insured and received by the Company, in the time period stipulated for reporting Losses in the Claims Basis section of the Schedule of Coverage.
 - c. The only exceptions to this section are: (i) unsettled Losses due to coordination of benefits, as defined in the applicable Policy, and (ii) unsettled Losses subject to subrogation/reimbursement. The Insured will have twelve (12) months from the beginning of the Coverage Period in which the Loss was incurred to submit these Losses to the Company.
 - d. Previously denied claims overturned by an IRO would be eligible for reimbursement. Eligible plan expenses would cover those claims in the normal course as if they had been paid on the date they were previously denied.
4. Loss Settlements. With respect to disputed Losses, all Loss settlements made by the Insured that are within the terms of this Agreement and the Policies and do not constitute ex gratia payments, shall be binding upon the Company.
5. Right of Association. The Insured shall cooperate with the Company and shall furnish the Company with such information as may be required by the Company with respect to Losses and settlements. Upon notification of Losses, the Company shall have the right to participate in the settlement or the defense of any claim or suit or proceeding involving this insurance at its own expense.
6. Loss Notices as described in this article shall be handled by the claim payor specified in the Schedule of Coverage.

ARTICLE IX

CONFIDENTIALITY

All information disclosed to the Company by the Insured, or to the Insured by the Company, either in the course of conducting negotiations or as the result of complying with the terms and conditions of this Agreement, shall be considered to be proprietary and confidential information ("Confidential Information") by both the Company and the Insured and shall not be disclosed without written consent of the other, except to auditors, attorneys and as required by applicable law or judicial process. The parties agree to maintain strict confidentiality under applicable federal and state laws and regulations relating to personally identifiable health information of Covered Persons to which the parties gain access pursuant to this Agreement. The parties understand that they may be obligated to enter into a separate agreement pursuant to the Health Insurance

Portability and Accountability Act (42 U.S.C. § 201, et seq.) which shall identify the respective responsibilities of the parties with regards to certain types of Confidential Information. Confidential Information shall not include any information which at the time of disclosure or thereafter is generally available to and known by the public other than by way of a wrongful disclosure by Insured or Company. The confidentiality and nondisclosure obligations set forth herein supersede any prior agreement between the parties addressing such obligations regarding the subject matter of this Agreement.

GOVERNMENT AGENCIES

The submission of this Agreement or other information related to this Agreement to any department of insurance or other appropriate state regulatory authority such as a department of health or department of public welfare of any state, federal agency or court having jurisdiction over the matter and having a legal right to the information shall not be considered a violation of this Article, provided that the other party is advised in advance of the submission.

ARTICLE X

ARBITRATION

Enforceability. Notwithstanding any choice of law provision set forth herein, the parties intend this Article to be enforceable in accordance with the Federal Arbitration Act ("FAA"), including any amendments to that Act which are subsequently adopted. In the event that either party refuses to submit to arbitration as required herein, the other party may request a United States Federal District Court to compel arbitration in accordance with the FAA. Both parties consent to the jurisdiction of such court to enforce this article.

Notice of Arbitration. Any dispute or other matter in question between the Company and the Insured arising out of, or relating to, the formation, interpretation, performance, or breach of this Agreement, whether such dispute arises before or after termination of this Agreement, and whether in contract, tort, or otherwise, shall be settled by arbitration.

To initiate arbitration, either the Company or the Insured shall notify the other party in writing of its desire to arbitrate. The notice shall identify the claimant, the contract at issue, and the nature of the claims and/or issues. Notice shall be sent certified mail, with return receipt, or another service that produces a receipt. The arbitration will be deemed to have been commenced on the date the notice of arbitration is received.

Arbitrators. There will be three arbitrators who will each have no less than ten years of insurance or insurance industry experience and who are current or former officers of life or health insurance or life or health insurance companies other than the parties to this Agreement, their affiliates or subsidiaries. The arbitrators shall not be under the control of any party, nor shall any employee of the panel have a financial interest in the outcome of the dispute. Within thirty

(30) days following the commencement of the arbitration proceedings, each party will provide the other with the identification of their appointed arbitrator, and provide a copy of the arbitrator's curriculum vitae. If either party refuses or neglects to appoint an arbitrator within thirty (30) days, the other party may appoint the second arbitrator to act as the appointed arbitrator for the defaulting party by providing notice and a copy of the arbitrator's curriculum vitae. Each party's appointed arbitrator shall propose a candidate (or a slate of up to five candidates) to serve as the third arbitrator (the "umpire"). In the event that the two party-appointed arbitrators fail to reach agreement on an umpire within sixty (60) days of their appointment, then either party may petition ARIAS-U.S. to appoint the umpire and each party shall cooperate and take whatever action is required to give effect to the ARIAS-U.S. umpire appointment procedures. In the event any arbitrator fails, refuses, or becomes unable to act as such before an award has been rendered, a successor shall be selected in the same manner as the original arbitrator.

Submission of Briefs. The claimant and respondent shall each submit initial briefs to the panel outlining the issues in dispute and the reasons for their respective positions within thirty (30) days of the notice of the appointment of the umpire.

Scope of Power. The arbitrators shall consider this Agreement an honorable engagement rather than merely a legal obligation, and the panel shall make its decision with consideration given to the custom and usage of the insurance and insurance industry. The arbitrators shall have the power to determine all procedural rules of the arbitration, including, but not limited to inspection of documents, examination of witnesses, and any other matter related to the conduct of the arbitration. The panel and the umpire shall have the authority to issue subpoenas (including subpoenas to third party witnesses) and other orders to enforce their decisions. Ex parte communications with party appointed arbitrators shall be permitted until the arbitration hearing commences. The arbitrators shall recognize the attorney/client privilege and the attorney work product doctrine. Neither a party nor an arbitrator may disclose the existence, content, or result of any arbitration hereunder, except to the extent such disclosure may be required for review and enforcement by a court of competent jurisdiction, to support insurance or retrocessional recoveries, or as otherwise agreed by the parties. The location of all proceedings shall be in Hagatna, Guam, unless the parties agree otherwise.

Panel Decision Final and Binding. The panel may issue orders for interim relief upon showing of good cause, including pre-award security. Absent good cause for an extension as determined by the panel, the panel shall render the final award within nine (9) months of the appointment of the umpire, unless the parties agree otherwise, and within thirty (30) days after the date of the closing of the hearing. The panel is authorized to award any remedy or sanctions allowed by applicable law, including, but not limited to monetary damages, equitable relief, pre or post award interest, costs of arbitration, attorneys fees, and other final or interim relief; provided that arbitrators shall not be empowered to award damages in excess of compensatory damages. The decision of the arbitrators will be made by majority rule, and shall be final and binding on both parties. Either party to the arbitration may petition any court having jurisdiction over the parties to reduce the decision to judgment.

Expenses. Each party shall bear its own costs in connection with any such arbitration, including, without limitation, (a) all legal, accounting, witness or other professional fees and expenses, (b) the fees and expenses of its own arbitrator, and (c) all other costs and expenses each party incurs to prepare for such arbitration. Each side shall pay one-half of the fees and expenses of the umpire and one-half of the other expenses that the parties jointly agree to share directly related to the arbitration proceeding. The parties acknowledge that the foregoing obligations are subject to, and may be superseded by, an award of the panel with respect to such costs and expenses.

ARTICLE XI

RENEWAL/TERMINATION

1. Renewal Process. This Agreement will automatically terminate at the end of the Coverage Period shown in the Schedule of Coverage.

Sixty (60) days prior to the end of the Coverage Period, the Insured, if it desires to renew coverage hereunder, shall submit a completed renewal information form provided by the Company. The parties will negotiate a new agreement, but until a new agreement is agreed upon, there is no renewal and coverage hereunder will be considered terminated as of the end of the Coverage Period. If the Insured submits Premiums after expiration of the Coverage Period, such payment may be returned or held by the Company, but such payment shall have no force and effect with respect to renewing this Agreement, or creating a new agreement between the parties.

2. Failure to Pay Premium. In the event that Premiums are not paid within sixty (60) days of the due date, coverage hereunder will automatically terminate, **provided that Company has first provided written notice to the Company of non-receipt of said premium within thirty (30) days of said termination.**

Terminated insurance may be reinstated, at the discretion of the Company, within ninety (90) days of the date of termination, upon payment of all Premiums in arrears including any interest accrued thereon at the Company's standard rates for these purposes.

3. Insolvency. Should the Company become Insolvent, this Agreement shall automatically terminate as of the date of Insolvency.
4. Effect of Termination. Except as otherwise specifically provided in this Agreement, termination shall have no effect on the rights and obligations of the parties arising prior to termination.

ARTICLE XII

MATERIAL CHANGE

1. **Definition.** A Material Change is a change that materially alters the nature, quality or quantity of the business or risk of the Insured. A Material Change includes, but is not limited to, the following:
 - a. Plan designs selected by the Government of Guam differ from the plan designs presented in the Government of Guam Request for Proposal;
 - b. Changes in the Insured's health benefits which would materially alter the type or amount of benefits provided or the terms or conditions for eligibility or participation;
 - c. Material changes in the information provided by the Insured to the Company, directly or indirectly, upon which assessment of risk was based.
2. **Notice of Material Change.** The Insured must provide written notice to the Company of any Material Change. Such notice must be made in advance, whenever possible, or as soon as reasonably possible thereafter, but in no event more than thirty (30) days following a Material Change.
3. **Effect of Material Change.** Upon receipt of a Material Change notice, the Company may, at its discretion:
 - a. Accept the Material Change without revising the Premium rates and coverage terms;
 - b. Accept the Material Change and revise the Premium rates and/or coverage terms, but if the Company rejects the revision within thirty (30) days after notice of the revised rates or terms, the Agreement shall terminate, effective as of the date of the Material Change;
 - c. Not accept the Material Change but continue to provide coverage and adjudicate claims as if the Material Change had not occurred; or
 - d. Terminate this Agreement effective as of the date of the Material Change.
 - e. A material change in this context is defined as a 10% change in covered membership or plan a benefit change that is expected to increase costs by more than 10%

If the Agreement is terminated in accordance with this Section, then the coverage and Premium shall be prorated according to the number of days in the reduced Coverage Period. In addition, if any Losses have been paid by the Company after the effective date of termination, i.e., after the date of the Material Change, such Loss payment shall be refunded to the Company.

Changes in the Agreement as the result of a Material Change will be effective as of the date of the Material Change. Until the Company accepts any Material Change in the Policy that would alter the type or amount of benefits provided or the terms or conditions for eligibility or participation, Losses will continue to be based upon the Policy, unchanged.

4. Failure to Give Notice. If the Company fails to give the Company timely notice of a Material Change, (or fails to give notice at all) the Company may, in its discretion:
 - a. Choose any option described in 3(a-e) above; or
 - b. Rescind the Agreement as of the Coverage Period first affected by the Material Change. In that event the Company will refund all Premium paid and the Company will return all Loss payments for the applicable period.
5. Legal and Equitable Rights. Nothing in this Article is intended or shall be interpreted to limit any rights the Company may have or be entitled to under law or the principles of equity, nor shall the Company's exercise of any rights under this Article constitute or be deemed a waiver of such other legal or equitable rights.

ARTICLE XIII

OTHER COVERAGE

1. Subrogation/Recovery. The Company shall be credited with reimbursement obtained or recovery made by the Insured (less the actual cost, excluding salaries of officials and employees of the Insured and sums paid to attorneys as retainer, of obtaining such reimbursement or making such recovery), on account of claims and settlements involving insurance hereunder. Such credit will be applied to any amounts either paid by the Company or that would be payable by the Company under this Agreement, and such credit will be repaid by the Insured to the Company within thirty (30) days, to the extent that the Insured has paid Loss amounts related to the reimbursement or recovery. The Insured hereby agrees to take reasonable action to enforce its rights to reimbursement or subrogation relating to any Loss hereunder, or the Company may elect to take credit as if the reimbursement or recovery had been obtained.

ARTICLE XIV

MISCELLANEOUS

1. Governing Law. This Agreement shall be governed by the laws of the Territory of Guam without giving effect to principles of conflicts of law.

2. Waiver. The failure of either party to insist on strict compliance with this Agreement, or to exercise any right or remedy hereunder, shall not constitute a waiver of any rights contained herein nor stop either party from thereafter demanding full and complete compliance nor prevent the parties from exercising such a remedy in the future.
3. Taxes and Expenses. Losses shall not include any expenses incurred by the Insured in connection with its Policies, including but not limited to dividends, commissions or taxes.
4. Currency. Whenever the word, "Dollars", or the "\$" sign appears in this Agreement, they shall be construed to mean United States Dollars, except those cases where the Company's original policies are issued in Canada by the Company in Canadian Dollars, they shall mean Canadian Dollars. All payments made by either party shall be made in United States Dollars, except that payments made on Company original policies issued in Canada in Canadian Dollars shall be made in Canadian Dollars.
5. Errors and Omissions. Any inadvertent delays, omissions or errors made in connection with this Agreement shall not be held to relieve either party hereto from any liability which would attach to such party if such delays, omission or errors had not been made, provided such errors or omissions are advised and rectified promptly upon discovery. The provisions of the preceding sentence, however, do not apply to any Loss or claim reporting obligations of the Plan under this Agreement.
6. Rules of Construction. The captions and headings in this Agreement are inserted for convenient reference only and are not intended to define, limit, modify or amplify the construction, interpretation or meaning of the terms of, or the scope or intent of, this Agreement. The parties acknowledge and agree that no provision of this Agreement shall be construed against or interpreted to the disadvantage of a party by reason of such party having drafted or structured any provision.
7. Third Party Beneficiaries. This is a contract between the Company and the Insured only, and nothing herein shall in any manner create any obligations or establish any rights against either the Company or the Insured in favor of any third parties or persons not party to this Agreement.
8. Notices. All notices and communications hereunder shall be in writing and shall become effective when received. Any written notice shall be by either certified or registered mail, return receipt requested, or overnight delivery service (providing for delivery receipt) or delivered by hand.
9. Compliance. The Company and the Insured each represent that to the best of its knowledge and belief it is, and shall use its best efforts to continue to be, in substantial compliance in all material respects with all laws, regulations, and judicial and

administrative orders applicable to the business reinsured under this Agreement (collectively, the "Law"). This includes the maintenance of an effective anti-money laundering policy to the extent the Company is required to have such a policy in place. Neither the Company nor the Insured shall be required to take any action under this Agreement that would result in it being in violation of the Law, which for purposes of companies subject to U.S. regulation, including the Insured, shall include requirements enforced by the U.S. Treasury Department Office of Foreign Asset Control. The Company and the Insured acknowledge and agree that a claim under this Agreement is not payable if payment would cause the Insured to be in violation of the Law. Should either party discover an insurance payment has been made in violation of the Law, it shall notify the other party and the parties shall cooperate in order to take all necessary corrective actions. The Company will return the insurance payment to the Insured to the extent, and at such time, as permitted by Law.

10. Severability. If any provision of this Agreement, or its application to any party or circumstance, shall be adjudged by a court or other authority to be invalid or unenforceable, the parties agree that such judgment shall in no way affect the validity and enforceability of other provisions of this Agreement that reasonably can be given effect apart from that which is invalidated.
11. Entire Contract. This Agreement contains the entire agreement between the Company and the Insured. No representations, promises, understandings or agreements, oral or otherwise, between the parties not contained in this Agreement or attached to it shall be of any force or effect. Any additions or amendments to this Agreement shall be of no force or effect unless in writing and signed by the parties.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed, as of the dates undermentioned.

****COMPANY****

GOVERNEMENT OF GUAM

By: _____
COMPANY SIGNATURE

By: _____
Edward M. Birn, Director
Department of Administration

Date: _____

Date: _____

GOVERNMENT OF GUAM
And
****COMPANY****

MEDICAL AND PRESCRIPTION SELF FUNDED PLAN DOCUMENTS
GROUP HEALTH INSURANCE (and FOSTER) AGREEMENT

October 1, 2024– September 30, 2025

ARTICLE 1: PREAMBLE & RECITALS

PREAMBLE:

This Agreement is made effective by and between the GOVERNMENT OF GUAM ("GovGuam") and **COMPANY** as the Third Party Administrators (TPA) each a party and together the "Parties." The effective date of this Agreement is October 01, 2024 through September 30, 2025.

RECITALS

WHEREAS, GovGuam has contracted with **COMPANY** to provide the Third Party Administration (TPA) to include medical network access, member and claim administration. The TPA has established a provider portal where GovGuam members are able to check Provider Directory, Member Handbook, Schedule of Benefits, Summary of Benefits and Claim information.

WHEREAS, the TPA is licensed to do business in Guam; and

WHEREAS, **COMPANY** is qualified to provide third party administrative services to GovGuam as a TPA for its group health insurance (and foster) program; and

WHEREAS, GovGuam selected **COMPANY** as a qualified TPA to GovGuam active and retired employees, their dependents, and survivors of retired employees who receive annuity benefits; and

WHEREAS, GovGuam selected **COMPANY** as the TPA to foster children under the legal custody of the Child Protective Services Division of the Department of Public Health and Social Services as defined in 4 G.C.A. 4301.1(h), and

WHEREAS, **COMPANY** offers TPA services as hereinafter set forth, under a group health insurance plan known as the "Government of Guam Health Plan", and

WHEREAS, the Parties entered into an agreement defining their mutual rights and obligations through the Third Party Administration Services Contract.

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 2: GENERAL PROVISIONS

- A. Scope:** This Agreement supersedes any and all prior agreements, either oral or in writing, if any, between the Parties hereto with respect to the retainer of ****COMPANY**** by GovGuam and contains all of the covenants and agreements between the parties with respect to the subject matter of this Agreement. Each party to this Agreement acknowledges that no representation, inducements, promises or agreements, orally or otherwise, have been made by any party, or anyone acting on behalf of any party, which is not embodied herein, and that any other agreement, statement, or promise not contained in this Agreement shall not be valid or binding on the Parties with respect to the subject matter of this Agreement. This Agreement, and any modification hereto, is not binding until approved by the Attorney General of Guam and executed by the Governor of Guam. Any modification of this Agreement will be effective only if it is in writing, approved by the Attorney General of Guam and executed by the Governor of Guam.

It is hereby mutually agreed that the following list of documents which are attached hereto, bound herewith or incorporated herein by reference shall constitute the "Contract Documents," all of which are made part hereof, and collectively evidence and constitute this Agreement between the parties hereto, and they are as fully a part of this Agreement, as if they were set out verbatim and in full herein:

- a. The Request for Proposals, and all notices, conditions, attachments, and instructions for DOA/ID-RFP-GHI-26-001 which includes the Specifications contained in the Scope of Services.
- b. Any addendum to, or Government of Guam responses to questions submitted for Request for Proposals DOA/ID-RFP-GHI-26-001
- c. ****COMPANY****'s Proposal submitted in response to Request for Proposals, DOA/ID-RFP-GHI-26-001. This Agreement, any of its Attachments, Exhibits, or Schedules, and any duly executed Amendment or Change Order thereto.
- d. All terms agreed upon as a result of negotiations.

- B. 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.

1. **Covered Services:** Shall be defined as medically necessary services, as defined under the Plan, that are not specifically excluded from coverage by this Agreement and other Services which are specifically included. Services shall include medical or other health care services, treatments, supplies, medications and equipment.
2. **Currency:** Shall be defined as money accepted as a medium of exchange for payment of debts such as the United States Dollar in the United States and the Peso in the Philippines.
3. **Deductible:** Shall be defined as the amount paid by a Covered Person or Family for Covered Services during a Plan Year before Covered Services shall be paid by ****COMPANY**** under this Agreement. No deductible shall apply to preventive services as defined by PPACA and applicable Guam statute and regulation, annual refraction eye exam, primary physician care, specialty care visits, prescription drugs, routine laboratory, urgent care, outpatient executive checkup and routine x-ray.

4. **Department of Administration (DOA).** Shall be defined as the Department of Administration. DOA shall be responsible for payment and administration of line agencies, agencies whom the DOA administers payroll, and the Foster program.
 - a) **Department of Public Health and Social Services (DPHSS) Child Protective Services (CPS):** Shall be defined as the Department of Public Health and Social Services, Division of Public Welfare, Bureau of Social Services Administration, Child Protection Services and administers the Foster Care program.
 - b) **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.
5. **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 ****COMPANY**** and the Participating Provider.
 - a) For a Non-Participating Provider, the Eligible Charges for covered medical Services rendered by a provider who is not a Participating Provider, shall be limited to the lesser of (a) the actual charge made by the provider, or (b) in the United States, the Medicare Participating Provider fees in the geographic area where the Service was rendered; or (c) in Asia, the fees most recently contracted by ****COMPANY**** at St. Luke's Medical Center, Manila, Philippines, or (d) elsewhere, the Medicare National Standard Fee.
6. **Enrollment:** Shall be defined as the acceptance, as of a specified date, of a written or online application for coverage under the Plan on forms provided by ****COMPANY****.
7. **Foster Children:** Includes only foster children under the legal custody of the Child Protective Services Division of the Department of Public Health as defined in 4 G.C.A 4301.1(h)
8. **GovGuam Line Agencies:** Shall be defined Government of Guam agencies that are Line Agency means any department, agency, or instrumentality of the Government of Guam which is funded by an annual appropriation from the Legislature. Such appropriations do not include subsidies. (5 GCA Chapter 6 § 6103(c)). All TPA fees payments and issues associated with GovGuam Line Agencies shall be paid by the Department of Administration.
9. **GovGuam Autonomous Agencies:** Shall be defined as any Government of Guam department, agency, or instrumentality which generates, or is intended to generate, as evidenced in law, all of its own operating revenues apart from annual appropriations from the General Fund. Annual appropriations do not include amounts appropriated to line agencies to pay for services rendered by autonomous agencies. Subsidies appropriated from the General Fund to an autonomous agency, whether or not annually appropriated, shall not mean that an autonomous agency becomes a line agency for purposes of this Chapter. All TPA fees payments and payment discrepancy issues associated with the GovGuam Autonomous Agencies shall be coordinated directly with the autonomous agency.
10. **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.
11. **Other Plan:** Shall be defined as any other health insurance or health benefits program offered

to GovGuam's employees, retirees and their eligible Dependents, through an Agreement with GovGuam.

12. Participating Providers, Non-Participating Providers, Providers and Network:

- a. **"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.
- b. **"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 ****COMPANY**** to provide the Covered Services; and (ii) are assigned from time to time by ****COMPANY**** to participate in the Network or any other network of ****COMPANY**** pursuant to this Agreement. (iii) or who GovGuam has a direct contract with and administered by ****COMPANY****.
- c. **"Network"** shall be defined as the network of Participating Providers. Network may also be referred to as "Plan Network".
- d. **"Non-Participating Provider"** shall be defined as Providers who have NOT been contracted by ****COMPANY**** to provide medical services to Covered Persons.

13. 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; and based on 100% of Medicare allowable rate or the Usual Customary Reasonable ("UCR") charges for non-participating facilities and 100% of Medicare allowable rate for non-participating providers whenever the services are rendered by a non-participating provider.

14. 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.

15. Plan: Shall be defined as the group health insurance benefits provided in accordance with this Agreement.

16. Plan Year: Shall be defined as the twelve (12) month period during which group health insurance benefits are provided under this Agreement.

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

18. Service Area: Shall be defined as Guam and the Commonwealth of the Northern Mariana Islands. Enrollment in this Plan is limited to individuals residing in the Service Area. However, residence in the service area shall not be a requirement for enrollment for dependent children below 26 years of age.

19. Subscriber: Shall be defined as a bona fide employee of GovGuam who is working 30 hours per week; or

1. Voluntarily working under the "Quality Time" program and classified as such by GovGuam pursuant to P.L. 25-72; or working under any GovGuam sponsored program that ensures continuity of health insurance benefits.
 - Classified as a retiree of GovGuam by GovGuam; or
 - Classified as a GovGuam Retiree who has returned back to GovGuam active employment; or
 - Classified as a survivor of a retired employee of GovGuam by GovGuam; or
20. A Foster Child under the legal custody of the Child Protective Services Division of the Department of Public Health.
21. **Third Party Administrator (TPA) Fees:** Shall be defined as the dollar amount paid to ****COMPANY**** for the administration of this Plan to Covered Persons.

ARTICLE 3: SERVICES

****COMPANY**** shall provide Covered Persons with the group health insurance and Foster health benefits, subject to the applicable limitations and conditions, set forth in this Agreement and the Certificates and Exhibits incorporated herein.

ARTICLE 4: RATES, TPA FEES & PROVIDER NETWORK

- A. **Rates.** ****COMPANY**** shall provide the group health insurance benefits set forth in the Certificate for the rates contained herein.
 - B. **TPA fees Payment. All agencies and departments shall remit premiums to the Department of Administration for all enrolled subscribers.** GovGuam shall pay the TPA fees due under this Agreement to ****COMPANY**** within thirty-one (31) days of each biweekly invoice for active employees and semi-monthly for retirees detailing the current TPA fees due. Payment in full of all TPA fees 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 TPA fees when due under this Agreement, ****COMPANY**** shall have the right to suspend performance under this Agreement with respect to any Covered Person whose TPA fees payments have not been paid by GovGuam, in addition to the right of termination under Article 5. However, such suspension may only take place after ****COMPANY**** provides written notice to Government of Guam at least fifteen (15) days prior to the suspension stating the names of the Covered persons at risk of suspension and the amount of TPA fee owed for each.
 - C. **PPO Network.** One of the advantages of a PPO network is the determination of what charge amounts are acceptable for benefit payment. As defined later in this document, covered expenses will be considered only up to the reasonable and customary charge for the geographic area in which the service is rendered. This means that if a PPO network physician bills an amount in excess of the reasonable and customary amount, Plan Participants cannot be billed for the excess charge.
- In addition, the Plan provides an Out-of-Area benefit at the level shown in the Schedule of Medical Benefits to the following Plan Participants only in the event the Plan Participant uses a PPO network provider outside the State of Guam, subject to prior approval:
- Plan Participants who reside outside of Guam and the CNMI (qualified dependents)
 - Plan Participants who reside within Guam, subject to prior approval
 - Emergency services

All other Plan Participants will receive benefits at the Out-of-Network benefit when using a provider outside of the State of Guam.

However, an out of network physician who bills an amount in excess of the reasonable and customary amount can bill Plan Participants for the excess charge. It is therefore to a Plan Participant's benefit to use the PPO network. Excess charges will not be paid by the Plan. Excess charges paid by a Plan Participant are not considered towards annual deductibles and /or maximum out of pocket limits.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Plan Participants are limited to covered charges incurred before termination.

ARTICLE 5: TERM, NOTICE & TERMINATION

- A. Term.** The Agreement is for a one-year Firm Fixed-Price Contract beginning October 1, 2024 ending September 30, 2025, 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.
- B. Notice to GovGuam.** **COMPANY** must provide written notice to GovGuam or directly to the autonomous agency after fifteen (15) days and thirty-one (31) days of the non-payment. The notices must state the names of the Covered Persons at risk of suspension and the amount of TPA fees owed for each. A list of line agencies and autonomous agencies are provided in Exhibit A.
- C. Termination By **COMPANY**.** If GovGuam or an autonomous agency fails to make any TPA fee payment fee, **COMPANY** shall have the right to suspend or terminate coverage of the Covered Persons for non-payment within thirty-one (31) days of the second notice. **COMPANY** shall not suspend or terminate agency coverage as a whole for the non-payment of individual TPA fees.
- D. Individual Notice.** **COMPANY** must provide direct written notice to individuals who have outstanding TPA fee payments fee due after fifteen (15) and thirty-one (31) days of the non-payment.

Suspension notices will be issued by the TPA on the 15th calendar day after notice of non-payment. Notices will be issued to the individual member and the respective department/agency.

If no payment is made within 15 calendar days after suspension notice, termination notice will be sent to the member & the respective department. Termination will be retroactive to last PPE payment was received.

Individual Termination. **COMPANY** may, in accordance with the notice provisions contained herein, terminate the coverage of one or more individual Covered Persons for non-payment of TPA fees without fee terminating this Agreement as to other Covered Persons for whom TPA fees have been received by **COMPANY**. **COMPANY** shall have the right to suspend or terminate coverage of the individual for non-payment within thirty-one (31) days of the notice. **COMPANY**

must provide individual termination notices to the subscriber and advise the government of such termination.

- E. Other Reasons.** Except for non-payment of TPA fees, ****COMPANY**** may only terminate a Covered Person as provided under the Plan.
- F. Review of Termination.** Any Covered Person whose coverage is terminated pursuant to the Notice and Termination stated herein, shall be entitled to a review through the PPACA Claims Procedure set forth in this Agreement, if so requested.
- G. 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 provided by GovGuam which will not be later than the last day of the pay period for which TPA fees has been remitted and GovGuam shall be responsible for payment of the TPA fees up to said effective date.
- H. Termination of Subscriber's Coverage.** If a Subscriber's coverage terminates, the coverage of all of that Subscriber's Covered Dependents also terminates as of the same date.

ARTICLE 6: ENROLLMENT

- A. 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 §6C, §6D and §6E 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.
- B. Foster Enrollment.** DPHSS CPS shall provide ****COMPANY**** with the names and other enrollment information of eligible foster children to be enrolled in this Plan. The parties to this Agreement shall provide ****COMPANY**** with the assistance and cooperation detailed on Article 8. The effective date of such Enrollment shall be the effective date of this Agreement, unless otherwise specified by GovGuam in accordance with this Agreement, or unless otherwise required under HIPAA.

DPHSS CPS agrees to abide by the provisions of coverage in the policy under which the Foster Child is enrolled. DPHSS CPS shall read and understand the eligibility requirements and attest that the foster child meets these requirements. DPHSS CPS understands that it is their responsibility to report any changes in eligibility. Child Protective Services further understands that newly eligible foster children may only be added within thirty-one (31) days from becoming eligible or during an Open Enrollment period for the group. DPHSS CPS understands on behalf of the Foster Child that ****COMPANY**** has the right to request required documents at any time and failure to submit these documents may result in a loss

of coverage or service at the discretion of the ****COMPANY****. Should this occur, DPHSS CPS understands and agrees they may be responsible for the cost of all health care provided to the Foster Child. DPHSS CPS understands that the provided coverage and service does not constitute acceptance of eligibility by ****COMPANY**** until eligibility for coverage has been proven.

- C. 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.

D. Newly Eligible Persons. Any individual who becomes a GovGuam employee, or for any other reason first becomes eligible to be a Covered Person outside the open Enrollment period, shall have thirty-one (31) 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 the applicable Plan certificate.

1. **Foster Eligibility.** When a Foster Child first becomes eligible to be a Covered Person, shall have thirty-one (31) days after the date on which he/she became eligible to become a Covered Person.
2. **Retirees who return to Active Employment.** When a Retiree has returned back to active employment with GovGuam, he/she shall enroll under the active status.

E. Otherwise Eligible. Enrollment shall be restricted to only those occasions provided for in this Article 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.

F. Disenrollment Permitted.

1. Covered persons for whom this group health insurance is secondary to Medicare coverage, shall be permitted to disenroll with thirty-one (31) days' notice to **COMPANY**, and enroll in the Retiree Supplemental Plan.
2. Retirees who return back to active employment with GovGuam, shall be permitted to disenroll under the Retiree status and enroll under the active status. Departments are responsible in ensuring that their employee is enrolled under the correct status. Should it be found that the employee's enrollment is under the wrong status, enrollment to the appropriate status shall be corrected upon discovery.

G. Notice of Ineligibility. **COMPANY** shall notify subscribers 30 days prior to when a dependent is no longer eligible for coverage. This includes children who are no longer deemed a dependent or the dependent has reached eligibility age of 26. Notification of subscribers shall be sent to the respective departments/agencies HR & payroll. Listing shall inform departments on the effective date and if there is a class change as a result of this change.

H. Responsibility of subscribers. Subscribers shall promptly notify GovGuam and **COMPANY** when there is a change in the status of any dependents (such as death, divorce, or separation) covered under the subscriber's plan. Subscribers shall remain in the current Class/Plan and are responsible for TPA fees until **COMPANY** notifies GovGuam of the effective date of the change. **COMPANY** shall notify GovGuam within fifteen (15) days of any changes received directly from Subscribers.

I. Foster. DPHSS CPS shall promptly notify GovGuam and **COMPANY** when an individual no longer qualifies for coverage under the Foster program. GovGuam shall remain responsible for TPA fees of the Foster Child until **COMPANY** notifies GovGuam of the effective date of the change.

ARTICLE 7: **COMPANY RESPONSIBILITIES**

A. 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.

- B. Benefits to be Provided.** **COMPANY** shall, in consideration of receipt of applicable TPA fees, administer 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.
- C. 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.
- D. 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.
- **Authorization.** DPHSS CPS authorizes any Medical/Healthcare Provider of Facility to give **COMPANY** information concerning the medical history, prescription utilization history, services or treatment provided to anyone enrolled with **COMPANY** pursuant to this Agreement, including any Mental Health, Substance Abuse and HIV/AIDS information. DPHSS CPS further authorizes **COMPANY** to use such information and to disclose such information to affiliates, other Providers, payers, other insurers, third party administrators, vendors, consultants and government authorities with jurisdiction when as deemed necessary by **COMPANY** for the Foster Child's care or treatment, payment of services, the operation of my health plan, or to conduct related activities.
- DPHSS CPS consents to the terms of this authorization. This authorization will remain valid for the term of this coverage and after finalizing the administration of any remaining open claims. DPHSS CPS understands that they are entitled to receive a copy of this authorization and that a photocopy is as valid as the original.
- E. Errors and Omission Insurance.** **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.
- F. 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 Section 2719 and regulations thereto on internal claims appeal process and external appeals process review requirements.
- G. Prompt Payment Report.** **COMPANY** shall send a status report on a claim filed by Covered Person against a Provider within forty-five (45) days after receipt if the claim is still pending disposition by **COMPANY** and Provider. At a minimum the report shall indicate that the claim is

under review and **COMPANY** is working to resolve the claim with the Provider. **COMPANY** shall send another status report on the claim to the Covered Person with a copy to the Provider thirty (30) days from the date the first status report was sent to the Covered Person if the claim has not been resolved.

- H. 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.
- I. Termination Notification.** If **COMPANY** terminates this Agreement, **COMPANY** shall provide notice announcing its termination at least fifteen (15) days prior to the date of termination on **COMPANY**'s website, an ad in any of the local newspaper publications, and email to subscribers of **COMPANY**'s Plan. Further, **COMPANY** shall fully cooperate with GovGuam in transitioning Covered Persons to Other Plans.
- J. 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.
- K. Online Access Capabilities.** **COMPANY** shall provide, for the benefit of the Covered Person and GovGuam, the following online access capabilities:
- 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.
 - For the Covered Person, access to a Personal Claim Record ("PCR"), whichever is applicable to **COMPANY**, to include historical health conditions, prescription medications, office visit summary and procedures where a medical claim has been filed.
 - For the Covered Person, access to record of medical and drug claims.
 - For the Covered Person, ability to verify eligibility.
 - Ability of Providers to submit claims through a separate portal rather than through **COMPANY**'s website for payment.
 - For the Covered Person, GovGuam, and Provider's access to Schedule of Benefits, Member Handbooks, Pharmacy Benefit Information, and Provider Network Information.
 - For the Covered Person, ability to print PHR or PCR, whichever is applicable to **COMPANY**, to federal compliance standard file formats or plain text file.
 - For the Covered Person, ability to print online membership cards.
 - For the Covered Person, access to interactive tools for researching health issues, treatments, and risk assessment tools for health conditions.
- L. Performance Guarantees.** Performance guarantees will have the appropriate annual penalties listed by each guarantee as stated with a maximum amount of \$ 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.

M. . ADDITIONAL GOVGUAM CLAUSE

a. Monthly Billing Statements

COMPANY shall provide detailed monthly billing invoices to DOA and each autonomous agency. The billing shall include the following:

1. Listing of all subscribers (active employees, retirees and survivors) and dependents, by plan and class enrolled through the agency with payroll beginning and end dates

indicated.

2. TPA fees due for each subscriber.
3. Any changes received until the end of the billing cycle provided. ****COMPANY**** must identify detailed information of any changes for easier reference by the departments.
4. Departments must report any changes to personnel, work status, coverage changes, to ****COMPANY**** by the close of the effective pay period ending or immediately after.

****COMPANY**** must receive a written confirmation from DOA and the autonomous agencies that they have certified the accuracy of the information in the detailed billing statements with the monthly payment. Any changes or discrepancies must be provided to the ****COMPANY**** with the monthly payment. ****COMPANY**** agrees to make changes and adjust payments as reported by DOA and the autonomous agencies.

b. Quarterly Billing Statements

****COMPANY**** shall provide a Quarterly Statement of Accounts by subscriber for each autonomous agency and DOA for all line agencies no later than 31 days after end of the quarter. The Quarterly Statement of Accounts will not reflect any Third-Party Administrator (TPA) fees or self funded amounts for carriers that are not contracted as the TPA.

GovGuam autonomous agencies and DOA shall confirm the accuracy and provide any changes or discrepancies no later than 31 days of receipt of the Quarterly Statement of Accounts.

c. Monthly Enrollment Extract

TPA shall provide DOA with a master extract of all GovGuam members on a monthly basis by the 15th of each month. TPA shall provide autonomous agencies monthly enrollment data for their respective agency. The extract shall include the following:

1. Listing of all subscribers and dependent/s
 - a. Subscriber status: Active employee, retirees and survivors of retirees.
 - i. If retiree or survivor, identify Define Benefit (DB) or Define Contribution (DC)
 - b. Dependent information listing relationship to subscriber.
2. Subscriber department/agency
3. Plan and class enrolled
 - a. Indicate payroll beginning effective and end dates.
4. Method of enrollment: Online or Hardcopy
5. Any changes received until the end of the billing cycle provided. ****COMPANY**** must identify in the detailed information of any changes for ease of reference for departments.

Departments must report any changes to personnel, work status, coverage changes, to the TPA's by the close of the effective pay period ending or immediately after. Departments are responsible to remit payment for unreported discrepancies or failure to respond to discrepancy listings provided by the TPA.

N. TPA Fee & Claims Audit

TPA is responsible to audit TPA fee payments against enrollment and report discrepancies to the

respective departments. TPA is responsible to verify enrollment & collected TPA fees prior to processing and paying claims. Any discrepancies shall be reported to the respective departments.

ARTICLE 8: GOVGUAM'S RESPONSIBILITIES

- A. 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 applicable Plan to GovGuam employees.
- B. 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.
- C. Personnel Changes.** GovGuam and autonomous agencies shall provide written notice to **COMPANY** of terminations, resignations, department transfers, and employees on leave status that would affect coverage or TPA fees. **COMPANY** shall ensure that coverage and rate changes or terminations are implemented at the appropriate time. GovGuam and autonomous shall make available to **COMPANY** a computer listing of each employee receiving an applicable payroll deduction for TPA fees no later than fifteen (15) working days following each pay period.
- Departments and agencies will continue to send the back-up payment details (enrollments, cancellations and other changes on qualifying events) to the TPAs for their respective plans. Any audits or discrepancies relating to enrollment or premiums is the responsibility of each respective agency. It is crucial that department personnel and payroll offices conduct audits on invoices received from the TPAs. Departments are responsible to pay any and all premiums should they fail to do the following:
 - Conduct audits of enrollment provided by the TPAs
 - Respond to discrepancy reporting by the TPAs
 - Report subscriber status changes timely
 - DOA Circular 2023-032 Departments and agencies must remit payments for all employees/retirees regardless of non-payment or non-deduction, i.e., Leave Without Pay (LWOP), leave-sharing, etc. Departments are responsible to recover premiums from those it advanced payment for. Termination must take effect after a cumulative of two (2) episodes of non-payment. Departments are required to track non-payments and terminate accordingly to the last pay period that payment was made. A form must be completed by the department advising the TPA of termination.
- D. Individual with Questionable Status.** If GovGuam does not provide the list of employees as required in 8(C), **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 TPA fee 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 PP'CA'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.

- E. Changes.** DPHSS CPS shall provide written notice to **COMPANY** and the Department of Administration of the terminations of the legal custody of the Child Protective Services Division of the Department of Public Health and Social Services of a foster child, and the like, in order for coverage to be terminated at the appropriate time.
- F. Certification of Recipients of Foster Child Program.** DPHSS CPS certifies that all Applicants under the Health Plan are bona fide recipients of the Foster Child Program and that Child Protective Services of the Department of Public Health and Social Services has been granted proper Legal Custody of all Applicants / Recipients
- G. No restrictions or guarantees on Enrollment.** GovGuam shall place no restriction or limitation on the percentage or number of Enrollments in the Plan. GovGuam shall not make any guarantees for a minimum number or minimum percentage of Enrollments in the Plan.
- H. TPA fee Collection fee and Remittance Arrangements.** The GovGuam DOA shall collect TPA fees from all participating line agency employees. **COMPANY** will not be responsible for billing individual participants. The DOA will remit the TPA fees to **COMPANY** for all line agencies on a biweekly basis for employees and a semi-monthly basis for retirees and survivors. Government of Guam line agencies, as well as, those agencies whom the DOA administers payroll, shall be responsible for payment and administration of their respective employee work groups and are to be held accountable for any balances due and must resolve any and all discrepancies directly with the carrier. **COMPANY** shall work directly with the respective agency to resolve any discrepancies.

Autonomous agencies are to be held accountable for any balances due and must resolve any and all discrepancies directly with the carrier. **COMPANY** shall work directly with the respective agency to resolve any discrepancies.

ARTICLE 9: COVERED PERSON'S RESPONSIBILITIES

- A. Acceptance.** By Enrolling in the Plan, all Covered Persons agree to the terms, provisions and conditions of this Agreement.
- B. Dual Coverage Prohibited.** Covered Persons shall not enroll for the purposes of receiving dual coverage. Covered Persons shall only be covered once and shall not submit additional claims in order to increase coverage. Exceptions to this prohibition may be waived as a result of a court order or settlement agreement.
- C. 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.

- D. Verification of residency.** **COMPANY** shall notify GovGuam when there is change in the mailing or residential address of a Covered Person that is located outside of the Service Area. **COMPANY** shall request a verification (such as a utility bill, real property tax, or individual tax return) from the Covered Person confirming continued domicile in the Service Area. **COMPANY** may terminate coverage if Covered Person fails to provide verification within thirty (30) days of the request and shall notify GovGuam of any pending or current terminations.

ARTICLE 10: NOTICES

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

To: **COMPANY**
 COMPANY ADDRESS

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

Method of Service. Notices shall be in writing and effective upon either receipt of a hand-delivered notice or the posting of notice by first class mail, postage prepaid, to the address listed herein or such other address as a party may designate by providing written notice to the other party from time to time.

ARTICLE 11: DISPUTE RESOLUTION

Mandatory Disputes Resolution Clause (As amended but consistent with 2 GAR Div. 4 § 9103(g) and applicable law). GovGuam and **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, **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 **COMPANY** may proceed as though GovGuam had issued a decision adverse to **COMPANY**.

GovGuam shall immediately furnish a copy of the decision to **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 **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, **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 (60) days of GovGuam's decision or from the date the decision should have been made. **COMPANY** shall exhaust all administrative remedies before filing an action in the Superior Court of Guam in accordance with applicable laws. **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 **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 **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

- A. 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 **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 TPA fees 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.
- B. 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.
- C. 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.
- D. 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.
- E. 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.

- F. 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.
- G. 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.
- H. Entire Agreement.** This Agreement, including its Attachments, Exhibits and Schedules, and all Contract Documents, constitutes the entire agreement between the Parties and supersedes all prior written or oral understandings. No agreement, oral or written, expressed or implied, has been made by any Party hereto, except as expressly provided herein. All prior agreements and negotiations are superseded hereby. This Agreement and the Contract Documents contain all of the covenants and agreements between the Parties with respect to the subject matter of this contract. By executing this Agreement, ****COMPANY**** and GovGuam each acknowledge that no representations, inducements, promises or agreement, orally or otherwise, have been made by any Party, or anyone acting on behalf of any Party, which are not embodied herein, and that any other agreement, statement, or promise which is not contained in the Agreement shall not be valid or binding on the Parties with respect to the subject matter of this contract.
- I. Amendment.** This Agreement may only be amended upon the written consent of both parties.
- J. Time of Essence.** Time is expressly made of the essence in this Agreement and for performance hereunder.
- K. 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.
- L. 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.
- M. 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.
- N. 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.
- O. Counterparts.** This Agreement, including the Certificate and Exhibits, may be executed by the parties in several counterparts, each of which shall be deemed to be an original copy.
- P. 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 PHS Act. 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, Guam law shall govern.

- Q. 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.
- R. Restriction Against Contractor Employing Sex Offenders to Work at Government of Guam Venues.** **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 **COMPANY** on property of the government of Guam other than a public highway. Further, **COMPANY** warrants that if any person providing services on behalf of **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.
- S. Ethical Standards.** With respect to this Agreement and any other contract **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.
- T. 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 **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.
- U. Access to Records.** **COMPANY**, including its subcontractors, if any, shall maintain all books, documents, papers, accounting records and other evidence pertaining to costs incurred and relative to its cost or pricing data, and shall make such materials available at all reasonable times during the contract term and for three (3) years from the date of final payment under this Formal Agreement, for inspection in Guam by GovGuam. Each subcontract by the Contractor pursuant to this Agreement shall include a provision containing the conditions of this Section.
- V. Right to Audit.** **COMPANY** shall establish and maintain a reasonable accounting system that

enables GovGuam to readily identify ****COMPANY****'s assets, expenses, costs of goods, and use of funds. GovGuam and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this Agreement kept by or under the control of ****COMPANY****, including, but not limited to those kept by ****COMPANY****, its employees, agents, assigns, successors, and subcontractors.

W. Right to Enter and Inspect. GovGuam, may, with 15 days notice, enter and inspect a Contractor's or subcontractor's facilities, place(s) of business, or any place(s) of performance of this Agreement, and may conduct any testing deemed necessary to determine the Contractor's or subcontractor's compliance or conformity to the solicitation or contract requirements. GovGuam may enter and audit the cost or pricing data, books, and records of the Contractor or any subcontractor, and/or investigate in connection with an action to debar or suspend a person from consideration for award of contracts pursuant to §9102 (Authority to Debar or Suspend) of the Guam Procurement Rules and Regulations.

ARTICLE 14: TRANSMISSION OF DATA IN DIGITAL FORM

If the parties intend to transmit any information or documentation in digital form, they shall establish necessary protocols governing such transmissions, unless otherwise already provided in this Agreement

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

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

****COMPANY****

Government of Guam

By:

****COMPANY****

By:

Edward M. Birn, Director
Department of Administration

Date:

Date:

By:

Michelle Santos, Insurance Commissioner
Department of Revenue & Taxation

Effective Date

October 1, 2024

Date:

By:

Lester Carlson, Director
Bureau of Budget and Management

Date:

Approved as to Legality and Form:

By:

Douglas B. Moylan
Attorney General

Date:

By:

Lourdes Leon Guerrero
Governor of Guam

Date:

Preferred provider organization (PPO) medical plan

Certificate of coverage Prepared exclusively for:

Policy holder:	Government of Guam
Plan name:	HSA 2000, PPO 1500, Retiree Supplemental Plan (RSP), and Foster
Plan effective date:	October 01, 2025
Plan issue date:	October 01, 2025

**GOVERNMENT OF GUAM SELF-INSURED
MEDICAL AND PRESCRIPTION BENEFITS FY2026**

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Introduction

This is your certificate of coverage or “certificate.” It describes your **covered services** – what they are and how to get them. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Along with the group policy, they describe your plan benefits. Each may have amendments attached to them. These changes or add to the document. This certificate takes the place of any others sent to you before.

It’s really important that you read the entire certificate and your schedule of benefits. If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the *General coverage provisions* section of the schedule of benefits.

If you need help or information, see the *Contact us* section below.

How we use words

When we use:

- “You” and “your” we mean you and any covered dependents (if your plan allows dependent coverage)
- “Us,” “we,” and “our” we mean ****COMPANY****
- Words that are in bold, we define them in the *Glossary* section

Contact us

For questions about your plan, you can contact us by:

- Calling ****COMPANY NUMBER****
- Logging in to the ****COMPANY**** website at [****COMPANY WEBSITE****](#)
- Writing to us at ****COMPANY ADDRESS****

Your member website is available 24/7. With your member website, you can:

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a **provider**, research **providers**, care and treatment options
- View and manage claims
- Find information on health and wellness

Your ID card

We will mail you an ID card for you and the enrolled dependents. You are also able to print a card from our web portal.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as a ****COMPANY**** member through incentives.

Gym benefit

- The Plan provides full or discounted coverage of a gym membership only at approved participating gym facilities in Guam. Anything beyond the allotted gym benefit fees as agreed by GovGuam and ****COMPANY**** is the responsibility of the member to pay.
 - o A list of participating gym facilities may be found in the Plans summary brochure and is subject to change. This benefit only provides coverage for the monthly membership fee per the agreement between ****COMPANY**** and the Gym.

- Each participating gym has a minimum age requirement that must be met.
- Insured family dependents do not have to select the same gym facility as the subscriber.
- Once a member has enrolled in a gym, they may not change mid-year.
- This benefit will cease should your coverage terminate for any reason.
- A member's agreement with a Gym is between them and the Gym.
- Members are responsible for all and any additional charges not covered by the benefit. This includes but is not limited to uniform fees, promotion fees, termination fees, etc.
- Under this benefit, member may be enrolled in only one (1) participating gym facility at a time.

Enrollment:

- Eligible members must register with a participating Gym.

Gym reward:

- Members are eligible to receive a USD \$75 cash reward when they have completed the Health Risk Assessment and workout at least 10 days per month at the selected gym partner, for three consecutive months per GovGuam Quarters.

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third-party service providers". These third-party service providers may pay us so that they can offer you their services.

Third-party service providers are independent contractors. The third-party service provider is responsible for the goods and services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third-party service providers for the services they offer. You are responsible for paying for their services and discounted goods. Discounts are offered through the ****COMPANY PROGRAM****.

Coverage and Exclusions

Your plan provides **covered services**. These are:

- Described in this section.
- Not listed as an exclusion in this section or the *General plan exclusions section*.
- Not beyond any limits in the schedule of benefits.
- **Medically necessary**. See the *How your plan works – Medical necessity and precertification requirements* section and the *Glossary* for more information.

For covered **services** under the outpatient **prescription** drug plan:

- You need a **prescription** from the prescribing **provider**
- You need to show your ID card to the network pharmacy when you get a **prescription** filled

This plan provides insurance coverage for many kinds of **covered services**, such as a doctor's care and **hospital stays**, but some services aren't covered at all or are limited. For other services, the plan pays more of the expense.

For example:

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.

- Home healthcare is generally covered but it is a **covered service** only up to a set number of visits a year.
 - This is a limitation.
- Your **provider** may recommend services that are considered **experimental or investigational** services.
 - But an **experimental or investigational** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.

Some services require **precertification** from us. For more information see the *How your plan works – Medical necessity and precertification requirements* section.

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. You can find out about limitations for **covered services** in the schedule of benefits. If you have questions, contact us.

Acupuncture

Covered services include acupuncture services provided by a **physician** if the service is provided as a form of anesthesia in connection with a covered **surgical procedure**.

The following are not covered **services**:

- Acupuncture, other than for anesthesia
- Acupressure

Airfare reimbursement benefit

For qualifying conditions where care is not be available on Guam; the Airfare Benefit may provide an economy round trip airfare for the insured member, a companion if medically required and a medical escort if medically required to one of our designated preferred facilities (Centers of Care). ****COMPANY**** must be your primary insurer or if Medicare is your primary insurer, ****COMPANY**** will cover secondary to Medicare. A ****COMPANY**** participating provider must provide your medical referral. Plan approval is required in advance of travel. This benefit does not cover Diagnostic Procedures, Second Opinions or Air Ambulance. To learn more about your eligibility for this benefit, please contact Member Services.

Qualifying conditions when care is not available on Guam:

Acute leukemia treatment, Ambulatory Surgical Center Services, Aneurysmectomy, Gamma knife surgery, Inpatient services expected to exceed USD \$25,000, Intracranial surgery, Oncology surgery performed by a surgical oncologist, Open heart surgery, Neurosurgery, NICU Level III services, Pneumonectomy and Transplants. Transplants must be obtained at an approved facility in the USA, or Joint Commission International (JCI) facility Outside the USA, for the transplant in need.

Centers of Excellence (COEs)

Centers of Excellence are specific facilities outside of Guam selected by the Plan and are the destination of travel for which a member is scheduled to receive care for any of the qualifying conditions noted above. Please refer to your plan summary brochure for a list of approved facilities, which is subject to change.

Reimbursement Policy:

- Members being referred for consultation do not qualify for the AirfareBenefit
- If an off-island consultation results in one of the above procedures, that cost of the airfare maybe reviewed for reimbursement.
- Member, who subsequently underwent surgery or treatment procedures that meet

****COMPANY****'s criteria for the airfare benefit, may request reimbursement for airfare.

Request for reimbursement requirements:

- Submit a ****COMPANY**** Deductible Request for Reimbursement Form, properly completed and signed within 120 days of the date of service
- Include a copy of the airfare receipt (proof of payment), airline ticket, boarding pass, and itinerary.
- Include medical records, including but not limited to the operative report indicating the date of service, name of procedure performed, detailed description of the procedure performed, name and address of the facility where service was performed.
- Requests will be reviewed and processed within 45 days of receipt of required documents.
- Tickets will only be reimbursed in monetary value. We are not able to reimburse tickets purchased using frequent flyer miles.
- This benefit does not cover charges for meals or lodging.

Ambulance services

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide emergency **services**
- From one hospital to another if the first hospital can't provide the emergency services you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency

Covered services also include **pre-certified** transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not covered **services**:

- Non-emergency airplane transportation by an **out-of-network provider**
- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not covered **services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include devices, treatments, or procedures from a **provider** under an “approved clinical trial” only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
 - It conforms to standards of the NCI or other applicable federal organization
 - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

- Services
 - Foot care to minimize the risk of infection
- Supplies
 - Injection devices including syringes, needles and pens
 - Test strips - blood glucose, ketone and urine
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs

- Equipment
 - External insulin pumps and pump supplies
 - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your plan only covers the same type of DME that Medicare covers but, there are some DME items Medicare covers that your plan does not.

Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:

- One item of DME for the same or similar purpose
- Repairing DME due to normal wear and tear
- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not covered **services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. You can get **emergency services** from **network providers** or **out-of-network providers**.

If your **physician** decides you need to **stay** in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity and precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your **network physician** or **primary care physician (PCP)**.

Non-emergency services

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for this information.

Habilitation therapy services

Habilitation therapy services help you keep, learn or improve skills and functioning for daily living (e.g., therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services must be performed by a:

- Licensed or certified physical, occupational or speech therapist
- **Hospital, skilled nursing facility** or hospice facility
- **Home health care agency**
- **Physician**

Outpatient physical, occupational, and speech therapy

Covered services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (speech function is the ability to express thoughts, speak words and form sentences)

The following are not covered **services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Hearing aids

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

Covered services include prescribed hearing aids and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
 - A **physician** certified as an otolaryngologist or otologist
 - An audiologist who:
 - Is legally qualified in audiology
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
 - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not covered **services**:

- Replacement of:
 - A hearing aid that is lost, stolen or broken
 - A hearing aid installed within a 36-month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hearing exams

Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing **specialist**.

The following are not covered **services**:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

Home health care

Covered services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- You are homebound
- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See *Rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not covered **services**:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

Covered services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis

- Services by a hospice care agency or hospice care provided in a hospital
- Psychological and dietary counseling
- Pain management and symptom control

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an employee of the hospice care agency responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
 - Physical and occupational therapy
 - Medical supplies
 - Psychological counseling
 - Dietary counseling

The following are not covered **services**:

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
 - Sitter or companion services for you or other family members
 - Transportation
 - Maintenance of the house

Hospital care

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of physicians employed by the **hospital**.
- Administration of blood and blood derivatives.

The following are not covered **services**:

- All services and supplies provided in:
 - Rest homes
 - Any place considered a person's main residence or providing mainly custodial or rest care
 - Health resorts
 - Spas
 - Schools or camps

Infertility services

Basic infertility

Covered services include seeing a **provider**:

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of infertility. Examples are endometriosis **surgery**
 - o or, for men, varicocele **surgery**.

The following are not covered **services**:

- All **infertility** services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Artificial insemination services.

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services.

After your child is born, covered **services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

Covered services also include services and supplies needed for circumcision by a **provider**. The

following are not covered **services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Mental health treatment

Covered services include the treatment of **mental disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider** including:

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies
Related to your condition that are provided during your stay in a **hospital, psychiatric hospital, or residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician or behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group, and family therapies for the treatment of mental **disorders**
 - Other outpatient mental health treatment such as:
 - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
 - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease to avoid placing you at risk for serious complications
 - Electro-convulsive therapy (ECT)
 - Transcranial magnetic stimulation (TMS)
 - Psychological testing

- Neuropsychological testing
- 23-hour observation
- Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Obesity surgery and services

Obesity **surgery** is a type of procedure performed on people who are morbidly obese for the purpose of losing weight. Your **physician** will determine whether you qualify for obesity **surgery**.

Covered services include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- One obesity **surgical procedure**
- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not covered **services**:

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
 - Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
 - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
 - Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial surgery (treatment of mouth, jaws and teeth)

Covered services include the following when provided by a **physician**, a dentist and **hospital**:

- **Surgery** needed to:
 - Cut out cysts, tumors, or other diseased tissues.
 - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.

The following are not covered **services**:

- Services normally covered under a dental plan
- Dental implants

Outpatient surgery

Covered services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery** center or a **hospital's** outpatient department.

Important note:

Some surgeries can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician, PCP** services and not for a separate fee for facilities.

The following are not covered **services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- A separate facility charges for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Physician services

Covered services include services by your **physician** to treat an illness or injury. You can get services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine**

Important note:

For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services**, either by a **network** or **out-of-network provider**, if you use **telemedicine** instead.

Telemedicine may have a different cost share from other **physician** services. See your schedule of benefits.

Other services and supplies that your physician may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Prescription drugs - outpatient

Prescription drugs are covered under the plan's formulary listing. For more information about **prescription** drug benefits, including limits and co-payments, see the schedule of benefits.

Important note:

A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgment of the pharmacist, it should not be filled or refilled.

Covered services are based on the drugs in the **drug formulary**. Your cost may be higher if you're prescribed a **prescription** drug that is not listed in the **drug formulary**. You can find out if a prescription drug is covered; see the Contact us section. Drugs *may* be added to the formulary during the Plan year. No drug can be reclassified from Generic to Brand name or Specialty Drug during the Plan Year.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a network pharmacy
- Calling or emailing a **prescription** to a network pharmacy
- Submitting the **prescription** to a network pharmacy electronically

Prescription drug synchronization

If you are prescribed multiple medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy can coordinate that for you. This is called

synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your prescription drugs.

How to access network pharmacies

You can find a network pharmacy either online or by phone. See the *Contacts* section for how.

You may go to any of our network pharmacies. If you don't get your prescriptions at a selected pharmacy, your prescriptions will not be a covered service under the plan. Pharmacies include network retail, mail order and specialty pharmacies.

Some **prescription** drugs are subject to quantity limits. This helps your **provider** and pharmacy ensure your **prescription** drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

Any prescription drug made to work beyond one month shall require the copayment amount that equals the expected duration of the medication.

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you a **generic drug** when it is available.

Pharmacy types

Retail pharmacy A network **retail pharmacy** will submit a claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit. The retail co-payment is applied to each covered formulary prescription drug charge, which is shown in the Schedule of Benefits. Formulary prescription coverage is available at any in-network retail pharmacy. The location of the in-network pharmacies is available through the Pharmacy Benefit Manager. Any one prescription is limited to a maximum of a 30- day supply with the exception of the Retail 90day program

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each **prescription** and refill is limited to a maximum 30-day supply. Certain medications, such as controlled substances for pain management, are not available through the mail order program. The list of covered mail order medications is available through the Pharmacy Benefit Manager and is the easiest way to obtain covered maintenance medications.

Specialty pharmacy

We cover **specialty prescription drugs** when filled through a network **retail** or **specialty pharmacy**. Each **prescription** is limited to a maximum 30-day supply. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by us, your **provider**, and/or your network pharmacy. The outcome of this review may include:

- Limited coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

What is the pharmacy you use leaves the network?

Sometimes a pharmacy might leave the network. If this happens, you will have to get your **prescriptions** filled at another network pharmacy. You can use your **provider** directory or call us to find another network pharmacy in your area.

Other covered services

Anti-cancer drugs taken by mouth, include chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be approved by the FDA.

Contraceptives (birth control)

For females who are able to become pregnant, **covered services** include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review.

Diabetic supplies

Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid Diabetic syringes, needles and pens
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the *Diabetic services, supplies, equipment, and self-care programs* section for medical **covered services**.

Immunizations

Covered services include preventive immunizations as required by the ACA when given by a network pharmacy. You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

OTC drugs

Covered services include certain OTC medications when you have a prescription from your provider. You can see a list of covered OTC drugs by logging to the Company website.

Preventive care drugs and supplements

Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA

Tobacco cessation prescription and OTC drugs

Covered services include FDA approved prescription and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the pharmacy for processing.

Risk reducing breast cancer prescription drugs

Covered services include **prescription** drugs used to treat people who are at:

- Increased risk for breast cancer

- Low risk for medication side effects

Important note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive care are not medically appropriate for you. Your provider may request a medical exception and submit the exception to us for review.

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When updated, they will apply to this plan. The updates are effective on the first day of the year, one year after the updated recommendation or guideline is issued.

For frequencies and limits, contact your **physician** or us. This information is also available at <https://www.healthcare.gov/>.

Important note:

Gender-specific preventive care benefits include **covered services** described regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

Breast-feeding support and counseling services

Covered services include assistance and training in breast-feeding and counseling services during pregnancy or after delivery. Your plan will cover this counseling only when you get it from a certified breast-feeding support **provider**.

Breast pump, accessories and supplies

Covered services include renting or buying equipment you need to pump and store breast milk.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

*Breast pumps limited to 1 per person per pregnancy up to \$100.

Counseling services

Covered services include preventive screening and counseling by your health **professional** for:

- Alcohol or drug misuse

- Preventive counseling and risk factor reduction intervention
 - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
 - Preventive counseling and risk factor reduction intervention
 - Nutritional counseling
 - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
 - Preventive counseling to help stop using tobacco products
 - Treatment visits
 - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are provided, administered, or removed by a **physician** during an office visit.
- Voluntary sterilization including charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

The following are not preventive **covered services**:

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- Male contraceptive methods, sterilization procedures or devices

Immunizations

Covered services include preventive immunizations for infectious diseases.

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel.

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician, PCP, OB, GYN** or OB/GYN office. The exams include initial and subsequent visits for:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening
- Maternal weight

Rh incompatibility screening

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services on topics such as:
 - Interpersonal and domestic violence
 - Sexually transmitted diseases
 - Human immune deficiency virus (HIV) infections
 - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Annual routine office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a **physician**, **PCP**, OB, GYN or OB/GYN for services including Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Private duty nursing - outpatient

Covered services include private duty nursing care, ordered by a **physician** and provided by an R.N. or L.P.N. when:

- You are homebound
- Your **physician** orders services as part of written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care

- Periodic skilled nursing visits are not adequate
- It is pre-approved by the Plan.

The following are not covered **services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

You may receive a prosthetic device as part of another **covered service** and therefore it will not be covered under this benefit.

The following are not covered **services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
 - **Surgery** on healthy breast to make it symmetrical with the reconstructed breast
 - Treatment of physical complications of all stages of the mastectomy, including lymphedema
 - Prostheses

Reconstructive surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in severe facial disfigurement or major functional impairment of a body part

- The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your surgery will improve function.

Covered services also include **surgery**, as soon as medically feasible, to fix teeth injured due to an accident when:

- Teeth are sound natural teeth. This means the teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** returns the injured teeth to how they functioned before the accident.

Short-term cardiac and pulmonary rehabilitation services Cardiac rehabilitation

Covered services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility** or **physician's** office, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Covered services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if they are part of a treatment plan ordered by your **physician**. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a **hospital, skilled nursing facility**, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your physician. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- **Hospital, skilled nursing facility**, or hospice facility
- **Home health care agency**
- **Physician**

Covered services include:

- Spinal manipulation to correct a muscular or skeletal problem. Your **provider** must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
 - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
 - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
 - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**

- Improve delays in speech function development caused by a gross anatomical defect present at birth (speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
 - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
 - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following are not covered **services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Skilled nursing facility

Covered services include **recertified** inpatient **skilled nursing facility** care. This includes:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies provided during a **stay** in a **skilled nursing facility**

Substance related disorders treatment

Covered services include the treatment of **substance related disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider** as follows:

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your stay in a **hospital, psychiatric hospital, or residential treatment facility**.

Treatment of **substance related disorders** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance related disorders** section or unit, unless you are admitted for the treatment of medical complications of substance **related disorders**.

As used here, "medical complications" include, but are not limited to:

- Electrolyte imbalances
- Malnutrition
- Cirrhosis of the liver
- Delirium tremens
- Hepatitis

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or**

residential treatment facility, including:

- Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
- Individual, group, and family therapies for the treatment of **substance related disorders**
- Other outpatient **substance related disorders** treatment such as:
 - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**

- Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
- Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
- 23-hour observation
- Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Tests, images and labs – outpatient Diagnostic complex imaging services

Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
 - Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
 - Nuclear medicine imaging including positron emission tomography (PET) scans
 - Other imaging service where the billed charge exceeds \$500
- Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

These are covered only when you get them from a licensed radiology **provider** or lab.

Diagnostic x-ray and other radiological services

Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology **provider**. See *Diagnostic complex imaging services* above for more information.

Therapies – Chemotherapy, infusion, radiation

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. **Covered services**

include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a **hospital**
- **A physician's office**
- **Your home from a home care provider**

You can access the list of preferred infusion locations by contacting us.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Certain infused medications may be covered under the outpatient prescription drug benefit. You can access the list of specialty prescription drugs by contacting us.

Radiation therapy

Covered services include the following radiology services provided by a health professional:

- ☐ Accelerated particles
- ☐ Gamma ray
- ☐ Mesons
- ☐ Neutrons
- ☐ Radioactive isotopes
- ☐ Radiological services
- ☐ Radium

Transplant services

Covered services include transplant services provided by a physician and hospital. This includes the following transplant types:

- ☐ Solid organ
- ☐ Hematopoietic stem cell
- ☐ Bone marrow
- ☐ Covered services also include:
- ☐ Travel and lodging expenses
 - o If you are working with a facility that is 100 or more miles away from where you live, travel and lodging expenses are covered services for you and a companion, to travel between home and the facility
 - o Coach class air fare, train or bus travel are examples of covered services

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as facilities in your provider directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

The following are not covered services:

- ☐ Services and supplies furnished to a donor when the recipient is not a covered person
- ☐ Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- ☐ Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness.

Urgent care services

Covered services include services and supplies to treat an urgent condition at an urgent care center as described below:

- ☐ Urgent condition within the network (in-network)
 - o If you need care for an urgent condition, you should first seek care through your physician, PCP. If your physician is not reasonably available, you may access urgent care from an urgent care center that is in network.
- ☐ Urgent condition outside the network (out-of-network)

o You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and getting the health care service cannot be

delayed.

The following are not covered services:

- ☐ Non-urgent care in an urgent care center

Vision care

Covered services include:

- ☐ Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not covered services:

- ☐ Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- ☐ Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes
- ☐ Any services exceeding the benefit limitation as stated on the summary of benefits

Walk-in clinic

Covered services include, but are not unlimited to, health care services provided at a walk-in clinic for:

- ☐ Scheduled and unscheduled visits for illnesses and injuries that are not emergency medical conditions
- ☐ Preventive care immunizations administered within the scope of the clinic's license

General Plan Exclusions and Limitations

Exclusions

The following are not covered **services** under your plan:

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

requirements.

- ☐ 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.
- ☐ No benefits will be paid for services and supplies to help you with activities of daily living or other personal needs such as: changing of dressings, administering oral medications, care of stable tracheostomy, care of stable colostomy/ileostomy/stable gastrostomy/bladder catheter, watching or protecting you, respite care, adult or child day care, convalescent care, institutional care, helping with walking/grooming/bathing/dressing/bathroom/eating, preparing foods or any other services that a person without medical or paramedical training could be trained to perform.
- ☐ 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)
- ☐ No benefits will be paid for private Duty Nursing. This provision does not apply to Home Health Care, except as specifically stated as covered.
- ☐ 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.)
- ☐ 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.
- ☐ No benefits will be paid for court ordered services, or those required by court order as a condition of parole or probation.
- ☐ 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.
- ☐ 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.
- ☐ 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.
- ☐ Unless otherwise specifically provided in the Agreement, no benefit will be paid for, or in connection with, airfare and **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.

- ☐ 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.
- ☐ No benefits 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.
- ☐ No benefits will be paid for home uterine activity monitoring.
- ☐ No benefits will be paid for services performed by an immediate family member for which, in the absence of any health benefits coverage, no charge would be made. Immediate family member is defined as parents, spouses, siblings, or children of the insured member.
- ☐ 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
- ☐ No benefits will be paid for:
 - Drugs or substances not approved by the Food and Drug Administration (FDA), or
 - 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
 - Drugs or substances labeled "Caution: limited by federal law to investigational use."
 - Any drug or substance which does not by federal or state law, require a prescription order (i.e., an over-the-counter "OTC" drug).
- ☐ No benefits will be paid for experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes, unless deemed medically necessary by the patient's physician, are associated with a qualifying clinical trial per PPACA regulations, and pre-authorized by the Company.

Per PHSA sec. 2709(a)(2), added by PPACA sec 10103(c), the plan must pay for items and services furnished in connection with approved clinical trials, and cannot exclude such items and services based on an exclusion for experimental or investigational treatments. The

requirement mandates coverage of all medically necessary charges associated with the clinical trial, such as physician charges, labs, X-rays, professional fees and other routine medical costs.

An approved clinical trial is defined as:

- Phase I, Phase II, Phase III, or Phase IV clinical trial,
 - Being conducted in relation to the prevention, detection or treatment for Cancer or other life threatening disease or condition, and
 - Is one of the following:
 1. A federally funded or approved trial.
 2. A clinical trial conducted under an FDA investigational new drug application.
 3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.
- ☐ No benefits will be paid for services or supplies related to Genetic Testing except as may be required by PPACA.
- ☐ No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care.
- ☐ No benefits will be paid for Services and supplies provided to perform transsexual surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and Services necessary to maintain transsexual status are also excluded from coverage, as are complications or medical sequela of such surgery or treatment.
- ☐ 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.
- ☐ 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 ****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.
- ☐ 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:

- Removal of bony impacted teeth, bone fractures, removal of tumors, and biopsy or excision of oral cysts.
 - 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.
 - Dental anesthesia when provided according to the conditions described in the Covered Benefits Section, "Limited General Anesthesia for Dental Procedures".
 - Procedures deemed medically necessary by patient's physician and pre-authorized by **COMPANY**.
- ☐ No benefits will be paid in connection with elective abortions unless Medically Necessary.
- ☐ 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 and the Schedule of Benefits.
- ☐ No benefits will be paid for eyeglasses or contact lenses or for Services and supplies in connection with surgery for the purpose of diagnosing or correcting errors in refraction except as provided in the Schedule of Benefits.
- ☐ 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.
- ☐ 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.
- ☐ No benefits will be paid for hypnotherapy and hypnosis.
- ☐ 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.
- ☐ 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:
- Medically Necessary reconstructive surgery as described in the Covered Benefits sections Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery.
 - surgery to correct the results of injuries causing an impairment;
 - surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;
 - surgery to correct congenital defects necessary to restore normal bodily functions,

including but not limited to, cleft lip and cleft palate.

- ☐ No benefits will be paid for routine foot/hand care, including pedicure, routine reduction of nails, calluses and corns when there is no illness or injury to the nails.
- ☐ 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 auto injections.
- ☐ 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 show 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.
- ☐ No benefits will be paid for Services and supplies provided for liposuction.
- ☐ 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.
- ☐ 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.
- ☐ Except as provided in this Agreement, or unless medically necessary for the treatment of Morbid Obesity or other disease, no benefit will be paid for gastric bypass, stapling or reversal if for the purpose of weight reduction or aesthetic purposes.
- ☐ No benefits will be paid for surgical operations, procedures or treatment of obesity, except when pre-authorized by Company.
- ☐ No benefits will be paid for the treatment of male or female Infertility, including but not limited to:
 - The purchase of donor sperm and any charges for the storage of sperm;
 - The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;
 - Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, hospital, ultrasounds, laboratory tests, etc.);
 - Home ovulation prediction kits;
 - Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;
 - 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;
 - Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds,

laboratory tests, etc.);

- Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
 - Any charge associated with a frozen embryo transfer including but not limited to thawing charges;
 - Reversal of sterilization surgery; and
 - Any charges associated with obtaining sperm for ART procedures.
- ☐ Except as provided in this Agreement, no benefits will be paid for the purchase or rental of durable or disposable medical equipment and supplies, other than for equipment and supplies used in a Hospital or Skilled Nursing Facility, or in conjunction with an approved Hospital or Skilled Nursing Facility confinement, or items covered as preventive care under well-women coverage such as breastfeeding supplies in accordance with reasonable medical management techniques, or as otherwise noted in the Agreement.
- ☐ 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.
- ☐ 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.
- ☐ No benefits will be paid for Services and supplies provided for penile implants of any type.
- ☐ No benefits will be paid for Services, drugs, and supplies to correct or enhance sexual dysfunction.
- ☐ 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.
- ☐ 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.
- ☐ 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
- ☐ Except as specifically provided in this Agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment.
- ☐ No benefits will be paid for Services for which the Covered Person or Subscriber is not legally obligated to pay.

- ☐ 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.
- ☐ 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.
- ☐ No benefits will be paid for hospital take-home drugs.
- ☐ No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the Covered Person.
- ☐ No benefits will be paid for educational services. Remedial educations and 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. Any service or supply for education, training or retraining services or testing is not covered.
- ☐ 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.
- ☐ 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.
- ☐ No benefits will be paid for non-medically necessary services, including but not limited to, those services and supplies:
 - Which are not Medically Necessary, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
 - That do not require the technical skills of a medical, mental health or a dental professional;
 - 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;
 - 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;
 - 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.
- ☐ No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care.
- ☐ No benefits will be paid for foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications

of diabetes.

- ☐ No benefits will be paid for nutritional support such as infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items.
- ☐ No benefits will be paid for CAR-T and T Cell receptor therapy for FDA-approved treatments
- ☐ Cosmetic drugs including medication and preparations used for cosmetic purposes
- ☐ Devices, products and appliances unless listed as a **covered service**

Limitations

- **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:
 - **Maximum Annual Benefit.** The total benefits payable to or on behalf of a Covered Person shall be unlimited per Plan Year.
 - **Cardiac surgery.** Benefits for cardiac surgery, including, but not limited to catheterization, angioplasty, valve replacement/repair, bypass and pacemaker are included.
 - **Non-Spouse Dependent.** Maternity benefits for a non-Spouse Dependent are covered. Except that Newborn care shall not be covered for a child born to a non-Spouse Dependent. A child born to a non-Spouse Dependent shall not be covered unless such child specifically meets the requirements for coverage as a Dependent of an employee (such as the employee becoming the guardian of such child).
 - **Nuclear medicine.** Coverage for nuclear medicine and all Covered Services related thereto are included.
 - **Orthopedic conditions.** Coverage for orthopedic conditions and related internal and external prosthetic devices, are included.
 - 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:
 - Prosthetic devices. Devices, including artificial joints, limbs and spinal segments.
 - 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.
 - **Radiation therapy.** Coverage for radiation therapy and all Services related thereto shall be included.
 - **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.

- **Annual refraction eye examination.** Coverage for annual eye examination is once per member per Plan Year.
- **Blood and blood products and derivatives.** Coverage for blood and blood products/derivatives and services related thereto shall be included.
- **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.
- **Acupuncture.** Coverage for acupuncture services is up to a maximum of thirty (30) visits per Plan Year as stated in Exhibit A. (Schedule of Benefits)
- **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.
- **Chiropractic.** Coverage for chiropractic Services is up to a maximum of thirty (30) visits per Plan Year as stated in Exhibit A. (Schedule of Benefits)
- **Short Term Rehabilitation Therapy.** Coverage for Short Term Rehabilitation therapy is up to a maximum of sixty (60) visits per Plan Year as stated in Exhibit A. (Schedule of Benefits)
- **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.
- **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:
 - **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 (48) hours. PPACA Emergency Services shall be provided as necessary to stabilize the Covered Person, without regard to such time limit.
 - **Hospital and Surgical authorization.** Prior Authorization must be obtained from ****COMPANY**** before a Covered Person is admitted to a Hospital or has one of the Surgeries or Medical Procedures listed in P.A. List. Prior Authorization will be handled in accordance to the Milliman Healthcare Guidelines.
 - **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 **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, to the extent required by PPACA.

- Reduced benefit without Prior Authorization. If a required Prior Authorization is not obtained, **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

Pre-Certification List

1	All diagnostic procedures performed or ordered by the same provider on a single patient two or more times
2	All inpatient services (surgical/ non-surgical, skilled nursing, rehabilitation)
3	All outpatient surgical procedures requiring the use of surgical facilities (except for female sterilization)
4	All Diagnostic Procedures (including laboratory/ pathology) in excess of \$500.00
5	Applied Behavioral Analysis services
6	BRCA Gene Testing (in accordance with the USPSTF Grade B Recommendation)
7	Cardiac Catheterization and Procedures
8	Carpal Tunnel Release, Monofilament Testing
9	Chemotherapy and Radiation Therapy
10	Durable Medical Equipment: Std. hospital bed, Std. wheelchairs, walkers, crutches, oxygen, suction machine
11	EMG / NCT (upper extremities)/ Autonomic Testing
12	Home Health, Hospice and Palliative Care Services
13	Hyperbaric Oxygen Therapy & Wound Care Services
14	Imaging (CT Scans, DEXA Scans, MRIs, MRAs, Angiographies, PET Scans, Ultrasounds – except first obstetric ultrasound)
15	Mammograms (except for routine screenings according to the guidelines of the American Cancer Society)
16	MIBI Scan, Thallium Stress Test, Exercise Stress Test
17	Nuclear Medicine Studies
18	Ophthalmology Diagnostic Procedures
19	Pain Management Studies & Treatment
20	Physical Therapy, Occupational Therapy, and Speech Therapy
21	Organ Transplant Services
22	Orthotics/ Prosthetics and Implantable Devices
23	Plastic/ Reconstructive procedures
24	Sleep Studies
25	Specialty Injections (Ophthalmic, Orthopedic)
26	Specialty Medications (See Drug Formulary)

- **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 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. ****COMPANY**** shall pay an amount for PPACA Emergency Services computed as provided in this Agreement.
- **Excessive Participating Provider charges.** Neither the Covered Person nor ****COMPANY**** shall be liable for charges by a Participating Provider in excess of the Eligible Charges. These charges shall be the responsibility of the Participating Provider.
- **Pregnancy termination.** Charges for the termination of Pregnancy is covered only when Medically Necessary.
- **Skilled Nursing Facility care.** Coverage for Skilled Nursing Facility Services is limited to sixty (60) days maximum per Plan Year.
- **Well Child Care.** Well Child Care is covered only as set forth and as required by PPACA (as a PPACA Preventive Care Services or otherwise).
- **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 ****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.

How your plan works

How your medical plan works while you are covered in-network

You're in-network coverage:

- Helps you get and pay for a lot of- but not all- health care services, your cost share is lower when you use a **network provider**

Providers

Our **provider** network is there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider** directory. Just log on to the ****COMPANY**** website ****COMPANY WEBSITE****

Service area

Your plan generally pays for **covered services** only within a specific geographic area, called a service area. There are some exceptions, such as for **emergency services**, urgent care, and transplant services.

See the *Who provides the care* section below.

How your medical plan works while you are covered out-of-network

With your out-of-network coverage:

- You can get care from providers who are not part of ****COMPANY****'s network and from **network providers** without a **PCP referral**
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **precertification**
- Your cost share will be higher

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already a ****COMPANY**** member and your provider stops being in our network

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details. If we approve your request to keep going to your current **provider**, we will tell you how long you can continue to see the **provider**. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

We will authorize coverage only if the **provider** agrees to our usual terms and conditions for contracting providers.

Who provides the care? Network providers

We have contracted with **providers** in the service area to provide **covered services** to you. These **providers** make up the network for your plan.

To get network benefits, you must use **network providers**. There are some exceptions:

- **Emergency services** – see the description of emergency **services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

You may select a **network provider** from the online directory through the ****COMPANY**** website.

You will not have to submit claims for services received from **network providers**. Your **network provider** will take care of that for you. And we will pay the **network provider** directly for what the plan owes.

Your PCP

We encourage you to get **covered services** through a **PCP**. They will provide you with primary care.

How you choose your PCP

You can choose a **PCP** from the list of **PCPs** in our directory.

Each covered family member is encouraged to select a **PCP**. You may each choose a different **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What your PCP will do for you

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Changing your PCP

You may change your PCP at any time by contacting us.

Medical necessity, referral and pre-certification requirements

Your plan pays for its share of the expense for **covered services** only if the general requirements are met. They are:

- ☐ The service is **medically necessary**
- ☐ For in-network benefits, you get the service from a **network provider**
- ☐ You or your **provider pre-certifies** the service when required

Medically necessary, medical necessity

The **medical necessity** requirements are in the *Glossary* section, where we define “**medically necessary, medical necessity**.” That is where we also explain what our medical directors or a **physician** they assign consider when determining if a service is **medically necessary**.

Important note:

We cover **medically necessary**, sex-specific **covered services** regardless of identified gender.

Pre-certification

You need pre-approval from us for some **covered services**. Pre-approval is also called **pre-certification**. Refer to the Pre-Certification List contained in the Ag

In-network

Your network **physician** is responsible for obtaining any necessary **pre-certification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **pre-certification**. But if your **physician** requests **pre-certification** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Out-of-network

When you go to an **out-of-network provider**, you are responsible to get any required **pre-certification** from us. If you don't **pre-certify**:

- ☐ Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- ☐ You will be responsible for the unpaid bills.
- ☐ Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit**.]

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should notify us as shown.

To obtain **precertification**, contact us. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled

An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your **physician** in writing of the **pre-certification** decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **pre-certified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **pre-certified**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your physician in writing of an approval or denial of the extra days.

If you or your **provider** request **pre-certification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require pre-certification

Pre-certification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Stays in a hospital	Cosmetic and reconstructive surgery
Stays in a skilled nursing facility	
Stays in a rehabilitation facility	
Stays in a hospice facility	
Stays in a residential treatment facility for treatment of mental disorders and substance related disorders	
Obesity surgery (bariatric)	

Contact us to get a list of the services that require **precertification**.

Sometimes you or your provider may want us to review a service that doesn't require **precertification** before you get care. This is called a predetermination, and it is different from **precertification**. Predetermination means that you or your **provider** requests the pre-service clinical review of a service that does not require **precertification**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You may find the bulletins and other information at [**COMPANY WEBSITE**](#)/

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following precertification information applies to these **prescription drugs**:

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

You will need to provide us with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

You, someone who represents you or your provider may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

- ☐ Contacting our Precertification Department at ****COMPANY NUMBER****
- ☐ Faxing the request to 671-477-7304
- ☐ Submitting the request in writing to [**COMPANY**](#)

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision.

Step therapy is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Contact us or go online to get the most up-to-date **precertification** requirements and list of step **therapy** drugs.

What the plan pays and what you pay

Who pays for your **covered services** – this plan, both of us, or just you? That depends.

The general rule

The schedule of benefits lists what you pay for each type of **covered service**. In general, this is how your benefit works:

- ☐ You pay the **deductible**, when it applies.
- ☐ Then the plan and you share the expense. Your share is called a **copayment** or **co-insurance**.
- ☐ Then the plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say “expense” in this general rule, we mean the **negotiated charge** for a **network provider**, and allowable amount for an out-of-network provider.

Negotiated charge

For health coverage:

This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or

a third-party vendor (including any administrative fee in the amount paid).

Some **providers** are part of ****COMPANY****'s **network** for some group plans but are not considered **network providers** for your plan. For those **providers**, the **negotiated charge** is the amount that **provider** has agreed to accept for rendering services.

We may enter into arrangements with **network providers** or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

Allowable amount

This is the amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area where you get the service or supply. **Allowable amount** doesn't apply to involuntary services.

These are services or supplies that are:

- Provided at a network facility by an **out-of-network provider**
- Not available from a **network provider**
- An **emergency service**

The table below shows the method for calculating the **allowable amount** for specific services or supplies:

Service or supply:	Allowable amount is based on:
Professional services and other services or supplies not mentioned	105% of Medicare allowed rate
Services of hospitals and other facilities	140% of Medicare allowed rate
Prescription drugs-Except retail or outpatient drugs	110% of average wholesale price (AWP)
Dental expenses	

Important note:

See *Special terms* used, below, for a description of what the **allowable amount** is based on.

If the **provider** bills less than the amount calculated using a method above, the **allowable amount** is what the **provider** bills.

Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a **prescription** drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility **provider's** estimated costs for the service and leave the **provider** with a reasonable profit. This means for:
 - **Hospitals** and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS

- Facilities that don't report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities

We may adjust the formula as needed to maintain the reasonableness of the **allowable amount**. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS.

- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific **provider** performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
 - The method CMS uses to set Medicare rates
 - How much other **providers** charge or accept as payment?
 - How much work it takes to perform a service?
 - Other things as needed to decide what rate is reasonable, we may make the following exceptions:
 - For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
 - Our rate may exclude other payments that CMS may make directly to **hospitals** or other **providers** and backdated adjustments
 - For anesthesia, our rate may be at least 105% of the rate CMS establishes
 - For lab, our rate may be 75% of the rate CMS establishes
 - For DME, our rate may be 75% of the rate CMS establishes
 - For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes.

When the **allowable amount** is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to **providers** under Medicare programs.

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the **allowable amount**. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

Get the most from your benefits:

We have online tools to help you decide whether to get care and if so, where. Use the 'Estimate the Cost of Care' tool or 'Payment Estimator' tool on the COMPANY website. The website may contain additional information that can help you determine the cost of a service or supply.

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. For in- **network** coverage, they are:

- ☐ The service is **medically necessary**
- ☐ You get your care from a **network provider**
- ☐ You or your **provider precertifies** the service when required

For out-of-network coverage:

- ☐ The service is **medically necessary**
- ☐ You get your care from an **out-of-network provider**
- ☐ You or your **provider precertifies** the service when required

For outpatient **prescription** drugs, your costs are based on:

- ☐ The type of **prescription** you're prescribed
- ☐ Where you fill the **prescription**

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

Generally, your plan and you share the cost for **covered services** when you meet the general requirements. But sometimes your plan will pay the entire expense, and sometimes you will. For details, see your schedule of benefits and the information below.

You pay the entire expense when:

- ☐ You get services or supplies that are not medically **necessary**.
- ☐ Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- ☐ You get care from an **out of-network provider** and the **provider** waives all or part of your cost share.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your deductible or your maximum **out-of-pocket limit**.

Where your schedule of benefits fits in

The schedule of benefits shows any out-of-pocket costs you are responsible for when you receive **covered services** and any benefit limitations that apply to your plan. It also shows any **maximum out-of-pocket limits** that apply.

Limitations include things like maximum age, visits, days, hours, and admissions. Out-of-pocket costs include things like deductibles, **copayments** and **coinsurance**.

Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB).

Key Terms

Here are some key terms we use in this section. These will help you understand this COB section. Allowable expense means a health care expense that any of your health plan covers.

In this section when we talk about “plan” through which you may have other coverage for healthcare expenses we mean:

- ☐ Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- ☐ Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- ☐ An automobile insurance policy
- ☐ Medicare or other government benefits
- ☐ Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage
- When this is your secondary plan:
 - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
 - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
 - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
 - The amount that the secondary plan saved due to COB
 - Used to cover any unpaid allowable expenses
 - Erased at the end of the year

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary Plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a	Plan covering you as a dependent
COB rule	Primary Plan	Secondary plan
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year

Child – parents separated, divorced, or not living together	<ul style="list-style-type: none"> • Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order 	<ul style="list-style-type: none"> • Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e., stepparent or	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. See the schedule of benefits for more information.

Your current plan must be offered through the policyholder.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Our rights

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *How your plan works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depend on the type of claim.

Claim type and timeframes Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 24 hours.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **pre-certify** them. We will make a decision within 15 days.

Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Filing a claim

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you should send it to us as soon as possible with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your provider for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and appeal procedures* section for that information.

Complaints, claim decisions and appeal procedures

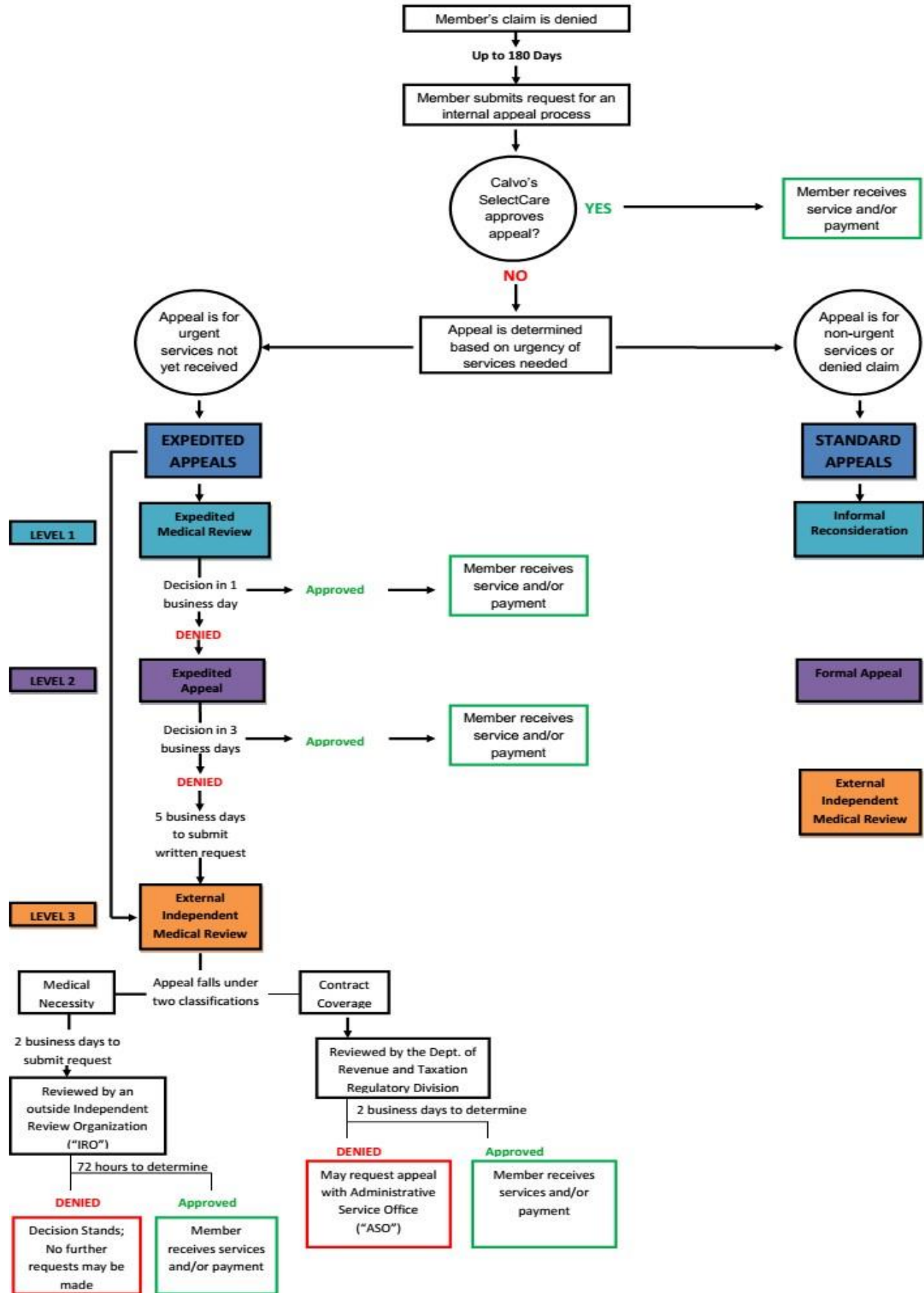
The difference between a complaint and an appeal Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us. We are providing our Appeals process flow chart.

Calvo's SelectCare Appeals Process Flowchart



Claim decisions and appeal procedures

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in *Benefit payments and claims* in the *How your plan works* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision.

Appeal of an adverse benefit determination Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

- Your name
- The policyholder’s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

If you are still not like us answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision.

This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

Eligibility, starting and stopping coverage

In order to enroll in the GovGuam plan, you and your dependents must first meet the eligibility requirements defined in the agreement between **COMPANY** & GovGuam.

You must complete an Enrollment application and submit it with any other required documentation during an Open Enrollment period or within 31 days from the date you first become eligible for enrollment under the plan.

Eligible Subscribers

A person is eligible for Employee, retiree or survivor coverage on the next pay period beginning upon enrollment.

1. Active Employee of GovGuam. An Employee is considered to be eligible if the employee works 30 hours or more per week routinely works in a position which is eligible for employer sponsored pension contribution, and the employee is on the regular payroll of the Employer for that work; and
2. A Retired Employee
3. A surviving Spouse of a Retired Employee,
4. In a class eligible for coverage under the terms of the Plan in effect prior to the Effective Date, who, within 31 days of the date of termination of employment, becomes an Employee of another public entity which provides coverage under the group health plan.
5. For the Retiree Supplemental Plan (RSP), continuous enrollment in both Medicare Part A and B.
6. A retiree who has returned back to active GovGuam employment.
7. Foster Children under the legal custody of Child Protective Services Division of the Department of Public Health and Social Services.

A person eligible for Employee coverage must timely comply with all enrollment requirements in order to be covered by the Plan.

Residency requirement

For purposes of this requirement, Service Area is defined as Guam and CNMI and Covered Persons excludes covered dependent children. 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 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.

When you can join the plan

You can enroll:

- ☐ Once each year during the annual enrollment period
- ☐ At other special times during the year (see the *Special times you can join the plan* section below)
- ☐ You can enroll eligible family members (these are your “dependents”) at this time too.
- ☐ Within thirty-one (31) days of the date of first becoming eligible

Dependent Eligibility Requirements

You can enroll the following family

- **Your legal spouse.** A copy of official marriage certificate must be submitted if a different last name or upon request
- **Your domestic partner** who meets policyholder rules and requirements under state law. A notarized affidavit and proof of domestic partner status. Domestic partner who is (1) 18 years of age or older; (2) in an exclusively mutually committed relationship with subscriber and intends to remain the subscriber’s sole domestic partner; (3) not married to any other person; (4) has cohabitated with the subscriber for two (2) consecutive years immediately preceding the proposed enrollment.

Domestic partners shall only be added to the plan during open enrollment.

- **Dependent children** – yours or your spouse’s
Dependent children must be Under 26 years of age
 - **Dependent children include:**
 - **Natural children.** A copy of official certificate listing the subscriber as a parent must be submitted.
 - For natural children with a different last name from the subscriber, you must provide the following:
 - A copy of the birth certificate which verifies you as a parent.
 - **Stepchildren.** A copy of an official birth certificate and official marriage certificate listing the subscriber’s legal spouse as a parent must be submitted.
 - **Adopted children** including those placed with you for adoption.
 - A copy of court document signed by a judge ordering a legal adoption.
 - **Legal Guardianship or Court Order.** Children you are responsible for under a qualified medical support order or court order. A copy of court document signed by a judge requiring such coverage must be submitted. More information below.
 - **Disabled children** over the age of twenty-six (26) years. A copy of a current disability certification detailing the disability signed by a licensed medical physician must be submitted upon enrollment
 - **Legal Guardianship** must be Full Guardianship and not limited or shared. Shared guardianship will only be allowed if the appointed guardians are legally married living in the same household. A court having jurisdiction over the parties has issued an order granting the full guardianship of such child to the subscriber. Such child is and remains otherwise eligible. Children under guardianship will only remain eligible until the guardianship terminates but no later than up to age 26.
 - Coverage will extend only if the child was covered under the plan prior to turning 18 years old.

Required documents:

- Court documentation signed by a judge ordering adoption or legal guardianship and,
- A copy of the guardian’s latest income tax filing or an affidavit stating that the dependent

will be included in the guardian's next tax filing.

The TPA, at the administrator's discretion, may require documentation such as certified marriage certificates, divorce decree, certified birth certificate, tax returns, adoption documents of certified copies of court orders. Additionally, TPA may request for supporting documents to verify eligibility throughout the plan year.

Guardianship/Legal Custody Children

Subject to the foregoing limitation, if a covered Employee or spouse is the court appointed Legal Guardian or has court ordered Legal Custody of a minor child or minor children, these children may be enrolled in this Plan as covered dependents.

The plan shall require that the dependent be dropped from the coverage upon reaching majority as ineligible. In the case of extended guardianship (if applicable through state statutes), the Plan shall require copies of the new petition for extended guardianship and Letters of Guardianship issued as a result of this petition. The Third-Party Administrator shall also request annually a copy of the member's tax return transcript from the Internal Revenue Service verifying the continued dependency of the minor child covered by this Plan through court appointed guardianship/custody.

If both the father and mother are Employees, their children or guardianship/legal custody children will be covered as Dependents of one employee, but not of both.

OR

Child(ren) who are a covered dependent(s) of the Plan due to their relationship with a covered employee who later become a benefit eligible employee must obtain primary coverage from the Plan and drop their dependent status.

A covered Dependent child who is Totally Disabled, incapable of self- sustaining employment by reason of mental challenge or incapacitation or physical disability, primarily dependent upon the covered employee for support and maintenance, and covered under the Plan when reaching age 26.

Documentation that a Dependent satisfies these conditions must be provided to the Third-Party Administrator within 31 days of the Dependent reaching age 26 or coverage will be terminated. The Third-Party Administrator may require, at reasonable intervals during the two years following the Dependent's reaching age 26, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Third-Party Administrator may require subsequent proof not more than once each year. The Third-Party Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Adding new dependents

You can add new dependents during the plan year if you have a Qualifying Event, as defined in the *Special Enrollment Periods* section below. These include any dependents described in the *Who can be a dependent on this plan* section above.

We must receive a completed enrollment form not more than thirty-one (31) days after the event date.

Special Enrollment Periods

You may enroll or change your status in these situations outside of open enrollment:

Qualifying Event	Detail	Effective Date
New Employee	May enroll within 31 days from the Date of Hire.	Beginning of the next pay period based on date submitted.
Newborn	May add newborn within 31 days from birth	Coverage effective when child/ren is born. Effective date for premium payments retroactive to pay period closest to date of birth.
Legal Guardian Appointment or Adoption	May add dependent within 31 days from the effective date of Court Order Approval	
Change of Work Schedule to 30 hours or more	May enroll within 31 days from work schedule change	Beginning of the next pay period upon completion of a change of status form within 31 days of status change
Marriage	Date of Marriage	Beginning of the next pay period based on date submitted.
Survivor of a Retiree (Surviving Spouse Enrollment)	May enroll for coverage within 31 days from survivorship	Beginning of the next pay period upon completion of a change of status form within 31 days of status change
Resignation	Date of Separation	Last pay period ending or last deduction.
Death of Subscribers	<p>Date of Death</p> <p>If subscriber deceased: Form shall be completed by the respective departments and transmitted to the TPA.</p> <p>If deceased dependent: Change of status form to be completed to delete dependent and change class deduction as applicable.</p>	Last pay period ending or last deduction.
Divorce	<p>May enroll within 31 days from date on Divorce Decree or;</p> <p>Change of Status form required to delete dependent and change class if currently enrolled.</p>	Beginning of the next pay period upon completion of a change of status form within 31 days of status change
Long Term Disability	Date of Disability	
Military Leave	May terminate plan prior to date of active orders.	Beginning of the next pay period upon completion of a change of status form

	May enroll within 31 days of return from active orders. <input type="checkbox"/> Military orders submission required.	within 31 days of status change
Loss of coverage	May enroll within 31 days from coverage loss. HIPAA certification required to enroll.	Beginning of the next pay period upon completion of a change of status form within 31 days of status change
New Medicare Part B Recipient	May enroll within 31 days from effective date of Part B. Must have both Part A & B to enroll under the Retiree Supplemental Plan.	Beginning of the next pay period upon completion of a change of status form. Pursuant to 4GCA 4301 (b) Medicare Part A & B eligible must enroll under the RSP should they elect to participate in GovGuam health plan.

- ☐ Enrollment in birth Medicare A & B, date of retirement, change in employment status (work hours increase – 30 hours or more)
- ☐ You didn't enroll before because you had other coverage and that coverage has ended
- ☐ A court orders that you cover a dependent on your health plan
- ☐ When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends. You can also enroll in these situations:

- ☐ You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- ☐ You are now eligible for state premium assistance under Medicaid or S-CHIP which will pay your premium contribution under this plan

We must receive the completed enrollment information within thirty-one (31) days of the date when coverage ends.

Notification of change in status

Tell us of any changes that may affect your benefits. Please contact us or your HR department as soon as possible when you have a:

- ☐ Change of address
- ☐ Change of work status (i.e. change in work hours, leave without pay, military leave, etc.)

Dependent status change (i.e. overage dependent: enrollment forms reflecting any class change would need to be submitted (Ex: Class 3 to Class 1).

- ☐ Dependent who enrolls in Medicare or any other health plan
- ☐ If you are a Retiree who has returned back to active employment with GovGuam
- ☐ Loss in Medicare Part A or B Coverage

Starting Coverage

Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your policyholder to confirm your effective date.

Stopping Coverage

Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- The policyholder asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer
- You have reached your overall maximum benefit under your plan

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making premium contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
 - Exhaustion of your overall maximum benefit.
 - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
- Your dependent has exhausted the maximum benefit under your medical plan.
- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends.

You will need to complete a Declaration of Termination of Domestic Partnership

How can you extend coverage for your disabled child beyond the plan age limits?

Your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on you for support, may continue to be covered under this Plan as an enrolled dependent during the continued disability provided proof of such incapacity and dependency is furnished to the TPA within thirty (30) days of the child's attainment of the limiting age and annually thereafter.

Coverage shall continue only as long as a medical **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

TPA may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

How can you extend coverage for a child in college on medical leave?

You have the right to extend coverage for your dependent college student who takes a **medically**

necessary leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins, or
- The date coverage would otherwise end.
- GovGuam's plan covers dependent children up to age 26 regardless of student status.

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness or injury**,
- Cause the dependent child to lose status as a full-time student under the plan, and
- Be certified by the treating doctor as **medically necessary** due to a serious **illness or injury**.

The doctor treating your child will be asked to keep us informed of any changes.

General provisions-other things you should know

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to ERISA and other federal and Guam laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this certificate when we administer your coverage.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this.

If a service cannot be provided to you

Sometimes things happen outside of our control. These are things such as natural disasters, epidemics, fire, and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund any unearned premium.

Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *Complaints, claim decisions and appeal procedures section*. You cannot take any action until 60 days after we receive written submission of a claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

- Names of **physicians** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception Honest mistakes

You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage:

- ☐ We will give you 30 days advance written notice of any rescission of coverage
- ☐ You have the right to a COMPANY appeal
- ☐ You have the right to a third-party review conducted by an independent ERO

Some other money issues

Assignment of benefits

When you see a **network provider**, they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. To the extent allowed by law, we will not accept an assignment to an **out-of-network provider**.

Financial sanctions exclusions

If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **covered services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC).

You can find out more by visiting

<http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Premium contribution

Your plan requires that the policyholder make premium contribution payments. We will not pay for benefits if premium contributions are not made. Any decision to not pay benefits can be appealed.

Recovery of overpayments

We sometimes pay too much for **covered services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your **provider**, to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

When you are injured

If someone else caused you to need care – say, a careless driver who injured you in a car crash– you may have a right to get money. We are entitled to that money, up to the amount we pay for your care. We have that right no matter whom the money comes from – for example, the other driver, the policyholder, or another insurance company.

To help us get paid back, you are doing these things now:

- Agreeing to repay us from money you receive because of your injury.
- Giving us the right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money for your injury or illness. You'll hold any money you receive until we are paid in full. And you'll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

We don't have to reduce the amount we're due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery.

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our *Notice of Privacy Practices*. Just contact us.

When you accept coverage under this plan, you agree to let your **providers** share information with us. We need information about your physical and mental condition and care.

Effect of benefits under other plans

Glossary of Terms

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.

Administrative Service Office: Shall be defined as the Company or an agent appointed by Company which is directly responsible for administrative procedures and for the processing and payment of Provider Claims on behalf of Covered Persons. ****COMPANY**** shall be the Administrative Service Office until otherwise notified in writing by Company.

A.C.A. is the acronym for the Affordable Care Act

Agreement: Shall be defined as this Group Health Insurance Plan Documents, including the Group Health Insurance Certificates and Exhibits.

Allowable amount

See *How your plan works – What the plan pays and what you pay.*

Behavioral health provider

A **health professional** who is properly licensed or certified to provide covered **services** for mental health and **substance related disorders** in the state where the person practices.

Benefits: are the medically necessary services covered by your health plan and paid in part or in full by ****COMPANY****.

Brand-name prescription drug

An FDA-approved drug marketed with a specific name by the company that manufactures it; often the same company that developed and patents it.

Centers of Excellence are the selected outstanding off-island hospitals, which have agreed to provide services at reduced rates to ****COMPANY**** members.

COBRA: COBRA, Consolidated Omnibus Budget Reconciliation Act, shall be defined as a federal statute that requires most employers to offer to employees and covered dependents who would otherwise lose health coverage for reasons specified in the statute, the opportunity to purchase the same health benefits coverage that the employer provides to its remaining employees. For the purpose of this Agreement, the COBRA benefit is not applicable to Government of Guam Employees, Retirees and Survivors

Coinsurance

Is the percentage of covered services that must be shared by a covered person as specifically set forth in the Schedule of Benefits. Co-insurance is expressed as dollar amounts rather than percentages.

Contract Year or Plan Year is normally a twelve-month period of your insurance coverage.

Copay/copayments

A dollar amount or percentage paid by a covered person for a **covered service**. **Covered service** The benefits, subject to varying cost shares, covered in this plan. These are:

- Described in the *Providing covered services* section
- Not listed as an exclusion in the *Coverage and exclusions – Providing covered services* section or the *General plan exclusions* section
- Not beyond any limits in the schedule of benefits

- **Medically necessary.** See the *How your plan works – Medical necessity, referral and precertification requirements* section and the *Glossary* for more information

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.

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

Covered Person: Shall be defined as a person entitled to receive Covered Services pursuant to the Plan. A covered person shall reside in the Service Area and shall be a subscriber or dependent of the plan.

- a. A bona fide employee of GovGuam who is classified as a full-time employee by GovGuam; or
- b. Voluntarily working under the "Quality Time" program and classified as such by GovGuam pursuant to PL 25-72; or
- c. Classified as a Retiree of GovGuam by GovGuam; or
- d. Classified as a survivor of a retired employee of GovGuam by GovGuam; or
- e. Except as otherwise provided in this Agreement, a Covered Dependent.
- f. Shall include a Foster child under the legal custody of the DOHSS CPS as defined in 4 G.C.A, 4301.1 (h)

Covered Services: Shall be defined as medically necessary services, as defined under the Plan, that are not specifically excluded from coverage by this Agreement and other Services which are specifically included. Services shall include medical or other health care services, treatments, supplies, medications and equipment.

Currency: Shall be defined as money accepted as a medium of exchange for payment of debts such as the United States Dollar in the United States and the Peso in the Philippines.

Custodial Care: Shall be defined as Services, whenever furnished and by whatever name called, designed primarily to assist an individual whether or not totally disabled in the activities of daily living. These activities include, but are not limited to, Services that constitute personal services such as help in walking, getting in and out of bed, assistance in bathing, dressing, feeding, and services which do not entail or required the continuing attention of trained medical or paramedical personnel.

Deductible

The amount a covered person pays for **covered services** per year before we start today.

Department of Administration (DOA): Shall be defined as the Department of Administration. DOA shall be responsible for payment and administration of line agencies, agencies whom the DOA Administers payroll, and the Foster Program.

Department of Public Health and Social Services (DPHSS): Child Protective Services (CPS): Shall be defined as the Department of Public Health and Social Services, Division of Public Welfare, Bureau of Social Services Administration, Child Protective Services and administers the Foster Care

Program.

Dependent: Shall be defined as a specified Group Health Insurance Certificate attached hereto.

Detoxification

The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Doctor/Physician: is a properly licensed doctor of medicine (M.D.), osteopath (D.O.) podiatrist (D.P.M.), dentist (D.D.S. or D.M.D), psychiatrist, psychologist (Ph.D.), or chiropractor (D.C.)

Domestic Partner: Shall be defined as a person who:

- a. Is 18 years of age or older.
- b. Is of the same sex or opposite sex as the subscriber;
- c. Is in an exclusive mutually committed relationship with the Subscriber and intends to remain the Subscribers sole domestic partner;
- d. Is not married to any other person;
- e. Is not related to the subscriber by blood to a degree that would prohibit marriage; and
- f. Has cohabitated with the subscriber for the two (2) consecutive years immediately preceding the proposed Enrollment.

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.

Drug Formulary

A list of **prescription** drugs and devices established by us or an affiliate. It does not include all **prescription** drugs and devices. The list can be reviewed and changed by us or an affiliate.

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 ****COMPANY**** and the Participating Provider.

For a Non-Participating Provider, the Eligible Charges for covered medical services shall be limited to the lesser of (a) the actual charge made by the provider, or (b) in the United States, the Medicare Participating Provider fees in the geographic area where the Service was rendered; or (c) in Asia, the fees most recently contracted by the Company at the St. Luke's Medical Center in Manila, Philippines, or (d) elsewhere, the Medicare National Standard Fee.

For a Non-Participating Provider, the Eligible Charges for covered dental services shall be the lesser of (a) the actual charges made by the provider or (b) the usual customary and reasonable charge, as determined by the Company, for the dental Service in the geographic region in which that Service was rendered.

Emergency: in general, 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

Emergency medical condition

A severe medical condition that:

- Comes on suddenly
- Needs immediate medical care
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
 - Danger to life or health
 - Loss of a bodily function
 - Loss of function to a body part or organ
 - Danger to the health of an unborn baby

Emergency services

Treatment given in a **hospital's** emergency room. This includes evaluation of and treatment to stabilize the emergency medical condition.

Employer: Shall mean the Government of Guam (GovGuam) and its agencies

Experimental or investigational

Drugs, treatments or tests not yet accepted by **physicians** or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

A drug, device, procedure, or treatment is **experimental or investigational** if:

- ☐ There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- ☐ The needed approval by the FDA has not been given for marketing.
- ☐ A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- ☐ It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

Family: Shall be defined as a Subscriber and his or her Covered Dependents.

Formulary exclusions list

A list of **prescription** drugs not covered under the plan. This list is subject to change. Once the Plan Year has commenced, all additions to the Formulary Exclusions List must include a 60-day prior written notice to any subscriber who is taking the medication explaining the reason(s) for excluding the medication and suggesting alternative medications. The Company must receive an acknowledgment from the subscriber of having received and read the notice.

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional: A person who is authorized by law to provide health care services to

the public; for example,

- **physicians**, nurses and physical therapists.

Foster Children: Includes only foster children under the legal custody of the Child Protective Services Division of the Department of Public Health and Social Services (DPHSS) as defined in 4 G.C.A. 4301.1

GovGuam Line Agencies: Shall be defined Government of Guam agencies that are Line Agency means any department, agency, or instrumentality of the Government of Guam which is funded by an annual appropriation from the Legislature. Such appropriations do not include subsidies. (5 GCA Chapter 6 § 6103(c)). All TPA fees payments and issues associated with GovGuam Line Agencies shall be paid by the Department of Administration

GovGuam Autonomous Agencies: Shall be defined as any Government of Guam department, agency, or instrumentality which generates, or is intended to generate, as evidenced in law, all of its own operating revenues apart from annual appropriations from the General Fund. Annual appropriations do not include amounts appropriated to line agencies to pay for services rendered by autonomous agencies. Subsidies appropriated from the General Fund to an autonomous agency, whether or not annually appropriated, shall not mean that an autonomous agency becomes a line agency for purposes of this Chapter. All TPA fees payments and payment discrepancy issues associated with the GovGuam Autonomous Agencies shall be coordinated directly with the autonomous agency.

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.

H.I.P.A.A.: 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.

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

- a) Part-time or intermittent home nursing Services from or supervised by a registered Nurse or a licensed practical Nurse;
- b) Part-time or intermittent home health aid Services;
- c) Physical and occupational therapy; and
- d) 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.
- e) To be Covered Service, Home Health Services shall:

- Replace a needed Hospital or Skilled Nursing Facility stay.
- Be for the care or treatment of Covered Person's Physician; and

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

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:

- f) Is legally qualified in the state or locality in which it operates;
- g) Keeps clinical records on all patients;
- h) Services are supervised by a Physician or Nurse; and
- i) 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.

Home health care agency

An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

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 Hospital or Skilled Nursing Facility would be Medically Necessary for the treatment of Covered Person's injury or illness if the Home Health Care Plan is not provided.

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.

- j) A Hospital may include a psychiatric or tuberculosis facility which satisfies the above requirements.
- k) 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 the purposes of this Agreement.

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, counselling, 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 counsellors. 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.

Hospital

An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can **stay** overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Infertile/infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
 - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
 - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:

- At least 12 cycles of donor insemination if under the age of 35
- 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
 - At least 2 abnormal semen analyses obtained at least 2 weeks apart

Illness: Shall be defined as a condition caused by Accidental means that results in damage to the Covered Persons 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

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

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

Intensive 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.

Jaw joint disorder

This is:

- ☐ A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- ☐ A myofascial pain dysfunction (MPD) of the jaw
- ☐ Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Lifetime maximum

The most this plan will pay for **covered services** incurred by a covered person during their lifetime.

Mail order pharmacy

A pharmacy where **prescription** drugs are legally dispensed by mail or another carrier.

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.

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

- l) Appropriate and necessary for the symptoms, diagnosis or treatment of the Injury or Illness or condition.
- m) Provided for the diagnosis or direct care and treatment of the Injury or Illness
- n) Within standards of good medical practice within the organized medical community
- o) Not primarily for the convenience of the Covered Person or of any Provider providing Covered Services to the Covered Person
- p) An appropriate supply or level of service needed to provide safe and adequate care
- q) Within the scope of the medical or dental specialty, education and training of the Provider;
- r) Provided in a setting consistent with the required level of care; or Preventative Services as provided by the Plan

Medically necessary/medical necessity

Healthcare services that we determine a **provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that we determine are:

- ☐ In accordance with generally accepted standards of medical practice
- ☐ Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- ☐ Not primarily for the convenience of the patient, **physician** or other health care **provider**
- ☐ Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice means:

- ☐ Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- ☐ Following the standards set forth in our clinical policies and applying clinical judgment

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.

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.

Mental disorder

A **mental disorder** is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of **mental disorder** is in the most recent edition of *The International Classification of Diseases, Tenth Edition (ICD-10)*.

Military Service: Shall be defined as service for any length of time in any branch of the Armed Forces or Merchant Marine of any country, combination of countries, or international organizations, except temporary training service for two months or less.

Negotiated charge

See *How your plan works – What the plan pays and what you pay*.

Network provider

A **provider** listed in the directory for your plan. A NAP **provider** listed in the NAP directory is not a **network provider**. A **network provider** can also be referred to as an in-network provider.

Newborn: Shall be defined as an infant during the period beginning on the date of birth until the initial Hospital discharge or until the infant is thirty (30) days old, whichever occurs first.

Non-Participating Providers shall be defined as Providers who are NOT contracted by ****COMPANY**** to provide medical or dental services to Covered Persons

Non-Participating Provider Eligible Charges: Eligible Charges for covered medical Services rendered by a provider who is not a Participating Provider, shall be limited to the lesser of (a) the actual charge made by the provider, or (b) whichever of the following is applicable: (i) in the United States, the Medicare participating provider fee schedule in the geographical area where the service was rendered, or (ii) in Asia, the fees most recently contracted by the Company at St. Luke's Medical Center, Manila, Philippines, or (c) elsewhere, the Medicare national standard fee schedule.

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.

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

Open Enrollment Period: is the annual period when you may join, cancel, or adjust your coverage.

Organ Transplant: Shall be defined as the replacement of a diseased organ with a healthy organ from a donor with a compatible issue type.

Other Plan: Shall be defined as any other health insurance or health benefits program offered to GovGuam's employees, retirees and their eligible Dependents, through an Agreement with GovGuam.

Out of Pocket Maximum: Shall be defined as the total maximum of any Eligible Charges paid, or payable as defined by a payment schedule or arrangement by a Covered Person to a Participating Provider to satisfy any applicable Deductible, Co-Payment, and/or Co-Insurance specified in this Agreement before the Plan will begin to pay Covered Services at one hundred percent (100%) for the remainder of the Plan Year, subject to the maximum amounts provided in the Plan as set forth in the Schedule of Benefits.

Out-of-network provider

A provider who is not a network provider.

Palliative 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.

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

- a. **"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.
- b. **"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 **COMPANY** to provide the Covered Services; and (ii) are assigned from time to time by **COMPANY** to participate in the Network or any other network of **COMPANY** pursuant to this Agreement. (iii) or who GovGuam has a direct contract with and administered by **COMPANY**.
- c. **"Network"** shall be defined as the network of Participating Providers. Network may also be referred to as "Plan Network".
- d. **"Non-Participating Provider"** shall be defined as Providers who have NOT been contracted by **COMPANY** to provide medical services to Covered Persons

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; and based on 100% of Medicare allowable rate or the Usual Customary Reasonable ("UCR") charges for non-

participating facilities and 100% of Medicare allowable rate for non-participating providers whenever the services are rendered by a non- participating provider.

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.

Physician

A **health professional** trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a **physician** can also be a **primary care physician (PCP)**.

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.

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

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.

Plan: Shall be defined as the group health insurance benefits provided in accordance with this Agreement.

Plan Year: Shall be defined as the twelve (12) month period during which group health insurance benefits are provided under this Agreement.

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

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

- u) Care considered PPACA Preventative Care shall be:
 - Evidence-based items or services that have in effect a rating of A or B in the current 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
 - Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
 - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
 - With respect to women, any additional evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.
 - No Co-Payments, Co-Insurance or Deductibles shall be imposed on Covered Persons

for PPACA Preventive Care Services. If Participating Provider billing data for office visits bill or track PPACA Preventive Care Services separately from other services or items provided at an office visit, Co-Payments, Co-Insurance and Deductibles shall apply (unless otherwise provided under this Agreement) to all services that are not PPACA Preventive Care Services. If PPACA Preventive Care Services are not billed or tracked separately, the entire office visit shall be treated as a PPACA Preventive Care Services visit if PPACA Preventive Care was the primary purpose of such visit, but otherwise the entire office visit shall (unless otherwise provided under this Agreement) be treated as not being a PPACA Preventative Care Service,

- Except as specifically provided in this Agreement, PPACA Preventive Care Services shall only be provided without Deductibles, Co-Insurance or Co-Payments if provided by Participating Providers.

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

Precertification, precertify

Pre-approval that you or your **provider** receives from us before you receive certain **covered services**. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Pre-certification is a process by which a medical provider obtains prior approval or authorization from the plan to perform certain treatment plans or provide covered services such as diagnostic testing, home health care, physical therapy, or the procurement of durable medical equipment. More information is contained in the "General Information" section of this Handbook.

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

Preferred drug

A **prescription** drug or device that may have a lower out-of-pocket cost than a non-preferred drug

Preferred Provider(s): Preferred Provider shall be defined as a Participating Provider that is a 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 listing of Preferred Providers.

Pregnancy: Shall be defined as the physical state which results in childbirth, abortion or miscarriage and any medical complications arising out of or resulting from such state.

Premium shall be defined as the dollar amount paid to ****COMPANY**** for the provision of this Plan to Covered Persons, including any contributions required from the Covered Persons.

Premium Period is the length of time covered by the periodic premium payments.

Prescription drug

This is an instruction written by a **physician** that authorizes a patient to receive a service, supply, medicine or treatment

Provider(s)

A **physician, health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

Psychiatric hospital

An institution licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or **mental disorders** (including **substance related disorders**).

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

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

Q.M.C.S.O. is an acronym for a Qualified Medical Child Support Order.

Referral is a formal recommendation by your doctor or physician for you to receive services from a specialist, consultant, or off-island facility.

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.

Residential treatment facility

An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for mental health or **substance related disorder** residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following: For residential treatment programs treating **mental disorders**:

- A **behavioral health provider** must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution) For substance related residential treatment programs:
- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Retail pharmacy

A community pharmacy that dispenses outpatient **prescription** drugs at retail prices.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

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.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, we will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

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.

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

Service Area: Shall be defined as Guam and the Commonwealth of the Northern Mariana Islands. Enrollment in this Plan is limited to individuals residing in the Service Area. However, residence in the service area shall not be a requirement for enrollment for dependent children below 26 years of age.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable laws to provide skilled nursing care.

Skilled nursing facilities also include:

- Rehabilitation **hospitals**
- Portions of a rehabilitation **hospital**
- A **hospital** designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

It does not include institutions that primarily provide for the care and treatment of mental disorders or Substance related disorders

2. **Skilled Nursing Facility:** Shall be defined as a specially qualified and licensed facility that:
 - a) 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
 - b) maintains daily clinical records; and

- c) complies with legal requirements applicable to the operation of a skilled nursing institution; and
- d) has transfer arrangements with one or more Hospitals; and
- e) has an effective utilization review plan; and
- f) is approved and licensed by the jurisdiction in which it operates.

Skilled nursing services

Services provided by a registered nurse or licensed practical nurse within the scope of their license.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drugs

These are **prescription** drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration. You can contact us to access the list of specialty drugs.

Specialty Drugs: Medications that meet a minimum of three (3) or more of the following characteristics: (a) produced through DNA technology or biological processes; (b) target chronic or complex disease; (c) route of administration could be inhaled, infused, oral, or injected; (d) unique handling, distribution and/or administration requirements; (e) are only available via limited distribution model to Specialty Pharmacy provider(s), per manufacturer requirements; and (f) require a customized medication management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training may be required. "Specialty Drug" also includes new-to-market specialty drugs, biosimilar drugs, and Limited Distribution Drugs (LDD)

Specialty pharmacy

This is a pharmacy designated by us as a network pharmacy to fill prescriptions for specialty **prescription drugs**.

Spouse: The Spouse of the Subscriber includes:

- g) Lawful wedded husband or wife; or

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 the Plan, provided that no Subscriber can enroll more than one person as a spouse at a time unless one spouse is covered pursuant to a court order.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Step therapy

A form of **precertification** under which certain **prescription** drugs are excluded from coverage, unless a first- line therapy drug is used first by you. The list of **step therapy** drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to **step therapy** is available upon request or on our website.

Subscriber: Shall be defined as a bona fide employee of GovGuam who is working 30 hours per week; or

1. Voluntarily working under the "Quality Time" program and classified as such by GovGuam pursuant to P.L. 25-72; or working under any GovGuam sponsored program that ensures continuity of health insurance benefits.

- Classified as a retiree of GovGuam by GovGuam; or
- Classified as a GovGuam Retiree who has returned back to GovGuam active employment; or
- Classified as a survivor of a retired employee of GovGuam by GovGuam; or

A Foster Child under the legal custody of the Child Protective Services Division of the Department of Public Health.

Substance related disorder

This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food or caffeine.

Surgery or surgical procedures

The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- ☐ Cutting
- ☐ Abrading
- ☐ Suturing
- ☐ Destruction
- ☐ Ablation
- ☐ Removal
- ☐ Lasering
- ☐ Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- ☐ Correction of fracture
- ☐ Reduction of dislocation
- ☐ Application of plaster casts
- ☐ Injection into a joint
- ☐ Injection of sclerosing solution
- ☐ Otherwise physically changing body tissues and organs

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.

Telemedicine

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service that can be provided electronically by:

- Two-way audiovisual teleconferencing
- Telephone calls
- Any other method required by law

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

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 or a Covered Person with a chronic, progressive illness which has been designated by the Covered Person's attending Physician as incurable.

Third Party Administrator (TPA) Fees: Shall be defined as the dollar amount paid to **COMPANY** for the administration of this Plan to Covered Persons.

U.C.R. is the "Usual, Customary and Reasonable" charge of a provider for a service or supply in the geographical area where it was rendered, not exceeding the amount ordinarily paid by Medicare for a comparable service or supply to their participating provider.

Urgent condition

An illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**

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.

USPSTF is the acronym for United States Preventive Services Task Force.

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- Physician's office
- Urgent care facility

Well Child Care: Shall be defined as Services rendered to a Dependent Child from newborn to seventeen (17) years of age solely for the purpose of health maintenance and not for the Treatment of an Illness or Injury.

W.H.C.R.A. is an acronym for the Women's Health and Cancer Rights Act of 1998. For more information, please refer to the "Summary of Federally Mandated Programs" section of this Handbook.

Rates

GovGuam HSA2000, PPO1500, RSP, and Foster

FY 2024 -Applicable October 01, 2025 to September 30, 2026

MEDICAL RATES			
HSA2000			
	CL AS S	BI-WEEKLY RATES	MONTHLY RATES
HSA 2000 ACTI VE	I		
	II		
	III		
	IV		
HSA200 0 RETIRE E	I		
	II		
	III		
	IV		
PPO1500			
	CL AS S	BI-WEEKLY RATES	MONTHLY RATES
PPO 1500 ACTI VE	I		
	II		
	III		
	IV		
PPO150 0 RETIRE E	I		
	II		
	III		
	IV		
RETIREE SUPPLEMENTAL PLAN (RSP) -			
Medicare Eligibility Requirements - Enrolled in Medicare A & B			
	CL AS S	BI-WEEKLY RATES	MONTHLY RATES
RSP	I		
	IIa		
	IIb		
	III		
	IV a		
	IV b		

Schedule of Benefits

Policyholder: Government of Guam
Plan Name: **(SOB) HSA2000, PPO1500, Retiree Supplemental Plan (RSP),
and Foster**
Plan Effective Date: October 1, 2024

SAMPLE

Schedule of Benefits

This schedule of benefits (scheduled) lists the deductibles, copayments or coinsurance, if any apply to the covered services that you will receive under the plan. You should review this schedule and become aware of any limits that apply to these services.

How your cost share works

- ☐ The deductibles and copayments, if any, listed in the schedule below are the amounts that you pay for covered services.
 - For the covered services under your medical plan, you will be responsible for the dollar amount
 - For pharmacy benefits where a percentage cost share acts like a copayment, you will be responsible for the percentage amount.
- ☐ Coinsurance amounts, if any, listed in the schedule below are what the plan will pay for covered services.
- ☐ Sometimes your cost share shows a combination of your dollar amount copayment that you will be responsible for and the coinsurance percentage that your plan will pay.
- ☐ You are responsible to pay any deductibles, copayments and remaining coinsurance, if they apply and before the plan will pay for any covered services.
- ☐ This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a covered service.
- ☐ This plan has limits for some covered services. For example, these could be visit, day or dollar limits. They maybe:
 - Combined limits between in-network and out-of-network providers
 - Separate limits for in-network and out-of network providers
 - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan.

See the schedule of benefits for more information about limits.

- ☐ Your cost share may vary if the covered service is preventive or not. Ask your physician or contact us if you have a question about what your cost share will be.

For examples of how cost share and deductible work, review the member handbook section under payment responsibilities. You may obtain a copy through our website at [**COMPANY WEBSITE**](#)

Important note:

Covered services are subject to the Plan Year **deductible, maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule of benefits.

All services outside of Guam/CNMI, require pre-authorization. Services which are not approved through the pre-authorization process may not be covered under your plan.

Under this plan you will:

1. Pay your copayment
2. Then pay any remaining deductible
3. Then pay your coinsurance

How your deductible works

The deductible is the amount you pay for covered services each year before the plan starts to pay. This is in addition to any copayment or co-insurance you pay when you get covered services from an in-network, out-of-network provider. This schedule of benefits shows the deductible amounts that apply to your plan. Once you have met your deductible, we will start sharing the cost when you get covered services. You will continue to pay copayments or coinsurance, if any, for covered services until you meet your deductible.

How your PCP or physician office visit cost share works

You will pay the PCP cost share when you get covered services from any PCP.

How your maximum out-of-pocket works

This schedule of benefits shows the maximum out-of-pocket limits that apply to your plan. Once you reach your maximum out-of-pocket limit, your plan will pay for covered services for the remainder of that year.

Contact Us

Please contact should you have any questions or concerns.

Plan features

Pre-certification covered services reduction

This applies to out-of-network covered services:

Your certificate contains a complete description of the pre-certification process. You will find details in the *Medical necessity, referral and precertification* section.

If precertification for covered services isn't completed, when required, it can result in any of the following benefit reductions:

- ☐ A \$400 benefit reduction applied separately to each type of covered services
- ☐ The service is not covered

You may have to pay an additional portion of the allowable amount because you didn't get pre-certification. This portion is not a covered service and doesn't apply to your deductible or maximum out-of-pocket limit if you have one.

Deductible

You have to meet your deductible before this plan pays for your benefits.

HSA2000

Deductible type	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	\$2,000 per year	\$4,000 per year
Individual Class 2-4	\$3,200 per year	
Family	\$4,000 per year	\$12,000 per year

PPO1500

Deductible type	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	\$1,500 per year	\$3,000 per year
Family	\$3,000 per year	\$9,000 per year

Deductible waiver

There is no in-network deductible for the following covered services:

- ☐ Preventive Care
- ☐ Family planning services-female contraceptives

Maximum out-of-pocket limit**HSA2000**

Maximum out-of-pocket type	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	\$4,000 per year	\$30,000 per year
Family	\$12,000 per year	\$90,000 per year

PPO1500

Maximum out-of-pocket type	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	\$3,000 per year	\$30,000 per year
Family	\$9,000 per year	\$90,000 per year

General coverage provisions

This section explains the deductible, maximum out-of-pocket limit and limitations listed in this schedule.

Deductible provisions

In-network covered services will apply only to the in-network deductible. Out-of-network covered services will apply only to the out-of-network deductible.

The deductible may not apply to some covered services. You still pay the copayment or coinsurance, if any, for these covered services.

Individual deductible

You pay for covered services each year before the plan begins to pay. This individual deductible applies separately to you and each covered dependent. After the amount paid reaches the individual deductible this plan starts to pay for covered services for the rest of the year.

Family deductible

You pay for covered services each year before the plan begins to pay. After the amount you paid for covered services reaches this family deductible, this plan starts to pay for covered services for the rest of the year. To satisfy this family deductible for the rest of the year, the combined covered services that you and each of your covered dependents incur toward the individual deductible must reach this family deductible in a year. When this happens in a year, the individual deductibles for you and your covered dependents are met for the rest of the year.

Copayment

This is the dollar amount or percentage you pay for a covered service. This is in addition to any out-of-pocket costs you have to pay to meet your deductible, if you have one.

Coinsurance

This is a percentage you pay for a covered service. This is in addition to any out-of-pocket costs you have to pay to meet your deductible, if you have one.

Maximum out-of-pocket limit

The maximum-out-of-pocket limit is the most you will pay per year in copayments, coinsurance, and deductible, if any, for covered services. Covered services that are subject to the maximum out-of-pocket limit include those provided under the medical plan and the outpatient prescription drug plan. Covered services apply to the in-network and out-of-network maximum out-of-pocket limit.

Individual maximum out-of-pocket limit

- This plan may have an individual limit and family maximum-out-of-pocket limit. As to the individual maximum out-of-pocket limit, each of you must meet your maximum out-of-pocket limit separately.
- After you or your covered dependents meet the individual maximum out-of-pocket limit this plan will pay 100% of the eligible charge for covered services that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family maximum out-of-pocket limit, this plan will pay 100% of the eligible charge for covered services that would apply toward the limit for the remainder of the year for all covered family members. The family maximum out-of-pocket limit is a cumulative maximum out-of-pocket limit for all family members.

To satisfy this maximum out-of-pocket limit for the rest of the year, the following must happen:

- The family maximum out-of-pocket limit is met by a combination of family members
- No one person within a family will contribute more than the individual maximum out-of-pocket limit amount in a year.

If the maximum out-of-pocket limit does not apply to a covered service, your cost share for that service will not count toward satisfying the maximum out-of-pocket limit amount.

Certain costs that you have do not apply toward the maximum out-of-pocket limit. These include:

- All costs for non-covered services which are identified in the certificate and the schedule
- Charges, expenses or costs in excess of the allowable amount

Limit provisions

Covered services will apply to the in-network and out-of-network limits

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of covered services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one year. Decisions regarding when benefits are covered are subject to terms and conditions of the group policy.

Emergency services Important note:

Out-of-network providers do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the plan. If the provider bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.

Schedule of Benefits- Retiree Supplemental Plan (RSP)

This schedule of benefits (scheduled) lists the deductibles, copayments or coinsurance, if any apply to the covered services that you will receive under the plan. You should review this schedule and become aware of any limits that apply to these services.

How your cost share works

- ☐ The deductibles and copayments, if any, listed in the schedule below are the amounts that you pay for covered services.
 - For the covered services under your medical plan, you will be responsible for the dollar amount
 - For pharmacy benefits where a percentage cost share acts like a copayment, you will be responsible for the percentage amount.
 - ☐ Coinsurance amounts, if any, listed in the schedule below are what the plan will pay for covered services.
 - ☐ Sometimes your cost share shows a combination of your dollar amount copayment that you will be responsible for and the coinsurance percentage that your plan will pay.
 - ☐ You are responsible to pay any deductibles, copayments and remaining coinsurance, if they apply and before the plan will pay for any covered services.
 - ☐ This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a covered service.
 - ☐ This plan has limits for some covered services. For example, these could be visit, day or dollar limits. They maybe:
 - Combined limits between in-network and out-of-network providers
 - Separate limits for in-network and out-of network providers
 - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan.
- See the schedule of benefits for more information about limits.
- ☐ Your cost share may vary if the covered service is preventive or not. Ask your physician or contact us if you have a question about what your cost share will be.

For examples of how cost share and deductible work, review the member handbook section under payment responsibilities. You may obtain a copy through our website at [**COMPANY WEBSITE**](#)

Important note:

Covered services are subject to the Plan Year **deductible, maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule of benefits.

Services covered by Medicare must be insured by a Medicare participating provider. If your provider accepts Medicare assignment, then you pay nothing for covered charges. Services covered by Medicare and incurred at a non-Medicare provider within Guam/CNMI (or the United States) are not covered. If services are not covered by Medicare, services will only be covered at a **COMPANY participating provider per the benefits noted below. All services outside of Guam/CNMI require pre-authorization, to include the U.S. Mainland and Hawaii. With the exception of urgent and emergency care, services incurred outside of Guam/CNMI where pre-authorization was not obtained in advance of care will not be covered under the plan. Plan pays Medicare A and Part B Deductible when applied by Medicare.**

Under this plan you will:

1. Pay your copayment
2. Then pay any remaining deductible
3. Then pay your coinsurance

How your PCP or physician office visit cost share works

You will pay the PCP cost share when you get covered services from any PCP.

Contact Us

Please contact should you have any questions or concerns. Plan features

Copayment

This is the dollar amount or percentage you pay for a covered service. This is in addition to any out-of-pocket costs you have to pay to meet your deductible, if you have one.

Coinsurance

This is a percentage you pay for a covered service. This is in addition to any out-of-pocket costs you have to pay to meet your deductible, if you have one.

Maximum out-of-pocket limit

The maximum-out-of-pocket limit is unlimited.

Limit provisions

Covered services will apply to the in-network and out-of-network limits

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of covered services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one year. Decisions regarding when benefits are covered are subject to terms and conditions of the group policy.

HSA 2000

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

Your Benefits: What the plan covers	Participating Providers	Non-participating Providers
DEDUCTIBLE PER INDIVIDUAL MEMBER	\$2,000	\$4,000**
DEDUCTIBLE PER FAMILY If an individual member of a family meets their \$3,200 embedded individual deductible, the plan begins to pay for covered services for that individual	\$4,000	\$12,000**
COVERAGE MAXIMUMS Individual member lifetime maximum	Unlimited	Unlimited
OUT OF POCKET MAXIMUMS (including accumulated deductible, copays, & member coinsurance) Per Individual member per policy year Per Family per policy year	\$4,000 \$12,000	\$30,000** \$90,000**
Any Services in the Philippines, Hawaii, the U.S. Mainland, and any foreign participating providers (Pre-Certification Required)	Requires a referral from your doctor and approval in advance from the plan	
Deductible and Co-Pay do not apply to these benefits when you go to a Participating Provider	Participating Providers	Non-participating Providers
PREVENTIVE SERVICES (Out-Patient Only) <ul style="list-style-type: none"> In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations except prescription drugs that are not otherwise in this plan Members may choose to receive age appropriate annual physical in the Philippines with no dollar limit Annual exam includes preventive lab tests 		
ANNUAL PHYSICAL EXAM One exam every 12 months	Plan pays 100%	Not Covered
IMMUNIZATIONS/VACCINATIONS In accordance with the guidelines established by the Advisory Committee on Immunization Practices	Plan pays 100%	Not Covered
PRE-NATAL CARE Including Routine Labs and first Ultrasound	Plan pays 100%	Not Covered
WELL-CHILD CARE In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care Infancy (Newborn to nine months) Maximum seven visits Early Childhood (One to four years old) Maximum seven visits Middle Childhood / Adolescence (Five to 17 years old) Maximum one visit/year	Plan pays 100%	Not Covered
ROUTINE CANCER SCREENINGS Including any applicable lab work, for cervical, prostate, colorectal, and breast (in accordance with PL 34-02, 34-03, and 34-109)	Plan pays 100%	Plan pays 50%*, Member pays 50%
ANNUAL EYE EXAM One exam every 12 months	Plan pays 100%	Not Covered
VISION CARE SUPPLIES Frames, lenses, contact lenses, fitting	Plan pays 100% up to \$150 per member per plan year Member pays anything beyond \$150	

* Eligible Charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges. ** A separate deductible applies for services rendered by non-participating providers.
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HSA 2000

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

Deductible and Co-Pay do not apply to these benefits when you go to a Participating Provider	Participating Providers	Non-participating Providers
TRAVEL BENEFIT <ul style="list-style-type: none"> Prior authorization (written approval) and coordination is required from Plan prior to departure from Guam Applicable only to approved referrals for conditions not treatable on Guam Airfare and/or lodging expenses coverage for eligible members for approved specialty care visits, consultations, treatments and hospitalization services at Participating Providers in the Philippines or in Taiwan Executive check-ups preventive services, primary care services and dental care DO NOT QUALIFY for this benefit Conditions and limitations apply as specified in the Member Handbook	Member pays all cost above \$500 Limited to once per plan year	Not Covered
Deductible must be met for these benefits	Participating Providers	Non-participating Providers
ACUPUNCTURE 30 visits per member per plan year	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
AIRFARE BENEFIT TO CENTERS OF EXCELLENCE ONLY For members who meet qualifying conditions, Plan provides roundtrip airfare (Plan Approval Required)	Plan pays 100%	Not Covered
ALLERGY TESTING	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
AMBULATORY SURGI-CENTER CARE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
AUTISM SPECTRUM DISORDER (In compliance with Guam Law)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
BLOOD & BLOOD DERIVATIVES	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
BREAST RECONSTRUCTIVE SURGERY (In accordance with 1998 W.H.C.R.A) (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
CARDIAC SURGERY	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
CATARACT SURGERY Outpatient Only (including conventional lens)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
CHEMICAL DEPENDENCY	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
CHEMOTHERAPY BENEFIT (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
CONGENITAL ANOMALY DISEASES COVERAGE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
DIAGNOSTIC TESTING MRI, CT scan, and other diagnostic procedures (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
DURABLE MEDICAL EQUIPMENT	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
ELECTIVE SURGERY (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
EMERGENCY CARE For off-island emergencies, Plan must be contacted and advised within 48 hours <ol style="list-style-type: none"> U.S. based and Out-of-U.S. emergency facility, physician services, laboratory, X-rays Ambulance Services (Ground Transportation Only) 	Plan pays 80% Member pays 20%	Plan pays 80%* Member pays 20%*
NON-EMERGENCY CARE In a hospital emergency room	Plan pays 50%* Member pays 50%	Plan pays 50%* Member pays 50%
END STAGE RENAL DISEASE / HEMODIALYSIS (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%

* Eligible Charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges. ** A separate deductible applies for services rendered by non-participating providers.

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HSA 2000

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

Deductible must be met for these benefits	Participating Providers	Non-participating Providers
HEARING AIDS Maximum \$500 per member per plan year	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
HOSPITALIZATION & INPATIENT BENEFITS 1. Room & Board for a semi-private room, intensive care, and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication 3. Physician's hospital services Inpatient Hospice (limited to 30 days)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
IMPLANTS (Limitations apply, please refer to contract) Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
INHALATION THERAPY	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
MATERNITY CARE Labor and Delivery	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
NUCLEAR MEDICINE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
ORGAN TRANSPLANT Including but not limited to: Heart, Lung, Liver, Kidney, Pancreas, Intestine, Bone Marrow, Cornea. Benefits include organ donor. (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
ORTHOPEDIC CONDITIONS Internal and External Prosthesis (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
OUTPATIENT PHYSICIAN CARE & SERVICES		
Primary Office Visits	Member pays \$20 copay	Plan pays 50%* Member pays 50%
Specialist Office Visits	Member pays \$40 copay	Plan pays 50%* Member pays 50%
Outpatient Laboratory	Member pays \$20 copay	Plan pays 50%* Member pays 50%
X-Ray Services	Member pays \$20 copay	Plan pays 50%* Member pays 50%
Home Health Care 120 visits per plan year	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
Hospice Care Facility Outpatient maximum 180 days per plan year (Pre-Certification Required)	Plan pays 100%	Plan pays 50%* Member pays 50%
Allergy Serum & Injections Does not include those on the Specialty Drugs List & Orthopedic injections	Plan pays 80%; Member pays 20%	Plan pays 50%* Member pays 50%
Chiropractic Care	Member pays \$40 copay	Plan pays 50%* Member pays 50%
Mental Health and Substance Abuse	Member pays \$40 copay	Plan pays 50%* Member pays 50%
Short Term Rehabilitation Includes coverage for Occupational, Physical and Speech Therapies; 60 combined visits per plan year	Member pays \$40 copay	Plan pays 50%* Member pays 50%
Urgent Care	Member pays \$50 copay	Plan pays 50%* Member pays 50%
Voluntary Second Surgical Opinion	Member pays \$40 copay	Plan pays 50%* Member pays 50%
RADIATION THERAPY (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%

* Eligible Charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges. ** A separate deductible applies for services rendered by non-participating providers. The Booklet is designed to provide general information about the plans offered to the Government of Guam employees, retirees and survivors. In the event of a discrepancy between this booklet and the contract, the terms of the contract will prevail.

HSA 2000

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

Deductible must be met for these benefits	Participating Providers	Non-participating Providers
ROBOTIC SURGERY/ROBOTICS SUITE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
SKILLED NURSING FACILITY Maximum 60 days per member per plan year (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
SLEEP APNEA Diagnostics and Therapeutic Procedure (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
STERILIZATION PROCEDURES Vasectomy (Outpatient Only)	Plan pays 80% Member pays 20%	Plan pays 50%* Member pays 50%
PRESCRIPTION DRUGS Deductible must be met for these benefits	Participating Providers	Non-participating Providers
PREVENTIVE MEDICATIONS (specific list)	\$0 Member copay 30 day supply	Plan pays 50% Member pays 50%
PREFERRED GENERIC DRUGS	\$15 copay per month supply \$0 copay for 90-day Mail Order Drugs	
PREFERRED BRAND NAME DRUGS	\$30 copay per month supply \$30 copay for 90-day Mail Order Drugs	
NON-PREFERRED GENERIC AND BRAND NAME DRUGS	\$100 copay per month supply \$100 copay for 90-day Mail Order Drugs	
SPECIALTY DRUGS (Medically Necessary Only and Pre-Certification Required)	\$100 Member Co-Pay (30 day supply)	Not Covered
PRESCRIPTION OUTSIDE GUAM/CNMI/USA Deductible does not apply	Plan pays 80%; Member pays 20% not to exceed Average Wholesale Price (AWP)	

* Eligible Charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges. ** A separate deductible applies for services rendered by non-participating providers.

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PPO1500

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

Your Benefits: What the plan covers	Participating Providers	Non-participating Providers
DEDUCTIBLE PER INDIVIDUAL MEMBER	\$1,500	\$3,000**
DEDUCTIBLE PER FAMILY If an individual member of a family meets their \$3,000 embedded individual deductible, the plan begins to pay for covered services for that individual	\$3,000	\$9,000**
COVERAGE MAXIMUMS Individual member lifetime maximum	Unlimited	Unlimited
OUT OF POCKET MAXIMUMS (including accumulated deductible, copays, & member coinsurance) Per Individual member per policy year Per Family per policy year	\$3,000 \$9,000	\$30,000** \$90,000**
Any Services in the Philippines, Hawaii, the U.S. Mainland, and any foreign participating providers (Pre-Certification Required)	Requires a referral from your doctor and approval in advance from the plan	
Deductible and Co-Pay do not apply to these benefits when you go to a Participating Provider	Participating Providers	Non-participating Providers
PREVENTIVE SERVICES (Out-Patient Only) <ul style="list-style-type: none"> In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations except prescription drugs that are not otherwise in this plan Members may choose to receive age appropriate annual physical in the Philippines with no dollar limit Annual exam includes preventive lab tests 		
ANNUAL PHYSICAL EXAM One exam every 12 months	Plan pays 100%	Not Covered
IMMUNIZATIONS/VACCINATIONS In accordance with the guidelines established by the Advisory Committee on Immunization Practices	Plan pays 100%	Not Covered
PRE-NATAL CARE Including Routine Labs and first Ultrasound	Plan pays 100%	Not Covered
WELL-CHILD CARE In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care Infancy (Newborn to nine months) Maximum seven visits Early Childhood (One to four years old) Maximum seven visits Middle Childhood / Adolescence (Five to 17 years old) Maximum one visit/year	Plan pays 100%	Not Covered
ROUTINE CANCER SCREENINGS Including any applicable lab work, for cervical, prostate, colorectal, and breast (in accordance with PL 34-02, 34-03, and 34-109)	Plan pays 100%	Plan pays 50%*, Member pays 50%
ANNUAL EYE EXAM One exam every 12 months	Plan pays 100%	Not Covered
VISION CARE SUPPLIES Frames, lenses, contact lenses, fitting	Plan pays 100% up to \$150 per member per plan year Member pays anything beyond \$150	

* Eligible Charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges. ** A separate deductible applies for services rendered by non-participating providers.
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PPO1500

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

Deductible and Co-Pay do not apply to these benefits when you go to a Participating Provider	Participating Providers	Non-participating Providers
OUTPATIENT PHYSICIAN CARE & SERVICES		
Primary Office Visits	Member pays \$20 copay	Plan pays 70%* Member pays 30%
Specialist Office Visits	Member pays \$40 copay	Plan pays 70%* Member pays 30%
Outpatient Laboratory	Member pays \$20 copay	Plan pays 70%* Member pays 30%
X-Ray Services	Member pays \$20 copay	Plan pays 70%* Member pays 30%
Home Health Care 120 visits per plan year	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
Hospice Care Facility Outpatient maximum 180 days per plan year (Pre-Certification Required)	Plan pays 100%	Plan pays 70%* Member pays 30%
Allergy Serum & Injections Does not include those on the Specialty Drugs List & Orthopedic injections	Plan pays 80%; Member pays 20%	Plan pays 70%* Member pays 30%
Chiropractic Care	Member pays \$40 copay	Plan pays 70%* Member pays 30%
Mental Health and Substance Abuse	Member pays \$40 copay	Plan pays 70%* Member pays 30%
Short Term Rehabilitation Includes coverage for Occupational, Physical and Speech Therapies; 60 combined visits per plan year	Member pays \$40 copay	Plan pays 70%* Member pays 30%
Urgent Care	Member pays \$50 copay	Plan pays 70%* Member pays 30%
Voluntary Second Surgical Opinion	Member pays \$40 copay	Plan pays 70%* Member pays 30%
TRAVEL BENEFIT - Prior authorization (written approval) and coordination is required from Plan prior to departure from Guam - Applicable only to approved referrals for conditions not treatable on Guam - Airfare and/or lodging expenses coverage for eligible members for approved specialty care visits, consultations, treatments and hospitalization services at Participating Providers in the Philippines or in Taiwan - Executive check-ups preventive services, primary care services and dental care DO NOT QUALIFY for this benefit Conditions and limitations apply as specified in the Member Handbook	Member pays all cost above \$500 Limited to once per plan year	Not Covered
Deductible must be met for these benefits	Participating Providers	Non-participating Providers
ACUPUNCTURE 30 visits per member per plan year	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
AIDS Treatment Exclusive of Experimental drugs (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
AIRFARE BENEFIT TO CENTERS OF EXCELLENCE ONLY For members who meet qualifying conditions, Plan provides roundtrip airfare (Plan Approval Required)	Plan pays 100%	Not Covered
ALLERGY TESTING	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
AMBULATORY SURGI-CENTER CARE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
AUTISM SPECTRUM DISORDER (In compliance with Guam Law)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%

* Eligible Charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges. ** A separate deductible applies for services rendered by non-participating providers. The Booklet is designed to provide general information about the plans offered to the Government of Guam employees, retirees and survivors. In the event of a discrepancy between this booklet and the contract, the terms of the contract will prevail.

PPO1500

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

Deductible must be met for these benefits	Participating Providers	Non-participating Providers
BLOOD & BLOOD DERIVATIVES	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
BREAST RECONSTRUCTIVE SURGERY (In accordance with 1998 W.H.C.R.A) (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CARDIAC SURGERY	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CATARACT SURGERY Outpatient Only (including conventional lens)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CHEMICAL DEPENDENCY	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CHEMOTHERAPY BENEFIT (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
CONGENITAL ANOMALY DISEASES COVERAGE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
DIAGNOSTIC TESTING MRI, CT scan, and other diagnostic procedures (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
DURABLE MEDICAL EQUIPMENT	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
ELECTIVE SURGERY (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
EMERGENCY CARE For off-island emergencies, Plan must be contacted and advised within 48 hours 1. U.S. based and Out-of-U.S. emergency facility, physician services, laboratory, X-rays 2. Ambulance Services (Ground Transportation Only)	Plan pays 80% Member pays 20%	Plan pays 80%* Member pays 20%*
NON-EMERGENCY CARE In a hospital emergency room	Plan pays 50%* Member pays 50%	Plan pays 70%* Member pays 30%
END STAGE RENAL DISEASE / HEMODIALYSIS (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
HEARING AIDS Maximum \$500 per member per plan year	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
HOSPITALIZATION & INPATIENT BENEFITS 1. Room & Board for a semi-private room, intensive care, and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication 3. Physician's hospital services Inpatient Hospice (limited to 30 days)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
IMPLANTS (Limitations apply, please refer to contract) Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopaedic internal prosthetic devices	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
INHALATION THERAPY	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
MATERNITY CARE Labor and Delivery	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
NUCLEAR MEDICINE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
ORGAN TRANSPLANT Including but not limited to: Heart, Lung, Liver, Kidney, Pancreas, Intestine, Bone Marrow, Cornea. Benefits include organ donor. (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
ORTHOPEDIC CONDITIONS Internal and External Prosthesis (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%

* Eligible Charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges. ** A separate deductible applies for services rendered by non-participating providers.

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PPO1500

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

Deductible must be met for these benefits	Participating Providers	Non-participating Providers
RADIATION THERAPY (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
ROBOTIC SURGERY/ROBOTICS SUITE (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
SKILLED NURSING FACILITY Maximum 60 days per member per plan year (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
SLEEP APNEA Diagnostics and Therapeutic Procedure (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
STERILIZATION PROCEDURES Vasectomy (Outpatient Only)	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%
PRESCRIPTION DRUGS		
Deductible and Co-Pay do not apply to these benefits when you go to a Participating Provider	Participating Providers	Non-participating Providers
PREVENTIVE MEDICATIONS (specific list)	\$0 Member copay 30 day supply	Plan pays 50% Member pays 50%
PREFERRED GENERIC DRUGS	\$15 copay per month supply \$0 copay for 90-day Mail Order Drugs	
PREFERRED BRAND NAME DRUGS	\$30 copay per month supply \$30 copay for 90-day Mail Order Drugs	
NON-PREFERRED GENERIC AND BRAND NAME DRUGS	\$100 copay per month supply \$100 copay for 90-day Mail Order Drugs	
SPECIALTY DRUGS (Medically Necessary Only and Pre-Certification Required)	\$100 Member Co-Pay (30 day supply)	
PRESCRIPTION OUTSIDE GUAM/CNMI/USA Deductible does not apply	Plan pays 80%; Member pays 20% not to exceed Average Wholesale Price (AWP)	

* Eligible Charges for Non-Participating Providers are limited to the lesser of actual charges or Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges. ** A separate deductible applies for services rendered by non-participating providers. The Booklet is designed to provide general information about the plans offered to the Government of Guam employees, retirees and survivors. In the event of a discrepancy between this booklet and the contract, the terms of the contract will prevail.

RETIREE SUPPLEMENTAL PLAN

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

ELIGIBILITY PROVISION

RETIREES & SURVIVORS

Medicare A and B Primary

Qualified GovGuam retirees and survivors, who are age 65 and older and who are enrolled in Medicare Parts A & B Primary.

Qualified retirees and survivors who are under 65 years of age with a disability or ESRD under Medicare.

RSP DEPENDENTS

Spouse or domestic partner who are both Medicare Part A and B, Primary Medicare A and B Primary

RSP DEPENDENTS

Not Medicare A and B Primary

Spouse, domestic partner and children up to age 26, regardless of student status NOT Medicare Primary or NOT Medicare enrolled are eligible to participate in either the PP01500 or HSA2000 plan.

Your Benefits: What the plan covers

In-Network Retiree Supplemental Plan Pays

PLAN DESCRIPTION

Medicare A & B is **primary**. The GovGuam plan pays secondary. Medicare covered services should be incurred at a Medicare provider. Services **not covered by Medicare**, but covered by the plan, should be received **at a carrier in-network provider**. Carrier will pay primary in this circumstance. **Out-of-Network services** are not covered unless referred and pre-approved by an in-network provider.

OUT-OF-AREA SERVICES

Any service outside Guam that includes but is not limited to Philippines, Hawaii, U.S. Mainland, Japan, Taiwan, and any foreign participating providers (Pre-Certification Required)

Requires a referral from your doctor and approval in advance from the plan; When Medicare is not payable (outside U.S.), covered services under the plan are paid at the copay or coinsurance listed and the Plan pays primary in this circumstance. There is no deductible under this plan.

COVERAGE MAXIMUMS

Individual member annual maximum

UNLIMITED

PREVENTIVE SERVICES (Out-Patient Only)

Retiree Supplemental Plan Pays

In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations.

Notes: Members may choose to receive age appropriate annual physical in the Philippines with no dollar limit. Annual exam includes preventive lab tests.

ANNUAL PHYSICAL EXAM

One exam every 12 months

Medicare covers;
When Medicare is not primary, the plan pays 100%

IMMUNIZATIONS/VACCINATIONS

In accordance with the guidelines established by the Advisory Committee on Immunization Practices

Medicare covers;
When Medicare is not primary, the plan pays 100%

WELL-WOMAN CARE

In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA) Contraceptives including Sterilization and Tubal Ligation

Medicare covers;
When Medicare is not primary, the plan pays 100%

ROUTINE CANCER SCREENINGS

Including any applicable lab work, for cervical, prostate, colorectal, and breast (in accordance with PL 34-02, 34-03, and 34-109)

Medicare covers;
When Medicare is not primary, the plan pays 100%

ANNUAL EYE EXAM

One exam every 12 months, covered in Guam only

Medicare covers;
When Medicare is not primary, the plan pays 100%

VISION CARE SUPPLIES

Frames, lenses, contact lenses, fitting

Plan pays 100% up to \$150 per member per 12-months Member pays anything beyond \$150

ROUTINE HEARING EXAM

Includes one routine exam every 24 months

Medicare covers;
When Medicare is not primary, the plan pays 100%

OUTPATIENT PHYSICIAN CARE AND SERVICES

PRIMARY OFFICE VISITS

Plan pays Medicare Part B deductible, and Medicare 20% coinsurance Member pays Nothing; Plan pays 80% when approved outside of Medicare

SPECIALIST OFFICE VISITS

Plan pays Medicare Part B deductible, and Medicare 20% coinsurance Member pays Nothing; Plan pays 80% when approved outside of Medicare

(1) If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the RSP will cover the percentage indicated on the Schedule of Benefits.

(2) For any benefit covered by Medicare requiring coinsurance, but not specifically listed in the Schedule of Benefits, the coinsurance shall be covered by the RSP.

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RETIREE SUPPLEMENTAL PLAN

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

OUTPATIENT PHYSICIAN CARE AND SERVICES

OUTPATIENT LABORATORY	Medicare covers; Member pays Nothing; Plan pays 80% when approved outside of Medicare
X-RAY SERVICES	Medicare covers; Member pays Nothing; Plan pays 80% when approved outside of Medicare
HOME HEALTH CARE 120 visits per plan year	Medicare covers; Member pays Nothing; Plan pays 80% when approved outside of Medicare
HOSPICE CARE FACILITY OUTPATIENT maximum 180 days per plan year (Pre-Certification Required)	Plan pays 80%; Member pays 20%
ALLERGY SERUM & INJECTIONS Does not include those on the Specialty Drugs List & Orthopedic injections	Medicare Primary: Plan pays 100% per visit Medicare Secondary: Plan pays 80% per visit outside of Medicare, Member pays 20% per visit
CHIROPRACTIC CARE	Plan pays 80%; Member pays 20%
MENTAL HEALTH AND SUBSTANCE ABUSE	Plan pays Medicare Part B deductible, and Medicare 20% coinsurance Member pays Nothing Plan pays 80% when approved outside of Medicare
SHORT TERM REHABILITATION Includes coverage for Occupational, Physical and Speech Therapies; 60 combined visits per plan year	Medicare Primary: Plan pays 100% per admission Outside of Medicare: Plan pays 80% per admission, Member pays 20% per admission
URGENT CARE	Plan pays Medicare Part B deductible, and Medicare 20% coinsurance; Member pays Nothing; Plan pays 80% when approved outside of Medicare
VOLUNTARY SECOND SURGICAL OPINION	Plan pays Medicare Part B deductible, and Medicare 20% coinsurance; Member pays Nothing; Plan pays 80% when approved outside of Medicare

ADDITIONAL BENEFITS

ACUPUNCTURE 30 visits per member, per plan year	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
AIRFARE BENEFIT TO CENTERS OF EXCELLENCE ONLY For members who meet qualifying conditions, Plan provides roundtrip airfare (Plan Approval Required)	Plan pays 100%
ALLERGY TESTING	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
AMBULATORY SURGI-CENTER CARE (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
BLOOD & BLOOD DERIVATIVES	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
BREAST RECONSTRUCTIVE SURGERY (In accordance with 1998 W.H.C.R.A) (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
CARDIAC SURGERY	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
CATARACT SURGERY Outpatient Only (Including conventional lens)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
CHEMICAL DEPENDENCY	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
CHEMOTHERAPY BENEFIT (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
CONGENITAL ANOMALY DISEASES COVERAGE (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%

- (1) If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the RSP will cover the percentage indicated on the Schedule of Benefits.
- (2) For any benefit covered by Medicare requiring coinsurance, but not specifically listed in the Schedule of Benefits, the coinsurance shall be covered by the RSP.

The Booklet is designed to provide general information about the plans offered to the Government of Guam employees, retirees and survivors. In the event of a discrepancy between this booklet and the contract, the terms of the contract will prevail.

RETIREE SUPPLEMENTAL PLAN

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

ADDITIONAL BENEFITS	RETIREE SUPPLEMENTAL PLAN PAYS
DIAGNOSTIC TESTING MRI, CT scan, and other diagnostic procedures (Pre-Certification Required)	Plan pays Medicare Part B deductible, and Medicare 20% coinsurance Plan pays 80% when approved outside of Medicare
DURABLE MEDICAL EQUIPMENT (DME) (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
ELECTIVE SURGERY (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
EMERGENCY CARE For of-island emergencies, Plan must be contacted and advised within 48 hours 1. U.S. based and Out-of-U.S. emergency facility, physician services, laboratory, X-rays Ambulance Services (Ground Transportation Only)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
NON-EMERGENCY CARE in a hospital emergency room	Plan pays 50%; Member pays 50%
END STAGE RENAL DISEASE / HEMODIALYSIS (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
HEARING AIDS Maximum \$500 per member per plan year	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
HOSPITALIZATION & INPATIENT BENEFITS 1. Room & Board for a 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 Inpatient Hospice limited to 30 days	Medicare Primary; Plan pays 100% per admission Outside of Medicare: Plan pays 80% per admission, Member pays 20% per admission
IMPLANTS (Limitations apply, please refer to contract) Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
INHALATION THERAPY	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
NUCLEAR MEDICINE (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
ORGAN TRANSPLANT (Pre-Certification Required) Including but not limited to: Heart, Lung, Liver, Kidney, Pancreas, Intestine, Bone Marrow, Cornea (Benefits include organ donor)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
ORTHOPEDIC CONDITIONS Internal and External Prosthesis (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
RADIATION THERAPY (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
ROBOTIC SURGERY/ROBOTICS SUITE	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
SKILLED NURSING FACILITY Maximum 60 days per member per plan year (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
SLEEP APNEA Diagnostics and Therapeutic Procedure (Pre-Certification Required)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%
STERILIZATION PROCEDURES Vasectomy (Outpatient Only)	Medicare primary; Plan pays 100% Outside of Medicare: Plan pays 80%, Member pays 20%

- (1) If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the RSP will cover the percentage indicated on the Schedule of Benefits.
(2) For any benefit covered by Medicare requiring coinsurance, but not specifically listed in the Schedule of Benefits, the coinsurance shall be covered by the RSP.

The Booklet is designed to provide general information about the plans offered to the Government of Guam employees, retirees and survivors. In the event of a discrepancy between this booklet and the contract, the terms of the contract will prevail.

RETIREE SUPPLEMENTAL PLAN

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

ADDITIONAL BENEFITS		RETIREE SUPPLEMENTAL PLAN PAYS
TRAVEL BENEFIT <ul style="list-style-type: none"> - Prior authorization (written approval) and coordination is required from Plan prior to departure from Guam - Applicable only to approved referrals for conditions not treatable on Guam - Airfare and/or lodging expenses coverage for eligible members for approved specialty care visits, consultations, treatments and hospitalization services at Participating Providers in the Philippines or in Taiwan - Executive check-ups preventive services, primary care services and dental care DO NOT QUALIFY for this benefit <p>Conditions and limitations apply as specified in the Member Handbook</p>		<p>Member pays all cost above \$500 Limited to once per plan year</p> <p>Not Covered</p>
PRESCRIPTION DRUGS		PARTICIPATING PHARMACIES ONLY
PREVENTIVE MEDICATIONS (specific list)		<p>\$0 Member copay</p> <p>30 day supply</p>
PREFERRED GENERIC DRUGS		<p>\$15 copay per month supply</p> <p>\$0 copay for 90-day Mail Order Drugs</p>
PREFERRED BRAND NAME DRUGS		<p>\$30 copay per month supply</p> <p>\$30 copay for 90-day Mail Order Drugs</p>
NON-PREFERRED GENERIC AND BRAND NAME DRUGS		<p>\$100 copay per month supply</p> <p>\$100 copay for 90-day Mail Order Drugs</p>
SPECIALTY DRUGS (Medically Necessary Only and Pre-Certification Required)		<p>\$100 Member Co-Pay (30 day supply)</p>
PRESCRIPTION OUTSIDE GUAM/CNMI/USA Deductible does not apply		<p>Plan pays 80%; Member pays 20% not to exceed Average Wholesale Price (AWP)</p>

(1) If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the RSP will cover the percentage indicated on the Schedule of Benefits.
 (2) For any benefit covered by Medicare requiring coinsurance, but not specifically listed in the Schedule of Benefits, the coinsurance shall be covered by the RSP.

The Booklet is designed to provide general information about the plans offered to the Government of Guam employees, retirees and survivors. In the event of a discrepancy between this booklet and the contract, the terms of the contract will prevail.

GOVGUAM SELF INSURED DENTAL PLAN DOCUMENT SAMPLE

GOVERNMENT OF GUAM

And

COMPANY

GROUP DENTAL SELF FUNDED PLAN DOCUMENTS

October 1, 2025- September 30, 2026

Preamble

This Dental Agreement is made and entered between ***COMPANY*** ("***COMPANY***") as the Third Party Administrators (TPA) and THE GOVERNMENT OF GUAM ("GovGuam") and together the "Parties." The effective date of this agreement is October 1, 2025 ("Effective Date") through September 30, 2026.

Recitals

WHEREAS, GovGuam has established a self-funded employee benefits plan, described in Exhibit A (Dental Service Schedule), (the "Plan(s)"), for certain covered persons, as defined in the Plan(s) (the "Plan Participants").

WHEREAS, GovGuam wants to make available to Plan Participants a dental and administrative services ("Services") offered by ***COMPANY***, as specified in the attached schedules, and ***COMPANY*** wants to provide those Services to GovGuam for the compensation described herein in Exhibit B (Service and Fee Schedule).

WHEREAS, GovGuam has contracted with ***COMPANY*** to provide the Third Party Administration (TPA) to include dental network access, member and claim administration. The TPA has established a provider portal where GovGuam members are able to check Provider Directory, Member Handbook, Schedule of Benefits, Summary of Benefits and Claim information.

WHEREAS, the TPA is an insurance company licensed to do business in Guam; and

WHEREAS, TPA is qualified to provide a group dental insurance program third party administrative services to GovGuam as a TPA for its group health insurance (and foster) program; and

WHEREAS, GovGuam selected ***COMPANY*** as a qualified TPA plan to provide group dental insurance benefits plan to GovGuam active and retired employees, their dependents, and survivors of retired employees who receive annuity benefits; and

WHEREAS, GovGuam selected ***COMPANY*** as the TPA to provide exclusive group dental insurance benefits to foster children under the legal custody of the Child Protective Services Division of the Department of Public Health and Social Services as defined in 4 G.C.A. 4301.1(h), and

WHEREAS, ***COMPANY*** offers TPA services group health insurance program benefits, as hereinafter set forth, under a group dental insurance plan known as the "Government of Guam Health 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

A. Scope: This Agreement supersedes any and all prior agreements, either oral or in writing, if any, between the Parties hereto with respect to the retainer of ***COMPANY*** by GovGuam and contains all of the covenants and agreements between the parties with respect to the subject matter of this Agreement. Each party to this Agreement acknowledges that no representation, inducements, promises or agreements, orally or otherwise, have been made by any party, or anyone acting on behalf of any party, which is not embodied herein, and that any other agreement, statement, or promise not contained in this Agreement shall not be valid or binding on the Parties with respect to the subject matter of this Agreement. This Agreement, and any modification hereto, is not binding until approved by the Attorney General of Guam and executed by the Governor of Guam. Any modification of this Agreement will be effective only if it is in writing, approved by the Attorney General of Guam and executed by the Governor of Guam.

It is hereby mutually agreed that the following list of documents which are attached hereto, bound herewith or incorporated herein by reference shall constitute the "Contract Documents," all of which are made part hereof, and collectively evidence and constitute this Agreement between the parties hereto, and they are as fully a part of this Agreement, as if they were set out verbatim and in full herein:

a. The Request for Proposals, and all notices, conditions, attachments, and instructions for DOA/ID-RFP-GHI-26-001 which includes the Specifications contained in the Scope of Services.

b. Any addendum to, or Government of Guam responses to questions submitted for Request for Proposals DOA/ID-RFP-GHI-26-001.

c. ***COMPANY***'s Proposal submitted in response to Request for Proposals,

DOA/ID-RFP-GHI-26-001

d. This Agreement, any of its Attachments, Exhibits, or Schedules, and any duly executed Amendment or Change Order thereto.

e. All terms agreed upon as a result of negotiations.

B. 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.

1. **Agreement:** Shall be defined as this Group Health Insurance Plan Document including, the Group Health Insurance Certificate and Exhibits.
 2. **Covered Person:** Shall be defined as a person entitled to receive Covered Services pursuant to the Plan. A Covered Person shall reside in the Service Area and shall be a subscriber or dependent of the Plan.
 3. **Covered Services:** Shall be defined as dental care services, as defined under the Plan, that are not specifically excluded from coverage by this Agreement and other Services which are specifically included. Services shall include dental care services, treatments, supplies, medications and equipment.
 4. **Currency:** Shall be defined as money accepted as a medium of exchange for payment of debts such as the United States Dollar in the United States and the Peso in the Philippines.
 5. **Department of Administration (DOA).** Shall be defined as the Department of Administration. DOA shall be responsible for payment and administration of line agencies, agencies whom the DOA administers payroll, and the Foster program.
 6. **Department of Public Health and Social Services (DPHSS) Child Protective Services (CPS):** Shall be defined as the Department of Public Health and Social Services, Division of Public Welfare, Bureau of Social Services Administration, Child Protection Services and administers the Foster Care program.
 7. **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.
 8. **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 ***COMPANY*** and the Participating Provider. For a Non-Participating Provider, the Eligible Charges for covered dental Services rendered by a provider who is not a Participating Provider, shall be limited to the lesser of (a) the actual charge made by the provider, or (b) in the United States, the Medicare Participating Provider fees in the geographic area where the Service was rendered; or (c) in Asia, the fees most recently contracted by ***COMPANY*** at St. Luke's Medical Center, Manila, Philippines, or (d) elsewhere, the Medicare National Standard Fee.
 9. **Enrollment:** Shall be defined as the acceptance, as of a specified date, of a written or online application for coverage under the Plan on forms provided by ***COMPANY***.
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10. **Foster Children:** Includes only foster children under the legal custody of the Child Protective Services Division of the Department of Public Health as defined in 4 G.C.A 4301.1(h)
 11. **GovGuam Line Agencies:** Shall be defined Government of Guam agencies that are Line Agency means any department, agency, or instrumentality of the Government of Guam which is funded by an annual appropriation from the Legislature. Such appropriations do not include subsidies. (5 GCA Chapter 6 § 6103(c)). All TPA fees payments and issues associated with GovGuam Line Agencies shall be paid by the Department of Administration.
 12. **GovGuam Autonomous Agencies:** Shall be defined as any Government of Guam department, agency, or instrumentality which generates, or is intended to generate, as evidenced in law, all of its own operating revenues apart from annual appropriations from the General Fund. Annual appropriations do not include amounts appropriated to line agencies to pay for services rendered by autonomous agencies. Subsidies appropriated from the General Fund to an autonomous agency, whether or not annually appropriated, shall not mean that an autonomous agency becomes a line agency for purposes of this Chapter. All TPA fee payments and payment discrepancy issues associated with the GovGuam Autonomous Agencies shall be coordinated directly with the autonomous agency.
 13. **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.
 14. **Other Plan:** Shall be defined as any other health insurance or health benefits program offered to GovGuam's employees, retirees and their eligible Dependents, through an Agreement with GovGuam.
 15. **Participating Providers, Non-Participating Providers, Providers and Network:**
 - a. **"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.
 - b. **"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 ***COMPANY*** to provide the Covered Services; and (ii) are assigned from time to time by ***COMPANY*** to participate in the Network or any other network of ***COMPANY*** pursuant to this Agreement.
 - c. **"Network"** shall be defined as the network of Participating Providers. Network may also be referred to as "Plan Network".
 - d. **"Non-Participating Provider"** shall be defined as Providers who have NOT been contracted by ***COMPANY*** to provide medical dental services to Covered Persons.
 16. **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;
 17. **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.
 18. **Plan:** Shall be defined as the group dental insurance benefits provided in accordance with this Agreement.
 19. **Plan Year:** Shall be defined as the twelve (12) month period during which group dental insurance benefits are provided under this Agreement.
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20. **PPACA:** Shall mean the Patient Protection and Affordable Care Act of 2010, as amended.
21. **Third Party Administrator (TPA) Fees:** Shall be defined as the dollar amount paid to ***COMPANY*** for the administration of this Plan to Covered Persons.
22. **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. However, residence in the service area shall not be a requirement for enrollment for dependent children below 26 years of age.
23. **Subscriber:** Shall be defined as a bona fide employee of GovGuam who is working 30 hours per week; or
- a. Voluntarily working under the "Quality Time" program and classified as such by GovGuam pursuant to P.L. 25-72; or working under any GovGuam sponsored program that ensures continuity of health insurance benefits.
 - b. Classified as a retiree of GovGuam by GovGuam; or
 - c. Classified as a GovGuam Retiree who has returned back to GovGuam active employment; or
 - d. Classified as a survivor of a retired employee of GovGuam by GovGuam; or
 - e. A Foster Child under the legal custody of the Child Protective Services Division of the Department of Public Health.
24. **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.
25. **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

COMPANY shall provide Covered Persons with the group health insurance and Foster health benefits, subject to the applicable limitations and conditions, set forth in this Agreement and the Certificates and Exhibits incorporated herein.

ARTICLE 4 Rates, TPA fees, Provider Network

- A. Rates.** ***COMPANY*** shall provide the group health insurance benefits set forth in the Certificate for the rates contained herein.
- B. TPA fees Payment. All agencies and departments shall remit premiums to the Department of Administration for all enrolled subscribers.** GovGuam shall pay the TPA fees due under this Agreement to ***COMPANY*** within thirty-one (31) days of each biweekly invoice for active employees and semi-monthly for retirees detailing the current TPA fees due. Payment in full of all TPA fees 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 TPA fees when due under this Agreement, ***COMPANY*** shall have the right to suspend performance under this Agreement with respect to any Covered Person whose TPA fees payments have not been paid by GovGuam, in addition to the right of termination under Article 5. However, such suspension may only take place after ***COMPANY*** provides written notice to Government of Guam at least fifteen (15) days prior to the suspension stating the names of the Covered persons at risk of suspension and the amount of TPA fee owed for each.
- C. Network.** One of the advantages of a dental network is the determination of what charge amounts are acceptable for benefit payment. As defined later in this document, covered expenses will be considered only up to the reasonable and customary charge for the geographic area in which the service is rendered. This means that if a PPO network physician bills an amount in excess of the reasonable and customary amount, Plan Participants cannot be billed for the excess charge. The Plan utilizes the current National Dental Advisory Service Fees, based on the geographic location where service was incurred, to determine the usual, customary and reasonable eligible expense.

All other Plan Participants will receive benefits at the Out-of-Network benefit rate when using a provider outside of the State of Guam.

However, an out of network physician who bills an amount in excess of the reasonable and customary amount can bill Plan Participants for the excess charge. It is therefore to a Plan Participant's benefit to use the provider network. Excess charges will not be paid by the Plan.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Plan Participants are limited to covered charges incurred before termination.

ARTICLE 5

Term, Notice, and Termination

- A. Term.** The Agreement is for a one-year Firm Fixed-Price Contract beginning October 1, 2025 ending September 30, 2026, 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.
- B. Notice to GovGuam.** ***COMPANY*** must provide written notice to GovGuam or directly to the autonomous agency after fifteen (15) days and thirty-one (31) days of the non-payment. The notices must state the names of the Covered Persons at risk of suspension and the amount of TPA fees owed for each.
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- C. Termination By ***COMPANY***.** If GovGuam or an autonomous agency fails to make any TPA fee payment fee, ***COMPANY*** shall have the right to suspend or terminate coverage of the Covered Persons for non-payment within thirty-one (31 days) of the second notice. ***COMPANY*** shall not suspend or terminate agency coverage as a whole for the non-payment of individual TPA fees.
- D. Individual Notice.** ***COMPANY*** must provide direct written notice to individuals who have outstanding TPA fee payments fee due after fifteen (15) and thirty-one (31) days of the non-payment.
- E. Individual Termination.** ***COMPANY*** may, in accordance with the notice provisions contained herein, terminate the coverage of one or more individual Covered Persons for non-payment of TPA fees without fee terminating this Agreement as to other Covered Persons for whom TPA fees have been received by ***COMPANY***. ***COMPANY*** shall have the right to suspend or terminate coverage of the individual for non-payment within thirty-one (31 days) of the notice. ***COMPANY*** must provide individual termination notices to the subscriber and advise the government of such termination.
- F. Other Reasons.** Except for non-payment of TPA fees, ***COMPANY*** may only terminate a Covered Person as provided under the Plan.
- G. Review of Termination.** Any Covered Person whose coverage is terminated pursuant to the Notice and Termination stated herein, shall be entitled to a review through the PPACA Claims Procedure set forth in this Agreement, if so requested.
- H. Effect of Termination.** In the event of termination of this Agreement for a Covered Person, ***COMPANY*** shall be responsible for administering the benefits contained in this Agreement up to the effective date of termination provided by GovGuam which will not be later than the last day of the pay period for which TPA fees has been remitted and GovGuam shall be responsible for payment of the TPA fees up to said effective date.
- I. Termination of Subscriber's Coverage.** If a Subscriber's coverage terminates, the coverage of all of that Subscriber's Covered Dependents also terminates as of the same date.

ARTICLE 6

Enrollment

- A. 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 §6C, §6D and §6E 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.
- B. Foster Enrollment.** DPHSS CPS shall provide ***COMPANY*** with the names and other enrollment information of eligible foster children to be enrolled in this Plan. The parties to this Agreement shall provide ***COMPANY*** with the assistance and cooperation detailed on Article 8. The effective date of such Enrollment shall be the effective date of this Agreement, unless otherwise specified by GovGuam in accordance with this Agreement, or unless otherwise required under HIPAA.

DPHSS CPS agrees to abide by the provisions of coverage in the policy under which the Foster Child is

enrolled. DPHSS CPS shall read and understand the eligibility requirements and attest that the foster child meets these requirements. DPHSS CPS understands that it is their responsibility to report any changes in eligibility. Child Protective Services further understands that newly eligible foster children may only be added within thirty-one (31) days from becoming eligible or during an Open Enrollment period for the group. DPHSS CPS understands on behalf of the Foster Child that ***COMPANY*** has the right to request required documents at any time and failure to submit these documents may result in a loss of coverage or service at the discretion of the ***COMPANY***. Should this occur, DPHSS CPS understands and agrees they may be responsible for the cost of all health care provided to the Foster Child. DPHSS CPS understands that the provided coverage and service does not constitute acceptance of eligibility by ***COMPANY*** until eligibility for coverage has been proven.

C. 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.

D. Newly Eligible Persons. Any individual who becomes a GovGuam employee, or for any other reason first becomes eligible to be a Covered Person outside the open Enrollment period, shall have thirty-one (31) 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 the applicable Plan certificate.

- **Foster Eligibility.** When a Foster Child first becomes eligible to be a Covered Person, shall have thirty-one (31) days after the date on which he/she became eligible to become a Covered Person.
- **Retirees who return to Active Employment.** When a Retiree has returned back to active employment with GovGuam, he/she shall enroll under the active status.

E. Otherwise Eligible. Enrollment shall be restricted to only those occasions provided for in this Article 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.

F. Disenrollment Permitted.

Retirees who return back to active employment with GovGuam, shall be permitted to disenroll under the Retiree status and enroll under the active status. Departments are responsible in ensuring that their employee is enrolled under the correct status. Should it be found that the employee's enrollment is under the wrong status, enrollment to the appropriate status shall be corrected upon discovery.

G. Notice of Ineligibility. ***COMPANY*** shall notify subscribers 30 days prior to when a dependent is no longer eligible for coverage. This includes children who are no longer deemed a dependent or the dependent has reached eligibility age of 26. TPA shall notify departments effective dates and class deduction as a result of change.

H. Responsibility of subscribers. Subscribers shall promptly notify GovGuam and ***COMPANY*** when there is a change in the status of any dependents (such as death, divorce, or separation) covered under the subscriber's plan. Subscribers shall remain in the current Class/Plan and are responsible for premiums until ***COMPANY*** notifies GovGuam of the effective date of the change. ***COMPANY*** shall notify GovGuam within fifteen (15) days of any changes received directly from Subscribers.

1. **Foster.** DPHSS CPS shall promptly notify GovGuam and ***COMPANY*** when an individual no longer qualifies for coverage under the Foster program. GovGuam shall remain responsible for

TPA fees of the Foster Child until ***COMPANY*** notifies GovGuam of the effective date of the change.

ARTICLE 7

COMPANY's Responsibilities

- A. 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.
- B. Benefits to be Provided.** ***COMPANY*** shall, in consideration of receipt of applicable TPA fees, administer 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.
- C. Financial and Dental 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.
- D. Confidential Information.** The parties hereto shall maintain the confidentiality of any and all dental 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 dental condition is reflected in such dental records or as shall be otherwise permitted under applicable law. Upon request and subject to applicable law, ***COMPANY*** shall make available to GovGuam dental records to assure Covered Persons are receiving adequate and appropriate benefits in accordance with the Certificate.

Authorization. DPHSS CPS authorizes any Dental/Healthcare Provider of Facility to give ***COMPANY*** information concerning the dental history, prescription utilization history, services or treatment provided to anyone enrolled with ***COMPANY*** pursuant to this Agreement, including any Mental Health, Substance Abuse and HIV/AIDS information. DPHSS CPS further authorizes ***COMPANY*** to use such information and to disclose such information to affiliates, other Providers, payers, other insurers, third party administrators, vendors, consultants and government authorities with jurisdiction when as deemed necessary by ***COMPANY*** for the Foster Child's care or treatment, payment of services, the operation of my health plan, or to conduct related activities.

DPHSS CPS consents to the terms of this authorization. This authorization will remain valid for the term of this coverage and after finalizing the administration of any remaining open claims. DPHSS CPS understands that they are entitled to receive a copy of this authorization and that a photocopy is as valid as the original.

- E. Errors and Omission Insurance.** ***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.
- F. Payment of Claims.** ***COMPANY*** shall pay claims in accordance with the Guam Health Care Prompt
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Payment Act of 2000 and the applicable claims payment requirements of PPACA. Appeals of claim denials shall comply with applicable requirements of PPACA Section 2719 and regulations thereto on internal claims appeal process and external appeals process review requirements.

- G. Prompt Payment Report.** ***COMPANY*** shall send a status report on a claim filed by Covered Person against a Provider within forty-five (45) days after receipt if the claim is still pending disposition by ***COMPANY*** and Provider. At a minimum the report shall indicate that the claim is under review and ***COMPANY*** is working to resolve the claim with the Provider. ***COMPANY*** shall send another status report on the claim to the Covered Person with a copy to the Provider thirty (30) days from the date the first status report was sent to the Covered Person if the claim has not been resolved.
- H. 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.
- I. Termination Notification.** If ***COMPANY*** terminates this Agreement, ***COMPANY*** shall provide notice announcing its termination at least fifteen (15) days prior to the date of termination on ***COMPANY***'s website, an ad in any of the local newspaper publications, and email to subscribers of ***COMPANY***'s Plan. Further, ***COMPANY*** shall fully cooperate with GovGuam in transitioning Covered Persons to Other Plans.
- J. 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.
- K. Online Access Capabilities.** ***COMPANY*** shall provide, for the benefit of the Covered Person and GovGuam, the following online access capabilities:
- 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.
 - For the Covered Person, access to a Personal Claim Record ("PCR"), whichever is applicable to ***COMPANY***, to include historical health conditions, prescription medications, office visit summary and procedures where a dental claim has been filed.
 - For the Covered Person, access to record of dental claims.
 - For the Covered Person, ability to verify eligibility.
 - Ability of Providers to submit claims through a separate portal rather than through ***COMPANY***'s website for payment.
 - For the Covered Person, GovGuam, and Provider's access to Schedule of Benefits, Member Handbooks, Pharmacy Benefit Information, and Provider Network Information.
 - For the Covered Person, ability to print PHR or PCR, whichever is applicable to ***COMPANY***, to federal compliance standard file formats or plain text file.
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- For the Covered Person, ability to print online membership cards.
- For the Covered Person, access to interactive tools for researching health issues, treatments, and risk assessment tools for health conditions.

L. Performance Guarantees. Performance guarantees will have the appropriate annual penalties listed by each guarantee as stated herein. 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.

M. ADDITIONAL GOVGUAM CLAUSE

a. Monthly Billing Statements

COMPANY shall provide detailed monthly billing invoices to DOA and each autonomous agency. The billing shall include the following:

- 1) Listing of all subscribers (active employees, retirees and survivors) and dependents, by plan and class enrolled through the agency with payroll beginning effective and end dates indicated.
- 2) TPA fees due for each employee and dependents.
- 3) Any changes received until the end of the billing cycle provided. ***COMPANY*** must identify in the detailed information of any changes for easier reference for the departments.
- 4) Departments must report any changes to personnel, work status, coverage changes, to departments by the close of the effective pay period ending or immediately after.

COMPANY must receive a written confirmation from DOA and the autonomous agencies that they have certified the accuracy of the information in the detailed billing statements with the monthly payment. Any changes or discrepancies must be provided to the ***COMPANY*** with the monthly payment. ***COMPANY*** agrees to make changes and adjust payments as reported by DOA and the autonomous agencies.

b. Quarterly Billing Statements

COMPANY shall provide a Quarterly Statement of Accounts by subscriber for each autonomous agency and DOA for all line agencies no later than 31 days after end of the quarter. The Quarterly Statement of Accounts will not reflect any Third Party Administrator (TPA) fees or self funded amounts for carriers that are not contracted as the TPA.

GovGuam autonomous agencies and DOA shall confirm the accuracy and provide any changes or discrepancies no later than 31 days of receipt of the Quarterly Statement of Accounts.

c. Monthly Enrollment Extract

TPA shall provide DOA with a master extract of all GovGuam members on a monthly basis by the 15th of each month. TPA shall provide autonomous agencies monthly enrollment data for their respective agency. The extract shall include the following:

- i. Listing of all subscribers and dependent/s
 - 1. Subscriber Status: (active employee, retirees and survivors)
 - a. If retiree or survivor, identify Define Benefit (DB) or Define Contribution (DC)
 - 2. Dependent information listing relationship to subscriber
- ii. Subscriber department/agency
- iii. Plan and class enrolled
 - 1. Payroll beginning effective and end dates indicated.
- iv. Method of enrollment: Online or hardcopy
- v. Any changes received until the end of the billing cycle provided. ***COMPANY*** must identify in the detailed information of any changes for easier reference for the departments.

Departments must report any changes to personnel, work status, coverage changes, to departments by the close of the effective pay period ending or immediately after.

ARTICLE 8

GovGuam's Responsibilities

- A. 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 applicable Plan to GovGuam employees.
 - B. 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.
 - C. Personnel Changes.** GovGuam and autonomous agencies shall provide written notice to ***COMPANY*** of terminations, resignations, department transfers, and employees on leave status that would affect coverage or TPA fees. ***COMPANY*** shall ensure that coverage and rate changes or terminations are implemented at the appropriate time. GovGuam and autonomous shall make available to ***COMPANY*** a computer listing of each employee receiving an applicable payroll deduction for TPA fees no later than fifteen (15) working days following each pay period.
 - D. Individual with Questionable Status.** If GovGuam does not provide the list of employees as required in 8C, ***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 TPA fee 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.
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- E. Changes.** DPHSS CPS shall provide written notice to ***COMPANY*** and the Department of Administration of the terminations of the legal custody of the Child Protective Services Division of the Department of Public Health and Social Services of a foster child, and the like, in order for coverage to be terminated at the appropriate time.
- F. Certification of Recipients of Foster Child Program.** DPHSS CPS certifies that all Applicants under the Health Plan are bona fide recipients of the Foster Child Program and that Child Protective Services of the Department of Public Health and Social Services has been granted proper Legal Custody of all Applicants / Recipient. DPHSS CPS certifies that all Applicants under the Health Plan are bona fide recipients of the Foster Child Program and that Child Protective Services of the Department of Public Health and Social Services has been granted proper Legal Custody of all Applicants / Recipient
- G. No restrictions or guarantees on Enrollment.** GovGuam shall place no restriction or limitation on the percentage or number of Enrollments in the Plan. GovGuam shall not make any guarantees for a minimum number or minimum percentage of Enrollments in the Plan.
- H. TPA fee Collection fee and Remittance Arrangements.** The GovGuam DOA shall collect TPA fees from all participating line agency employees. ***COMPANY*** will not be responsible for billing individual participants. The DOA will remit the TPA fees to ***COMPANY*** for all line agencies on a biweekly basis for employees and a semi-monthly basis for retirees and survivors. Government of Guam line agencies, as well as, those agencies whom the DOA administers payroll, shall be responsible for payment and administration of their respective employee work groups and are to be held accountable for any balances due and must resolve any and all discrepancies directly with the TPA. ***COMPANY*** shall work directly with the respective agency to resolve any discrepancies.

Autonomous agencies are to be held accountable for any balances due and must resolve any and all discrepancies directly with the TPA. ***COMPANY*** shall work directly with the respective agency to resolve any discrepancies.

ARTICLE 9

Covered Person's Responsibilities

- A. Acceptance.** By Enrolling in the Plan, all Covered Persons agree to the terms, provisions and conditions of this Agreement.
- B. Dual Coverage Prohibited.** Covered Persons shall not enroll for the purposes of receiving dual coverage. Covered Persons shall only be covered once and shall not submit additional claims in order to increase coverage. Exceptions to this prohibition may be waived as a result of a court order or settlement agreement.
- C. 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 dental 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.
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- D. Verification of residency.** ***COMPANY*** shall notify GovGuam when there is change in the mailing or residential address of a Covered Person that is located outside of the Service Area. ***COMPANY*** shall request a verification (such as a utility bill, real property tax, or individual tax return) from the Covered Person confirming continued domicile in the Service Area. ***COMPANY*** may terminate coverage if Covered Person fails to provide verification within thirty (30) days of the request and shall notify GovGuam of any pending or current terminations.

ARTICLE 10

Notices

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

To: ***COMPANY ADDRESS***	To: Government of Guam Director Department of Administration 590 S. Marine Corps Dr. Suite 224 Tamuning, Guam 96913
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- B. Method of Service.** Notices shall be in writing and effective upon either receipt of a hand-delivered notice or the posting of notice by first class mail, postage prepaid, to the address listed herein or such other address as a party may designate by providing written notice to the other party from time to time.

ARTICLE 11

Dispute Resolution

Mandatory Disputes Resolution Clause (As amended but consistent with 2 GAR Div. 4 § 9103(g) and applicable law). GovGuam and ***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, ***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 ***COMPANY*** may proceed as though GovGuam had issued a decision adverse to ***COMPANY***.

GovGuam shall immediately furnish a copy of the decision to ***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 ***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, ***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 (60) days of GovGuam's decision or from the date the decision should have been made. ***COMPANY*** shall exhaust all administrative remedies before filing an action in the Superior Court of Guam in accordance with

applicable laws. ***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 ***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 ***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

- A. 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 ***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 TPA fees 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.
 - B. 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.
 - C. 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.
 - D. 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.
 - E. 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.
 - F. 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.
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- G. 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.
- H. Entire Agreement.** This Agreement, including its Attachments, Exhibits and Schedules, and all Contract Documents, constitutes the entire agreement between the Parties and supersedes all prior written or oral understandings. No agreement, oral or written, expressed or implied, has been made by any Party hereto, except as expressly provided herein. All prior agreements and negotiations are superseded hereby. This Agreement and the Contract Documents contain all of the covenants and agreements between the Parties with respect to the subject matter of this contract. By executing this Agreement, ***COMPANY*** and GovGuam each acknowledge that no representations, inducements, promises or agreement, orally or otherwise, have been made by any Party, or anyone acting on behalf of any Party, which are not embodied herein, and that any other agreement, statement, or promise which is not contained in the Agreement shall not be valid or binding on the Parties with respect to the subject matter of this contract.
- I. Amendment.** This Agreement may only be amended upon the written consent of both parties.
- J. Time of Essence.** Time is expressly made of the essence in this Agreement and for performance hereunder.
- K. 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.
- L. 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.
- M. 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.
- N. 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.
- O. Counterparts.** This Agreement, including the Certificate and Exhibits, may be executed by the parties in several counterparts, each of which shall be deemed to be an original copy.
- P. 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, Guam law shall govern.
- Q. 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
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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.

- R. Restriction Against Contractor Employing Sex Offenders to Work at Government of Guam Venues.** ***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 ***COMPANY*** on property of the government of Guam other than a public highway. Further, ***COMPANY*** warrants that if any person providing services on behalf of ***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.
- S. Ethical Standards.** With respect to this Agreement and any other contract ***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.
- T. 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 ***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.
- U. Access to Records.** ***COMPANY***, including its subcontractors, if any, shall maintain all books, documents, papers, accounting records and other evidence pertaining to costs incurred and relative to its cost or pricing data, and shall make such materials available at all reasonable times during the contract term and for three (3) years from the date of final payment under this Formal Agreement, for inspection in Guam by GovGuam. Each subcontract by the Contractor pursuant to this Agreement shall include a provision containing the conditions of this Section.
- V. Right to Audit.** ***COMPANY*** shall establish and maintain a reasonable accounting system that enables GovGuam to readily identify ***COMPANY***'s assets, expenses, costs of goods, and use of funds. GovGuam and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this Agreement kept by or under the control of ***COMPANY***, including, but not limited to those kept by ***COMPANY***, its employees, agents, assigns, successors, and subcontractors.
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W. Right to Enter and Inspect. GovGuam, may, with 15 days notice, enter and inspect a Contractor's or subcontractor's facilities, place(s) of business, or any place(s) of performance of this Agreement, and may conduct any testing deemed necessary to determine the Contractor's or subcontractor's compliance or conformity to the solicitation or contract requirements. GovGuam may enter and audit the cost or pricing data, books, and records of the Contractor or any subcontractor, and/or investigate in connection with an action to debar or suspend a person from consideration for award of contracts pursuant to §9102 (Authority to Debar or Suspend) of the Guam Procurement Rules and Regulations.

Article 14 Transmission of Data in Digital Form

If the parties intend to transmit any information or documentation in digital form, they shall establish necessary protocols governing such transmissions, unless otherwise already provided in this Agreement

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, GovGuam and ***COMPANY*** hereto have caused this Agreement to be executed, as of the dates undermentioned.

*****COMPANY*****

GOVERNEMENT OF GUAM

By: _____

By: _____
Edward M. Birn, Director
Department of Administration

Date: _____

Date: _____

By: _____
Michelle Santos, Insurance Commissioner
Department of Revenue & Taxation

Effective Date

Date: _____

Research

By: _____
Lester Carlson, Director
Bureau of Budget and Management

October 1, 2025

Date: _____

Approved as to Legality and Form:

By: _____
Douglas B. Moylan
Attorney General

Date: _____

By: _____
Lourdes Leon Guerrero
Governor of Guam

Date: _____

EXHIBIT A

PERFORMANCE STANDARDS/CRITERIA

Commencement and Termination of Performance Guarantees

The Performance Guarantee set forth will commence as of sixty (60) days following GovGuam's effective date of coverage and after receiving all required documentation including a fully executed Administrative Services Agreement and Addendum.

The termination of the Performance Guarantee shall occur on the first day of the month after a thirty (30) day notice by either party.

Claims Savings Guarantee

COMPANY shall submit a monthly claims savings report by the fifteenth day of the following month for the month prior and reporting its claims savings by categories such as Ineligible Charges and Plan Limitations. The categories shall include filing requirements; non-covered benefits; terminated members; claims editing; 90-day claims submittal denials; and non-dental necessity denials etc.

Claims Turnaround Time

The Claims Turnaround Time measures the time elapsed from the date all information necessary to process a claim is received to the date the claim is processed.

The following claims turnaround timeframe shall be followed:

80% adjudication of clean claims in 14 business days from the date received by
COMPANY

100% of adjudication of clean claims in 30 business days from the date received by
COMPANY

With the exception of electronic claims as defined and governed by HIPAA, 80% of all clean claims must be processed by ***COMPANY*** within 14 business days and the remaining 20% of claims must be processed as soon as possible but no later than 30 days from receipt of initial proof of loss.

Procedural Accuracy

Procedural Accuracy is defined as the number of audited claims processed correctly. ***COMPANY*** agrees to maintain a claim procedural accuracy standard of 95% or better based on ***COMPANY***'s random audit of 2% of paid claims.

Financial Accuracy

Financial Accuracy is defined as the total amount of claims dollars paid correctly divided by the

total dollars paid (expressed as a percentage). ***COMPANY*** agrees to maintain a claim financial accuracy standard as follows:

99.0% Financial Accuracy. Financial Accuracy statistics will be established by an outside auditing firm that is not affiliated with ***COMPANY*** nor retained on a contingency fee basis at GovGuam's sole expense.

Benefit Plan

The benefit plan including enrollment processing will be accurately implemented and processed by ***COMPANY*** within five (5) to seven (7) calendar days of receiving all completed documents and information from GovGuam, provided no systems programming is required. If programming is required, ***COMPANY*** will complete programming within the timeframes mutually agreed upon by the parties.

Management Reports

COMPANY will allow GovGuam to produce required weekly, monthly or annual management and accounting reports from the WLT system. Otherwise, ***COMPANY*** will produce standard management reports within ten (10) calendar days after the close of the reporting period and transmit required reports to GovGuam.

Eligibility and Member Identification Cards

Member Identification Cards must be generated and issued to members within ten (10) business days of the receipt of enrollment file. Therefore, ***COMPANY*** must process enrollment and benefit information within 1 business day of receiving complete eligibility and benefit information from GovGuam.

Performance Penalties for Commercial Block of Business

COMPANY agrees to place one month (1/12 of annual) Administrative fee (described in addendum) at risk (the "At Risk Amount") should the Performance Guarantees for the measurement period not be met. ***COMPANY*** will pay the following amounts if the performance falls below the established standards as calculated on an annual average during the plan year:

- | | |
|-------------------------------|--------------------------|
| • Claims Turnaround Time: | 5% of the At Risk Amount |
| • Procedural Accuracy: | 5% of the At Risk Amount |
| • Financial Accuracy: | 5% of the At Risk Amount |
| • Management Reports: | 2% of the At Risk Amount |
| • Benefit Plan Information: | 2% of the At Risk Amount |
| • Enrollment and Eligibility: | 2% of the At Risk Amount |

Notwithstanding anything herein to the contrary, ***COMPANY*** shall only be liable to GovGuam for any performance guarantee penalties once for not meeting an applicable performance guarantee standard and shall not be liable to pay double penalties; for example, if

COMPANY fails to achieve a performance guarantee with respect to GovGuam, it shall pay the applicable penalty once to GovGuam, but shall not have to pay the penalty twice.

SAMPLE

GOVERNMENT OF GUAM

And

*****COMPANY*****

GROUP DENTAL SELF INSURED AGREEMENT

October 1, 2025- September 30, 2026

Preamble

This Dental Agreement is made and entered between ***COMPANY*** ("***COMPANY***") as the Third Party Administrators (TPA) and THE GOVERNMENT OF GUAM ("GovGuam") and together the "Parties." The effective date of this agreement is October 1, 2025("Effective Date") through September 30, 2026.

GovGuam has established a self-funded employee benefits plan, described in Exhibit 1 (Dental Service Schedule), (the "Plan(s)"), for certain covered persons, as defined in the Plan(s) (the "Plan Participants").

GovGuam wants to make available to Plan Participants one or more products and administrative services ("Services") offered by ***COMPANY***, as specified in the attached schedules, and ***COMPANY*** wants to provide those Services to GovGuam for the compensation described herein in Exhibit 2 (Service and Fee Schedule).

This Agreement supersedes any and all prior agreements, either oral or in writing, if any, between the Parties hereto with respect to the retainer of ***COMPANY*** by GovGuam and contains all of the covenants and agreements between the parties with respect to the subject matter of this Agreement. Each party to this Agreement acknowledges that no representation, inducements, promises or agreements, orally or otherwise, have been made by any party, or anyone acting on behalf of any party, which is not embodied herein, and that any other agreement, statement, or promise not contained in this Agreement shall not be valid or binding on the Parties with respect to the subject matter of this Agreement. This Agreement, and any modification hereto, is not binding until approved by the Attorney General of Guam and executed by the Governor of Guam. Any modification of this Agreement will be effective only if it is in writing, approved by the Attorney General of Guam and executed by the Governor of Guam.

The parties therefore agree as follows:

1. TERM

The term of this Agreement will be one year beginning on October 1, 2025 ending on September 30, 2026. The term shall be considered an "Agreement Period".

2. STANDARD OF CARE

COMPANY and GovGuam will discharge their obligations under this Agreement with that level of reasonable care which a similarly situated services provider or plan

administrator, respectively, would exercise under similar circumstances. If GovGuam delegates claim fiduciary duties to ***COMPANY*** pursuant to the applicable schedule, ***COMPANY*** shall observe the standard of care and diligence required of a fiduciary under ERISA Section 404(a)(1)(B).

3. **BENEFIT FUNDING**

GovGuam shall choose one of the banking facilities offered by ***COMPANY*** through which Plan benefit payments, Service Fees and Plan benefit related charges will be made. All such amounts will be paid through the banking facility by check, electronic funds transfer or other reasonable transfer methods. GovGuam shall reimburse the banking facility for all such payments on the day of the request. All such reimbursements will be made by wire transfer in federal funds using the instructions provided by, or by another transfer method agreed upon by both parties.

Since funding is provided on a checks issued basis, GovGuam and ***COMPANY*** agree that outstanding payments to providers (e.g., uncashed checks or checks not presented for payment) will be handled in the manner indicated and agreed upon.

In the event that ***COMPANY*** has exercised its right to suspend claim payments or terminate this Agreement as stated in section 17(8) (Termination), ***COMPANY*** may place a stop payment order on all of GovGuam's outstanding benefit checks.

4. **FIDUCIARY DUTY**

It is understood and agreed that GovGuam, as plan administrator, retains complete authority and responsibility for the Plan, its operation, and the benefits provided there under, and that ***COMPANY*** in collaboration with GovGuam to determine eligibility of persons to participate in the Plan.

Claim fiduciary responsibility is identified in the applicable Schedule.

5. **GovGuam's RESPONSIBILITIES**

(A) Plan Document Review - GovGuam shall provide ***COMPANY*** with all Plan documents at least 30 days prior to the Effective Date. ***COMPANY*** will review the Plan documents to determine any potential differences that may exist among such Plan documents and ***COMPANY***'s claim processing systems and internal policies and procedures. ***COMPANY*** will assist in reviewing GovGuam's Summary of Benefits and Coverage ("SBC"), Summary Plan Description (SPD) or other Plan documents for compliance with applicable law. GovGuam also agrees that it is responsible for satisfying any and all Plan reporting and disclosure requirements imposed by law, including updating the SBC or SPD and other Plan documents and issuing any necessary summaries of material modifications to reflect any changes in benefits.

(B) Notice of Plan or Benefit Change - GovGuam shall notify ***COMPANY*** in writing of any changes in Plan documents or Plan benefits (including changes in eligibility requirements) at least 30 days prior to the effective date of such changes. ***COMPANY*** will have 30 days following receipt of such notice to inform GovGuam whether

COMPANY will agree to administer the proposed changes. If the proposed changes increase ***COMPANY***'s costs, alter ***COMPANY***'s ability to meet any performance standards or otherwise impose substantial operational challenges, ***COMPANY*** may require an adjustment to the Service Fees or other financial terms.

(C) Employee Notices - GovGuam shall furnish each Employee covered by the Plan written notice that GovGuam has complete financial liability for the payment of Plan benefits. GovGuam shall inform its Plan Participants, in a manner that satisfies applicable law, that confidential information relating to their benefit claims may be disclosed to third parties in connection with plan administration.

(D) Third Party Consents - GovGuam shall obtain any consents, authorizations or other permissions from Employees or relevant third parties, which may be required under law or otherwise necessary in order for ***COMPANY*** to access, use or disclose information and data for the purposes of providing Services under this Agreement.

(E) Miscellaneous - GovGuam shall promptly provide ***COMPANY*** with such information regarding administration of the Plan as required by ***COMPANY*** to perform its obligations and as ***COMPANY*** may otherwise reasonably request from time to time. Such information shall include, at no cost to ***COMPANY***, all relevant medical records, lab and pharmacy data, claim and other information pertaining to Plan Participants and/or Employees. ***COMPANY*** is entitled to rely on the information most recently supplied by GovGuam in connection with the Services and ***COMPANY***'s other obligations under the Agreement. ***COMPANY*** is not responsible for any delay or error caused by GovGuam's failure to furnish correct information in a timely manner. ***COMPANY*** is not responsible for responding to Plan Participant requests for copies of Plan documents. GovGuam shall be liable for all Plan benefit payments made by ***COMPANY***, including those payments made following the termination date or which are outstanding on the termination date.

6. RECORDS

COMPANY, its affiliates and authorized agents shall use all Plan-related documents, records and reports received or created by ***COMPANY*** in the course of delivering the Services ("Plan Records") in compliance with applicable privacy laws and regulations. ***COMPANY*** shall de-identify Plan Records and use them for quality improvement, statistical analyses, product development and other lawful, non-Plan related purposes. Such Plan Records will be kept by ***COMPANY*** for a minimum of seven years, unless ***COMPANY*** turns such documentation over to GovGuam or a designee of GovGuam.

7. CONFIDENTIALITY

(A) Business Confidential Information - Neither party may use "Business Confidential Information" (as defined below) of the other party for its own purpose, nor disclose any Business Confidential Information to any third party. However, a party may disclose Business Confidential Information to that party's representatives who have a need to know such information in relation to the administration of the Plan, but only if such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them. GovGuam shall not disclose ***COMPANY***'s provider discount or

payment information to any third party, including GovGuam's representatives, without ***COMPANY***'s prior written consent and until each recipient has executed a confidentiality agreement reasonably satisfactory to ***COMPANY***.

The term "**Business Confidential Information**" as it relates to GovGuam means GovGuam identifiable business proprietary data, procedures, materials, lists and systems, but does not include Protected Health Information ("PHI") as defined by HIPAA or other claims-related information.

The term "**Business Confidential Information**" as it relates to ***COMPANY*** means the ***COMPANY*** identifiable business proprietary data, rates, fees, provider discount or payment information, procedures, materials, lists and systems.

(B) Plan Participant Information - Each party will maintain the confidentiality of Plan Participant-identifiable information, in accordance with applicable law and, as appropriate, the terms of the HIPAA business associate agreement associated with this Agreement. GovGuam may identify, in writing, certain GovGuam employees or third parties, who the Plan has authorized to receive Plan Participant-identifiable information from ***COMPANY*** in connection with Plan administration. Subject to more restrictive state and federal law, ***COMPANY*** will disclose Plan Participant-identifiable information to GovGuam designated employees or third parties. In the case of a third party, ***COMPANY*** may require execution by the third party of a non-disclosure agreement reasonably acceptable to ***COMPANY***. GovGuam agrees that it will only request disclosure of PHI to a third party or to designated employees if: (i) it has amended its Plan documents, in accordance with 45 CFR 164.314(b) and 164.504(f)(2), so as to allow GovGuam designated employees or third parties to receive PHI, has certified such to the Plan in accordance with 45 CFR 164.504(f)(2)(ii), and will provide a copy of such certification to ***COMPANY*** upon request; and (ii) the Plan has determined, through its own policies and procedures and in compliance with HIPAA, that the PHI that it requests from ***COMPANY*** is the minimum information necessary for the purpose for which it was requested.

(C) Upon Termination - Upon termination of the Agreement, each party, upon the request of the other, will return or destroy all copies of all of the other's Business Confidential Information in its possession or control except to the extent such Business Confidential Information must be retained pursuant to applicable law or cannot be disaggregated from ***COMPANY***'s databases. ***COMPANY*** may retain copies of any such Business Confidential Information it deems necessary for the defense of litigation concerning the Services it provided under this Agreement, for use in the processing of runoff claims for Plan benefits, and for regulatory purposes.

8. AUDIT RIGHTS

GovGuam may, at its own expense, audit Plan claim transactions upon reasonable notice to ***COMPANY***. GovGuam may conduct one audit per year and the audit must be completed within two years of the end of the time period being audited. Audits of any performance guarantees, if applicable, must be completed in the year following the period to which the performance guarantee results apply. Audits must be performed at the location where GovGuam's claims are processed.

GovGuam may select its own representative to conduct an audit, provided that the representative must be qualified by appropriate training and experience for such work and must perform the audit in accordance with published administrative safeguards or procedures and applicable law. In addition, the representative must not be subject to an Auditor Conflict of Interest which would prevent the representative from performing an independent audit. An "Auditor Conflict of Interest" means any situation in which the designated representative (i) is employed by an entity which is a competitor of ***COMPANY***, (ii) has terminated from ***COMPANY*** or any of its affiliates within the past 12 months, or (iii) is affiliated with a vendor subcontracted by ***COMPANY*** to adjudicate claims. If the audit firm is not licensed or a member of a national professional group, or if the audit firm has a financial interest in audit findings or results, the audit agent must agree to meet ***COMPANY***'s standards for professionalism by signing ***COMPANY***'s Agent Code of Conduct prior to performing the audit. Neither GovGuam nor its representative may make or retain any record of provider negotiated rates or information concerning treatment of drug or alcohol abuse, mental/nervous, HIV/AIDS or genetic markers.

GovGuam or its representative shall provide ***COMPANY*** with a complete listing of the claims chosen for audit at least four weeks prior to the on-site portion of the audit.

GovGuam's auditors shall provide their draft audit findings to ***COMPANY***, prior to issuing the final report. This draft will provide the basis for discussions between ***COMPANY*** and the auditors to resolve and finalize any open issues. ***COMPANY*** shall have a right to review the auditor's final Audit Report, and include a supplementary statement containing information and material that ***COMPANY*** considers pertinent to the audit.

Additional guidelines related to the scope of the audit are included in the applicable schedules.

9. RECOVERY OF OVERPAYMENTS

COMPANY shall reprocess any identified errors in Plan benefit payments (other than errors ***COMPANY*** reasonably determines to be *de minimis*) and seek to recover any resulting overpayment by attempting to contact the party receiving the overpayment twice by letter, phone, or email. GovGuam may direct ***COMPANY*** not to seek recovery of overpayments from Plan Participants, in which event ***COMPANY*** will have no further responsibility with respect to those overpayments. GovGuam shall reasonably cooperate with ***COMPANY*** in recovering all overpayments of Plan benefits.

If ***COMPANY*** elects to use a third-party recovery vendor, collection agency, or attorney to pursue the recovery, the overpayment recoveries will be credited to GovGuam net of fees charged by ***COMPANY*** or those entities.

Any requested payment from ***COMPANY*** relating to an overpayment must be based upon documented findings or direct proof of specific claims, agreed to by both parties, and must be due to ***COMPANY***'s actions or inactions. Indirect or inferential methods of proof - such as statistical sampling, extrapolation of error rate to the population, etc., may not be used to determine overpayments. In addition, use of software or other review processes that analyze a claim in a manner different from the claim determination and payment procedures and standards used by ***COMPANY*** shall not be used to determine overpayments.

When seeking recovery of overpayments from a provider, ***COMPANY*** has established the following process: if it is unable to recover the overpayment through other means, ***COMPANY***

may offset one or more future payments to that provider for services rendered to Plan Participants by an amount equal to the prior overpayment. ***COMPANY*** may reduce future payments to the provider (including payments made to that provider involving the same or other health and welfare plans that are administered by ***COMPANY***) by the amount of the overpayment, and ***COMPANY*** will credit the recovered amount to the plan that overpaid the provider. By entering into this Agreement, GovGuam is agreeing that its right to recover overpayments shall be governed by this process and that it has no right to recover any specific overpayment unless otherwise provided for in this Agreement.

GovGuam may not seek recovery of overpayments from network providers, but GovGuam may seek recovery of overpayments from other third parties once GovGuam has provided ***COMPANY*** notice that it will seek such recovery and ***COMPANY*** has been afforded a reasonable opportunity to recover such amounts. ***COMPANY*** has no duty to initiate litigation to pursue any overpayment recovery. GovGuam agrees to comply with all of the applicable terms of ***COMPANY***'s network provider contracts.

10. INDEMNIFICATION

COMPANY shall indemnify GovGuam, its affiliates and their respective directors, officers, and employees (only as employees, not as Plan Participants) for that portion of any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees) ("Losses") caused directly by (i) any material breach of this Agreement by ***COMPANY***, including a failure to comply with the standard of care in section 3; (ii) ***COMPANY***'s negligence, willful misconduct, fraud, or breach of fiduciary responsibility; or (iii) ***COMPANY***'s infringement of any U.S. intellectual property right of a third party, arising out of the Services provided under this Agreement.

(A) The party seeking indemnification under this Agreement must notify the indemnifying party within 20 days in writing of any actual or threatened action, to which it claims such indemnification applies. Failure to so notify the indemnifying party will not be deemed a waiver of the right to seek indemnification, unless the actions of the indemnifying party have been prejudiced by the failure of the other party to provide notice as indicated above. The indemnifying party may join the party seeking indemnification as a party to such proceeding; however, the indemnifying party shall provide and control the defense and settlement with respect to claims to which this section applies.

(B) GovGuam and ***COMPANY*** agree that: (i) health care providers are not the agents or employees of GovGuam or ***COMPANY*** and neither party renders dental services or treatments to Plan Participants; (ii) health care providers are solely responsible for the health care they deliver to Plan Participants, and neither GovGuam nor ***COMPANY*** is responsible for the health care that is delivered by health care providers; and (iii) the indemnification obligations of (A) or (B) above do not apply to any portion of any loss relating to the acts or omissions of health care providers with respect to Plan Participants.

(C) These indemnification obligations above shall not apply to any claims caused by (i) an act, or failure to act, by one party at the direction of the other, or (ii) with respect to intellectual property infringement, GovGuam's modification or use of the Services or materials that are not contemplated by this Agreement, unless directed by ***COMPANY***, including the combination of such Services or materials with services, materials or processes not provided by ***COMPANY*** where the combination is the basis for the claim of infringement. For purposes of the exclusions in this paragraph, the term "GovGuam"

includes any person or entity acting on GovGuam's behalf or at GovGuam's direction. For purposes of (A) and (B) above, the standard of care to be applied in determining whether either party is "negligent" in performing any duties or obligations under this Agreement shall be the standard of care set forth in section 3.

11. DEFENSE OF CLAIM LITIGATION

In the event of a legal, administrative or other action arising out of the administration, processing or determination of a claim for Plan benefits, the party designated in this document as the fiduciary which rendered the decision in the appeal last exercised by the Plan Participant which is being appealed to the court ("appropriate named fiduciary") shall undertake the defense of such action at its expense and settle such action when in its reasonable judgment it appears expedient to do so. If the other party is also named as a party to such action, the appropriate named fiduciary will defend the other party PROVIDED the action relates solely and directly to actions or failure to act by the appropriate named fiduciary and there is no conflict of interest between the parties. GovGuam agrees to pay the amount of Plan benefits included in any judgment or settlement in such action. The other party shall not be liable for any other part of such judgment or settlement, including but not limited to legal expenses and punitive damages, except to the extent provided in section 12 (Indemnification).

Notwithstanding anything to the contrary in this section 13, in any multi-claim litigation disputing reimbursement for benefits for more than one Plan Sponsor, GovGuam authorizes ***COMPANY*** to defend and reasonably settle GovGuam's benefit claims in such litigation.

12. REMEDIES and DISPUTE RESOLUTION

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.

13. COMPLIANCE WITH LAWS

COMPANY shall comply with all applicable federal and state laws including, without limitation, the Patient Protection and Affordable Care Act of 2010 ("PPACA"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Employee Retirement Income Security Act of 1974 ("ERISA"), and all applicable Guam laws.

14. TERMINATION

This Agreement may be terminated by ***COMPANY*** or GovGuam as follows:

(A) Termination by GovGuam - GovGuam may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving ***COMPANY*** at least 90 days' prior written notice of when such termination will become effective.

(B) Termination by *COMPANY*** and Suspension of Claim Payments-**

(1) ***COMPANY*** may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving GovGuam at least ninety (90) days' prior written notice of when such termination will become effective.

(2) If GovGuam fails to fund claim wire requests from ***COMPANY***, or fails to pay Service Fees by the Payment Due Date, ***COMPANY*** has the right to cease paying claims and suspend Services until the requested funds or Service Fees have been provided. ***COMPANY*** may terminate the Agreement immediately upon notice to GovGuam if GovGuam fails to fund claim wire requests or pay the applicable Service Fees in full within (15) fifteen days of written notice by ***COMPANY***.

(C) Legal Prohibition - If Guam enacts a law to prohibit the continuance of the Agreement or some portion thereof, the Agreement or that portion shall terminate automatically as to such jurisdiction on the effective date of such law or interpretation; provided, however, if only a portion of the Agreement is impacted, the Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

(D) Responsibilities on Termination - Upon termination of the Agreement, for any reason other than default of payment by GovGuam, ***COMPANY*** will continue to process runoff claims for Plan benefits that were incurred prior to the termination date, which are received by ***COMPANY*** within 12 months following the termination date. The Service Fee for such activity is included in the Service Fees described in the Service and Fee Schedule(s). Runoff claims will be processed and paid in accordance with the terms of this Agreement. New requests for benefit payments received after the 12-month runoff period will be returned to GovGuam or to a successor administrator at GovGuam's expense. Claims which were pending

or disputed prior to the start of the runoff period will be handled to their conclusion by ***COMPANY***, as well as provider performance or incentive payments paid for prior period performance pay outs, and GovGuam agrees to fund such claims or payments when requested by ***COMPANY***.

GovGuam shall continue to fund Plan benefit payments and agrees to instruct its bank to continue to make funds available until all outstanding Plan benefit payments have been paid or until such time as mutually agreed upon by ***COMPANY*** and GovGuam. GovGuam's wire line and bank account from which funds are requested must remain open for one year after runoff processing ends, or two years after termination.

Upon termination of the Agreement and provided all Service Fees have been paid, ***COMPANY*** will release to GovGuam, or its successor administrator, all claim data in ***COMPANY***'s standard format. within a reasonable time period following the termination date. All costs associated with the release of such data shall be paid by GovGuam.

GENERAL

(A) Relationship of the Parties - The parties to this Agreement are independent contractors. This Agreement is not intended and shall not be interpreted or construed to create an association, agency, joint venture or partnership between the parties or to impose any liability attributable to such a relationship. Each party shall be solely responsible for all wages, taxes, withholding, workers compensation, insurance and any other obligation on behalf of any of its employees.

(B) Intellectual Property- ***COMPANY*** represents that it has either the ownership rights or the right to use all of the intellectual property used by ***COMPANY*** in providing the Services under this Agreement (the "***COMPANY*** IP"). ***COMPANY*** has granted GovGuam a nonexclusive, non-assignable, royalty free, limited right to use certain of the ***COMPANY*** IP for the purposes described in this Agreement. GovGuam agrees not to modify, create derivative product from, copy, duplicate, decompile, disassemble, reverse engineer or otherwise attempt to perceive the source code from which any software component of the ***COMPANY*** IP is compiled or interpreted. Nothing in this Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent or otherwise transfer or convey, the ***COMPANY*** IP to GovGuam.

(C) Communications - ***COMPANY*** and GovGuam may rely upon any communication believed by them to be genuine and to have been signed or presented by the proper party or parties. For a notice or other communication under this Agreement to be valid, it must be in writing and delivered (i) by hand, (ii) by e-mail or (iii) by fax to a representative of each party as mutually agreed upon. Notices or communications may also be sent by U.S. mail to the address below.

To: ***COMPANY ADDRESS***	To: Government of Guam Director Department of Administration 590 S. Marine Corps Dr. Suite 224 Tamuning, Guam 96913
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- (D) Force Majeure** - With the exception of GovGuam's obligation to fund benefit payments and Service Fees, neither party shall be deemed to have breached this Agreement, or be held liable for any failure or delay in the performance of any portion of its obligations under this Agreement, including performance guarantees if applicable, if prevented from doing so by a cause or causes beyond the reasonable control of the party. Such causes include, but are not limited to: acts of God; acts of terrorism; pandemic; fires; wars; floods; storms; earthquakes; riots; labor disputes or shortages; and governmental laws, ordinances, rules, regulations, or the opinions rendered by any court, whether valid or invalid.
- (E) Governing Law** - The Agreement shall be governed by and interpreted in accordance with applicable federal law, including ERISA. To the extent such federal law does not govern, the Agreement shall be governed by Guam law.
- (F) Financial Sanctions** - If Plan benefits or reimbursements provided under this Agreement violate or will violate any economic or trade sanctions, such Plan benefits or reimbursements are immediately considered invalid. ***COMPANY*** cannot make payments for claims or Services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written office of Foreign Assets Control (OFAC) license.
- (G) Waiver** - No delay or failure of either party in exercising any right under this Agreement shall be deemed to constitute a waiver of that right.
- (H) Third Party Beneficiaries** - There are no intended third-party beneficiaries of this Agreement.
- (I) Severability** - If any provision of this Agreement or the application of any such provision to any person or circumstance shall be held invalid, illegal or unenforceable in any respect by a court of competent jurisdiction, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement and all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect.
- (J) Entire Agreement; Order of Priority** - This Agreement, and the accompanying HIPAA business associate agreement, constitutes the entire understanding between the parties with respect to the subject matter of this Agreement, and supersedes all other agreements, whether oral or written, between the Parties.
- (K) Amendment** - No modification or amendment of this Agreement will be effective unless it is in writing and signed by both Parties, except that a change to a party's address of record as set forth in section 18(C) (Communications) may be made without being countersigned by the other party.
- (L) Assignment** - This Agreement may not be assigned by either party without the written approval of the other party. The duties and obligations of the parties will be binding upon, and inure to the benefit of, successors, assigns, or merged or consolidated entities of the parties.
- (M) Survival** - Sections 5, 8 through 13 and 17(0) shall survive termination of the Agreement.
- (N) 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.

- (O) **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.
- (P) **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.
- (Q) **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.
- (R) **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.
- (S) **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.
- (T) **Time of Essence.** Time is expressly made of the essence in this Agreement and for performance hereunder.
- (U) **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.
- (V) **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.
- (W) **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.
- (X) **Counterparts.** This Agreement, including the Certificate and Exhibits, may be executed by the parties in several counterparts, each of which shall be deemed to be an original copy.
- (Y) **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.
- (Z) **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.

- (AA)** Restriction Against Contractor Employing Sex Offenders to Work at Government of Guam Venues. ***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 ***COMPANY*** on property of the government of Guam other than a public highway. Further, ***COMPANY*** warrants that if any person providing services on behalf of ***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.
- (BB)** Ethical Standards. With respect to this Agreement and any other contract ***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.
- (CC)** 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 ***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.
- (DD)** Access to Records. ***COMPANY***, including its subcontractors, if any, shall maintain all books, documents, papers, accounting records and other evidence pertaining to costs incurred and relative to its cost or pricing data, and shall make such materials available at all reasonable times during the contract term and for three (3) years from the date of final payment under this Formal Agreement, for inspection in Guam by GovGuam. Each subcontract by the Contractor pursuant to this Agreement shall include a provision containing the conditions of this Section.

EXHIBIT 1

DENTAL SERVICE SCHEDULE

Subject to the terms and conditions of the Agreement, the Services available from ***COMPANY*** are described below. Unless otherwise agreed in writing, only the Services selected by GovGuam in the Service and Fee Schedule (as modified by ***COMPANY*** from time to time pursuant to section 4 of the Agreement) will be provided by ***COMPANY***. Additional Services may be provided at GovGuam's written request under the terms of the Agreement. This Schedule shall supersede any previous documents describing the Services.

I. CLAIM FIDUCIARY

GovGuam and ***COMPANY*** agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, ***COMPANY*** will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. GovGuam understands that the performance of fiduciary duties under ERISA necessarily involves the exercise of discretion on ***COMPANY***'s part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, GovGuam hereby delegates to ***COMPANY*** discretionary authority to determine entitlement to benefits under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between GovGuam and ***COMPANY***, ***COMPANY***'s decision on any claim is final and that ***COMPANY*** has no other fiduciary responsibility.

II. ADDITIONAL AUDIT GUIDELINES

COMPANY is not responsible for paying GovGuam's audit fees or the costs associated with an audit. ***COMPANY*** will bear its own expenses associated with an audit; provided (i) the on-site portion of the audit is completed within five days, and (ii) the sample size is no more than 250 claims. ***COMPANY*** will notify GovGuam prior to the audit, if an audit request would require an additional payment from GovGuam for any audits in excess of the aforementioned thresholds.

III. DENTAL MANAGEMENT SERVICES:

1. Dental Utilization Management:

The Dental utilization management program provides for appropriate review, by licensed dentists and other dental professionals, of certain dental claims, as well as of voluntary predeterminations, in order to assist in making coverage determinations based on the necessity and appropriateness of services rendered to treat Plan Participants' dental conditions.

2. Dental/Medical Integration (DMI) Program:

The DMI program is designed to educate Plan Participants on the on the impact of good oral health care on the management of certain diseases and conditions. Plan Participants identified with diabetes, coronary artery disease/cerebrovascular disease or who are pregnant, are sent educational materials explaining the correlation between their disease or condition and periodontal disease. The following programs are included

Enhanced Benefit Program for Pregnant Women (offers additional benefits, i.e., an additional cleaning). Enhanced Benefit Program for Diabetes and Coronary Artery Disease (offers additional benefits, i.e., an additional cleaning). Member Outreach Program (educational materials sent to Plan Participants or outreach phone calls made to Plan Participants encouraging the importance of oral care).

IV. TECHNOLOGY/WEB TOOLS

COMPANY's online participating provider directory shall be updated promptly when changes occur within fifteen (15) days,

V. ID CARDS

Dental ID cards are not required to obtain dental services; therefore, ***COMPANY*** does not mail ID cards to Plan Participants. However, Plan Participants can print their card by going to their secure website at .****COMPANY WEBSITE***

Upon GovGuam's request, ***COMPANY*** will include third-party vendor information on Plan Participant identification cards. In such event, GovGuam shall indemnify ***COMPANY***, its affiliates and their respective directors, officers, and employees from that portion of any actual third-party loss (including reasonable attorney's fees) resulting from the inclusion of such third-party vendor information on identification cards.

VI. DENTAL SAVINGS PROGRAMS

1. DENTAL PPO NETWORK PROGRAM (PPO).

PPO dental Providers are considered participating providers in GovGuam's Plan, and Covered Services rendered by such Providers will be paid as in-network services in accordance with the terms of GovGuam's Plan. When available, the Contracted Rates with PPO Providers may result in savings for GovGuam and Plan Participants. ***COMPANY*** contracts with one or more third-party network vendors to access their Contracted Rates with Providers. The Providers have agreed to accept the Contracted Rate and not to balance bill Plan Participants.

2. Terms and Conditions Applicable to Both Programs

A. GovGuam Charges For Provider Payments

For Plan benefits rendered by a Provider for which ***COMPANY*** has accessed a Contracted Rate, GovGuam shall be charged the amount paid to the Provider, less any applicable coinsurance and/or deductible and non-covered charges owed by the Plan Participant under the Plan.

B. Access Fees

- (i) As compensation for the services provided by ***COMPANY*** under either program for Savings achieved, GovGuam shall pay an Access Fee to ***COMPANY*** as described in the Service and Fee Schedule (excluding Savings with respect to claims for which ***COMPANY*** is liable for funding, e.g., claims in excess of an individual or aggregate stop loss point).

- (ii) ***COMPANY*** shall provide a quarterly report of Savings and Access Fees. Access Fees may be included with claims in other reports.

C. Plan Participant Information Regarding the Programs

GovGuam is responsible for informing Plan Participants of the availability of the programs.

D. Definitions

As used in this section VI:

"Access Fee" means the amount to be paid by GovGuam to ***COMPANY*** for access to the Savings provided under the program, as indicated in the Service and Fee Schedule.

Administrative Office Administrative Service Office: Shall be defined as the ***COMPANY*** or an agent appointed by ***COMPANY*** which is directly responsible for administrative procedures and for the processing and payment of Provider claims on behalf of Covered Persons. ***COMPANY*** shall be the Administrative Service Office until otherwise notified in writing by ***COMPANY***.

"Contracted Rate" means the amount the Provider has agreed to accept as payment under the Provider's contract with a third-party network vendor.

"Provider" means those dentists and other dental care providers who have agreed pursuant to a contract with a third-party network vendor to provide Plan benefits at a Contracted Rate under the program.

"Recognized Charge" is defined in GovGuam's Plan. Where a similar term (such as "reasonable charge amount") is used in GovGuam's Plan instead of "recognized charge", it will have the same meaning as Recognized Charge.

"Savings" means: the difference between the average charges for the area as identified in the FAIR Health claims database and the Contracted Rate. For any Plan benefit where the Recognized Charge is lower than the Contracted Rate, the Savings will be zero.

GovGuam acknowledges that:

- i. ***COMPANY*** does not credential, monitor or oversee those Providers who participate through third-party contracts; such providers may not necessarily be available or convenient.
- ii. Information about participating PPO Providers can be found on ***COMPANY***'s provider listing, on our website at ****COMPANY WEBSITE****
- iii. The following claim situations may not be eligible for either program:
 - Claims involving Medicare when ***COMPANY*** is the secondary payer
 - Claims involving coordination of benefits (COB) when ***COMPANY*** is the secondary payer

E. General Provisions

(i) ***COMPANY***'s only liability to GovGuam for any loss of access to a discount arising under or related to either program, regardless of the form of action, shall be limited to the Access Fees actually paid to ***COMPANY*** by GovGuam for services rendered; provided, however, this limitation will not apply to or affect any performance standards set forth in the Agreement.

(ii). The terms and conditions of either program shall remain in effect for any claims incurred prior to the termination date that are administered by ***COMPANY*** after the termination date

SAMPLE

EXHIBIT 2

SERVICE AND FEE SCHEDULE

The Service Fees and Services effective for the period beginning October 1, 2025 and ending September 30, 2026 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

Product	Per Employee Per Month Fee - A person within classes that are specifically described in the Certificates including employees, retirees, and affiliates of GovGuam who are reported, in writing, to ***COMPANY*** for inclusion in the Services Agreement.
Comprehensive Dental	\$ _____ per employee per month
All Payments Made by ***COMPANY*** to Providers rendering covered dental services to eligible Plan members will be paid by GovGuam to ***COMPANY***	

Services	
Dental Utilization Management	Included
	Included
	Included

Late Payment

If GovGuam fails to provide funds on a timely basis to cover benefit payments as provided in the Agreement, and/or fails to pay service fees on a timely basis as provided in such Agreement, ***COMPANY*** will assess a late payment charge in accordance with Article 5 of Chapter 22 of Title 5 of the Guam Code Annotated.

COMPANY reserves the right to collect any incurred late payment charges through the claim wire on a monthly basis provided there is no other special payment arrangements in-force to fund any incurred late payment charges. GovGuam will be notified by ***COMPANY*** in writing to obtain approval prior to billing any late payment charges through claim wire.

The late payment charges described in this section are without limitation to any other rights or remedies available to ***COMPANY*** under the Agreement or at law or in equity for failure to pay.
See Section 4.

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, GovGuam and ***COMPANY*** hereto have caused this Agreement to be executed, as of the dates undermentioned.

COMPANY

GOVERNEMENT OF GUAM

By: _____

By: _____
Edward M. Birn, Director
Department of Administration

Date: _____

Date: _____

By: _____
Michelle Santos, Insurance Commissioner
Department of Revenue & Taxation

Date: _____

Effective Date:

By: _____
Lester Carlson, Director
Bureau of Budget and Management Research

October 1, 2025

Date: _____

Approved as to Legality and Form:

By: _____
Douglas B. Moylan
Attorney General

Date: _____

By: _____
Lourdes Leon Guerrero
Governor of Guam

Date: _____

Preferred Provider Organization (PPO) Dental Plan Booklet
Prepared exclusively for

Employer:	Government of Guam
Contract Number:	Self-Funded Dental
Plan Effective:	October 1, 2025
Plan Issue Date:	October 1, 2025

Third Party Administrative Services provided by
*****COMPANY*****

SAMPLE

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Welcome

Welcome to ****COMPANY**** ! Here are some basics. First things first some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details and this is very important you need to read this entire booklet and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

1. Some notes on how we use words

How we use words

- When we say “you” and “your”, we mean both you and any covered dependents. When we say “us”, “we”, and “our” we mean ****COMPANY**** when we are describing administrative services provided by ****COMPANY**** as Third- Party Administrator.
- Some words appear in **bold** type and we define them in the *Glossary* section.

Sometimes we use technical dental language that is familiar to **dental providers**.

2. What your plan does providing covered benefits

Your plan provides in-network and out-of-network **covered benefits**. These are **eligible dental services** for which your plan has the obligation to pay.

3. How your plan works starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as reaching the age of 27.

4. Service area

Your plan generally pays for **covered services** only within a specific geographic area, called a service area. There are some exceptions, such as for **emergency services** and urgent care.

5. How your plan works while you are covered in-network

Your in-network coverage helps you:

- Get and pay for a lot of but not all dental care services. These are called **eligible dental services**.
- Pay less cost share when you use an **in-network provider**.

Important note:

See the schedule of benefits for any payment percentage, and maximum age or visit limits that may apply.

6. Eligible dental services meet these requirements:

- They are listed in the *Eligible dental services* section in the Schedule of Benefits. They are not carved out in some *Eligible Dental Service Exclusions* section. (We refer to this section as the “Exclusions” section.)
- They are not beyond any limits in the schedule of benefits.

7. **COMPANY**** network Dental Providers**

You can find **in-network providers** and see important information about dental providers on our online **provider directory**. Just log into your secure member website at *****company website*****. You can choose any **dental provider** who is in the dental network.

8. Paying for eligible dental services - general requirements

There are general requirements for the plan to pay any part of the expense for an eligible dental service. They are:

- The **eligible dental service** is **dentally necessary**.
- You get the **eligible dental services** from **in-network** or **out-of-network providers**.

You will find details on **dental necessity** requirements in the *Dental Necessity* section.

9. Paying for eligible dental services - sharing expense

Generally, your plan and you will share the expense of your **eligible dental services** when you meet the general requirements for paying.

10. How your plan works while you are covered out-of-network

The section above tells you how your plan works while you are covered in-network. You also have coverage when you want to get your care from **providers** who are not part of the network.

Your out-of-network coverage:

- Means you can get care from **dental providers** who are not part of the network.
- Means you may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible dental services** that you paid directly to a **dental provider**.
- Means you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Out-of-network providers** and any exclusions in the *Who provides the care* section. Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

Who the Plan Covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

- Government of Guam Employee, Retiree, or Survivor
- Maintain Residency in Guam or the CNMI (for dependents, exceptions to child(ren) up to age 26 who are not living in the service area).
- GovGuam employee working 30 hours or more per week
- For RSP, continuous enrollment in both Medicare Part A and B
- Any Retiree/Survivor who has returned back to Active GovGuam employment
- Foster Children under the legal custody of Child Protective Services Division of the Department of Public Health and Social Services (DPHSS)

1. Residency requirement

For purposes of this requirement, Service Area is defined as Guam and CNMI and Covered Persons excludes covered dependent children. 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. The 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 dental Services 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.

2. When you can join the plan

As an employee you can enroll yourself and your dependents:

- Once each **Plan Year** during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)
You can enroll eligible family members (these are your “dependents”) at this time too.
Within thirty-one (31) days of the date of first becoming eligible

If you do not enroll yourself and your dependents when you first qualify for dental benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan If your plan includes coverage for dependents, you can enroll the following family members on your plan.

Your legal spouse. A copy of official marriage certificate must be submitted.

- Your domestic partner who meets the rules set by the employer and requirements under state law. A notarized affidavit and proof of domestic partner status. Domestic partner who is (1) 18 years of age or older; (2) in an exclusively mutually committed relationship with subscriber and intends to remain the subscriber's sole domestic partner; (3) not married to any other person; (4) has cohabitated with the subscriber for two (2) consecutive years immediately preceding the proposed enrollment.

Your dependent children your own or those of your spouse or domestic partner

- Under age 26 and they include your:
 - Biological children A copy of official certificate listing the subscriber as a parent must be submitted.
 - Stepchildren A copy of an official birth certificate and official marriage certificate listing the subscriber's legal spouse as a parent must be submitted.
 - Legally adopted children, including any children placed with you for adoption . A copy of court document signed by a judge ordering a legal adoption.
 - Disabled children over the age of twenty-six (26) years. A copy of disability enrollment form signed by a licensed physician must be submitted.
 - Legal Guardianship
 - A court having jurisdiction over the parties has issued an order granting the full guardianship of such child to the subscriber.
 - Such child is and remains otherwise eligible. Children under guardianship will only remain eligible until the guardianship terminates but no later than up to age 26.

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

3. Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or Administrative Order

-

—

4. We must receive a completed enrollment form not more than thirty-one (31) days after the event date. Notification of Change in Status

It is important that you notify your Employer of any changes in your benefit status. This will help your Employer effectively maintain your benefit status. Please notify your Employer as soon as possible of status changes such as:

- Change of address or phone number
- Change of work status (i.e. change in work hours, leave without pay, military leave, etc.)
- Change in marital status
- Change of covered dependent status (i.e. overage dependent, enrollment forms reflecting any class change would need to be submitted (Ex: Class 3 to Class 1)
- A covered dependent who enrolls in any other group dental plan

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
 - You were covered by another group dental plan, and now that other coverage has ended.
 - You had COBRA, and now that coverage has ended.
- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- When a court orders that you cover a dependent on your dental plan.

Your Employer or the party they designate must receive your completed enrollment information from you within thirty-one (31) days of that date on which you no longer have the other coverage mentioned above.

Starting Coverage

Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your policyholder to confirm your effective date.

Stopping Coverage

Your coverage typically ends when you leave your job; but it can happen for other reasons. We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- The policyholder asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply

- We end your coverage
- You start coverage under another dental plan offered by your employer
- You have reached your overall maximum benefit under your plan

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making premium contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
- Exhaustion of your overall maximum benefit.

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on you for support.

The right to coverage will continue only as long as a physician certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once per contract year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

You must keep us informed of any changes. See also when coverage ends.

Eligible Dental Services

1. Dental necessity requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible dental services**. See the *Eligible dental services* and *Exclusions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible dental services** only if the **eligible dental service** is **dentally necessary**.

This section addresses the **dental necessity** requirements.

2. Dentally Necessary / Dental Necessity

As we said in the *Let's get started!* section, **dental necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **dental necessity** requirements are in the *Glossary* section, where we define "**dentally necessary, dental necessity**"

3. What are your eligible dental services?

The information in this section is the first step to understanding your plan's **eligible dental services**.

Your plan covers many kinds of dental care services and supplies. Your **eligible dental services** are listed in the schedule of benefits. There you will find the detailed list of **eligible dental services**. But sometimes those services are not covered at all or are covered only up to a limit.

You can find out about exclusions in the *Exclusions* and the *What rules and limits apply to dental care* sections, and about the limitations in the schedule of benefits.

4. Dental emergency

Eligible dental services include dental services provided for a **dental emergency**. The care provided must be a **covered benefit**.

If you have a **dental emergency**, you should consider calling your dental **in-network provider** who may be more familiar with your dental needs. However, you can get treatment from any **dentist** including one that is an **out-of-network provider**. If you need help in finding a **dentist**, call Member Services.

If you get treatment from an **out-of-network provider** for a **dental emergency**, the plan pays a benefit at the in-network cost-sharing level of coverage.

For follow-up care to treat dental emergencies, you should consider using your **in-network dental provider** so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of **provider** that gives you the care.

5. What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

6. Alternate treatment rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service or supply and an **eligible dental service** that would provide an acceptable result, then your plan will pay a benefit for the **eligible dental service** or supply.

If a charge is made for an **eligible dental service** but another **eligible dental service** that would provide an acceptable result is less expensive, the benefit will be for the least expensive **eligible dental service**.

The benefit will be based on the **in-network provider negotiated charge** for the **eligible dental service** or, in the case of an **out-of-network provider**, on the **recognized charge**.

You should review the differences in the cost of alternate treatment with your **dental provider**. Of course, you and your **dental provider** can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

7. Coverage for dental work begun before you are covered by the plan

Your plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

8. Reimbursement policies

We have the right to apply reimbursement policies. Those policies may reduce the **negotiated charge** or **recognized charge**. These policies take into account factors such

- as: The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider reimbursement policies are based on our review of:

The Centers for Medicare and (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate Generally accepted standards of dental practice and the views of **providers** and **dentists** practicing in the relevant clinical areas We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

9. Replacement rule

Some **eligible dental services** are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns Inlays
- Onlays
- Implants
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures(bridges)
- Other prosthetic services

These **eligible dental services** are covered only when you give us proof that: While you

- were covered by the plan:
 - You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge. The present item cannot be made serviceable, and is:
- made serviceable, and is:
 - A crown installed at least 5 years before its replacement.
 - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 5 years before its replacement.
- While you were covered by the plan: You had a tooth (or teeth) extracted.
 - Your present denture is an immediate temporary one that replaces that tooth (or teeth).
 - A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

10. Tooth missing but not replaced rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

11. An advance claim review

When to get an advance claim review, what is a course of dental treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

What Your Plan Doesn't Cover

We informed you about the many dental care services and supplies that are eligible for coverage under your plan. In that section we also told you that some dental care services and supplies have exclusions and some are not covered at all (exclusions).

In this section we tell you about the exclusions that apply to your plan and just a reminder, you'll find benefits and coverage limitations in the schedule of benefits.

Exclusions

The following are not **eligible dental services** under your plan except as described in: The

- *Eligible dental services under your plan* section of this booklet or
- A rider or amendment issued to you for use with this booklet:

1. Charges for services or supplies

- Provided by **in-network providers** in excess of the **negotiated charge**
- Provided by an **out-of-network provider** in excess of the **recognized charge**
- Provided for your personal comfort or convenience, or the convenience of any other person, including a **dental provider**
- Provided in connection with treatment or care that is not covered under the plan
- Cancelled or missed appointment charges or charges to complete claim forms
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage, including:
 - Care in charitable institutions
 - Care for conditions related to current or previous military service
 - Care while in the custody of a governmental authority

2. Charges in excess of any benefit limits

Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

3. Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the *Eligible Dental Services* section of the schedule of benefits)

- **Cosmetic** services and supplies including:
 - Plastic surgery
 - Reconstructive surgery
 - **Cosmetic** surgery
 - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
 - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach, alter the appearance of teeth whether or not for psychological or emotional reasons
 - Facings on molar crowns and pontics will always be considered **cosmetic**

4. Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole,

probation, release or as a result of any legal proceeding.

5. Dental services and supplies

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
 - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
 - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another **eligible dental service**
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- **Orthodontic treatment** except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- Temporomandibular joint dysfunction/disorder

6. Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan
- Under any other plan of group benefits provided by the Customer

7. Examinations

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a court order requires it.

- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

8. **Experimental or investigational**

- **Experimental or investigational** drugs, devices, treatments, or procedures. **Non-dentally necessary services**
- Services, including but not limited to, those treatments, services, prescription drugs and supplies which are not **dentally necessary** (as determined by ****COMPANY****) for the diagnosis and treatment of **illness, injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended, or approved by your **physician** or **dentist**.

9. **Other primary payer**

- Payment for a portion of the charge that another party is responsible for as the primary payer

10. **Outpatient prescription drugs, and preventive care drugs and supplements**

- Prescribed drugs, pre-medication or analgesia

11. **Personal care, comfort or convenience items**

- Any service or supply primarily for your convenience and personal comfort or that of a third party

12. **Providers and other health professionals**

- Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:
 - Scaling of teeth
 - Cleaning of teeth
 - Topical application of fluoride.
- Charges submitted for services by an unlicensed **provider** or not within the scope of the license.

13. **Services paid under your dental plan**

- Your plan will not pay for amounts that were paid for the same services under a dental plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your dental plan. If there is any difference, this plan will pay it. If the amount paid by your dental plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

14. **Services provided by a family member**

- Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

15. **Work related illness or injuries**

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you

waived your right to payment from that source. You may also be covered under a workers compensation law or similar law.

- If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered not work related regardless of cause.

Additional Exclusions

- Work in progress on the effective date of coverage. Work in progress is defined as:
 - A prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered.
 - A crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered.
 - Root canal therapy if the pulp chamber was opened before the patient was covered.
- Services not specifically listed in the Agreement, Services not prescribed, performed, or supervised by a Dentist, Services which are not 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.
- Any Service unless required and rendered in accordance with accepted standards of dental practice.
- A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement or modification of a crown, cast restoration, denture or bridge installed less than five years ago or one that replaces a tooth that was missing before the date of the Covered Person became eligible for Services under the plan (including previously extracted missing teeth).
- Replacement of existing dentures, crowns, or fixed bridgework if the existing dentures, crowns, or fixed bridgework can be made serviceable.
- Precision attachments, Interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.
- Replacement of any lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.
- Any Service for which the Covered Person received benefits under any other coverage offered by the Company.
- Spare or duplicate prosthetic devices. Services included, related to, or required for:
 - - Implants;
 - - Cosmetic purposes;
 - - 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;
 - - Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction of harmful habits;
 - - Experimental procedures; and
 - - Intentionally self-inflicted injury unless resulting from a dental condition (including physical or mental conditions) or from domestic violence.
- Any over the counter drugs or medicine. Fluoride varnish.
- Charges for finance charges, broken appointments, completion of insurance forms or reports, providing records, oral hygiene instruction, pit and fissure sealants and dietary instruction,

or

lack of cooperation on the part of the patient.

- Charges in excess of the amount allowed by the Plan for a Covered Service.
- Any treatment, material, or supplies which are for orthodontic treatment, including extractions for orthodontics.
- Services for which no charge would have been made had the Agreement not been in effect.
- All treatments not specifically stated as being covered.
- Surgical grafting procedures.
- General anesthetic, conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein.
- Services paid for by Workers' Compensation.
- 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.
- Treatment and/or removal of oral tumors.
- 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.
- Panoramic x-ray if provided less than three (3) years from the Covered Person's last full mouth x-rays; and full mouth x-rays if provided less than three (3) years from the Covered Person's last panoramic x-ray.

Who provides care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible dental services**, the foundation for getting covered care is through our network. This section tells you about **in-network** and **out-of-network providers**.

1. In-network providers

We have contracted with **dental providers** to provide **eligible dental services** to you. These **dental providers** make up the network for your plan. For you to receive the network level of benefits you must use **in-network providers** for **eligible dental services**.

The exceptions are:

- **Dental emergency services** - Refer to the *What are your eligible dental services* section
- **In-network providers** are not available to provide the service or supply that you need

You may select **in-network providers** from the **directory** or by logging on to our website www.****COMPANY**** You can search our online **directory** for names and locations of **dental providers**.

You will not have to submit claims for treatment received from **in-network providers**. Your **in-network provider** will take care of that for you. And we will directly pay the **in-network provider** for what the plan owes.

2. Out-of-network dental providers

You also have access to **out-of-network providers**. This means you can receive **eligible dental services** from an **out-of-network provider**. If you use an **out-of-network provider** to receive **eligible dental services**, you are subject to a higher out-of-pocket expense and

are responsible for:

- Your out-of-network **payment**
- **percentage** Any charges over our
- **recognized charge** Submitting your own claims

What the plan pays and what you pay

Who pays for your **eligible dental services** — this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **payment percentage**
- Your maximums

We also remind you that sometimes you will be responsible for paying the entire bill for example, if you get care that is not an **eligible dental service**.

1. The general rule

When you get **eligible dental**

- **services**: You pay your **co-insurance**.

And then

- Your plan and you share the expense up to any **Plan Year** and **lifetime maximum**. The schedule of benefits lists how much you pay and how much your plan pays. The payment percentage may vary by the type of expense. Your share is called payment percentage.

And then

- You are responsible for any amounts above the **maximum**.

When we **negotiated charges** for **in-network providers**, and **recognized charge** for **out-of-network providers**. See the *Glossary* section for what these terms mean.

2. Important note when you pay all

You pay the entire expense for an **eligible dental service**:

When you get a dental care service or supply that is not **dentally necessary**.

In all these cases, the **dental provider** may require you to pay the entire charge. And any amount you pay will not count towards your **Plan Year** or lifetime **maximum**.

3. Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay Charges that would not be made if you did not have coverage
- Charges, expenses or costs in excess of the **negotiated charge** for in-network **covered benefits**

4. Where your schedule of benefits fits in

This section explains some of the terms you will find in your schedule of benefits.

5. How your payment percentage works

Your **payment percentage** is the amount your plan pays for **eligible dental services** after you have paid your **co-insurance**. Your schedule of benefits shows you which **payment percentage** your plan will pay for specific **eligible dental services**.

6. How your maximum works

The maximum is the most your plan will pay for **eligible dental services** per **Plan Year** and lifetime incurred by you or your covered dependent after any applicable charges and **payment percentage**. You are responsible for any amounts above the **maximum**.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us. We are providing our Appeals process.

Member Appeals & Grievance Process

Members are assured of a fair and equitable process for addressing their complaints, appeals and grievances against ****COMPANY****. This review process is designed to evaluate all aspects of the situation and arrive at a solution that strives to be mutually satisfactory to the member and the organization. Members are notified of the processes available for resolving grievances in their plan documents.

A member appeals & grievance may relate to dissatisfaction with quality of care, access to services, staff attitude, operational policies and procedures, benefits, eligibility and requests for services and care they believe are available under their coverage.

A member can contact ****COMPANY**** office at ***COMPANY NUMBER**** 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 a Schedule of Benefits;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that is used to make ****COMPANY****'s decision; or
- Disagree with the denial or the amount not covered, and members want to appeal.

All appeals or grievances for claim denials (or any decision that does not cover expenses a member believes should have been covered) or of ****COMPANY****'s operations must be submitted in writing to ****COMPANY**** within 180 days of the date a member receives a denial or operational occurrence. ****COMPANY**** will provide a full and fair review of the claim by individuals associated with the Plan, but who were not involved in making the initial denial of the claim.

When a member appeals a claim, ****COMPANY**** 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 the member appeal concerns urgent care, the member 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 ****COMPANY****, including claims after dental care have been provided, such as reimbursement or payment of the costs of the services provided.

Valid member complaints and grievances against a Provider may be included in the Provider's file at ****COMPANY**** and reviewed as part of the recredentialing process. Grievances are tracked and trended on an ongoing basis to identify potential problems with a Provider or with ****COMPANY****'s policies and procedures.

a. **Provider Participation in member Resolution**

The established procedures for resolving member appeals & grievances may require the Provider's participation under certain circumstances. ****COMPANY**** will advise a member of any involvement required or information that must be provided. Grievances about clinical issues will be reviewed by at least one practitioner provided by ****COMPANY**** and practicing in the same or a similar specialty that typically manages the related dental condition, procedure or treatment who was not previously involved in the patient's care. Because of this review, members may be asked as part of the investigation to respond by email regarding the concern or request.

b. Member Resolution Procedure

One of the rights that members are apprised is that they have the right to participate in a candid discussion with the Provider of all available options regardless of cost or benefit coverage. members have the right to a candid discussion with their Physician about appropriate or dentally necessary treatment options for condition(s), regardless of cost or benefit coverage. members are encouraged to ask questions, even if they think they're not important. members should be satisfied with answers to questions and concerns before consenting to any treatment. members may refuse any recommended treatment if they do not agree with it or if it conflicts with religious beliefs.

If the issue cannot be resolved this way, we encourage the member to contact a Customer Services representative at ****COMPANY****. If the Provider presents a grievance on behalf of a member, and the issue is felt to be of an emergent nature, one that could seriously jeopardize the member's life, health, or ability to regain maximum function, the Provider or the member may contact ****COMPANY****'s Customer Service representative for an Expedited External Review.

c. Processes for Resolution

If the problem is not amenable to immediate resolution at the point of service, the member may submit an appeal or grievance through any of the following methods:

- in person to a Customer Service Representative at ****COMPANY****'s office
- via ****COMPANY****'s website at www.****COMPANY****.com
- by completing a Grievance Form or writing a letter and mailing it to a Customer Service Representative or ****COMPANY****'s Quality Assurance Officer.

A member may provide ****COMPANY**** with additional information that relates to a claim. ****COMPANY**** will notify the member of its decision in writing within **60 days** of receiving an appeal or grievance. If the member does not receive ****COMPANY****'s decision within **60 days** of receiving the appeal or grievance, a member may be entitled to file a request for an external review.

****COMPANY**** representatives will advise the member about the resolution process and ensure that the appropriate parties review the complaint.

Grievances reviewed through the standard process are generally acknowledged within 60 days, and resolved as quickly as the member's health requires, but no longer than regulatory timeframes. Depending on the issue and the applicable regulatory requirements, the resolution time frame is generally within 72 hours to 60 days.

d. Expedited Review

A member who believes that their health status would be seriously jeopardized by submitting an issue through the standard process may request an expedited review.

The Expedited Review portion handles determinations and redeterminations meeting the expedited review criteria. Post-service may not be expedited. When a member's expedited request is received by ****COMPANY****, it is the responsibility of ****COMPANY****'s Quality Assurance Officer to screen the request to immediately identify whether the request meets the established qualifying criteria for expedited review. Requests that meet these criteria are immediately referred to the Appeals & Grievance Committee for review.

The Committee determines if the request meets the criterion for expedited review, which includes screening against regulatory requirements. If a Plan or non-Plan Physician states that an expedited review is required for reasons of clinical urgency, an expedited review will be automatically granted.

Requests meeting expedited criteria are reviewed by a ****COMPANY**** designated physician in consultation, as needed, with the appropriate specialist(s). If the physicians deny the request, in whole or in part, the member is informed of the reason for the denial and given information for the next steps to take to have the determination reconsidered.

The member will be notified of the expedited decision verbally and in writing, as quickly as the member's health requires but no later than the required expedited timeframes - generally within 72 hours.

Requests that do not meet the qualifying criteria for expedited review will be processed in accordance with standard review timeframes.

e. How to File a Grievance

****COMPANY**** is committed to providing members with quality care and with a timely response to their concerns. members can discuss their concerns with ****COMPANY****'s Customer Service representatives or Quality Assurance Officer.

members can file an appeal or grievance for any issue that must explain the issue, such as the reasons why they believe a decision was in error or why they are dissatisfied about services they received. members must submit their grievance in writing within 180 days of the date of the incident that caused their dissatisfaction.

****COMPANY**** will acknowledge receipt of a member's appeal & grievance after receiving it and provide a resolution as soon as their health requires but no later than regulatory time frames allow, which is generally within 30-60 days. If we do not approve a member's request, we will tell them the reason and inform them about additional dispute resolution options.

****COMPANY**** will send written communication to the member specifying reason or describe any additional information required in the appeal and grievance procedures.

f. Independent External Review

The member will have the opportunity to seek resolution of the problem using ****COMPANY****'s grievance process. If the member is not satisfied with the outcome of the grievance process, or if the grievance has remained unresolved for more than 60 days, the member may contact ****COMPANY**** for assistance. ****COMPANY**** will determine whether the member is eligible to participate in the Independent External Review, described below.

The independent external review process is offered to ****COMPANY**** members who are not satisfied with the outcome of their appeal or grievance process, have been denied services because the services were deemed not dentally necessary or considered experimental or investigational. This includes denial of emergency and urgent care services from non-****COMPANY**** providers. If the member's case reaches the Independent Dental Review phase, dental experts not affiliated with ****COMPANY**** will conduct the review.

A member may qualify for the external review if the issue has been denied or is unresolved after 60 days, or 3 days for requests that meet expedited review criteria, if ****COMPANY****:

- Denies, changes, or delays a service or treatment because the plan determines it is not dentally necessary
- Will not cover an experimental or investigational treatment for a serious dental condition
- Will not pay for emergency or urgent dental services that you have already received

Members can request an Independent External review by completing and submitting the required form to ****COMPANY****. members should attach copies of letters or other documents about the treatment or service that ****COMPANY**** denied and submit to:

Attn: ****COMPANY**** Quality Assurance
Officer Contact: ***COMPANY CONTACT***
Email: ***COMPANY EMAIL***
Address: ***COMPANY ADDRESS***

Coordination of Benefits

Some people have dental coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB)

1. Key terms

Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:

- A dental care expense that any of your dental plans cover to any degree. If the dental care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic surgery** generally is not an allowable expense under this plan.

In this section we talk about other “plans” which are those plans where you may have other coverage for dental care expenses, such as:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization
- plans An automobile insurance policy
- **Medicare** or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

2. How COB works

- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

3. Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

The following charts provide an outline of group COB order of benefits determination rules and their application to dual coverage situations. These charts are to be used as a guideline only and are based on the NAIC Model COB regulations. It is assumed there is no conflict in the order of benefit determination provisions of the plans being coordinated. The existence of Medicare is not considered. This Plan has adopted the Birthday Rule for the order of benefit determination of dependent children.

ORDER OF BENEFIT DETERMINATION RULES		
RULE	The FIRST rule that applies determines primary carrier and <u>supercedes</u> following rules.	
1	NON-DEPENDENT (EMPLOYEE OR FORMER EMPLOYEE) PRIME OVER DEPENDENT	
2	CHILDREN-BIRTHDAY RULE/CUSTODY/COURT DECREE	
	If claimant is child of:	Order of Benefit Determination is based on:
	Married parents or parents not married-living together -or- Parents with joint custody (whether ever married or not)	Birthday Rule (parent with birthday earlier in year is prime) -or- Gender Rule (male parent is prime)- if in COB provisions
	Divorced Parents -or- Parents never married and not living together	Coverage order: 1. Custodial Natural Parent's plan 2. Custodial Step-Parent's plan 3. Non-Custodial Natural Parent's plan 4. Non-Custodial Step-Parent's plan
	If a court decree exists assigning financial responsibility for health insurance or health care expenses for the child, the assigned party's plan (if it exists and the other parent has knowledge of it) is primary.	
3	ACTIVE EMPLOYEE PLAN OVER INACTIVE EMPLOYEE PLAN	
4	ACTIVE EMPLOYEE PLAN OVER COBRA (OR OTHER CONTINUATION) PLAN	
5	PLAN IN EFFECT LONGER TIME OVER PLAN IN EFFECT SHORTER TIME	
6	IF ABOVE RULES DON'T ESTABLISH PRIMARY PLAN- PLANS SHARE EXPENSES EQUALLY	

COB ORDER OF BENEFIT DETERMINATION CHART-GROUP PLANS			
Claimant is:	Other Insurance	Primary Plan	Rule
Child	Child is also covered by another parent's plan.	See Rule	Rule 2
	Child is also covered as an employee under another plan.	Child's Plan	Rule 1
Spouse	Spouse is also covered as an employee under another plan, whether active, inactive or continuation plan.	Spouse's Plan	Rule 1
Employee	Employee is also covered as an employee under another plan.		
	Active/Active	See Rule	Rule 5
	Active/Inactive	Active	Rule 3
	Active/Continuation	Active	Rule 4
	Inactive/Inactive	See Rule	Rule 5
	Inactive/Continuation	See Rule	Rule 5
	These rules also apply to the dependents of the employee if their coverage is as dependents of employee under both plans.		
Group coverage is primary to Medicaid, TRICARE and Indian Health Services.			

4. COB Updates

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly. See the *How to contact us for help* section for details.

5. Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other dental plans.

6. Right to pay another TPA

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

7. Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess

- from: Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules.

When coverage ends

1. When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends.

2. When will your coverage end?

Coverage under this plan will end if:

- This plan is discontinued
- You are no longer eligible for coverage, including when you move out of the service area
The policyholder asks to end coverage.
- Your employer has notified us that your employment is ended
- You do not make any required contributions
We end your coverage
- You become covered under another dental plan offered by your employer

3. When coverage may continue under the plan

Your coverage under this plan will continue if:

<p>Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by your employer and us.</p>	<p>If required contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <p>Your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.</p>
<p>Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by your employer.</p>	<p>If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <p>Your coverage will stop on the date that your employment ends.</p>
<p>Your employment ends because:</p> <ul style="list-style-type: none"> • Your job has been eliminated • You have been placed on severance, <p>This plan allows former</p>	<p>You may be able to continue coverage. See the <i>Special coverage options after your plan coverage ends</i> section.</p>
<p>Your employment ends because of a paid or unpaid dental leave of absence</p>	<p>If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <p>Your coverage may continue until stopped by your employer but not beyond 30 months from the start of the absence.</p>
<p>Your employment ends because of a leave of absence that is not a dental leave of absence</p>	<p>If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <p>Your coverage may continue until stopped by your employer but not beyond 1 month from the start of the absence.</p>
<p>Your employment ends because of a military leave of absence.</p>	<p>If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:</p> <p>Your coverage may continue until stopped by your employer but not beyond 24 months from the start of the absence.</p>

It is your employer's responsibility to let us know when your employment ends. The limits above may be extended only if your employer agrees in writing to extend them.

4. When will coverage ends for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- You do not make the required contribution toward the cost of dependent coverage
- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner or civil union partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners or civil unions
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide your employer a completed and signed Declaration of Termination of Domestic Partnership.

5. What happens to your covered dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

6. Why could coverage end for you and your dependents?

Your employer may end your coverage for any number of reasons -for some reasons your employer will give you notice before terminating your coverage, for other reasons your employer may terminate your coverage immediately.

Your employer will give you 30 days advance written notice if your employer ends your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

You can enroll in these situations:

- When you did not enroll in this plan before because:
 - You were covered by another group dental plan, and now that other coverage has ended.
 - You had COBRA, and now that coverage has ended.
- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- When a court orders that you cover a current spouse, domestic partner, or a minor child on your dental plan.

Your Employer or the party they designate must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

1. Effective date of coverage

Your coverage will be in effect as of the effective date of the plan if you were eligible for dental benefits at that time.

2. Continuation of coverage for other reasons

What exceptions are there for dental work when coverage ends?

Your dental coverage may end while you or your covered dependent are in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends:

- Inlays
- Onlay
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed partial dentures (bridges)
- Root canals

Ordered means:

- For a denture: The impressions from which the denture will be made were taken for a root canal:
- The pulp chamber was opened
- For any other item: The teeth which will serve as retainers or supports, or the teeth which are being restored:
 - Must have been fully prepared to receive the item
 - Impressions have been taken from which the item will be prepared

3. How can you extend coverage for your disabled child beyond the plan age limits? You have the right to extend dental coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability, and Depends mainly (more
- than 50% of income) on you for support

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We ask for this proof more than once a year. You must send it to us within 31 days of our request. If you child.

Your disabled child's coverage will end:

On the date the child is no longer disabled and dependent upon you for support or as explained in the *When will coverage end for any dependents* section

4. How can you extend coverage for a child in college on dental leave?

You have the right to extend coverage for your dependent college student who takes a **dentally necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

One year after the leave of absence begins, or the date coverage would otherwise end.

To extend coverage the leave of absence must:

Begin while the dependent child is suffering from a serious **illness** or **injury**,

Cause the dependent child to lose status as a full-time student under the plan,
Be certified by the treating **physician** as **dentally necessary** due to a serious **illness** or **injury**

We must receive documentation or certification of the **dental necessity** for a leave of absence: At least 30 days prior to the absence, if the dental reason for the absence and the absence are foreseeable, or 30 days after the start date of the dental leave of absence from school. The **physician** treating your child will be asked to keep us informed of any changes.

General provisions - other things you should know

1. Administrative provisions

How you and we will interpret this booklet

We prepared this booklet according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet when we administer your coverage, so long as we use reasonable discretion.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. They are not our employees or agents.

2. Coverage and services

Your coverage can change

Your coverage is defined by the **group contract**. This document may have amendments too. Under certain circumstances, we or the customer or the law may change your plan. Only ****COMPANY**** may waive a requirement of your plan. No other person including the customer or **provider** can do this.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if

we fee. Financial sanctions exclusions:

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible dental services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Assets Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-c/enter/sanctions/Pages/default.aspx>.

Legal action

We encourage you to complete the appeal process before you take any legal action against us for any expense or bill. You cannot take any action until 60 days after we receive written submission of claim. See the *When you disagree - claim decisions and appeals procedures* section.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations

At our expense, we have the right to have a **provider** of our choice examine you. This will be done at all reasonable times while a claim for benefits is pending or under review. Records of expenses You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **dental providers, dentists** and others **providers** who provide services
Dates expenses are incurred
Copies of all bills and receipts

Honest mistakes and intentional deception

You or your customer may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **fee** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward. Denial of benefits.
Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

3. *Some other money issues*

Assignment of benefits

When you see **in-network providers** they will usually bill us directly. When you see **out-of-network providers**, we may choose to pay you or to pay the **provider** directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** under this **group contract**. This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this group contract.

To request assignment, you must complete an assignment form. The assignment form is available from the customer. The completed form must be sent to us for consent.

Recovery of overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to request the return of the overpayment. The Plan has the right to reduce by the amount of overpayment any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the third-party administrator ****COMPANY****. Under this process, ****COMPANY**** reduces future payments to providers by the amount of the overpayment they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when ****COMPANY**** recovers overpayments for other plans administered by ****COMPANY****.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Payment of fees

The first **fee** payment for this contract is due on or before your **effective date of coverage**. Your next **fee** payment will be due on the 1st of every month thereafter.

Your dental information

We will protect your dental information. We will use it and share it with others to help us process your **provider** claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call our Customer Service Department. When you accept coverage under this plan, you agree to let your **providers** share your information with us. We will need information about your physical and mental condition and care.

4. Effect of benefits under other plans

Effect of prior coverage - transferred business

Prior coverage means:

- Any plan of group coverage that has been replaced by coverage under part or all this plan. The plan
- must have been sponsored by the customer (e.g., transferred business).

- ☐ If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan. If your coverage under any part of this plan replaces any prior coverage any benefits provided under such prior coverage may reduce benefits payable under this plan. See the *General coverage provisions* section of the schedule of benefits.

Dental coverage under this plan will continue uninterrupted for your dependent college student who takes a **dentally necessary** leave of absence from school. See the *Special coverage options after your plan coverage ends How can you extend dental coverage for a child in college on dental leave?* section.

Glossary

Insurance Company

This plan is self-insured by the Government of Guam and ******COMPANY****** as a Third Party Administrator.

Fiscal year maximum

This is the most this plan will pay for **eligible dental services** incurred by you during the **calendar year**.

Contribution

The amount you or the customer are required to pay to **GovGuam** to continue coverage.

Copayments/Co-insurance

The specific dollar amount you have to pay for **eligible dental services**. **Copayments/Co-insurance**

may be changed by ******COMPANY****** upon 30 days written notice to the customer.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered Benefits

Eligible dental services that meet the requirements for coverage under the terms of this plan.

Dental emergency

Any dental condition that:

- Occurs unexpectedly.
- Requires immediate diagnosis and treatment in order to stabilize the condition and is
- characterized by symptoms such as severe pain and bleeding.

Dental emergency services maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person for any one **dental emergency** is called the **dental emergency services maximum**.

Dental Emergency Services

Services and supplies given by a **dental provider** to treat a **dental emergency**.

Dental Provider/Professional

Any individual legally qualified to provide dental services or supplies who is licensed, certified or otherwise authorized by law to provide dental care services to the public. For example, **providers** and dental assistants.

Dentist

A legally qualified **dentist** licensed to do the dental work he or she performs.

Directory

The list of **in-network providers** for your plan. The most up-to-date **directory** for your plan appears at ***company website*** When searching for **in-network providers**, you need to make sure that you are searching for **providers** that participate in your specific plan. **In-network providers** may only be considered **in-network providers** for certain ****COMPANY**** plans.

Drugs, Prescribed or Over the counter

An FDA approved drug prescribed by a Provider. Drugs is not an **eligible dental service**.

Eligible Dental Services

The dental care services and supplies listed in the schedule of benefits and not listed or limited in the *What rules and limits apply to dental care* and *Exceptions* sections of this plan.

Experimental or Investigational

A drug, device, procedure, or treatment that we find is **experimental** or **investigational** because: There is not enough outcome data available from controlled clinical trials published in the peer reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved. The needed approval by the FDA has not been given for marketing. A national dental or dental society or regulatory agency has stated in writing that it is **experimental** or **investigational** or suitable mainly for research purposes.

It is the subject of Phase I, Phase II or the experimental or research arm of a Phase III clinical trials. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.

Written protocols or a written consent form used by a facility **provider** state that it is experimental or investigational. It is provided or performed in a special setting for research purposes.

Illness

Poor health resulting from disease of the teeth or gums.

Injury or Injuries

Physical damage done to the teeth or gums.

In-network / Participating Provider

A dentist who is contracted with ****COMPANY**** to provide service to members based on Covered Charges. A

provider listed in the **directory** for your plan.

Medicare

As used in this plan, **Medicare** means the health coverage provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare**.

Dental Necessity

Dental care services that we determine a **provider** using sensible clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an **illness, injury**, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of dental practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and **illness, injury** or disease
- Not primarily for the convenience of the patient, **dentist**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce the same benefit or diagnostic results as to the diagnosis or treatment of that **illness, injury** or disease

Generally accepted standards of dental practice mean standards based on credible scientific evidence published in peer-reviewed dental literature and is:

- Generally recognized by the relevant dental community
- Consistent with the standards set forth in policy issues involving clinical judgment

Negotiated Charge

This is either:

- The amount **in-network providers** have agreed to accept
- The amount we agree to pay directly to **in-network providers** or third-party vendor (including any administrative fee in the amount paid)

Out-of-network/ Non-participating Provider

A dentist who is not contracted with ****COMPANY**** to provide service to members whereas benefits are payable based on UCR. A **provider** who is not **in-network provider** does not appear in the **directory** for your plan.

Payment Percentage

The specific percentage we have to pay for **eligible dental services**.

Precertification, Precertify

Pre-approval that you or your **provider** receives from us before you receive certain **covered services**.

This may include a determination by us as to whether the service meets dental necessity guidelines and eligible for coverage.

Provider

A **dentist**, or other entity or person licensed, or certified under applicable state and federal law to provide dental care services to you.

Recognized Charge

The amount of an **out-of-network** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge**. The **recognized charge** may be less than the full charge. **Recognized charge** applies to all out-of-network **eligible dental services**. In all cases, the **recognized charge** is based on the geographic area where you receive the service or supply.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

80% of the **prevailing charge rate**

The **recognized charge** for **providers** in the dental out-of-network savings program is the lesser of what the **provider** bills and the agreed upon rate for **providers**, with whom we have a contract through any third party that is not an affiliate of ******COMPANY******.

Your out-of-network cost sharing applies when you get care from dental out-of-network savings program **providers** except for **emergency services**.

Special terms used: Geographic area

The geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Specialist

A dentist who practices in any generally accepted dental or surgical sub-specialty.

Surgery or Surgical Procedures

The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abradig
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts

- Injection into a joint
- Otherwise physically changing body tissues and organs

Temporomandibular joint dysfunction/disorder

This is:

A temporomandibular joint (TMJ) dysfunction/disorder or any similar disorder of the jaw joint; A myofascial pain dysfunction (MPD) of the jaw; Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Additional Information Provided by Government of Guam ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specific locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified child support order (QMCSO).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

1. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case,

the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan decision or lack thereof concerning the status of a domestic relations order or a child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

2. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

3. Continuation of Coverage During an Approved Leave of Absence Granted to Comply with Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between

****COMPANY**** and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.

- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such a request within 31 days, coverage will again be effective under the group contract only if ****COMPANY**** gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment.

Rates and Administrative Fees
 GovGuam Self-Insured Dental FY2026
 Applicable October 1, 2025 to September 30, 2026

ACTIVES	MONTHLY RATES	BI-WEEKLY RATES
CLASS I		
CLASS II		
CLASS III		
CLASS IV		
RETIREES	MONTHLY RATES	SEMI-MONTHLY RATES
CLASS I		
CLASS II		
CLASS III		
CLASS IV		
FOSTER	MONTHLY RATES	BI-WEEKLY RATES
CLASS I		
MONTHLY ADMINISTRATIVE DENTAL FEES		
PER EMPLOYEE/RETIREE/FOSTER CHILD PER MONTH (PEPM)		

Schedule of Benefits

Policyholder: Government of Guam

Plan Name: (SOB) 1E / Self-Funded Dental

Plan Effective Date: October 1, 2025

Schedule of Benefits

This schedule of benefits (scheduled) lists the coinsurance, if any apply to the covered services that you will receive under the plan. You should review this schedule and become aware of any limits that apply to these services.

How your cost share works

- Coinsurance amounts, if any, listed in the schedule below are what the plan will pay for covered services.
- You are responsible to pay any remaining coinsurance if they apply.
- Care & service you get that is not a covered service. This plan has limits of \$1,500
- See the schedule of benefits for more information about limits.
- Your cost share may vary if the covered service is preventive or not. Ask your physician or contact us if you have a question about what your cost share will be.

For examples of how cost share work, review the member handbook section under payment responsibilities. You may obtain a copy through our website [***company website***](#)

Under this plan you will:

1. Pay your insurance
2. Then pay any remaining charges exceeding the dental limit of \$1,500

Contact Us

Please contact should you have any questions or concerns.

General coverage provisions

This section explains the deductible, maximum out-of-pocket limit and limitations listed in this schedule.

Coinsurance

This is the percentage you pay for a covered service. This is in addition to any out-of-pocket costs you must pay to meet your deductible if you have one.

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of the covered services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group policy.

Emergency services Important note:

Out-of-network providers do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by

the provider and the amount paid by the plan. If the provider bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.

SAMPLE

DENTAL

GOVERNMENT OF GUAM SCHEDULE OF BENEFITS

Your Benefits: What the plan covers	Participating Providers	Non-participating Providers
DIAGNOSTIC & PREVENTIVE CARE 1. Caries Susceptibility Test 2. Exams (including Treatment Plan) (Once every 6 months) 3. Fluoride Treatment (Annually for Children age 19 & under) 4. Prophylaxis (Cleaning and polishing of teeth) (Once every 6 months) 5. Sealants (For permanent molars of children age 15 & under) 6. Space maintainers (For children age 15 & under) includes adjustments within 6 months of installation 7. Study Models 8. X-rays (Bite Wing, Maximum of 4 per Plan Year) X-rays (Full Mouth, Once every 3 years)	100% of Eligible Expenses	70% of Eligible Expenses
BASIC & RESTORATIVE CARE	Participating Providers In-Network	Non-participating Providers Out-of-Network
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 6 months) 8. Periodontal Treatment 9. Pulpotomy & Root Canals/Endodontic Surgery & Care 10. Oral Surgery (1) 11. Conscious Sedation and Nitrous Oxide (for children under the ages of 13)	80% of Eligible Expenses	70% of Eligible Expenses
MAJOR & REPLACEMENT CARE	Participating Providers In-Network	Non-participating Providers Out-of-Network
Fixed Prosthetics 1. Crowns & Bridges 2. Gold Inlays & onlays 3. Replacement of Crown Restoration (limited to once every 5 years)	50% of Eligible Expenses	Not Covered
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 6.	50% of Eligible Expenses	Not Covered
DEDUCTIBLE	None	None
REGISTRATION FEE PER VISIT TO DENTIST	None	None
COVERAGE MAXIMUM PER MEMBER PER PLAN YEAR	\$1500	

TERMS: (CONFIRM AGREEMENT OR IDENTIFY DISCREPANCIES)

- Unused balances are not transferable to the following year.
 - Charges for Non-participating Providers are limited to the lesser of actual charges of the Company's determination or the usual, customary, and reasonable charge in geographic location where the service was rendered, unless otherwise provided in the agreement.
 - The Covered member pays any excess above Eligible Charges.
 - Additional bidder plan design comments:
- (1) Oral Surgery is typically covered under this dental benefit. However, in the case of accidental injury to the mouth or teeth, biopsy of oral tissue, incision/drainage of abscess, and cyst or hematoma of floor of mouth, these items are covered under the medical plan.