

I Mina'Trentai Kuåttro Na Liheslaturan
BILL STATUS

BILL NO.	SPONSOR	TITLE	DATE INTRODUCED	DATE REFERRED	CMTE REFERRED	PUBLIC HEARING DATE	DATE COMMITTEE REPORT FILED	FISCAL NOTES	NOTES
133-34 (COR)	Dennis G. Rodriguez, Jr.	AN ACT TO REPEAL AND REENACT ARTICLE 9 OF CHAPTER 2, DIVISION 1, TITLE 10 OF THE GUAM CODE ANNOTATED, RELATIVE TO TRANSFORMING THE MEDICALLY INDIGENT PROGRAM (MIP) INTO THE ISLAND COMMUNITY HEALTH PLAN TO AFFORD GREATER ACCESS TO HEALTHCARE SERVICES AND EFFICIENCY IN PROGRAM OPERATIONS AND FOR OTHER PURPOSES TO BE KNOWN AS THE "MAÑAINA YAN MAÑE'LU ISLAND COMMUNITY HEALTH PLAN OF 2017".	6/23/17 4:58 p.m.						

MINA' TRENTAI KUATTRO NA LIHESLATURAN GUAHAN
2017 (FIRST) Regular Session

Bill No. 133 -34 (COR)

Introduced by:

D.G. RODRIGUEZ, JR. 

**AN ACT TO REPEAL AND REENACT ARTICLE 9 OF
CHAPTER 2, DIVISION 1, TITLE 10 OF THE GUAM
CODE ANNOTATED, RELATIVE TO TRANSFORMING
THE MEDICALLY INDIGENT PROGRAM (MIP) INTO
THE ISLAND COMMUNITY HEALTH PLAN TO
AFFORD GRETER ACCESS TO HEALTHCARE
SERVICES AND EFFICIENCY IN PROGRAM
OPERATIONS AND FOR OTHER PURPOSES TO BE
KNOWN AS THE "MAÑAINA YAN MAÑE'LU ISLAND
COMMUNITY HEALTH PLAN OF 2017".**

2017 JUN 23 PM 4: 58

1 **BE IT ENACTED BY THE PEOPLE OF GUAM:**

2 **Section 1. Legislative Intent.** The Island Community Health Plan
3 (currently the Medically Indigent Program, MIP) is a 100% locally funded
4 program established by Public Law (P.L.) 17-83 in December 1984 to provide
5 hospital access and medical services to those who lack sufficient income and
6 cannot afford to pay for health care. The program is intended as the last resort
7 for those in need. Services provided by federal or other local programs are to be
8 utilized first.

9 It is the intent of I Liheslaturan Guåhan to provide for the care of this
10 portion of our population via a commercially managed care program called the
11 Island Community Health Plan. The MIP program currently covers qualified
12 individuals to 100% FPL. The Government of Guam has a great deal of
13 flexibility in modifying this program. The Island Community Health Plan will
14 consist of three programs. The first program would be Mañelu Care. We
15 anticipate the target group will remain those that fall within the 0%-100% FPL.
16 This program would mirror the existing MIP but be converted to a managed-
17 care methodology. During the transition, specific benefits will be reviewed and

1 adjusted to meet the current needs of this population.

2 The second program is called Mañelu Plus. Working with representatives
3 from our FAS/COFA neighbors Mañelu Plus would expand the eligibility
4 criteria to FAS/COFA citizens from the current maximum of 100% FPL to a
5 level based on contributions from various FAS governments to the program up
6 to 200% FPL. Benefits would remain the same as proffered in the Mañelu Care
7 plan except more FAS/COFA citizens would be eligible.

8 The third program is called Mañaina Care. Many of our manãmko' are
9 not eligible for Medicare or have needs that are not covered by Medicare. A
10 core principle in our culture is respect for our elders. Mañaina Care would
11 provide coverage to our local, US citizens over the age of 65. Specifically,
12 coverage would be provided for skilled nursing care to take care of the special
13 needs of the elderly. Additional coverage/benefits will be reviewed to focus on
14 the specific needs of the over-65 population.

15 I Liheslaturan Guåhan find in the research that significant cost savings
16 and quality improvements may be achieved in the commercial managed care
17 arena and that this initiative is a first step toward evolving into future innovative
18 practices such as Accountable Care Organizations.

19 **Section 2.** Article 9 of Chapter 2, Division 1, Title 10, Guam Code
20 Annotated is hereby *repealed and reenacted*, to read:

21 **“ARTICLE 9**

22 **Mañaina yan Mañe'lu Island Community Health Plan**

23 **§ 2901. Legislative Intent.** *I Liheslaturan Guåhan* believes that social
24 programs should evolve to meet the situation at hand and to take advantage of
25 developing evidenced based research in order to meet our obligation to increase
26 access to quality health care for those individuals who lack sufficient financial
27 resources to meet the costs of medical care. In the past several years, there have
28 been attempts to make changes and revise the Medically Indigent Program

1 (MIP). However, these changes have not yielded the results, both from a
2 financial and medical outcomes standpoint that we currently desire. We still
3 find challenges to improve services, benefits, decrease costs and provide the
4 best health care possible using scarce public resources.

5 *I Liheslaturan Guåhan* finds that not since “Johnson’s Great Society” has
6 the United States government undertaken such a broad reaching expansion of
7 healthcare to its citizens. The inception of the Patient Protection and Affordable
8 Care Act (PPACA) in March of 2010 changed the landscape of providing
9 healthcare to the people. This large endeavor rolled across the United States but
10 not all States jumped on board immediately. The complexity of the system
11 caused many to take pause. This was especially true in the territories. Now that
12 PPACA is in its 6th year, we have the luxury of seeing the approaches taken by
13 different States and the knowledge of lessons learned. We find that one size
14 does not fit all and each State and Territory has unique variables that need to be
15 addressed. Comparing what would work in Puerto Rico with a population of
16 3.5 million is not the same as Guam with a population of 172,326. In addition
17 to the challenges of instituting a complex expansion program it is further
18 complicated by the fact that not all of PPACA rules apply to the territories.
19 This situation causes extreme problems for the territories as PPACA is a
20 systems approach and each part works in tandem with the other parts.
21 Unfortunately, many of these “parts” are missing for the territories. Thus, a
22 considerable amount of innovation and research is required to develop and meet
23 the intent of PPACA for the Territorial citizens.

24 The lessons learned over the last six years shows that prepaid managed
25 health care plans offer improvements to a government claims based process. It
26 is our purpose, in view of the spiraling cost of comprehensive medical care, to
27 provide this type of protection for the people of Guam.

28 *I Liheslaturan Guåhan* believes that a bold move, using proven research,

1 is required to achieve the results desired. I Liheslaturan Guåhan further
2 believes that changing the Island Community Health Plan (ICHP) and moving
3 this program into the managed care arena have the potential to decrease cost,
4 increase quality and access. The ICHP (previously known as the Medically
5 Indigent Program MIP) currently covers qualified individuals to 100% FPL. As
6 of the 3rd quarter 2016, 11,034 participants are covered under ICHP with an
7 appropriation of \$13,168,453. The Government of Guam has a great deal of
8 flexibility in modifying this program. In the spirit of “Buen Binidu”, the
9 Medically Indigent Program is converted into the Island Community Health
10 Plan and will consist of 3 programs described in this Article. One concept of
11 the ICHP that is established is that of a medical home.

12 The colloquial version of a medical home exists on Guam. In this version
13 patients are seen and are loyal to a specific clinic or physician. In fact, the basic
14 concept of the medical home existed for some time. In the modern version this
15 model is developed and shows potential for improving the health care system. I
16 Liheslaturan Guåhan finds that the health care community should be
17 encouraged to follow the Patient Center Medical Home (PCMH) model outlined
18 by the Agency for Healthcare Research and Quality (AHRQ) that will set the
19 stage for payment reform and increased quality. It is therefore the intent of I
20 Liheslaturan Guåhan to use the revisions contained in this Article to move
21 toward these goals and also, if successful, share these tools in other future
22 healthcare contracts issued by the Government of Guam. Further growth in the
23 PCMH model may be expected to lead to the Accountable Care Organization
24 model. Thus, it is the intent of I Liheslaturan Guåhan to provide the framework
25 in this Article for the healthcare community to move toward these goals.

26 A goal is also to leverage the commercial insurance company’s networks
27 to increase access to more providers. Moving ICHP to the commercial market
28 will take advantage of established processes of care coordination, disease
29 management and patient education and utilization management. Additionally,

1 this Article will require a small copayment of services. Studies have shown that
2 even very small copayments at a level recipients can afford- can reduce
3 utilization without adversely affecting health outcomes. A small copayment
4 also creates value for the service rendered.

5 It is the not the intent of *I Liheslaturan Guåhan* to provide a complete
6 contract or to hamper the Contract Negotiating Committee established by this
7 Article. Therefore, contractual items not included in this Article are left to the
8 Contract Negotiating Committee to include during the bid process and contract
9 administration.

10 It is therefore the intent of *I Liheslaturan Guåhan* to change the criteria
11 for eligibility and benefit coverage to reflect current constraints and
12 opportunities within the Island Community Health Plan without compromising
13 the health care services provided by the government of Guam.

14 § 2902. Definitions. In this Article, unless the context otherwise
15 requires:

16 (a) Accountable Care Organization means groups of doctors, hospitals,
17 and other health care providers, who come together voluntarily to give
18 coordinated high quality care to their Medicare patients.

19 (b) ‘Eligible Person’ means any person who is:

20 (1) a resident of Guam and has been a resident of Guam for a period of
21 no less than six (6) months; and who has been physically living on Guam
22 within the last six (6) months of the year and who did not reside outside
23 the Guam service area for more than one hundred eighty-two (182) days
24 during the preceding year, except for temporary absences in the past year
25 which cannot be reasonably construed as absences due to bona fide
26 residency outside of Guam; who applies for and qualifies for assistance
27 under this Article; who is unable to pay the cost of the necessary medical
28 care; and who also:

29 (A) is not eligible for Medicaid or Medicare coverage and

1 has exhausted all benefits under Title XVIII or XIX of the Social
2 Security Act; or the State Children's Health Insurance Program
3 under Title XXI of the Balanced Budget Act as of 1997; or

4 (B) does not have medical insurance coverage nor the
5 financial ability to pay for medical insurance coverage or for
6 medical services as determined by the cost-sharing Program
7 developed by the Administrator based upon the criteria established
8 in this Article; or

9 (C) who has medical insurance coverage, but such coverage
10 is inadequate to cover the cost of medically required treatment and
11 is otherwise qualified for the Program as a result of inadequate
12 income or other resources;

13 (2) is a child in foster care, age eighteen (18) years and below, for
14 whom public agencies are assuming financial responsibility in whole or
15 in part; or

16 (c) 'Exclusive proposal' means a proposal based upon the assumption
17 that the Government will contract with only one health insurance provider
18 that is selected by the Negotiating Team from the available Health Insurance
19 Carriers that all negotiate best and final offers with the Negotiating Team.

20 (d) 'Federal Poverty Guideline' means the poverty guidelines updated
21 annually in the Federal Register by the U.S. Department of Health and
22 Human Services under authority of §673(2) of the Omnibus Budget
23 Reconciliation Act of 1981.

24 (e) 'Guam ICHP Income Guidelines' means the Federal poverty
25 guidelines adjusted for the higher cost of living on Guam relative to the
26 national standard.

27 (f) Health Maintenance Organization (HMO) is a health plan in which
28 you must choose a Primary Care Physician (PCP) from a network of local
29 healthcare providers who will refer you to in-network specialists or hospitals

1 when necessary. All your care is coordinated through that PCP.

2 (g) Medical Home also known as the patient-centered medical home
3 (PCMH), is a team-based health care delivery model led by a health care
4 provider that is intended to provide comprehensive and continuous medical
5 care to patients with the goal of obtaining maximized health outcomes

6 (h) ‘Medical Necessity’ or ‘Medically Necessary’ must be determined on
7 an individual basis and must consider available research findings, health care
8 practice guidelines and standards issued by professionals, recognized
9 organizations or government agencies. ‘Medical Necessity’ or ‘Medically
10 Necessary’ means the treatment must be certain to save lives or significantly
11 alter an adverse prognosis:

12 (1) in accordance with generally accepted standards of medical
13 practice; and

14 (2) clinically appropriate in terms of type, frequency, extent, site
15 and duration.

16 (i) ‘Member’ or ‘covered person’ means an eligible person who enrolls
17 in the Program.

18 (j) ‘Non-Provider’ means a person who provides hospital, medical,
19 dental or behavioral health care, but does not have a contract or subcontract
20 with the Program.

21 (k) ‘Preferred Provider Organization’ (PPO) is a type of health plan in
22 the Individual and Family health insurance market. PPO plans allow you to
23 visit whatever in-network physician or healthcare provider you wish without
24 first requiring a referral from a primary care physician. This ICHP does not
25 use a PPO model for provision of services.

26 (l) ‘Practitioner’ means a person licensed pursuant to Chapter 12 of
27 Division 1, Part 1 of Title 10 of the Guam Code Annotated.

28 (m) ‘Prepaid capitated’ means a mode of payment by which a health

1 care Provider directly delivers health care services for the duration of a
2 contract to a maximum specified number of members based on a fixed rate
3 per member notwithstanding:

4 (1) the actual number of members who receive care from the Provider; or

5 (2) the amount of health care services provided to any member.

6 (n) 'Primary Care Physician means a physician who is a family
7 practitioner, general practitioner, pediatrician, general internist, obstetrician,
8 psychiatrist or gynecologist.

9 (o) Primary Care Practitioner' also means a nurse practitioner licensed
10 pursuant to Article 3 of Chapter 12, Division 1, Part 1 of Title 10 of the
11 Guam Code Annotated, or a physician's assistant licensed pursuant to
12 Article 16 of Chapter 12, Division 1, Part 1 of Title 10 of the Guam Code
13 Annotated. Nothing in this Act shall expand the scope of practice for nurse
14 practitioners or for physician assistants as defined in Chapter 12 of Division
15 1, Part 1 of Title 10 of the Guam Code Annotated.

16 (p) 'Provider' means any person who contracts with the Program for the
17 provision of hospitalization, medical, dental or behavioral health care to
18 members according to the provisions of this Chapter, or any subcontractor of
19 such Provider delivering services pursuant to this Article.

20 (q) Provider Sponsored Health Plan means a health insurance company
21 owned by a health system, physicians group, or hospital.

22 (r) 'Program' means the Island Community Health Plan-established by
23 this Article.

24 **§ 2903. Contract .** The Governor of Guam is authorized to enter into
25 contracts and reject proposals with insurance companies for group insurance
26 including but not limited to hospitalization and medical care. In connection
27 with such group benefits, the Government of Guam (Government) will accept
28 proposals from interested and qualified health insurance companies (including

1 health maintenance organizations, preferred provider networks, accountable
2 care organizations and provider sponsor health plans), and/or Third Party
3 Administrators coupled with Reinsurance, licensed under applicable Guam
4 laws, to provide health insurance coverage for eligible residents of Guam under
5 the Island Community Health Plan previously known as the Medically Indigent
6 Program. All health insurance companies and/or Third Party Administrators
7 coupled with Reinsurance must be licensed and comply with all regulatory
8 requirements as promulgated by the Guam Insurance Commissioner, pursuant to
9 the Insurance Statute of Guam and other applicable laws. The intent, pursuant
10 to this Article is to present to the Governor of Guam one exclusive negotiated
11 proposed contract for consideration for the requested services. The governor
12 will then choose to enter into one exclusive contract from the bids provided.
13 All qualified proposals will be reviewed, evaluated and scored separately by the
14 Negotiating Team. The IHCP Negotiating Team is established pursuant to this
15 Article. The top ranked exclusive proposal will be chosen, and those offerors
16 will enter into negotiations with the Negotiating Team.

17 At the conclusion of negotiations, the Negotiating Team will use
18 established criteria stated in the RFP and rank the three exclusive negotiated
19 agreements. The top ranked exclusive negotiated agreement will be presented
20 to the Governor. The Governor will choose to execute either the one exclusive
21 agreement or send the contract back with amendments. The executed exclusive
22 contract will be offered to the residents of Guam meeting the eligibility
23 requirements established herein. The term of the exclusive contract is for three-
24 years and will be rated and quoted as such. At the time of enrollment the
25 Contractor shall provide enrollees at a minimum the following:

- 26 a. Explanation of the Plan and Benefit Schedule.
- 27 b. Selection, assignment and contact information of a Primary Care
28 Provider.
- 29 c. Health Risk Appraisal with basic biometrics.

1 The Negotiating Team may determine additional enrollment processes.
2 The contractor is encouraged to engage local non-profit organizations and
3 health consortia to participate in the enrollment process. Health Plans are
4 encouraged to seek and attain accreditation from the National Committee for
5 Quality Assurance (NCQA) and to include Accredited Patient Centered Medical
6 Homes (PCMH) within their networks.

7 **§ 2903.1. Island Community Health Plan.** (a) There is established
8 within the Department of Public Health and Social Services, within the Division
9 of Public Welfare, a Program unit entitled the ‘Bureau of Health Care Financing
10 Administration,’ (BHCFA) which shall continue to administer the Guam
11 Medicaid Program. The BHCFA shall coordinate the Island Community Health
12 Plan (the ‘Plan’), subject to the requirements and exceptions of this Article.

13 (b) The Island Community Health Plan is established for the purpose of
14 providing medical, dental and behavioral health assistance to qualified people of
15 Guam in a manner that ensures access to basic quality health care at an
16 affordable cost. The Plan shall be composed of the following:

17 (1) Defining eligibility for financial assistance with health care costs,
18 consistent with § 2913 of this Article; and as may be amended from time to
19 time;

20 (2) Evaluating the scope of services covered by the Programs along with
21 a mechanism for updating the scope of services from time to time.

22 (3) Establishing Provider reimbursements and a care contribution or cost-
23 sharing program for persons with the ability to pay for a portion of their health
24 care costs, based upon family size, monthly income and resources as these terms
25 are defined in this Article;

26 (4) Establishing procedures to verify the validity of need and eligibility of
27 persons applying for assistance under this Program; and

28 (5) A plan to effectively implement policies and procedures for
29 operations of this Program.

1 § 2903.2. Mañelu Care. This program generally mirrors the previous
2 ICHP but is converted to a managed-care methodology as described in this
3 Article. The schedule of benefits at §2916 provides specific information on the
4 Mañelu Care plan benefits, copays and coverage.

5 § 2903.3. Mañelu Care Plus: The Government of Guam will provide a
6 process to representatives to the FAS/COFA Governments to provide funding to
7 expand the eligibility criteria to FAS/COFA citizens from the current maximum
8 of 100% FPL to a level based on contributions from FAS governments to the
9 program up to 200% FPL. Benefits would remain the same as proffered in the
10 Mañelu Care plan except more FAS/COFA citizens would be eligible. The
11 Department of Administration shall develop a memorandum of agreement and
12 process to accept funding from FAS Governments for the purpose of providing
13 health care to FAS citizens.

14 § 2903.4. Mañaina Care. We recognize that many of our manãmko' are
15 not eligible for Medicare or have needs that are not covered by Medicare. A
16 core principle in our culture is respect for our elders. Mañaina Care provides
17 coverage to our local, US citizens over the age of 65. Specifically, coverage
18 would be provided for skilled nursing care to take care of the special needs of
19 the elderly. Additional coverage/benefits for this program are provided and
20 focus on the specific needs of the over-65 population. The schedule of benefits
21 at §2916 provides specific information on the Mañaina Care plan benefits,
22 copays and coverage.

23 § 2904. Establishment of Negotiation Team. The Director, Department
24 of Administration, shall form an ICHP Negotiating Team to solicit bids for
25 selection of a contractor. The composition of the Negotiating Team shall
26 include:

27 (a) Director of Administration- shall serve as Chairperson

1 (b) Director of Bureau of Budget and Management Branch, or designee.

2 (c) Director of the Department of Public Health and Social Services, or
3 designee.

4 (d) Chairperson of the Committee on Health of I Liheslaturan Guåhan or
5 designee.

6 (e) Chairperson of the Committee on Appropriations of I Liheslaturan
7 Guåhan or designee.

8 (f) One member of the general public, appointed by I Maga'lahaen
9 Guåhan

10 **§ 2904.1. Authority of Negotiating Team's Consultant. The**

11 Negotiating Team may obtain technical support from other financial and health-
12 related agencies. The Negotiating Team shall develop its rules of procedure in
13 accordance with the Administrative Adjudication Law. The Negotiating Team
14 with the approval of I Maga 'lahi Guåhan is authorized to contract an actuary
15 competent to develop proposed health insurance rates or other recognized
16 expert to train and/or advise the Negotiating Team."

17 The Negotiating Team and its consultant will review all proposals. The
18 consultant is authorized to communicate with any offeror or registered party and
19 to request and obtain information.

20 The Negotiating Team shall issue a Request for Proposal (RFP) subject to
21 the competitive selection procedures for professional services found in the
22 Guam Procurement Law (Title 5 GCA § 5001, et seq.) and its regulations (Title
23 2 GAR Div. 4 § 1101, et seq.) Specifically, the procedure for this RFP is found
24 at Title 2 GAR Div. 4, § 3114 and its subsections. The Negotiating Team shall
25 follow a process similar to that of the Government of Guam Employee Health
26 Insurance negotiating process.

1 Proposed plan design. The Negotiating Team's desired plan designs and
2 alternatives shall, to the extent practicable, follow the provisions of this Article.
3 Changes to the plan are allowed in so far the changes do not materially change
4 the intent of this Article. Offeror must specify in their proposal any component
5 to which they cannot comply and any changes they desire to the proposed plan
6 design. The Negotiating Teams decision on any interpretation of the benefit
7 plan design shall be final.

8 **§ 2904.2 Duration of Contract.** The duration of any contract resulting
9 from the RFP shall be for three years, from October 1, 2017 to September
10 30, 2020.

11 **§ 2905. Community Health Centers (CHC).** The contractor shall
12 utilize the CHC's as a network provider.

13 **§ 2906. Member Use of Primary Care Physicians (PCP).** The
14 contractor shall provide a list of network primary care physicians from which
15 members may select for their "medical home". The list will contain the
16 Physicians name, clinic name if available, location, phone number and
17 specialty. The contractor shall coordinate with the PCP on the number of new
18 members the PCP will accept and manage the enrollment to that PCP.

19 **§ 2907. Change in Primary Care Physician.** Contractor shall
20 develop processes for members to change their primary care physician/medical
21 home to include a satisfaction survey that addresses the reason for change. The
22 de-identified information from this survey will be shared with the PCP and the
23 Administrator, DPHSS.

24 **§ 2908. Medical Home.** Network primary care providers shall strive
25 to provide the concepts of a patient centered medical home as provided below:

- 26 (a) Patient-centered: A partnership among practitioners, patients, and their
27 families ensures that decisions respect patients' wants, needs, and
28 preferences, and that patients have the education and support they need to
29 make decisions and participate in their own care.
30

1 (b) Comprehensive: A team of care providers is wholly accountable for a
2 patient's physical and mental health care needs, including prevention and
3 wellness, acute care, and chronic care.

4
5 (c) Coordinated: Care is organized across all elements of the broader health
6 care system, including specialty care, hospitals, home health care,
7 community services and supports.

8
9 (d) Accessible: Patients are able to access services with shorter waiting
10 times, "after hours" care, 24/7 electronic or telephone access, and strong
11 communication through health IT innovations.

12
13
14 (e) Committed to quality and safety: Clinicians and staff enhance quality
15 improvement to ensure that patients and families make informed
16 decisions about their health.

17
18 **§ 2909. Reports and Surveys.** The Contractor shall provide the
19 reports and surveys required and described pursuant to this Article to the
20 Director, Department of Public Health and Social Services, and to the Guam
21 Legislature through the Chairperson of the Health Care Committee. The
22 contractor shall also provide information to the appropriate network providers.

23 **§ 2909.1. Health Risk Appraisal.**

24 (a) The Contractor shall administer a Health Risk Appraisal (HRA) at the
25 time of member enrollment into the ICHP.

26 (1) The HRA shall have either National Committee for Quality
27 Assurance (NCQA) Wellness and Health Promotion (WHP) Certification
28 or Health Information Products (HIP) Certification.

29 (2) The member shall be provided a copy of the HRA and
30 encouraged to take the HRA to their first appointment.

31 (3) The contractor shall have a process to recall an individual
32 member HRA in event the HRA is misplaced.

33 (4) The contractor shall establish a process to provide the HRA to
34 the Members PCP/Medical Home.

1 (5) The contractor shall aggregate the HRA data and provide a
2 report of de-identified aggregated information to the Director, DPHSS,
3 Chairperson, Guam Legislature Health Care Committee.

4 (6) The contractor shall provide aggregate data reports to network
5 providers.

6 **§ 2909.2. Healthcare Effectiveness Data and Information Set**
7 **(HEDIS).**

8 The contractor shall participate in the United States Department of Health
9 and Human Services, Agency for Healthcare Research and Quality (AHRQ),
10 HEDIS clinical performance program. HEDIS is a tool used by more than 90
11 percent of America's health plans to measure performance on important
12 dimensions of care and service. Altogether, HEDIS consists of 81 measures
13 across 5 domains of care. Because so many plans collect HEDIS data, and
14 because the measures are so specifically defined, HEDIS makes it possible to
15 compare the performance of health plans on an "apples-to-apples" basis.

16 **§ 2909.3. Consumer Assessment of Healthcare Providers and**
17 **Systems (CAHPS).** The contractor shall participate in the United States
18 Department of Health and Human Services, Agency for Healthcare Research
19 and Quality (AHRQ), CAHPS consumer experience survey program. The
20 CAHPS surveys ask consumers and patients to report on their experiences with
21 health care services in different settings. The surveys are a product of the
22 Agency for Healthcare Research and Quality's CAHPS program, which is a
23 public-private initiative to develop and maintain standardized surveys of
24 patients' experiences with ambulatory and facility-level care. Participation in the
25 CAHPS Database is entirely free to sponsors. By participating, survey sponsors
26 contribute to a national database that confers many benefits related to
27 benchmarking for quality improvement and ongoing research.

- 1 a. At a minimum, the contractor shall conduct the CAHPS survey
2 modules, CAHPS Health Plan Survey Measures and the Clinician
3 and Group Survey.
- 4 b. Specific benefits for sponsors of the Health Plan Survey (in the
5 Medicaid and CHIP sectors) include receiving a customized
6 case-mix adjusted sponsor report comparing results to
7 appropriate benchmarks. All sponsors also have access to annual
8 chart books that present summary-level comparisons of survey
9 results by selected characteristics (region, sector, facility size,
10 etc.). The contractor shall maintain information as provided in the
11 CAHPS guidelines and share access information to the public.
12 Specifically, the contractor shall inform the Director, DPHSS and
13 Chairperson, Guam Legislature, Committee on Health on the
14 process to access this database.
- 15 c. The Contractor and network providers are encouraged to ensure
16 CAHPS surveys are accessible, standardized, health plans,
17 providers, and other sponsoring organizations are able to use the
18 results to compare and assess their performance vis-à-vis similar
19 organizations and pinpoint strengths and weaknesses in patients’
20 experiences. Sponsoring organizations can also use the results to
21 evaluate the effectiveness of interventions to improve specific
22 aspects of patients’ experiences.

23 **§ 2909.4. Claims Reports.** The contractor shall provide the following
24 reports:

25 **Medical Claims Report**

- 26 a. Claim by type of Service
27 b. Large claim report
28 c. Number of Days Hospitalized
29 d. Average Days of Confinement

- e. Average Hospital Charges
- f. Average Hospital Payments
- g. Number of Outpatient Physician Visits
- h. Average Cost of Outpatient Physician Visits
- i. Average Hospital Charges
- j. Average Hospital Payments
- k. Professional Procedures
- l. Average Cost of Professional Procedures

Pharmacy Claims Report

- a. Prescription utilization report
- b. Number of Brand Prescriptions Filled
- c. Number of Generic Prescriptions Filled
- d. Average Brand Prescriptions Cost
- e. Average Brand Generic Cost
- f. Top 50 prescribed prescriptions
- g. Top 50 high cost prescriptions

Subject to 4 GCA § 4302 (g), the contractor shall provide, at a minimum, the monthly data requirements outlined below. Plans must also submit a corresponding data dictionary describing the data provided.

A.2.d.a.i.1. A unique contract identifier that links detailed demographic, claims utilization, and cost information

A.2.d.a.i.2. Enrollment by Plan, Tier/Class, Employment Status, and other Subgroups as required by the Government

A.2.d.a.i.3. Patient demographics including date of birth, gender, and relationship to subscriber

A.2.d.a.i.4. Medical, Dental, Vision and Wellness claims by line detail, including:

1	A.2.d.a.i.4.a.	<u>Diagnosis code (ICD9 or</u>
2	<u>ICD10)</u>	
3	A.2.d.a.i.4.b.	<u>Procedure codes (CPT,</u>
4	<u>HCPC, CDT)</u>	
5	A.2.d.a.i.4.c.	<u>Revenue codes</u>
6	A.2.d.a.i.4.d.	<u>Service dates</u>
7	A.2.d.a.i.4.e.	<u>Service provider,</u>
8	<u>including:</u>	
9	A.2.d.a.i.4.e.i. <u>Name</u>	
10	A.2.d.a.i.4.e.ii. <u>Tax ID</u>	
11	A.2.d.a.i.4.e.iii. <u>Provider ID</u>	
12	A.2.d.a.i.4.e.iv. <u>Specialty code</u>	
13	A.2.d.a.i.4.e.v. <u>City</u>	
14	A.2.d.a.i.4.e.vi. <u>State</u>	
15	A.2.d.a.i.4.e.vii. <u>Zip code</u>	
16	<u>Plan payments</u>	
17	<u>Member payment responsibility, including:</u>	
18	A.2.d.a.i.4.g.i. <u>Copay</u>	
19	A.2.d.a.i.4.g.ii. <u>Coinsurance</u>	
20	A.2.d.a.i.4.g.iii. <u>Deductible</u>	
21	<u>Claim paid date</u>	
22	<u>Type of bill</u>	
23	<u>Facility type</u>	
24	A.2.d.a.i.5.	<u>Prescription Drug claims by</u>
25	<u>line detail, including:</u>	
26	A.2.d.a.i.5.a.	<u>NDC codes</u>
27	A.2.d.a.i.5.b.	<u>Formulary tier identifier</u>
28	A.2.d.a.i.5.c.	<u>Pharmacy, including:</u>
29	A.2.d.a.i.5.c.i. <u>Name</u>	

1 A.2.d.a.i.5.c.ii. Provider ID

2 A.2.d.a.i.5.c.iii. City

3 A.2.d.a.i.5.c.iv. State

4 A.2.d.a.i.5.c.v. Zip code

5 A.2.d.a.i.5.d. Plan payments

6 A.2.d.a.i.5.e. Member payment

7 responsibilities, including:

8 A.2.d.a.i.5.e.i. Copay

9 A.2.d.a.i.5.e.ii. Coinsurance

10 A.2.d.a.i.5.e.iii. Deductible

11 A.2.d.a.i.5.f. Claim paid date

12 A.2.d.a.i.5.g. Injectable drug indicator

13 A.2.d.a.i.5.h. GPI number

14 A.2.d.a.i.5.i. Ingredient cost

15 A.2.d.a.i.5.j. Dispensing fee

16 A.2.d.a.i.5.k. Rebate

17 **§ 2909.5. Quality of Care, Performance and Outcomes Measures.**

18 The following performance goals are given. Participation in achieving these

19 performance goals is voluntary though encouraged to network providers. They

20 are provided as a measure to improve quality of care. The Health Insurance

21 Contractor shall develop a process for PCP's to participate. At a minimum, the

22 following resources shall be used in determining performance incentives.

- 23 (1) CAHPS survey results
- 24 (2) USPTF measures
- 25 (3) Claims data
- 26 (4) HRA

<u>Measure</u>	<u>Reference</u>	<u>Measure</u>	<u>Data Source</u>
<u>Completion of Contractor provided Health Risk Appraisal</u>	<u>§ 2909.1</u>	<u>Percent of members completed</u>	<u>HRA count</u>

<u>Number of members completing a physical examination.</u>	<u>Schedule of Benefits</u>	<u>Percent of members completed</u>	<u>Claims database</u>
<u>Getting Timely Care, Appointments, and Information</u>	<u>§ 2909.3</u>	<u>Clinician and Group survey</u>	<u>CAHPS</u>
<u>How Well Your Providers Communicate</u>	<u>§ 2909.3</u>	<u>Clinician and Group Survey</u>	<u>CAHPS</u>
<u>Patients Rating of Provider</u>	<u>§ 2909.3</u>	<u>Clinician and Group Survey</u>	<u>CAHPS</u>
<u>Health Status/Functional Status</u>	<u>§ 2909.1</u>	<u>Health Risk Appraisal</u>	<u>HRA</u>
<u>Tobacco use counseling and interventions: non-pregnant adults</u>	<u>The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Obesity screening and counseling: adults</u>	<u>The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Obesity screening and counseling: children</u>	<u>The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up</u>	<u>The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Diabetes screening</u>	<u>The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.</u>	<u>Claims</u>	<u>USPSTF</u>

<u>Hypertension (HTN): Controlling High Blood Pressure</u>	<u>The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Colorectal Cancer Screening</u>	<u>The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Breast Cancer Screening</u>	<u>The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Cervical cancer screening</u>	<u>The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Lung cancer screening</u>	<u>The USPSTF recommends annual screening for lung cancer with low- dose computed tomography in adult's ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Chlamydia screening: women</u>	<u>The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Rh incompatibility screening: first pregnancy visit</u>	<u>The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Hepatitis B screening: pregnant women</u>	<u>The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit</u>	<u>Claims</u>	<u>USPSTF</u>

<u>Breastfeeding interventions</u>	<u>The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Syphilis screening: pregnant women</u>	<u>The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Preeclampsia prevention: aspirin</u>	<u>The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Immunizations</u>	<u>The Advisory Committee on Immunization Practices (ACIP) approves immunization schedules recommended for persons living in the United States. The adult immunization schedule provides a summary of ACIP recommendations on the use of licensed vaccines routinely recommended for adults aged 19 years or older. The adult immunization schedule is also approved by the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Nurse-Midwives (ACNM).</u>	<u>Database</u>	<u>DPHSS Immunization Database</u>

1
2 **§ 2910. Incentives.** The Negotiation Team shall provide for both
3 provider and insurance contractor incentives within the contract.

4 **§ 2910.1 PCP Reimbursement Incentive.**

5 (a) The Health Insurance Contractor shall provide a two-tier
6 reimbursement system for Primary Care Providers within the network:

7 1) The first tier of reimbursement will be at a standard level and is
8 negotiated between the Health Insurance Contractor and the Provider.

9 2) The second tier of reimbursement will be at a higher rate than
10 the first tier as negotiated between the Health Insurance Contractor and
11 the Provider. This higher reimbursement rate serves as an incentive for

1 providers to participate in the quality care improvement aspect outlined in
2 § 2909.5

3 3) All providers will be compensated at Tier one in the first year
4 of the contract.

5 4) Providers will be eligible for Tier Two rates based on
6 achievement of performance goals outlined in § 2909.5.

7 5) The tier two rates will become effective upon successful
8 completion and certification of these goals.

9 6) The health insurance contractor will establish the methodology
10 and criteria for network providers to be eligible for tier two rates.

11 **§ 2910.2. Health Insurance Contractor Incentive.** The Negotiation
12 shall establish a Health Insurance Contractor Incentive.

13 a) The Director, DOA will provide certification of the Health Insurance
14 Contractor Incentive; and

15 b) The incentive will be based on the aggregate data from the CAPHS,
16 HEDIS and HRA information described in § 2909.

17 c) Incentives will be based on improvements in the health status of the
18 members based on the information from the CAPHS, HEDIS and
19 HRA information described in § 2909.

20 d) The Negotiation team may formulate incentives around the Premium
21 Retention / Medical Loss Ratio described in § 2911.

22 **§ 2911. Premium Retention / Medical Loss Ratio.** The Negotiation
23 Team shall use the methodology contained in the current Government of Guam
24 Employee Health Insurance Plan as applicable.

25 **§ 2912. Appeals and Grievance Process.** The contractor shall provide a
26 process to address grievances by members acceptable to the Negotiating Team.

27 **§ 2913. Responsibilities of the Bureau of Health Care Financing**
28 **Administration, DPHSS.** (a) There is established within the Department of
29 Public Health and Social Services, within the Division of Public Welfare, a

1 Program entitled the 'Bureau of Health Care Financing Administration'
2 (BHCFA), which shall continue to administer the Guam Medicaid Program.
3 The BHCFA shall coordinate the Guam Island Community Health Plan, subject
4 to the requirements and exceptions of this Article.

5 (b) The Administrator serves as the technical liaison, subject to
6 supervision by the Chief Human Services Administrator of the Division of
7 Public Welfare, between the DPHSS, Department of Administration and the
8 contractor with such duties that may include any or all of the following:

9 (1) Define and certify eligibility consistent participation in the Island
10 Community Health Plan (ICHP).

11 (2) Establishing a system for eligibility fraud detection and investigation.

12 (3) Develop and implement policies and procedures in entertaining and
13 resolving questions, complaints, and /or concerns from applicants
14 regarding eligibility

15 (4) Develop and maintain procedures to refer applicants requesting for a
16 fair hearing in the event that their application has been terminated or
17 denied.

18 (5) Maintain a quality improvement process in regard to the application
19 process.

20 (6) Provide monthly reports of eligibility enrollment status to the
21 Director, DPHSS and the public via the DPHSS website. The report
22 shall provide at a minimum: Application disposition, number of
23 members by ethnicity, age group, village, and gender.

24 (7) Communicating with the contractor on member enrollment eligibility.

25 (8) Communicating with the contractor on member disenrollment.

26 (9) Receiving reports from contractor in accordance with § 2909 of this
27 Article.

28 (10) Produce an annual narrative reports on the state of the ICHP. This
29 report will outline program benefits, concerns, costs in relation to

1 types of medical conditions, and the impact of benefit payments on
2 limited ICHP funding. This report shall be made available to the
3 public and specifically provided to the Governor and the Guam
4 Legislature through the Chair, of the Healthcare Committee.

5 (11) Making recommendations to the Director, DPHSS on
6 improvements to the ICHP.

7 (12) Provision of technical assistance services to the contract
8 negotiating team.

9 (13) Assistance to and liaison with medical, dental and behavioral
10 health care consortiums to provide information on covered health and
11 medical services under the Plan.

12 **§ 2913.1 Program Participation and Eligibility Process Standards.**

13 (a) The BHCFA will construct and use a standardized checklist of
14 requirements for each ICHP program and a filing system for case files.

15 (b) At intake, an Eligibility Specialist meets with the applicant and
16 obtains the required information and documents according to the checklist for
17 the program(s) being applied for. These are then arranged in a specific order in
18 the applicant's new or existing case file. The intent of standardizing the
19 checklist and filing system will help caseworkers unfamiliar with program
20 requirements, and serve as a primary reference for determining eligibility. Since
21 Eligibility Specialists may not be dedicated to a specific public assistance
22 program, a uniform process would be an important tool in error management
23 and mitigation. The checklist should be continuously developed for improved
24 efficiency and as program requirements change.

25 (c) The Eligibility Specialist shall verify the information through various
26 government information databases, such as motor vehicle registration, property,
27 employment, and income tax records. This individual then documents the
28 verification and includes it in the applicant's file. The use of IEVS shall be used
29 the resource and income eligibility determination process more efficient and

1 reliable.

2 (d) A second Eligibility Specialist then inputs the verified information
3 into the AGUPA system. Separating the intake and input processes serves as a
4 review to ensure the accuracy and completeness of the information gathered by
5 the first Eligibility Specialist.

6 (e) A supervisor(s) or other designated individual(s) should conduct
7 independent reviews of at least 1% of cases per month to ensure quality and
8 accuracy of determinations made, and compliance with public assistance
9 program requirements. This independent or tertiary review allows supervisors to
10 track staff workloads, the timeliness and accuracy of determinations, policy
11 compliance, case activities, as well as to pinpoint program violations and areas
12 of potential fraud.

13 **§2913.2. Program Residency Requirements.** (a) The Administrator
14 shall establish rules and regulations for use in determining whether an
15 applicant is a resident of Guam or is eligible for temporarily assisted care,
16 as provided in this Article. The rules shall require that an applicant shall
17 be eligible for Program benefits only if the applicant is a resident of
18 Guam and has been a resident on Guam for a period of no less than six
19 (6) months, and has physically resided on Guam for a period of not less
20 than six (6) consecutive months immediately preceding the proposed
21 Enrollment, except for temporary absences in the past year which cannot
22 be reasonably construed as absences due to bona fide residency outside of
23 Guam.

24 (b) Continued Residency. Except as specifically stated in this Article,
25 enrollment in the health insurance program for an eligible covered person shall
26 be limited to persons domiciled in the Service Area of Guam, and who do not
27 reside outside the service area for more than one hundred eighty-two (182) days
28 per plan year, and the health insurance contractor shall be entitled to require
29 substantiation from a Covered Person to determine the Covered Person's

Domicile and may deny benefits under this Agreement for lack thereof, as provided pursuant to this Article. 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.

(c) The Administrator shall establish rules and regulations for use in determining whether an applicant is a resident of Guam or is eligible for temporarily assisted care, as provided in this Article. The rules shall require that an applicant shall be eligible for Program benefits only if the applicant is a resident of Guam and has been a resident on Guam for a period of no less than six (6) months, and has physically resided on Guam for a period of not less than six (6) consecutive months immediately preceding the proposed Enrollment, except for temporary absences in the past year which cannot be reasonably construed as absences due to bona fide residency outside of Guam.

(d) In order for an applicant to prove residency, the requirements of Subsections (a) and (b) of this Section must be met. Applicants shall produce a Guam rent, mortgage receipt, or utility bill in order to establish beyond a reasonable doubt proof of residency of no less than six months. In addition, applicants shall produce one of the following:

- (1) A current Guam motor vehicle driver's license;
- (2) A current Guam motor vehicle registration;
- (3) A document showing that the applicant is or was employed on Guam, and if currently unemployed, an applicant shall provide a document showing that the applicant has registered with a public or

1 private employment service on Guam

2 (4) Evidence that the applicant has enrolled the applicant's children
3 in a school on Guam;

4 (5) Evidence that the applicant is receiving public assistance on
5 Guam; or

6 (6) Evidence of registration to vote on Guam.

7 (e) Applicants signs an affidavit attesting that all of the following applies
8 to the applicant:

9 (1) Does not own or lease a residence outside of Guam

10 (2) Does not own or lease a motor vehicle registered outside of
11 Guam

12 (3) Is not receiving public assistance outside of Guam; and

13 (4) The applicant is actively seeking employment on Guam, if the
14 applicant is able to work and is not employed.

15 (f) Applicants who refuse to cooperate in the eligibility determination
16 process pursuant to this Subsection are not eligible. Refusal to cooperate shall
17 be construed to mean that the applicant is unwilling to obtain documentation
18 required for eligibility determination. The Program shall maintain its own
19 applicant file copies of the application submitted to the Program in accordance
20 with this Subsection.

21 (g) An applicant denied eligibility by a program eligibility worker may
22 appeal the determination through the established fair hearing process.

23 **§ 2913.3 Medical Exceptions to Residency Requirements, Emergency**
24 **Medical, Tuberculosis, Pre-Natal Care.** (a) Persons who would be otherwise
25 eligible as provided by this Article, except for their failure to meet the residency
26 requirements prescribed in § 2913.2, who are ineligible for Title XIX services,
27 are eligible to receive temporary emergency services on Guam that are
28 determined by the Administrator as necessary to treat an emergency medical
29 condition.

1 (b) No residency requirement shall be imposed for persons with
2 tuberculosis or pregnant women requiring pre-natal care as described in the
3 statement of benefits. Persons with tuberculosis, leprosy, or require pre-natal
4 care shall be required only to meet income and resource eligibility standards.

5 (c) Each person desiring to be classified as eligible pursuant to this
6 Section shall apply for certification pursuant to rules established by the
7 Administrator. The Administrator shall make the final determination regarding
8 eligibility. On determination that the person is eligible for emergency care, the
9 Administrator shall issue certification of limited eligibility to the applicant and
10 shall provide notification to Program Providers.

11 (d) All persons who are applying for eligibility pursuant to this Section
12 shall submit the application with copies of verification documents to the
13 Administrator, which shall determine the applicant's eligibility. If the person is
14 hospitalized at the time of the application, the Administrator may certify the
15 person as eligible pursuant to this Section pending a final determination of
16 eligibility.

17 **§ 2913.4 Income Eligibility Standards.** The Administrator shall set
18 standards for determining monthly income for purposes of eligibility, which
19 shall consider the individual's average pattern of income and earnings, subject
20 to subsequent adjustment if actual experience deviates substantially from the
21 amount determined by such method.

22 (a) Income Limitations. The Guam ICHP Income Guidelines [MIP] shall
23 be used to determine income eligibility for programs within the Island
24 Community Health Plan. In the calculation of income, payments for medical
25 insurance or Medicare premiums shall be excluded.

26 **§ 2913.5 Resource Eligibility Standards.** For the purposes of this
27 Article, the term 'resources' shall include all real or personal property, or any
28 combination of both, held by household members. If the holdings are in the
29 form of real property, the value shall be the assessed value determined under the

1 most recent Guam property tax assessment less the unpaid amount of any
2 encumbrance of record. If the holdings consist of money on deposit, the value
3 shall be the actual amount thereof. If the holdings are in any other form of
4 personal property or investment, except life insurance, the value shall be the
5 conversion value as of the date of application. The value of property holdings
6 shall be determined as of the date of application and, if the household member
7 is found eligible, this determination shall establish the amount of such holdings.

8 (a) Resources

9 (1) The following will be included in determining liquid resources:

10 cash on hand, checks or savings account amount, stocks or bonds,
11 and shares in credit union wages.

12 (2) Cash resources that will be used for medical treatment-related
13 expenditures are exempted in determining liquid resources.

14 (3) Entire value of one licensed vehicle shall be excluded for one-
15 parent households and two vehicles for two parent households. All
16 other vehicles shall individually be evaluated at fair market value.

17 (4) Real property is excluded in determining household resources
18 when it is their primary home.

19
20 (b) Effective date of coverage is the first day of the month of application
21 that the individual has been deemed eligible for ICHP. Failure to report
22 changes in an eligible household within 10 calendar days, which would have
23 resulted in ineligibility, making false or misleading statements or withholding
24 information, shall result in the head of household and spouse (if any) to be
25 suspended from ICHP participation for three months for the first occasion; and
26 six months for the second and subsequent occasions,

27 (c) Disposition. The providing of assistance under this Article shall not
28 impose any limitation or restriction upon the individual's right to sell, exchange
29 or change the form of property holdings, nor shall the care provided constitute

any encumbrance on the holdings. However, any transfer of the holdings, by gift or without adequate or reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance. Such act shall disqualify the seller for assistance under this Article for future claims for a period determined under standards established by the Administrator. In no event shall the period of ineligibility be for less than the period of time that the capital value of the transferred property would have supplied the person's income or resource needs from the time of the transfer in excess of allowable income or resource limitations.

(d) Resource Limitation. Household's total resources shall not exceed Two Thousand Dollars (\$2,000.00).

(1) Resources, personal and real properties are counted toward the resource reserve limit, for all persons included in the assistance unit. Property of the caretaker, natural, legally liable, or adoptive parents, with whom the children are living, is also included in the assistance unit's property reserve. Properties are evaluated at market value less encumbrances. The following are considered real property: land, houses, mobile homes, and immovable property attached to the land; personal property is all assets other than real property.

(2) Client who is a 'Representative Payee' or 'Legal Guardian' or managing someone else's funds. These funds are not included in the client's personal property reserve when they are kept in an account separate and apart from the client's monies and can be identified as being received and designated for someone other than the client.

(e) Assets. In determining the liquid resources of a household applying for the Program, the following shall be included as liquid assets, unless otherwise exempted in this Article:

(1) cash on hand;

(2) check or savings account amount;

1 (3) stocks or bonds; and

2 (4) shares in credit union wages from employment, including lump
3 sum payments, time certificates, and other investments or cash
4 holdings.

5 (f) Cash Resources for Medical Treatment Exempted. Cash resources that
6 will be used for medical treatment-related expenditures are exempted in
7 determining liquid resources.

8 (g) Vehicles. The entire value of one (1) licensed vehicle shall be
9 excluded for one-(1) parent households and two (2) vehicles shall be excluded
10 for two (2) parent households. All other vehicles shall individually be evaluated
11 at Fair Market Value (FMV) and that portion of the value, which exceeds the
12 current Food Stamp Program vehicle disregard, shall be attributed in full toward
13 the household's resource limit, regardless of any encumbrances on the vehicles.
14 Vehicles for individuals with disabilities that are customized with a lift to
15 accommodate those individuals with wheelchairs for the purpose of transporting
16 those individuals shall be exempted on a case-by-case basis.

17 (1) Verifications. Client's statement regarding the number of vehicles
18 owned, ownership status and availability is acceptable. To obtain a
19 vehicle's market value, the possible sources of verification include, but
20 are not limited to:

21 (A) Kelly Blue Book (Wholesale Value);

22 (B) Copy of Bill of Sale;

23 (C) Estimate from Auto Dealer; or

24 (D) Cars not in the Kelly Blue Book, ES assessments.

25 (h) Real Property. Real property is excluded in determining the resources
26 of the household when it is their primary home, including the surrounding land
27 that is not separated from the home by intervening property owned by others.
28 Public rights of way, such as roads that run through the surrounding property
29 and separate it from the home will not affect the property exemption.

1 Households that currently do not own a home, but own or are buying a land on
2 which they intend to build or are building a permanent home, shall receive an
3 exclusion for the value of the land and, if it is partially completed for the home.

4 (1) Verifications:

5 (A) Signed and Dated statement from a licensed real estate
6 broker;

7 (B) Tax Listings;

8 (C) Copy of the Mortgage Papers; and

9 (D) Copy of the Deed of Gift.

10 The agency shall exclude from 'resources' consideration the necessary
11 non-liquid income producing property but not real property as defined under the
12 following criteria: Stocks, inventory, tools, equipment and other non-liquid
13 income-producing property which are usual customary for a given trade,
14 profession or business.

15 **§ 2913.6. Uncovered Medical Procedure.** In situations where a person's
16 health insurance will not be able to cover a particular condition or procedure,
17 and the condition or procedure is within the scope of services covered by the
18 Program, the person may apply for assistance. If found eligible, only the
19 uncovered procedure will be covered by the Program.

20 **§ 2913.7 Discontinuance of Insurance.** If otherwise insured, any
21 household member at the time of application must maintain the member's
22 insurance. Any household member who is discontinued from insurance
23 coverage for reasons beyond that person's control may be eligible for Program
24 coverage if eligibility criteria are met. A one (1) year penalty shall be imposed
25 for applicants that knowingly violate this requirement.

26 **§ 2913.8 Potential Medicaid Clients.** Potential Program applicants that
27 may qualify for Medicaid benefits must apply for assistance to the appropriate

1 Medicaid categorical program and exhaust all eligible benefits before they can
2 be eligible for coverage under the Island Community Health Plan.

3 **§ 2913.9 Last Resort for Medical Services.** The Island Community
4 Health Plan is intended to be the last resort for the provision of medical services
5 for those persons who cannot pay for medical services. Therefore, a person with
6 medical insurance must refer claims to that person's insurance company first,
7 before the bills can be submitted to the Island Community Health Plan. Those
8 services provided by Federal or other Guam Programs shall be utilized first, in
9 order that the Island Community Health Plan is the payer of last resort.

10 **§ 2913.10. Treatment of Eighteen-Year-Old Applicants.** An individual
11 who has attained the age of eighteen (18) years and who is not a dependent for
12 tax purposes of another household may apply to the Island Community Health
13 Plan. An individual who is between the ages of eighteen (18) and twenty-three
14 (23) years who is still attending high school or college and living at home may
15 be included under that person's parents, or household member's application to
16 the Island Community Health Plan and the family's income.

17 **§ 2913.11. Emancipated Adult.** A minor may apply for Program
18 eligibility as a legally declared emancipated adult; provided, that an affidavit is
19 submitted by the minor indicating that the minor is living a life as an adult apart
20 from the minor's parents, and is 'self-sufficient.'

21 **§ 2913.12. Eligibility Certification Periods.** Once qualified as eligible,
22 persons may participate in the Program for periods that run from six (6) months
23 to one (1) year, subject to the restrictions established herein. Households with
24 at least one (1) member between the ages of seventeen (17) and fifty-four (54)
25 years shall be given a certification for a period of six (6) months. A household
26 with all members who are fifty-five (55) years old or older, or with at least one
27 (1) member with a permanent disability affirmed by a Provider, shall be given
28 certification for a period of one (1) year. Shorter periods of certification may be
29 established if deemed necessary by the Administrator.

1 **§ 2913.13. Special Provisions for Children in Child Protective**
2 **Services.** All children in the legal custody of Child Protective Services shall be
3 eligible to receive health care benefits as provided in § 2916 of this Article, if
4 either parent is not covered by a health insurance plan or does not qualify for
5 the Island Community Health Plan.

6 **§ 2914. Contributions from FAS Governments to Mañelu Plus**
7 **Program.** The following Subsections regulate FAS government contributions:

8 **§ 2914.1.** The Director, Department of Administration shall develop
9 methodologies to accept funding from the Federation of Associated States for
10 the purpose of expanding healthcare eligibility above the stated income
11 guidelines of this Act.

12 **§ 2914.2.** The Director, Department of Administration shall establish a
13 timeline of acceptance of these funds to provide coverage to the effected
14 population group.

15 **§ 2914.3.** The Director, Department of Administration shall establish all
16 necessary policy and procedures related to the expansion of eligibility in
17 coordination with the relevant FAS government officials to meet the plan
18 requirements of the Mañelu Plus Program.

19 **§ 2915. Administrative Provisions.** (a) The Administrator may:

20 (1) prescribe uniform forms to be used by all Providers and shall
21 prescribe and furnish uniform forms and procedures, including methods
22 of identification of members, to be used for determining and reporting
23 eligibility of members; and

24 (2) enter into an interagency agreement with the Department to
25 determine the eligibility of all persons defined pursuant to this Article,
26 and ensure that the eligibility process is coordinated with other assistance
27 Programs.

1 (b) No less than sixty (60) days prior to the implementation of a policy or
2 a change to an existing policy relating to reimbursement, the Administrator shall
3 provide notice to interested parties.

4 (c) The Administrator is authorized to apply for any Federal funds
5 available for the support of Programs to investigate and prosecute violations
6 arising from the administration and operation of the Program. Available local
7 funds appropriated for the administration and operation of the Program may be
8 used as matching funds to secure Federal funds pursuant to this Subsection.

9 (d) Determination of Head of Household.

10 (1) In a single-member household the person shall be the head of
11 household.

12 (2) In a household where there is only one (1) parent, that parent
13 shall be the head of household.

14 (3) In a household where both the male and female parents have
15 earned income, the parent with the higher income shall be the head of
16 household.

17 (e) Document Verification; Birth Certificates and Social Security Card.

18 (1) A birth certificate and social security card are required for each
19 member of the household applying for assistance.

20 (2) Birth certificates may be substituted by a passport, baptismal
21 certificate, an Alien Registration Receipt Card (green card) or a
22 government of Guam Identification Card, if birth certificates are not
23 available.

24 (3) In the absence of a Social Security Card, a receipt of the
25 application for Social Security Card should be sufficient; however, the
26 member shall provide the Program with a photocopy of the Social
27 Security Card after its receipt. For verification, a written statement or
28 other documents from the Social Security Administration, or a Guam

1 driver's license or Guam ID if the social security number is indicated on
2 it shall be accepted.

3 (f) Alien Registration Receipt Card. The Alien Registration Receipt Card
4 will be required for all resident alien applicants.

5 (g) Income.

6 (1) Last two (2) month's check stubs and current month's check
7 stub shall be provided as part of income verification.

8 (2) An employment verification from the employer must be
9 obtained showing the average hours worked and hourly rate the employee
10 has earned for the last three (3) months.

11 (3) Self-employed individuals, other than those farming and
12 fishing, with income over One Hundred Dollars (\$100.00) a month must
13 provide the latest business privilege, tax receipts and the latest 1040
14 Forms. If no 1040 Forms can be provided, an affidavit indicating
15 expenses for the same month shall be furnished. For fishermen or
16 farmers, a notarized statement of income will be required and proof of
17 being exempted from filing the business privilege tax must be obtained
18 from the Department of Revenue and Taxation and submitted to the
19 Program. Those others with income less than One Hundred Dollars
20 (\$100.00) a month will be required also to submit a notarized statement
21 of earnings.

22 (h) Vehicle and Property. An affidavit shall be provided indicating that
23 the applicant meets the eligibility restrictions on ownership of vehicles and real
24 property as provided in this Act.

25 (i) Cash Resources. Photocopies of passbooks and bank statements are
26 required if an applicant indicates amounts of cash resources in the application
27 form.

28 (j) Permanent Resident Alien. Aliens who are applying for assistance
29 shall provide information and required documentation concerning the sponsor's

1 income and resources as a condition for eligibility. In determining the
2 eligibility for all qualified aliens, the income and resources of any person who
3 executed an affidavit of support pursuant to the Immigration and Nationality
4 Act on behalf of the qualified alien and the income and resources of the spouse,
5 if any, of the sponsoring individual shall be counted at the time of application
6 and for the re-determination of eligibility for the duration of the attribution
7 period, as specified in Federal law. If a resident alien's sponsor did not execute
8 an affidavit of support pursuant to the Immigration and Nationality Act on
9 behalf of the qualified alien, then the income and resources of a sponsor(s) and
10 the sponsor's spouse, if living together, shall be treated as unearned income and
11 resources.

12 (k) Issuance of Program Card. The Contractor shall issue an identification
13 card identifying all eligible family members. Each household will be assigned a
14 unique number. Cards will indicate the period of Program coverage, other
15 medical insurance coverage, applicable liability rates, and selected primary
16 physicians and /or specialist(s).

17 (l) Denials. Applicants will be denied when:

18 (1) ineligibility is established;

19 (2) an applicant fails to provide necessary information to determine
20 eligibility; or

21 (3) the Program loses contact with the applicant before eligibility is
22 determined.

23 (m) Reporting Requirements. All Program Participants shall report
24 within ten (10) days to the Program any changes in their households, such as the
25 following:

26 (1) moved to another house;

27 (2) someone moved into the household;

28 (3) someone moved out of the household;

29 (4) someone in the household has given birth;

- 1 (5) someone in the household terminated from employment;
2 (6) someone in the household received a raise in wage or salary;
3 (7) someone in the household obtained a job;
4 (8) someone in the household reached the age of nineteen (19) or
5 sixty-five (65) years old;
6 (9) someone in the household becomes permanently disabled; or
7 (10) someone in the household has expired.

8 (n) Penalty for Failure to Report Changes. The above list is not inclusive.
9 Therefore, all changes shall be reported. Failure to report changes within ten
10 (10) calendar days, a change or changes in household circumstances which
11 should have resulted in ineligibility, making false or misleading statements or
12 withholding information at the time of application which should have resulted
13 in ineligibility, the head of household and spouse (if any) shall be suspended
14 from the Program participation for:

- 15 (1) Three (3) months, for the first occasion;
16 (2) Six (6) months, for the second and subsequent occasions. The
17 individual(s) must be notified in writing once it is determined that he/she
18 is to be penalized. The period of suspension shall be no later than the
19 second month that follows the date the individual(s) receive the written
20 notice of the suspension. The period of suspension must continue
21 uninterrupted until completed regardless of the eligibility of the
22 suspended individual's household. This penalty is in addition to the
23 recoupment of improper payments made to the service provider.

24 (o) Termination of Assistance. In addition to any other penalties imposed
25 elsewhere in this Article for fraud or false declarations with an intention to
26 obtain improper access to Program services, the following shall constitute
27 grounds for the termination of assistance:

- 28 (1) false declarations in seeking Program eligibility; or
29 (2) failure to report changes in household status as required by this

1 Article.

2

§ 2916. ICHP Schedule of Benefits

Schedule of Benefits

<u>Your Benefits: What your plan covers</u>	<u>Mañelu Participating Providers</u>	<u>Mañelu Non-Participating Providers</u>	<u>Mañelu Plus Participating Providers above 138% FPL, (members below 138% share the same charges as Standard Mañelu Program)</u>	<u>Mañelu Plus Non-Participating Providers</u>	<u>Mainaina Participating Providers</u>
<u>Deductible Per Individual Member</u>	<u>\$0</u>	<u>\$1,500</u>	<u>\$500</u>	<u>\$1,500</u>	<u>\$0</u>
<u>Deductible Per Family</u>	<u>\$0</u>	<u>\$3,000</u>	<u>\$0</u>	<u>\$3,000</u>	<u>\$0</u>
If a member meets their \$1,500 deductible, the plan begins to pay for covered services for that individual					
<u>Coverage Maximums</u>	<u>None</u>	<u>None</u>	<u>None</u>	<u>None</u>	<u>None</u>
<u>Individual member annual maximum</u>					
<u>Out of Pocket Maximums (including accumulated deductible and copays)</u>	<u>No Maximum</u>	<u>No Maximum</u>	<u>No Maximum</u>		
<u>Per Individual member per policy year</u>	<u>\$3,000</u>		<u>\$3,000</u>		<u>\$3,000</u>
<u>Per Family per policy year</u>	<u>\$9,000</u>		<u>\$9,000</u>		<u>\$9,000</u>
<u>Lifetime Maximum Cap</u>	<u>\$1,000,000</u>	<u>No Maximum</u>	<u>\$1,000,000</u>	<u>No Maximum</u>	<u>\$1,000,000</u>
<u>Any Services in the Philippines, Hawaii & the U.S. Mainland and any foreign participating providers. (Pre-Certification Required)</u>	<u>Requires a referral from your doctor and approval in advance from the plan</u>	<u>Requires a referral from your doctor and approval in advance from the plan</u>	<u>Requires a referral from your doctor and approval in advance from the plan</u>	<u>Requires a referral from your doctor and approval in advance from the plan</u>	<u>Requires a referral from your doctor and approval in advance from the plan</u>
<u>Deductible and Co-Pay do not apply to these benefits when you go to a Participating Provider:</u>	<u>Participating Providers</u>	<u>Non-Participating Providers</u>	<u>Participating Providers</u>	<u>Non-Participating Providers</u>	<u>Participating Providers</u>
	<u>(deductible does not apply to this benefit)</u>	<u>(after deductible is met)</u>	<u>(deductible does not apply to this benefit)</u>	<u>(after deductible is met)</u>	<u>(deductible does not apply to this benefit)</u>

Preventive Services (Out-Patient Only)	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>
Includes Annual Preventive Exams, Health Risk Appraisal and Preventive Lab Services (Guam and Philippines only)					
In accordance with the current guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations. These guidelines are found at www.uspreventiveservicestaskforce.org					
Immunizations/Vaccinations	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>
In accordance with the guidelines established by the Advisory Committee on Immunization Practices. Current immunization schedules may be found at www.cdc.gov .					
Pre-Natal Care	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Not Covered</u>
Including Routine Labs and 1st Ultrasound					
Well-Child Care	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Not Covered</u>
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					
In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care					
Well-Woman Care	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>
In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA), and the Women's Health and Cancer Act					
Deductible does not apply to these benefits when you go to a Participating Provider. Co-payments do not accrue towards the deductible :	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers
	(deductible does not apply to this benefit)	(after deductible is met)	(deductible does not apply to this benefit)	(after deductible is met)	(deductible does not apply to this benefit)
Annual Eye Exam	<u>\$5 Member Co-Pay</u>	<u>Not Covered</u>	<u>\$10 Member Co-Pay</u>	<u>Not Covered</u>	<u>\$5 Member Co-Pay</u>
Once per Member per Plan Year	<u>Covered in Guam Only</u>	<u>Covered in Guam Only</u>	<u>Covered in Guam Only</u>	<u>Covered in Guam Only</u>	<u>Covered in Guam Only</u>
Outpatient Physician Care & Services					

1. Primary Care Visits	\$5 Member Co-Pay	Plan pays 80% Member pays 20%	\$10 Member Co-Pay	Plan pays 70% * Member pays 30%	\$5 Member Co-Pay
2. Specialist Care Visits	\$10 Member Co-Pay	Plan pays 80% Member pays 20%	\$20 Member Co-Pay	Plan pays 70% * Member pays 30%	\$10 Member Co-Pay
3. Urgent Care Centers	\$5 Member Co-Pay	Plan pays 80% Member pays 20%	\$1 Member Co-Pay	Plan pays 70% * Member pays 30%	\$5 Member Co-Pay
4. Voluntary Second Surgical Opinion	\$20 Member Co-Pay	Plan pays 80% Member pays 20%	\$20 Member Co-Pay	Plan pays 70% * Member pays 30%	\$20 Member Co-Pay
5. Home Health Care Visit	Plan pays 100% (PA required)	Not Covered	Plan pays 100% (PA required)	Not Covered	Plan pays 100% (PA required)
6. Hospice Care in Guam only, maximum 180 days at a maximum of \$150 per day (Pre-Certification Required)	Limited to two 90-day periods, PA required beyond 180 days. Not covered off island.	Plan pays 80% Member pays 20%	Limited to two 90-day periods, PA required beyond 180 days. Not covered off island.	Plan pays 70% * Member pays 30%	Limited to two 90-day periods, PA required beyond 180 days. Not covered off island.
7. Outpatient Laboratory	Plan pays 100%	Plan pays 80% Member pays 20%	Plan pays 100%	Plan pays 70% * Member pays 30%	Plan pays 100%
8. X-Ray Services	Plan pays 90% member pays 10%	Plan pays 80% Member pays 20%	Plan pays 90% member pays 10%	Plan pays 70% * Member pays 30%	Plan pays 90% member pays 10%
9. Injections (Does not include those on the Specialty Drugs List and Orthopedic injections)	Plan pays 100%	Plan pays 80% Member pays 20%	Plan pays 100%	Plan pays 70% * Member pays 30%	Plan pays 100%
Prescription Drugs					
1. Formulary generic drugs per prescription unit	\$2.50 Member Co-Pay (30 day supply)	Plan pays 50% of Average Wholesale Price	\$5.00 Member Co-Pay (30 day supply)	Plan pays 50% of Average Wholesale Price	\$2.50 Member Co-Pay (30 day supply)
2. Formulary brand name drugs per prescription unit	If no generic available or if physician directed (no substitution) \$5.00 co-payment per prescription filled 30-day supply.	Plan pays 50% of Average Wholesale Price	If no generic available or if physician directed (no substitution) \$10.00 co-payment per prescription filled 30-day supply.	Plan pays 50% of Average Wholesale Price	If no generic available or if physician directed (no substitution) \$5.00 co-payment per prescription filled 30-day supply.
3. Mail Order	Co-Pay waived	Plan pays 50% of Average Wholesale Price	Co-Pay waived	Plan pays 50% of Average Wholesale Price	Co-Pay waived

4. Non-Formulary (Medically Necessary Only and Pre-Certification Required)	Plan pays 100% ,PA required	Plan pays 50% of Average Wholesale Price	Plan pays 100% , PA required	Plan pays 100% , PA required
5. Specialty Drugs (Medically Necessary Only and Pre-Certification Required)	Plan pays 100% ,PA required	Not Covered	Plan pays 100% , PA required	Plan pays 100% , PA required
Deductible must be met for the following services:	Participating Providers	Non-Participating Providers	Participating Providers	Participating Providers
	(after deductible is met)	(after deductible is met)	(after deductible is met)	(after deductible is met)
Acupuncture	\$50.00 per visit, 10 visits per contract period	Not Covered	\$50.00 per visit, 10 visits per contract period	\$50.00 per visit, 10 visits per contract period
AIDS Treatment	Plan pays 100%	Not Covered	Plan pays 100%	Plan pays 100%
Exclusive of Experimental drugs				
Airfare Benefit to Centers of Excellence only	Plan pays 100% for medically necessary services that are not available on island. (PA required) Round trip air transportation to an eligible patient, one (1) parent/guardian if patient is a minor.	Not Covered	Plan pays 100% for medically necessary services that are not available on island. (PA required) Round trip air transportation to an eligible patient, one (1) parent/guardian if patient is a minor.	Plan pays 100% for medically necessary services that are not available on island. (PA required) Round trip air transportation to an eligible patient, one (1) escort.

For members who meet qualifying conditions. Plan provides round-trip airfare (Plan Approval Required)

Allergy Testing	For medically necessary service	Plan pays 70% * Member pays 30%	For medically necessary service	Plan pays 70% * Member pays 30%	For medically necessary service
\$1000 per member per plan year					
Ambulatory Surgi-center Care	Plan pays 100%	Plan pays 70% * Member pays 30%	Plan pays 100%	Plan pays 70% * Member pays 30%	Plan pays 100%
Blood & Blood Derivatives (Pre-Certification Required)	Plan pays a maximum of \$50,000 per fiscal year excluding any person with hemophilia, or any condition requiring the administration of blood and blood products	Plan pays 70% * Member pays 30%	Plan pays a maximum of \$50,000 per fiscal year excluding any person with hemophilia, or any hemophilia-related condition requiring the administration of blood and blood products	Plan pays 70% * Member pays 30%	Plan pays a maximum of \$50,000 per fiscal year excluding any person with hemophilia, or any hemophilia-related condition requiring the administration of blood and blood products

<u>Breast Reconstructive Surgery (in accordance with 1998 W.H.C.R.A)</u>	<u>Plan pays 100% (PA required)</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100% (PA required)</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100% (PA required)</u>
<u>Cardiac Surgery</u>	<u>Plan pays 90% member pays 10%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90% member pays 10%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90% member pays 10%</u>
<u>Cataract Surgery Outpatient Only (including conventional lens)</u>	<u>Plan pays 90% member pays 10%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90% member pays 10%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90% member pays 10%</u>
<u>Chemical Dependency</u>	<u>Maximum \$10,000 per fiscal year</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Maximum \$10,000 per fiscal year</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Maximum \$10,000 per fiscal year</u>
<u>Chemotherapy Benefit</u>	<u>plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>plan pays 100%</u>
<u>Chiropractic Care- 10 visits per member per plan year</u>	<u>10 visits at \$25 per visit per fiscal year</u>	<u>Not Covered</u>	<u>10 visits at \$25 per visit per fiscal year</u>	<u>Not Covered</u>	<u>10 visits at \$25 per visit per fiscal year</u>
<u>Congenital Anomaly Diseases Coverage</u>	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>	<u>Not Covered</u>	<u>Plan pays 100%</u>
<u>Diagnostic Testing</u>	<u>Plan pays 90% Member pays 10%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90% Member pays 10%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90% Member pays 10%</u>
<u>MRI, CT scan, and other diagnostic procedures (Pre-Certification Required)</u>					
<u>Durable Medical Equipment (DME)</u>	<u>Plan pays 100% One (1) of each type DME Every Five Years: Standard wheelchair, standard hospital bed, walker, crutches, CPAP, and oxygen and accessories, Physician Prescription and PA is required. The lesser amount between purchase and rental of each type DME.</u>	<u>Not Covered</u>	<u>Plan pays 100% One (1) of each type DME Every Five Years: Standard wheelchair, standard hospital bed, walker, crutches, Prescription and PA is required. The lesser amount between purchase and rental of each type DME.</u>	<u>Not Covered</u>	<u>Plan pays 100% One (1) of each type DME Every Five Years: Standard wheelchair, standard hospital bed, walker, crutches, standard CPA P, and oxygen and accessories, Physician Prescription and PA is required. The lesser amount between purchase and rental of each type DME.</u>

<u>Elective Surgery</u> (Pre-Certification Required)	<u>Plan pays 100%. PA is required for elective surgery with one or more day admission prior to surgery.</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%. PA is required for elective surgery with one or more day admission prior to surgery.</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%. PA is required for elective surgery with one or more day admission prior to surgery.</u>
<u>Emergency Care</u>	<u>Plan pays 100%. Maximum \$175,000 per year, including airfare/travel and escort fees. PA is required.</u>	<u>Plan pays 80% * Member pays 20% *</u>	<u>Plan pays 100%. Maximum \$175,000 per year, including airfare/travel and escort fees. PA is required.</u>	<u>Plan pays 80% * Member pays 20% *</u>	<u>Plan pays 100%. Maximum \$175,000 per year, including airfare/travel and escort fees. PA is required.</u>
1. On/Off Island emergency facility, physician services, laboratory, X-rays					
2. Ambulance Services (Ground Transportation Only) For off-island emergencies, Plan must be contacted and advised within 48 hours					
<u>End Stage Renal Disease / Hemodialysis</u>	<u>Plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%</u>
<u>Audiological examinations, Hearing Aids</u> Maximum \$500 per member per plan year	<u>Maximum \$500.00. Plan pays 100% of the maximum amount</u>	<u>Not Covered</u>	<u>Maximum \$500.00. Plan pays 100% of the maximum amount</u>	<u>Not Covered</u>	<u>Maximum \$500.00. Plan pays 100% of the maximum amount</u>
<u>Hospitalization & Inpatient Benefits</u> 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	<u>Plan pays 100%. Prior Authorization is required after the first 60 days that includes weekends.</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%. Prior Authorization is required after the first 60 days that includes weekends.</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%. Prior Authorization is required after the first 60 days that includes weekends.</u>
<u>Implants</u> Limited to cardiac pacemakers, heart valves, stents, orthopedic internal prosthetic devices	<u>Plan pay 100%. cardiac pacemakers, heart valves, stents, intraocular lenses are not covered</u> <u>Plan pays 100%</u>	<u>Plan pays 50% * Member pays 50%</u> <u>Plan pays 70% * Member pays 30%</u>	<u>Plan pay 100%. cardiac pacemakers, heart valves, stents, intraocular lenses are not covered</u> <u>Plan pays 100%</u>	<u>Plan pays 50% * Member pays 50%</u> <u>Plan pays 70% * Member pays 30%</u>	<u>Plan pay 100%. cardiac pacemakers, heart valves, stents, intraocular lenses are not covered</u> <u>Plan pays 100%</u>
<u>Inhalation Therapy</u>	<u>Plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%</u>
<u>Maternity Care</u> Labor and Delivery	<u>Plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100%</u>
<u>Mental Health Care</u>	<u>Maximum of 30 days inpatient hospitalization per illness. Plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Maximum of 30 days inpatient hospitalization per illness. Plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Maximum of 30 days inpatient hospitalization per illness. Plan pays 100%</u>

<u>Nuclear Medicine</u> (Pre-Certification Required)	<u>Plan pays 90%; Member pays 10%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90%; Member pays 10%</u>	<u>Plan pays 70% * Member pays 30%</u>
<u>Occupational Therapy</u> 20 visits per Plan Year (Pre-Certification Required)	<u>Limited to 20 visits, thereafter 50% coinsurance. Plan pays 100%</u>	<u>Not Covered</u>	<u>Limited to 20 visits, thereafter 50% coinsurance. Plan pays 100%</u>	<u>Not Covered</u>
<u>Organ Transplant</u>	<u>Not covered</u>		<u>Not covered</u>	<u>Not covered</u>
<u>Orthopedic Conditions</u> <u>Internal and External Prosthesis</u>	<u>Plan pays 90%, member pays 10%. Maximum \$50,000 per year.</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90%, member pays 10%. Maximum \$50,000 per year.</u>	<u>Plan pays 70% * Member pays 30%</u>
<u>Physical Therapy(Pre-Certification Required)</u>	<u>Plan pays 100% (PA required) Limited to 20 visits, thereafter 50% coinsurance.</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100% (PA required) Limited to 20 visits, thereafter 50% coinsurance.</u>	<u>Plan pays 70% * Member pays 30%</u>
<u>Radiation Therapy</u> (Pre-Certification Required)	<u>Plan pays 90%, 10% co-pay</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90%, 10% co-pay</u>	<u>Plan pays 70% * Member pays 30%</u>
<u>Robotic Surgery/Robotics Suite</u> (Pre-Certification Required)	<u>Plan pays 90%, 10% co-pay</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 90%, 10% co-pay</u>	<u>Plan pays 70% * Member pays 30%</u>
<u>Skilled Nursing Facility</u> (Pre-Certification Required)	<u>Limited to 60 days maximum per fiscal year. Plan pays 100%</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Limited to 60 days maximum per fiscal year. Plan pays 100%</u>	<u>Limited to 180 days maximum per fiscal year. Plan pays 100%</u>
<u>Sleep Apnea Diagnostics and Therapeutic Procedure</u> (Pre-Certification Required)	<u>Plan pays 100% (PA required)</u>	<u>Not Covered</u>	<u>Plan pays 100% (PA required)</u>	<u>Plan pays 100% (PA required)</u>
<u>Voluntary Sterilization Procedures</u>				
<u>Vasectomy (Outpatient Only)</u>	<u>Plan pays 100% (PA required)</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100% (PA required)</u>	<u>Plan pays 70% * Member pays 30%</u>
<u>Hysterectomy</u>	<u>Plan pays 100% (PA required)</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Plan pays 100% (PA required)</u>	<u>Plan pays 70% * Member pays 30%</u>
<u>Vision Care</u>	<u>Eye Exam: Maximum \$50 every year. Corrective Lenses: Maximum \$100 every two (2) years. Bi-focal Lenses: Maximum \$130 every two (2) years. (PA is required)</u> <u>Plan pays 100% of the</u>	<u>Plan pays 70% * Member pays 30%</u>	<u>Eye Exam: Maximum \$50 every year. Corrective Lenses: Maximum \$100 every two (2) years. Bi-focal Lenses: Maximum \$130 every two (2) years. (PA is required)</u> <u>Plan pays 100% of the maximum limit</u>	<u>Eye Exam: Maximum \$50 every year. Corrective Lenses: Maximum \$100 every two (2) years. Bi-focal Lenses: Maximum \$130 every two (2) years. (PA is required)</u> <u>Plan pays 100% of the maximum limit</u>

	<u>maximum limit</u>				
Additional Benefits: What the Plan Covers					
Wellness and Fitness Benefit	\$200.00 annually (PA required)	Not Covered	\$200.00 annually (PA required)	Not Covered	\$200.00 annually (PA required)

1 **§ 2917. Medical Exclusions.** (a) General listing:

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

10 2. No benefits will be paid if any material statement made in an
11 application for coverage, enrollment of any Dependent or in any claim for
12 benefits is false. Upon identifying any such false statement, Company shall
13 give the Covered Person at least 30 day's notice that his or her benefits have
14 been suspended and that his or her coverage is to be terminated. If the false
15 statement is fraudulent or is an intentional misrepresentation of a material
16 fact, such termination shall be retroactive to the date coverage was provided
17 or continued based on such fraudulent statement or intentional
18 misrepresentation of material fact. If the false statement was not a fraudulent
19 statement or intentional misrepresentation of material fact, termination of
20 coverage shall be effective no earlier than the date of the suspension. The
21 Covered Person may dispute any termination of coverage by filing a claim
22 under the grievance procedure provided for in the Agreement. If a grievance
23 is filed, the resolution of the matter shall be in accordance with the outcome
24 of the grievance proceedings. If no grievance is filed for any retroactive
25 termination and the Company paid benefits prior to learning of any such
26 false statement, the Subscriber must reimburse the Company for such

1 payment. Terminations of coverage shall be handled in accordance with the
2 applicable claims procedure requirements of Section 2719 of the PHSA, as
3 added by PPACA. Retroactive terminations of coverage shall not violate the
4 applicable prohibitions on rescissions of Section 2712 of the PHSA, as added
5 by PPACA, and rescissions shall be handled in compliance with PPACA's
6 applicable claim denial requirements.

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

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

20 5. No benefits will be paid for private Duty Nursing. This provision
21 does not apply to Home Health Care.

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

25 7. No benefits will be paid for services required by third parties,

1 including but not limited to, physical examinations, diagnostic services and
2 immunizations in connection with obtaining or continuing employment,
3 obtaining or maintaining any license issued by a municipality, state, or
4 federal government, securing insurance coverage, travel, school admissions
5 or attendance, including examinations required to participate in athletics,
6 except when such examinations are considered to be part of an appropriate
7 schedule of wellness services.

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

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

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

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

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

1 of any deceased person.

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

5 14. No benefits will be paid for Services and supplies provided to a
6 dependent of a non-Spouse Dependent. Dependents of non-Spouse
7 Dependents are not eligible for coverage. For example, when a Dependent,
8 other than a Spouse of the Subscriber, has a child, that child is a dependent
9 of a non-Spouse Dependent and is not eligible to become covered under the
10 Plan, unless such child otherwise becomes eligible for enrollment.

11 15. No benefits will be paid for home uterine activity monitoring.

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

16 17. No benefits will be paid for treatment of occupational injuries and
17 occupational diseases, including those injuries that arise out of (or in the
18 course of) any work for pay or profit, or in any way results from a disease or
19 injury that does. If a Member is covered under a Workers' Compensation law
20 or similar law, and submits proof that the Member is not covered for a
21 particular disease or injury under such law, that disease or injury will be
22 considered "non-occupational" regardless of cause. The Covered Benefits
23 under the Group Health Insurance Certificate for Members eligible for
24 Workers' Compensation are not designed to duplicate any benefit to which
25 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

18. No benefits will be paid for:

18.a) Drugs or substances not approved by the Food and Drug Administration (FDA), or

18.b) 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.

19. No benefits will be paid for experimental or Investigational treatments and Procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational treatments and procedures or pharmacological regimes, unless deemed medically necessary by patient's physician and pre-authorized by Company.

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

Experimental and investigational treatments include off label therapies. Off-label therapies are those medical therapies that use a FDA approved drug or

procedure for a non-indicated use. Also, these Experimental or investigational medical and surgical procedures, equipment, and items or medications, are otherwise not covered by Medicare or covered under qualifying clinical trials.

20. No benefits will be paid for services or supplies related to Genetic Testing.

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

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

23. No benefits will be paid for any medical Service or supply which is available to the Covered Person on Guam and which is paid by or reimbursable through a governmental agency or institution. However, notwithstanding the aforesaid, in no event will the Company consider the availability of benefits under Medicaid or Island Community Health Plan when paying benefits under this Agreement.

24. No benefits will be paid for dental services including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the

gums, apicoectomy (dental root resection), orthodontics, dental splint and other dental appliances, root canal treatment, soft tissue impactions, alveolectomy, augmentation, and vestibuloplasty, treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, maxillary and mandible implants (Osseo integration) and all related services, removal of impacted teeth, bite plates, orthognathic surgery to correct a bite defect. This exclusion does not apply to:

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

24.b) Emergency Services 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.

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

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

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

26. 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.

27. 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.

28. 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.

29. 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.

30. No benefits will be paid for hypnotherapy.

31. 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.

32. 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:

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

32.b) surgery to correct the results of injuries causing an

1 impairment;

2 32.c) surgery as a continuation of a staged reconstruction
3 procedure, including but not limited to post-mastectomy reconstruction;

4 32.d) surgery to correct congenital defects necessary to restore
5 normal bodily functions, including but not limited to, cleft lip and cleft
6 palate.

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

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

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

20 36. No benefits will be paid for Services and supplies provided for
21 liposuction.

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

38. 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.

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

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

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

41.a) The purchase of donor sperm and any charges for the storage of sperm;

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

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

41.d) Home ovulation prediction kits;

41.e) Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;

41.f) Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube

1 transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any
2 advanced reproductive technology ("ART") procedures or services related
3 to such procedures;

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

6 41.h) Donor egg retrieval or fees associated with donor egg
7 programs, including but not limited to fees for laboratory tests;

8 41.i) Any charge associated with a frozen embryo transfer
9 including but not limited to thawing charges;

10 41.j) Reversal of sterilization surgery; and

11 41.k) Any charges associated with obtaining sperm for ART
12 procedures.

13 42. Except as provided in this Agreement, no benefits will be paid for the
14 purchase or rental of durable or disposable medical equipment and supplies,
15 other than for :

16 42.a) equipment and supplies used in a Hospital or Skilled Nursing
17 Facility or in conjunction with an approved Hospital or Skilled Nursing
18 Facility confinement or as otherwise noted in the Agreement or

19 42.b) items covered as preventive care under well-women coverage
20 such as breastfeeding supplies in accordance with reasonable medical
21 management techniques.

22 43. No benefits will be paid for household equipment, including but not
23 limited to, the purchase or rental of exercise cycles, water purifiers, hypo-
24 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.

44. 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.

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

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

47. 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.

48. 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.

49. 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

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

51. No benefits will be paid for Services for which the Covered Person

1 or Subscriber is not legally obligated to pay.

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

6 53. No benefit will be paid for elective or voluntary enhancement
7 procedures, surgeries, services, supplies and medications including, but not
8 limited to, hair growth, hair removal, hair analysis, sexual performance,
9 athletic performance, anti-aging, and mental performance, even if prescribed
10 by a Physician.

11 54. No benefits will be paid for hospital take-home drugs.

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

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

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

20 58. No benefits will be paid for Psychoanalysis or psychotherapy
21 credited toward earning a degree or furtherance of education or training
22 regardless of diagnosis or symptoms or whether providing or receiving the
23 Service.

24 59. No benefits will be paid for non-medically necessary services,

1 including but not limited to, those services and supplies:

2 59.a) Which are not Medically Necessary for the diagnosis and
3 treatment of illness, injury, restoration of physiological functions, or
4 covered preventive services;

5 59.b) That do not require the technical skills of a medical, mental
6 health or a dental professional;

7 59.c) Furnished mainly for the personal comfort or convenience of
8 the Member, or any person who cares for the Member, or any person who
9 is part of the Member's family, or any Provider;

10 59.d) Furnished solely because the Member is an inpatient on any
11 day in which the Member's disease or injury could safely and adequately
12 be diagnosed or treated while not confined;

13 59.e) Furnished solely because of the setting if the service or
14 supply could safely and adequately be furnished in a Physician's or a
15 dentist's office or other less costly setting.

16 60. As required by HIPAA, no source-of-injury exclusion, such as
17 exclusion 28 for off-road sporting events, will apply if the accident resulted
18 from an act of domestic violence or a medical condition (including both
19 physical and mental health conditions).

20 (b) elective cosmetic surgery, except as provided for in the Women's Health
21 Act;

22 (c) custodial care, domiciliary care, private duty nursing services or rest
23 cures, except as provided for in hospices;

24 (d) personal comfort or convenience items;

1 (e) any service not medically necessary for the diagnosis or treatment of a
2 disease, injury or condition;

3 (f) non-emergency use of Emergency Room;

4 (g) over-the-counter drugs not listed in the Drug Formulary;

5 (h) drugs not listed in the Drug Formulary, unless otherwise provided in this
6 Act.

7 (i) experimental drugs, experimental and palliative treatments or procedures,
8 unless approved by the Administrator;

9 (j) fertility procedures, reversal of sterilization and services related to
10 artificial conception;

11 (k) treatment, services and supplies related to sexual dysfunction;

12 (l) trans-sexual surgery and related services;

13 (m) motorized limbs;

14 (n) services for any incarcerated person;

15 (o) care or services furnished by immediate relatives or members of the
16 patient's household, unless rendered as a duly licensed medical practitioner
17 employed by a health care Provider;

18 (p) health cares services, which are provided and reimbursed by other local
19 or Federal programs, ICHP is the payer of last resort;

20 (q) speech and language therapy;

21 (r) tissue and organ transplants, and any other related hospital, surgical drug,
22 radiology, laboratory or other medical services before, during and after transplant;

23 (s) treatment and services for artificial weight reduction, including gastric
24 bypass stapling or reversal, or liposuction;

25 (t) treatment by any method for temporomandibular joint disorders,
26 including, but not limited to, crowning, wiring or repositioning of teeth;

1 (u) treatment for injuries sustained in the commission of an illegal or
2 criminal act, including driving under the influence;

3 (v) any work-related injury, subject to compensation pursuant to the
4 Workers Compensation Law;

5 (w) care for military service connected disabilities to which the patient is
6 legally entitled to government benefits or care;

7 (x) orthopedic footwear, unless attached to an artificial foot or unless
8 attached as a permanent part of a leg brace; and

9 (y) benefits and services not specifically listed as covered

10 **§ 2918. Dental Services.** Dental benefits must include at least the following
11 coverage at participating dentists:

12 a) 100% coverage for diagnostic and preventive services

13 b) 80% coverage for fillings, simple extractions and surgical extractions

14 c) 80% coverage for anesthesia, such as conscious sedation and nitrous
15 oxide/analgesia (laughing gas), for children under age 13

16 d) 50% coverage for endodontics, periodontics and prosthodontics,
17 including crowns and bridges

18 e) \$1,000 annual plan maximum (no separate maximums on benefits may
19 be imposed)

20 **§ 2919. Dental Exclusions.** General listing:

21 1. Work in progress on the effective date of coverage. Work in
22 progress is defined as:

- 23 • A prosthetic or other appliance, or modification of one, where an impression
24 was made before the patient was covered, or
- 25 • A crown, bridge, or cast restoration for which the tooth was prepared before
26 the patient was covered, or

- Root canal therapy, if the pulp chamber was opened before the patient was covered.

2. Services not specifically listed in the agreement, services not prescribed, performed or supervised by a dentist; services which are not medically or dentally necessary or customarily performed; services that are not indicated because they have a limited or poor prognosis; or services for which there is a less expensive, professionally acceptable alternative.

3. Any service unless required and rendered in accordance with accepted standards or dental practice.

4. A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement or modification of a crown, cast restoration, denture or bridge installed less than 5 years ago, or one that replaces a tooth that was missing before the date the enrollee became eligible for services under the plan (including previously extracted or missing teeth).

5. Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable.

6. Precision attachments, interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth-borne and/or prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stress .

7. Replacement of lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.

8. Any service for which the enrollee received benefits under any other coverage offered by the company.

- 1 9. Spare or duplicate prosthetic devices.
- 2 10. Services included, related to or required for:
- 3 • Implants;
- 4 • Cosmetic purposes;
- 5 • Services or appliances to change the vertical dimension or to restore or
- 6 maintain the occlusion, including but not limited to equilibrium, full mouth
- 7 rehabilitation and restoration for malalignment of teeth;
- 8 • Temporomandibular joint (TMJ) or craniomandibular disorders,
- 9 myofunctional therapy or the correction or harmful habits;
- 10 • Experimental procedures; and
- 11 • Intentionally self-inflicted injury unless resulting from a medical condition
- 12 (including physical or mental conditions) or from domestic violence.
- 13 11. Any over the counter drugs or medicine, unless prescribed by a
- 14 dentist or physician.
- 15 12. Fluoride varnish.
- 16 13. Charges for finance charge, broken appointments, completion of
- 17 insurance forms or reports, providing records, oral hygiene instruction, pit
- 18 and fissure sealants and dietary instruction, or lack of cooperation on the part
- 19 of the patient.
- 20 14. Charges in excess of the amount allowed by the plan for a covered
- 21 service.
- 22 15. Any treatment, material, or supplies that are for orthodontic
- 23 treatment, including extractions for orthodontics.
- 24 16. Services for which no charge would have been made had the
- 25 agreement not been in effect.

- 1 17. Surgical grafting procedures.
- 2 18. General anesthetic, conscious sedation, and other forms of relative
3 analgesia, except as otherwise specifically provided herein, unless deemed
4 medically necessary by patient's dentist or physician and pre-authorized by
5 Company.
- 6 19. Services paid for by Workers' Compensation.
- 7 20. Charges incurred while confined as an inpatient in hospital unless
8 such charges would have been covered had treatment been rendered in dental
9 office.
- 10 21. Treatment and/or removal of oral tumors.
- 11 22. All surgical procedures except for surgical extractions of teeth and
12 periodontal surgeries performed by a dentist.
- 13 23. Panoramic x-ray or full mouth x-ray if provided less than 3 years
14 from the covered person's last full mouth x-ray; and full mouth x-rays if
15 provided less than three years from Covered Person's last panoramic x-ray.

16 **§ 2920. Catastrophic Illness Program.** The Department of Public
17 Health and Social Services shall continue to administer the Catastrophic Illness
18 Program, as established by Public Law Number 18-8, as further amended by Public
19 Law Numbers 18-31 and 23-76, and as further regulated by the rules and
20 regulations previously adopted by the Department pursuant to the public laws that
21 originally established the Catastrophic Illness Program. The Department may also
22 adopt additional rules in accordance with the Administrative Adjudication Law to
23 administer the Catastrophic Illness Program. The Program shall provide for care of
24 victims of catastrophic illnesses, whether such care is provided on Guam or at off
25 Guam medical facilities. The Catastrophic Illness Assistance Program ('CIAP')

1 maximum coverage per individual is established at One Hundred Seventy-five
2 Thousand Dollars (\$175,000.00).”

3

4 **Section 3. Effective Date.** This legislation shall become effective upon
5 enactment.

6 **Sections 4. Severability.** If any provision of this law or its application to
7 any person or circumstance is found to be invalid or contrary to law, such
8 invalidity shall not affect other provisions or applications of this Law which can be
9 given effect without the invalid provisions or application, and to this end the
10 provisions of this law are severable.