## COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS SAIPAN, MARIANA ISLANDS 96950

## VOLUME 24 NUMBER 06



JUNE 17, 2002

# COMMONWEALTH

# REGISTER

## COMMONWEALTH REGISTER Volume 24 Number 06 JUNE 17, 2002

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#### NOTICE OF EMERGENCY REGULATIONS AND NOTICE OF INTENT TO ADOPT AMENDMENTS TO THE IMMIGRATION RULES AND REGULATIONS TO STANDARDIZE THE PROCESS OF APPLICATION FOR A VISITOR ENTRY PERMIT

**EMERGENCY:** The Commonwealth of the Northern Mariana Islands Department of Labor and Immigration ("DOLI") finds that under 1 CMC §9104(b), the public interest requires the repeal and re-enactment of Section 703 of the Immigration Rules and Regulations as the Emergency Regulations attached hereto to Standardize the Process of Application for a Visitor Entry Permit. As a result of promulgating these emergency regulations, Section 702(A) of the IRR is hereby repealed. DOLI further finds that the public interest mandates adoption of these regulations upon fewer than thirty (30) days notice, and that these regulations shall become effective immediately after filing with the Registrar of Corporations, subject to the approval of the Attorney General and the concurrence of the Governor and shall remain effective for 120 days.

**REASONS FOR EMERGENCY:** DOLI finds that there is currently no uniform process within which to process applications for tourist visas for entry into the Commonwealth of the Northern Mariana Islands. In order to prevent the arbitrary approval of tourist visas, DOLI seeks to create a definitive system of admitting persons who desire to visit. DOLI also recognizes that the Commonwealth's security is dependent on the uniform enforcement of rules and regulations regarding tourist visa applications. Therefore, DOLI finds that in the interest of the public, it is necessary that these regulations are approved and adopted immediately in order to facilitate the administration of the tourist visa application process.

CONTENTS: These regulations provide a standard process for the review of applications for and the issuance of tourist visas for entry into the Commonwealth of the Northern Mariana Islands. These emergency regulations also intend to repeal the present provisions of Section 703 of the Immigration Rules and Regulations and re-enact Section 703 under the following terms.

**INTENT TO ADOPT:** DOLI intends to adopt these regulations as emergency regulations as permanent amendments to the Immigration Rules and Regulations.

AUTHORITY: DOLI is authorized to adopt and issue regulations regarding tourist visas under 3 CMC §4331.

Issued by: Dr. Joaquin A. Tenorio Secretary (Acting) Concurred Ьv Juan N. Babauta Governor Received by: Thomas A. Tebuteb Special Assistant for Administration

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Date  $\frac{5/23/02}{5/28/02}$ Date  $\frac{5/28/02}{5/28/02}$ 

Pursuant to 1 CMC §2153, as amended by Public Law 10-50, the rules and regulations attached hereto have been reviewed and approved as to form and legal sufficiency by the Attorney General of the CNMI.

Dated this **21**<sup>+</sup> day of May, 2002.

Filed and Recorded by:

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Robert T. Torres Attorney General

Soledad B. Sasamoto Registrar of Corporations

Date \_ 5/29/02

## NUTISIA PUT GOTPE NA NISIDÀT MAMATINAS REGULASION YAN NUTISIA PUT INTENSION PARA U MA ADÀPTA I AMENDÀSION SIHA GI AREKLAMENTO YAN REGULASION IMIGRASION PARA U GUAHA PAREHU NA KONDISION YAN MANERA GI APLIKASION LISENSIAN HUMÅLUN PARA I BISITA SIHA.

**GOTPE NA NISISIDAT:** I Commonwealth Sumankattan Siha Na Islas Marianas Dipattamenton Hotnaleru yan Imigrasion (D.O.L.I.) ha sodda' gi papa 1 CMC 9104(b), kumo minaolek yan interes pupbliku nisisariu para u madiroga yan talun odetna Seksion 703 gi Areklamento yan Regulasion Gotpe Na Nisisidat Para u Guaha Parehu Na Kondision Yan Manera Gi Aplikasion Lisensian Humalon Para I Bisita Siha ni checheton guine. Put I risuta ni mana ofisiat este na Gotpe Na Regulasion, Seksion702(A) ginen I Dipattamenton Hotnaleru yan Imigrasion na madiroga. Lokkue' I Dipattamenton Hotnaleru yan Imigrasion ha sodda' na para interes yan minaolek pupbliku ha mandatu para u ma adapta este siha na regulasion menos ki trenta (30) dias na nutisia, ya este siha na regulasion u fanefektibu ensigidas despues di ma <u>file</u> ni Rehistradoran Kotporasion, komu inapreba ni Abugadon Henerat yan inakonfotma ni Gobietno ya u efektibu ha' gi halom siento-bente (120) dias.

**RASON PUT GOTPE NA NISISIDĂT:** I Dipåttamenton Hotnaleru yan Imigrasion ha' sodda' na gi prisenti tåya parehu na kondision yan manera para manaplikan lisensian humalun para i bisita siha para hu fanhålum gi Commonwealth Sumankattan Siha na Islas Marianas. Put para u maprutehi katkuet na inapreban lisensian humålun para i bisita siha, I Dipåttamenton Hotnaleru yan Imigrasion ha aliligao para u na'guaha mås fotmat na sistema para u ma admiti ayu siha na petsona I manmalålågo' manbisita. I Dipåttamenton Hotnaleru yan Imigrasion ha rekognisa na I asgurait Commonwealth dipendi gi ma enfuetsan I parehu na areklamento yan regulasion put manaplika lisensian humålun para i bisita siha. Ayu mina, I Dipåttamenton Hotnaleru yan Imigrasion na para i minaolek yan interes I pupbliku, nisisariu para u ma adapta yan apreba este siha na regulasion ensigidas, put para u alibia minaneha kondision yan manera put aplikasion lisensian humålun para i bisita siha.

**SUHETU:** Este siha na regulasion para u na'guaha parehu na kondision yan manera para ma ribisan aplikasion yan malaknos I lisensian humalun para i bisita siha para hu fanhalom gi Commonwealth Sumankattan Siha na Islas Marianas. Este siha na regulasion lokkue' ha intensiona para u diroga I manprisenti siha na prubinsion gi Seksion 703 gi Areklamento yan Regulasion Imigrasion yan agon tuma'lo Seksiona 703 gi segenti na sinangan.

**INTENSION INADĂPTA:** I Dipattamenton Hotnaleru yan Imigrasion ha intensiona para u adápta este siha na regulasion komu regulasion gotpe na nisisidat para u petmanente na admendasion gi Areklamento yan Regulasion Imigrasion.

**ATURIDAT:** I Dipåttamenton Hotnaleru yan Imigrasion ma aturisa para u adapta yan fanlaknos regulasion put lisensian humålun para i bisita siha sinangan yan fuetsan 3 CMC 4331.

Linaknos as: Dr. Joaquin A. Tenorio Secretary (Acting) Inakonfotme as: Juan N. Babauta Gobietno Rinisibi as: Espisiat Na Ayudantín Atministrasion

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Sigun 1 CMC 2153, ni inamenda ni Lia Pupbliku 10-50, I areklamento yan regulasion siha ni checheton guine esta man maribisa yan apreba gi fotma yan sufisiente na ligat ginen Ofisinan Abugadon Henerat gi Commonwealth Sumankattan Siha na Islas Marianas.

Ma fetcha guine gi mina <u>29</u> na dia Mayu, 2002

Robert T. Torres Abugådon Henerat

Ginen as: しん

Robert T. Torres Abugådon Henerat

Pine'lo yan Renekot as:\_

Soledad B. Sasamoto Rehistradoran kotporasion

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### ARONGORONG REEL FFÉÉRÚL ALLÉGHÚL GHITPWOTCH ME ARONGORONGOL MÁNGEMÁNGIL IGHA REBWE <u>ADOPTL-LI</u> LLIWEL KKA LLÓL AUTOL ALLÉGHÚL <u>IMMIGRATION</u> BWE EBWE YOOR AWEEWE REEL MWÓGHÚTÚL <u>APPLICATION-UL VISITOR ENTRY PERMIT</u>

**Ghitipwotch:** Bwulasiyol Labor and Immigration ("DOLI") mellól Commonwealth of the Northern Marianas nge ee schuungi bwe faal 1 CMC Tálil 9104(b), nge bwelle reel igha ebwe ghatch ngáliir toulap nge ee fil bwe rebwe atoowowu Tálil 703 mellól alléghúl Immigration. bwe ebwe atotolong ngáre alléghúl Ghitipwotch igha ebwe ayoora aweewe reel mwóghútúghútúl Application-ul Visitor Entry Permit ikka ee appasch ngáli schéé kaal. Reel atowowul igha ebwe arongowow alléghúl ghitipwotch kkaal Tálil 702 (A) 1161 IRR aa lliwel. DOLI ebwal schuungi bweigha reel ghatchúúr Toulap nge eghi welepakk bwe ebwe adopt-ló allégh mwal eliigh (30) ral igha ebwe yoor arongorong, Nge allégh kkaal nge ebwe llúgheeyiló igha schagh ee mwet ngáli Registrar of Corporations, ngáre aléghúyal Attorney General me Iléghúyal sóulemelem nge ebwe llúgheyiló schagh llól Ebwughúw ruweigh (120) rál.

**Bwúlúl Ghitipwotch:** <u>DOLI</u> nge e schuungi bwe esóór aweewe (<u>uniform process</u>) reel <u>application-ul visitor entry permit</u> igha rebwe atootolong <u>Commonwealth</u> Metawal Wóól Falúw Kka<u>Marianas</u>. Igha rebwe pileey bwe ete yoor ammang reel anguúngú reel visitor entry permit nge<u>DOLI</u> ekke amwuri fischiiy bwe ebwe ayoora tappal <u>system</u> ye ebwe <u>definitive</u> ngáliir aramasal lúghúl kka re tipáli bwe rebwe tooto. <u>DOLI</u> nge e bwal ghuleey aléghéléghúl <u>Commonwealth</u> nge elo ngáli igha rebwe amamaawa aweweel allégh reel <u>application-ul visitor entry permit</u>. Ila milla, <u>DOLI</u> e ghuleey bwe ghatchúúr toulap nge eghi auscheeya bwe allégh kkaal ebwe kkáyil angúúngú me adopted bwe ebwe mwetemwet lemlemil <u>application-ul visitor entry permit</u>.

**AUTOL:** Allégh kkaal nge ebwe ayoora aweewe igha rebwe amwuri fischiiy <u>application</u> me isiisiwowul <u>visitor entry permit</u> igha rebwe tooto <u>Commonwealth</u> Metawal Wóól Falúw kka Marianas. Alléghúl Ghitipwotch kkaal nge ebwe Liwili Tálil 703 mellól Alléghúl <u>Immigration</u> meigha e pwal amalawa sefáliiy Tálil 703 faal fféér kkaal.

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**MÁNGEMÁNGIL ADOPTION:** DOLI nge eghi mángiiy fischiiy bwe ebwe <u>adopt-li</u> allégh kkaal ngáre Lliwel kka a aléghélégh llol Autol Alléghúl <u>Immigration</u>.

**BWÁNGIL:** DOLI nge eyoor bwángil bwe ebwe <u>adopt-li</u> me isáliiwow allégh kka e ghil ngáli <u>visitor entry permit</u> reel aileewai 3 CMC Section 4331.

Mereel: Dr. Joaquin A. Tenorio Secretary (Acting) Alleghúúyah Juan N. Babauta Soulemelem Bwughiiyal:

Rál: 5/23/02

5/20/02 Rál:

Rál·

Thomas A. Tebuteb Special Assistant For Administration

Sángi bwali me aileewal 1 CMC 2153, iye Alleghúl Toulap 10-50 e liwili nge alleégh kka e schu ngáli schéél tiliigh kkaal mwir me angúúngú bwe e fis me tabweey allégh mereel Bwulasiyool CNMI <u>Attorney General</u>.

E fféér ráálil ye <u>29</u> Maram ye Ghúúw, 2002.

Robert T. Torres **Attomey General** 

Mereel:\_

Robert T. Torres Attomey General

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Isáliiyal me Rekodliiyal:

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Rál:\_\_5/29/02 Soledad B. Sasamoto **Registrar of Corporations** 

#### Section 703. Visitor Entry Permit

#### A. APPLICABILITY

A visitor entry permit is required for entry by aliens who are intending to enter the CNMI for tourism purposes only. The term "tourism purposes" is defined as traveling for pleasure or recreation by an alien who has a residence in a foreign country which he has no intention of abandoning and who is visiting the Commonwealth of the Northern Mariana Islands temporarily for pleasure or recreation. Such visitor shall not include nonresident workers.

#### **B.** WAIVER OF TOURIST VISA

The following aliens do not require a visitor entry permit in order to enter the CNMI:

- 1. Any alien with a valid United States entry visa which is valid for at least 60 days from the date of entry into the CNMI provided that the United States visa permits re-entry back into the United States after entry and departure from the CNMI.
- 2. Any alien who is a national or citizen of a country that is permitted to enter the United States under the United States visa waiver program.

#### C. PERSONS NOT PERMITTED TO ENTER

- 1. No alien may enter the CNMI by exiting their country of citizenship or point of origin with a visitor entry permit as described under these regulations and then entering the CNMI with a work entry permit issued under Section 706 of these regulations.
- 2. Citizens of countries identified on the United States Department of State listing of excluded nations are not permitted to enter the CNMI under these regulations by right. They may enter under the terms contained herein if the country under which their citizenship was obtained has an embassy or consulate in the CNMI.

#### **D.** APPLICATION

In order to enter the CNMI using a visitor entry permit, the applicant must submit an application via fax, email or posted mail to the CNMI Department of Labor and Immigration. All applications shall be submitted under penalty of perjury and be without charge. The visitor entry permit application shall include the following information:

- 1. Name;
- 2. Certified copy of a valid passport;

- 3. Home address, telephone number, fax number, place of birth;
- 4. Length of time at home address;
- 5. Expected date and time of arrival;
- 6. Expected date and time of departure;
- 7. Name and address of sponsor/reference/hotel in the CNMI;
- 8. Declaration of financial responsibility;
- 9. Copy of a round trip ticket or e-ticket or verified itinerary;
- 10. Indication whether applicant has visited NMI previously; and
- 11. Indication whether applicant has ever applied and been denied an entry permit.

Additional information may be requested as needed.

#### E. FINDING OF DEFICIENCY

Once the Department of Labor and Immigration receives an application for a visitor entry permit, it will review the application to determine whether all of the information required has been provided. This deficiency review will be completed within three working days after receipt of the application. If the application is found to be complete, it will be reviewed in accordance with the standards of review provided herein. If the application is found to be deficient, then the deficiencies shall be listed and forwarded to the applicant by the third day of the deficiency review period in the same manner as the application was received.

#### F. STANDARDS FOR REVIEW

Once a visitor entry permit application is determined to be complete, it will be reviewed for substantive compliance based on the following standards within three working days:

- a. valid passport for at least sixty (60) days after the expected time of departure from the CNMI;
- b. round trip ticket or verified electronic itinerary (i.e., e-ticket);
- c. finding that person resides permanently in place of residence and is reliably expected to return there;
- d. valid sponsorship from a party who has not been found in violation of prior sponsorships,
- e. proof of means sufficient to support a stay for the duration of the trip, which shall be no less than \$100 per day or proof of a valid credit card with an equivalent available credit; and
- f. determination and finding of accuracy in application.

#### G. ISSUANCE OF PERMIT- DECISION WITHIN SEVEN WORKING DAYS

Once a visitor entry permit application is determined to be complete and all of the substantive standards are determined to be satisfied, then a visitor entry permit will be granted within seven working days after the initial receipt of the application. If any of the standards are determined to be in non-compliance, the application shall be denied and the applicant shall be notified of the denial within two working days of the determination.

The approved visitor entry permit shall be delivered to the applicant with a copy to the airline carrier in the CNMI. The airline carrier in the CNMI shall forward a copy of the visitor entry permit to the point of embarkation to the CNMI. The airline carrier at the point of embarkation shall not board a visitor entry permit holder if the holder's copy does not match the carrier's copy.

#### H. DURATION OF VISA AND EXTENSION

Once the application is approved, it will be valid for a single entry and for thirty (30) days from the original date of entry to the CNMI. The visitor entry permit holder may request one extension pursuant to Section 706 (c) of these rules and regulations.

#### I. NO TRANSFER OF PERMIT

An alien with a valid visitor entry permit shall not seek and may not obtain a work permit under Section 706(k) of these regulations during a visitor permit entry. An alien who violates this provision shall be subject to deportation pursuant to applicable statutes and regulation.

#### J. TEMPORARY ADMISSION PENDING EXAMINATION

No alien may seek or obtain entry into the Commonwealth as a matter of right. If entry is denied to a valid visitor entry permit holder, the applicant may be temporarily admitted at the discretion of the Director of Immigration Service under such conditions as will insure the visitor availability for further proceedings, including retaining the visitor's passport and return airline ticket. An alien so admitted shall be deemed not to have entered the Commonwealth. The exclusion or removal of a temporarily admitted alien shall not require deportation proceedings. A decision regarding the future admission of the visitor shall be made by the Secretary or his designee within two working days of the temporary admission.





"Investing For The Future Financial Security Of Our Members"

#### NOTICE OF EMERGENCY ADOPTION OF INTERIM AMENDMENTS TO THE RULES AND REGULATIONS <u>GOVERNING THE GROUP HEALTH INSURANCE PROGRAM</u>

#### AUTHORITY:

The Board of Trustees of the Northern Mariana Islands Retirement Fund, pursuant to the authority of Public Law 10-19, adopts and promulgates the attached interim Rules and Regulations Governing the Group Health Insurance Program.

#### CONTENTS:

The attached regulations are intended to *effectuate critical changes* to the Group Health Insurance Program, *crucial to the proper operation and survival of the Program* and the public interest, and will serve the best interests of the members and public by providing experienced, professional, high-quality service to Group Health Insurance members and providers, prevention of fraud and abuse, and proper and appropriate expenditure of public funds.

#### EMERGENCY:

The Board of Trustees of the Northern Mariana Islands Retirement Fund, tasked with administration and oversight of the Group Health Insurance Program, has found that pursuant to 1 CMC Sec. 9104(b) that the public interest and imminent peril to the public welfare requires the adopt of these interim regulations on an emergency basis as further detailed below.

The Board finds that the public interest and this imminent peril to the public welfare mandates adoption of these interim regulations upon fewer than thirty (30) days notice, and these interim regulations shall become effective immediately after filing with the Registrar of Corporations, subject to the approval of the Attorney General and the concurrence of the Governor and shall remain in effect for a period of 120 days.

#### INTENT TO ADOPT:

The Board of Trustees intends to adopt these regulations as permanent, pursuant to 1 CMC Sec. 9104(a), and therefore notifies the public of the opportunity to submit comments upon the publication of these regulations in the Commonwealth Register.

Copies of the Regulations and supplemental material relating to the regulations will be available at the Group Health and Life Insurance office,

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located on the second floor of the Retirement Fund Building, Capitol Hill, Saipan, MP 96950;

- Written comments on the regulations should be addressed and submitted to the Administrator, NMIRF, P.O. Box 501247 CK, Saipan, MP 96950, or may be delivered to the Administrator at the Retirement Fund office;
- Comments must be received by the Administrator of NMIRF within sixty (60) days of the date the interim regulations are published in the Commonwealth Register.

Further, the Group Health Program is finalizing the new Member Handbook, summarizing the Group Health Plan, which will be made available to members within thirty (30) days of the effectiveness of these interim regulations. Members will be given the opportunity to:

- comment on and ask questions about the Regulations and Handbook and all information contained therein;
- at five (5) separate public meetings three (3) on Saipan and one (1) each on Rota and Tinian - properly noticed and scheduled during the sixty (60) day comment period; and
- review supplemental information relating to the interim regulations which is available for viewing at the Group Health Office, Retirement Fund Building on Capitol Hill.

#### **REASONS FOR EMERGENCY**:

Pursuant to Public Law 10-19 and Article 15 of the Rules and Regulations governing the Group Health Insurance Program, the Board of Trustees of the Northern Mariana Islands Retirement Fund has a fiduciary duty to ensure proper administration and management of the health insurance program. This authority includes promulgating rules and regulations necessary for said proper administration of the Program.

I. The Board of Trustees has determined that there are significant and severe deficiencies in the Program's operation and a <u>critical</u> need for highly qualified and experienced administration of the Program due to:

- severely inadequate management, experience and staffing of the Program;
- Iack of education and training of Program staff to properly review and examine claims and detect fraud and abuse;
- > prior fraud and abuses perpetrated against the Program;
- > the ongoing open opportunity for abuse of the Program,

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> ineffective, inefficient claims review and payment;

#### inadequate funding of the Program leading to a critical need to implement measures leading to appropriate and effective expenditure of premiums.

Pursuant to authority granted in Article 15 of the Rules and Regulations governing the Program, the Board of Trustees issued an RFP for appropriate administration services and subsequently approved a contract with a Third Party Administrator (hereinafter "TPA") in August 2001.

In conjunction with the hiring of a TPA to properly administer the Program, after much research into the standards, practices and procedures applied by private insurance carriers, the Board considered and approved numerous changes to the Plan Document, which governs the benefits and operation of the Program, addressing the immediate need to ensure:

> adequate and proper oversight and *expenditure of public funds*;

- > prevent fraud and abuses of the Program through:
  - highly experienced and professional experts;
  - specific expertise regarding health care and insurance management;
  - the proper framework (the Plan Document); and
  - proper review, adjudication and payment of only valid medical claims.

In November of 2001 the Program properly published proposed changes to the Rules and Regulations Governing the Group Health Insurance Program and solicited comments from the members of the Program and the public. Many comments were received, all were considered, and many were incorporated into the Rules and Regulations adopted by the Board in April 2002. A summary of those comments, and the reasons for either adopting or not adopting the comments into the Plan, is attached hereto, and will be available for viewing at the Group Health Office within fourteen (14) days of the effective date of these interim regulations.

Based on the regulations adopted by the Board, and the contractual relationship with the TPA, the Program is anticipating:

> highly qualified, professional and experienced Program management;

- proper claims review and examination;
- fraud and abuse prevention;

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GHLIP EmergNotRegsAdopt --- 3 of 7

> enhanced medical benefits to Members;

> more equitable reimbursement rates and timely payment to providers;

> reduction in the overall expenditures of Program;

II. Changes in the categories of coverage to more appropriately and equitably assess premiums are included in the amended regulations. In order to properly place all members into these categories, new enrollments are required. To effectuate the appropriate changes in a timely manner and ensure that all member and dependant information is accurate at or near implementation of these regulations, a Special Enrollment period was publicly announced and numerous information sessions have been ongoing since mid-May.

Failure to immediately implement these interim regulations will result in:

- confusion to Members and staff regarding appropriate enrollment categories, coverage, premiums, and effectiveness of regulations;
- wasted efforts that will have to be duplicated after the regulations can be implemented at a later date, resulting in additional costs and *further deteriorating the fragile financial condition of the Program*;
- potential for unintentional loss or lack of coverage to countless thousands of members and dependents who submitted new enrollment forms which would be rendered void without the new regulations;
- inappropriate, improper or non-payment of claims due to duplicate or convoluted enrollment and eligibility information (from newly completed forms), leading to:
  - excess, inadequate and/or improper claims payments, again further damaging the fragile financial condition of the Program,
  - Iegal liability to the Program and Government for improper claims payment and improper expenditure of public funds.

III. Based on specific provisions in the amended regulations, the TPA has gone to great expense and effort to negotiate contracts with medical providers, creating a world-wide provider network, to meet the medical needs of the Program's Members; print provider directories detailing the provider network; and print new insurance cards to be issued to all members.

Without the amended regulations:

the provider contracts will be rendered null and void,

>> preventing the Program from meeting its obligations to the TPA;

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- >> preventing the TPA from meeting its obligations to providers;
- creating a domino effect of contractual breaches with anticipated damages reaching millions of dollars;
- > the provider directories will be rendered virtually null and void,
  - >> creating confusion regarding provision of medical services;
  - giving rise to a cause of action against the Program, and Government as Plan Sponsor, for the TPA's expenses;

If the Program cannot meet its contractual obligations to the TPA due to failure to immediately implement new regulations, the Program, and hence the Government as the Plan Sponsor, will be in default under the contract, giving rise to an action for breach of contract by the TPA, by Members for failure to provide coverage, services and claims payment, and by providers for failure to pay for services rendered. Any such actions would very likely result in:

- recovery of all costs expended by the TPA related to the anticipated implementation of the new regulations;
- > recovery of costs of services and damages by medical providers, world-wide;
- recovery of damages by Members for failure to provide the anticipated coverage and claims payment; and
- > damages reaching untold amounts.

The liability for such damages rests with the Government as the Plan Sponsor. Such legal actions would cause the decimation and bankruptcy of the Program, with no assets to satisfy claims and/or judgments, leaving a massive debt to the Government and severely limited access to necessary medical treatment for Government employees and their dependents.

IV. The amended regulations will implement a prescription medication Formulary and Pharmacy Benefit Management Program, due to which the Program anticipates significant savings (in conjunction with the discount contracts that will garner much savings) as compared to prior claims data for medication costs, as well as ensuring detection and prevention of fraud that the Program has encountered in the past, costing the Program hundreds of thousands of dollars which it cannot recover. *The Program intends to use these savings to settle past due claims and secure the viability and stability of the Program, and it is crucial that these savings be realized immediately, as they provide the only source of revenue to resolve these outstanding obligations*.

Should the Program be prevented from implementing these regulations and realizing these savings, thereby being unable to remit payments for these prior claims:

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- many Members' past due claims will be sent to collection agencies by the facility that provided the medical service, in turn:
  - damaging the credit of Members;
  - interest charges being assessed to Members on balances owed;
  - Members being refused further treatment by the facility;
  - the Program being subject to legal action by Members for any and all resulting damage for its failure to pay valid claims.
- providers critical to the network have expressed intent to immediately cease accepting Program Members for admittance, and cease providing medical services to Program Members;
  - one such major hospital in Hawaii has served notice that as of June 2002, no CNMI patients will be accepted into that facility unless satisfactory arrangements for payment of past due claims are made immediately;
  - another hospital facility, as well as off-island private providers are making similar threats;
- Members will not be able to receive the proper and necessary medical treatment for which the Program was designed to provide assistance;
- > the Program and the Government will be held liable for that failure.

The public interest and imminent peril to the public welfare therefore requires, consistent with 1 CMC Sec. 9104(b), that these regulations be adopted upon fewer than 30 days notice and that they be immediately effective.

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Issued by

Vicente C. Camacho, Chairman Board of Trustees, **NMI** Retirement Fund Group Health & Life Insurance Trust Fund

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Karl T. Reves Administrator NMI Retirement Fund Group Health & Life Insurance Trust Fund

Date: <u>4/3/02</u>

Date: 6/3/02

Reviewed as to form and legal sufficiency on behalf of NMIRF/GHLITF:

nathlan Isay Kell

Kathleen Troy-Rucker, Legal Counsel NMI Retirement Fund Group Health & Life Insurance Trust Fund

Filed by:

Date: 3 June 2102

Date:\_ 6/1/02

**Registrar of Corporations** Commonwealth of the Northern Mariana Islands

#### Attorney General Review:

Pursuant to 1 CMC Sec. 2153, as amended by P.L. 10-50, the emergency regulations attached hereto have been reviewed and approved as to form and legal sufficiency by the Office of the Attorney General.

mut

Robert Torres, Attorney General Commonwealth of the Northern Mariana Islands

Received at the Governor's Office by:

Date:

**0**7 JUN 2002

Governor's Representative Commonwealth of the Northern Mariana Islands

Concurred by:

Juan N/ Babauta, Governor Componwealth of the Northern Mariana Islands

Date:

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## NOTISIAN IMIDIAMENTE NA INADOPTASION PUT I INIMENDAN <u>INTERIM</u> PARA I AREKLAMENTO YAN Regulasion ni ginibebietna put i prugraman <u>Group Health Insurance</u>.

#### Aturidat:

l <u>Board of Trustees</u> genin i Fundon Altirao gi Commonwealth Gi Sankattan Siha Na Islas Marianas, tinatittiyi ni aturidat Lai Pupbliku 10-19, ma adopta yan otdena i man checheton na Areklamento yan Regulasion <u>Interim</u> ni Ginibebietna Put Prugraman Group Health Insurance.

#### Sinaguan:

I man checheton na regulasion ma intensiona para u guaha na tinilaika put i Prugráman <u>Group Health Insurance</u>, kritikát para i propiát na operasion yan lina'la' i prugráma yan I interes pupbliku, para u setbe minaolek na interes para i membru siha yan pupbliku an mapribebeni i profesot ekspiriensia, takilu' yan kualidát na setbisu para u ma pribeni i membrun <u>Group Health Insurance</u>, empidision put digeria yan abusu, yan propiu yan aproposito, pot ginastan salápe' pupbliku.

#### Imidiamente:

l <u>Board of Trustees</u> genin i Fundon Ritirao gi Sankattan Siha Na Islas Mariánas, chineguen i atministrasion minanea ni Prugraman <u>Group</u> <u>Health Insurance</u>, ma sodda' sigun gi 1 CMC Sek. 9104(b) put interes pupbliku na u mahatáhi gi bandan piniligru para pupbliku kumo midiamente na rason sigun ni ma mensiona.

I <u>Board</u> ma sodda' na i interes yan este u mahatahi gi bandan piniligru para i pupbliku ni ma manda i inadoptasion put este <u>interim</u> na regulasion siha ma notisia antes di trenta (30) dias, yan este <u>interim</u> na regulasion siha debidi u fan efektibu an munayan ma polu gi Rihistradoran Koporasion, suhetu an ma apreba ni Abugadan Henerat yan kininfotme ni Gobietno yan u huyong gi duranten siento benty (120) dias.

#### Intension Para U Ma Adopta:

I <u>Board of Trustees</u> ma intensiona para u ma adopta este na regulasion siha petmanente, tinattiyi ni 1 CMC Sek. 9104 (a), enao na ha notifika i pupbliku put i opotunidat para u ma entrega siha na sinangan put i pupblikasion ni este na regulasion siha gi Alhistradoran Commonwealth.

> Kopia put i regulasion siha yan palu na matiriat ni inekspliplika put i regulasion siha gaige na mutero gi Ofisinan <u>Group Health and Life</u> <u>Insurance</u>, gaige gi sigundo na bibenda gi Ofisinan Fundon Ritirao, giya Capitol Hill, Saipan MP 96958.

> Notisia ni man matuge put i regulasion debi na u ma na hanao yan entrega i atministradot gi NMIRF, P.O. Box 501247 C.K., Salpan MP 96950.

> I Atministradot i Fundon Ritirao debidi hu resibi notisia åntes di sisienta (60) dias genin anai ma fecha i <u>interim</u> na regulasion ni ma pupblisa gi Rihistradoran i Commonwealth.

l Prugråman <u>Group Health</u> ma finalilisa i nuebu na lepblon membru, sumariria i planun i Grupon Hinemlo', ni siempre muterao para i membru siha dentro gi trenta (30) dias genin anal efektibu este siha na <u>Interim</u> na regulasion. Hu fan ma nâ'l' i membru siha opotunidăt para:

> Hu fan mamaisen kuestion pat hu fan masångan håfa put i regulasion siha pat i <u>handbook</u> yan todu i infotmasion ni kininsiste;

> Gi singko (5) na seperao na miteng pupbliku - tres (3) giya Salpan yan kåda uno (1) giya Luta yan Tinian - gi durånten sisienta (60) dias na tiempo debidi hu guaha propiu na sinangan nutisia yan planu; yan

> ribisa palu na infotmasion ni inekspliplika put I <u>Interim</u> i mutero na regulasion ni para ma rebisa gi Ofisinan Group Health, gi Fondun Ritirao giya Capitol Hill.

### **Rason Para Imidiamente:**

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> Sigun i Lai Pupbliku 10-19 yan attikulu 15 put Areklamento yan Regulasion ni ginibebietna i <u>Group Health Insurance</u> na prugråma i <u>Board of Trustees</u> gi Fundon Ritirao i Sankattan Siha Na Islas Mariånas man ma angokko yan u mana asigura i atministrasion para i Prugråman <u>Group Health Insurance</u>. Este na aturidat ni man ma angoko, inkluso uma estableshi i Areklamento yan Regulasion siha man nisisåriu hu fan ma atministra para i prugråma.

1. I <u>Board of Trustees</u> ma detitmina na guaha siha signifikante yan difekto na prublema gi båndan i prugrama, manlsisita kualidåt yan ekspiriensa na petsona gi båndan atministrasion put rason:

> Mampos inefektibu na mañante yan empliao ni man machochochu gi halom i ofisina.

> Ti nahong edukasion yan training nu i empliao put para u sina mu eksamina yan u detitmina i prublema i bandan dinigeria yan abusu gi bandan <u>claims</u>.

> I man ma lofan siha na tiempo guaha fraud yan abusu,

> Gl prisente ma chuchule bintáha ya ma abusu i prugrâma.

> Ti efektibu yan ti sanu i <u>claims</u> man ma apási.

> Put ti sufisiente fondun-na i prugrama a nisisita na u ma implimenta i manera anai para u sano yan efektibu put i gaston i primiu siha.

Sigun ni aturidat gi Atikulu Kinsi (15) genin i Areklamento yan Regulasion siha ni ginibebietna i prugrama, l <u>Board of Trustees</u> man na'i' <u>RFP</u> para i apropiat na setbisun atministrasion tinatitiyi ni ma apreba na kontrata gi mina tres na patida gi atministrasion (TPA) gi Agosto 2001.

Put asunton empliao na bánda para i <u>TPA</u> debidi u atministra propiu i prugråma, despues ma estudiayi gi prisente i sistema, ma praktitika yan ma apliplika i <u>private insurance</u>. I <u>board</u> ha konsidera yan apreba i noskuåntos na tinilaika gi plånun dokomento ni ginibietna i binifisu yan operasion i prugråma ni ha sasangan i imidlante na nisisidat ni para u ma na asigura.

> Debidi u sufisiente yan u guaha propiu na inadahi put gåston salåpen i pupbliku.

> Hu guaha inatahi put bandan dinigeria yan abusu siha put i prugrama.

» Maolek na ekspiriensia yan profesinåt na petsona.

- >> Este na petsona debidi u guaha tiningoña yan ekspiriensao gi båndan setbisun mañånten hinemlo yan <u>insurance</u> na prugråma
- » Debidi propiu i estroktura ( put plånun dokomento) yan
- >> Debidi u propiu rebisa; u ma husgua yan apasi eyu siha k ligåt na medical claims.

Gi Nobiembre 2001 i prugråma a pupblisa i ma proposito para u ma tulaika i Areklamento yan Regulasion put asunton Prugråman <u>Group Health Insurance yan man solisitea opinion genin i membru siha ni</u> man patisipao gi prugråma yan i pupbliku henerat. Meggal opinion ma risibi, todu man ma konsidera, yan meggai-na ha man hålom gi Areklamento yan Regulasion siha ni ma adopta genin i board gi Abrit 2002. Ma sumaria este siha na opinion yan i rason parehu ha kao u ma adopta pat åhe', ni <u>attached</u>, para u <u>available</u> para u attan guato gi Ofisinan <u>Group Health gi</u> hålom katotse (14) dias anai efektibu i fechan este na tempulåriu na regulasion siha.

Sigun i regulasion ni man ma adopta nu i <u>board,</u> put asunton kontråta yan i (TPA), i prugråma a antisipao:

> Hu kualifikao, profisinåt yan ekspiriensia kumo mañånten i prugråma.

> Ma ribisa yan eksamina propiu put båndan <u>claim</u>.

> V ma atáhi i bándan dinigiria yan abusu.

> Ma adulánta i benifisu para í membru siha gi bándan <u>medical</u>.

> Gi båndan apas, debidi u chilung yan ma apåsi manu sina na chinadek i umekstetendi i setbisu.

> Guaha rinibåhå gi enteru ginastan prugråma.

II. Gi regulasion siha ni man ma amenda guaha tinilalka gi katiguria gi båndan <u>coveriage</u> para u mås konsiste yan chilung gi båndan primiu siha ni man ma inklusu. An para u ma dipusita propiu todu i membru siha gi katiguråt, debibi u rehistra di nuebu. Yangen para u ma efektibu este siha na tinilaika u ma konsidera i manera ya u ma na sigura na todu i membru yan dipendente, debidi u kabåles i infotmasion durånten anai ma implimenta este siha na regulasion, u guaha espisiat gi båndan rehistrasion yan u ma pupblika este na asunto ya u ma indika put sesion ni ma kundudukta durånten Måyu na mes.

Yangen ti un kumple este siha na tempuláriu na regulasion Imidiante estaque siempre un susede:

> Siempre u guaha kubukao ni este na rehistrasion gi båndan katiguria siha, <u>coveriage,</u> primiu, yan efektibun i regulasion.

> Tiempon-mu ni un despedisia siempre ma duplika despues i regulasion sina ma implimenta despues, siempre u ma umenta i gasto yan lokkue inafekta finansiat kondision i prugrama.

> I membru yan i indipendenten-niha tåya pat ti man kunubre nu este na <u>coveriage</u> ni ti man intensiona, ni este ma submiti i nuebu na rehistrasion siempre u fan ma nulu ya u fuera gi nuebu na regulasion.

> ti aproposito, ti propiu, pat ti ma apasi i <u>claim</u> siha put rason na para u ma duplika pat gai ginadon i rikohida yan i infotmasion (ni para u inihible i nuebu na aplikasion), siempre un susede,

>> bula ti man sufisiente yan / pat ti man propiu na <u>claims</u>

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man ma apåsi, siempre ha distrosa yan ana dilikao i kondision i finansiåt i prugrama.

» I ligat na dibi para i prugráma yan gobietnamento para ti propiu na <u>claims</u> para u fan ma apasi yan ti propiu i ginastan salápe' i pupbliku.

III. Sigun i spesifikat na pribension put regulasion ni man ma amenda, i <u>TPA</u> ha gasta mas yan ha yute tiempon-na para u negosiu i kontråta yan i mananten i <u>medical</u> na setbisu, ha kriådu i <u>worldwide network</u>, ni para u afakcha i nisisidåt i medikåt para i membru ni man patisipao gi halom i prugrama; ma printa i mañånte gi direktorio siha ya ma indika i mañånte yan eyun-niha <u>network</u>; yan ma Imprinta i nuebu na <u>insurance card</u>s ni para u fan ma nå'i' i membru.

Sin i man ma amenda na regulasion siha;

- > I kontråta para i mañánte siempre u ma nulu.
  - » Debidi u guaha inatăhi para i prugrăma nl para u eksisa i obligasion-na para i <u>TPA</u>.
  - » Debidi u guaha inatåhi i <u>TPA</u> para u eksisa i obligasion-ña para i manante.
  - » Gumuaha meggai na prublema gi bandan kontrata ni man ma intensiona siempre ta ekspekta dangkolo' na gasto sina ha ginasta miyon na salape'.
- > I direktoriu genin i mañånte siempre ha u fan ma nulu.
  - » Siempre guaha kubukao put i probension setbisu gi bandan medical.
  - » Siempre guaha aksion kontra i prugråma yan i gobletnamento kumo i <u>plan sponsor</u> para i <u>TPR</u> na gasto.

Yangen i prugrama ti sina ha kumple i obligasion-ña sigun i kontråta para i <u>TPA</u> put rason na ti ha kumple ma implimenta insigidas i nuebu na regulasion siha, i prugråma, yan i gobietnamento kumo gulya i <u>plan sponsor</u>, siempre u <u>default</u> sigun i kontrata, ha kontradisi sigun gi aksion-na gi halom i kontråta halom i <u>TPA</u>, para i membru ni ti ha kumple muna guahayi este na <u>coveriage</u>, lokkue i setbisu yan åpas i <u>claims</u>, yan para i mañånte ni ti ha kumple para u apåsi i setbisu esta munåyan ma ekstende. Maseha håfa na aksion siempre u guaha risuta genin:

> U ma rekohi todu i gasto ni ma gasta genin i <u>TPA</u> ni ti ma antisipao put l implimentasion genin i nuebu na regulasion.

> U ma redima i gasto put i setbisu siha yan <u>damages</u> genin i mañånten <u>medical</u> na prugrama; <u>worldwide;</u>

> Guaha redima gi <u>damages</u> i membru siha put ti ha kumple para u probeni i antisipao gi båndan <u>coveriage</u> yan i inapåsin i <u>claims</u>, yan

> i <u>damages</u> i ti man ma mensiona kuanto.

I liabilidåt put este na <u>damages</u> siempre u ditetmina i gobletnamento kumo guiya i <u>plan sponsor</u>, i ligåt na aksion siempre u tutuhun ma desiminuyi yan kåra (salåpe') i prugråma, siempre tumåya fenkas-ña ya ti sina u satesfecho i <u>claims</u> yan eyu siha na disision esta munåyan man ma husgua, siempre dångkolo' i debin i gobletnamento ya u inefekta i abilidåt-ña para u ekstende i nisisåriu na setbisu para i empliaon gobietno yan familian-niha put <u>medical</u> <u>treatment.</u>

IV. I ma amenda na regulasion siha u ma implimenta eyu i <u>prescription</u> <u>medication Formulary and Pharmacy Benefit Management Program</u>, kosaki i prugråma sina a realisa dangkolo' na <u>savings</u> (yan lokkue genin i kontråta ni guaha <u>discount</u> mås siña ma realisa eyu na <u>savings</u>). Yangen ma kumpåra yan i mapos na statistiku gi båndan <u>claims</u> put i gaston åmot, yan lokkue asigura u ma ripåra yan ma probeni gi båndan digeria ni ma susede gi mapos gl halom i prugråma, eyu mina meggai gaston-na i prugråma gi båndan salåpe', kahulu i gaston i prugråma mås ki mit-kinentos na salåpe' lao ti ti siña ha rikohi tatte'. I intension i prugråma para u na setbe este siha na salåpe' (kaha) put para u kumple i <u>claims</u> ni para u fan ma apåsi i man mapos yan u na siguru i kinalamten-ña i prugråma, yan impotånte u rekognisa este siha na salåpe' (kåhå) na siña ha realisa imidiamente, an ma probeni mismo na hå'len re'ditu para u såtba este siha i man tetenan na obligasion.

An a nisisita i prugråma para u pripribeni an ma implimente este siha na regulasion ya ma realilisa este siha na <u>savings,</u> siempre kumohu ya ti siña para u apåsi este i man hagas siha na <u>claims</u>.

> Meggai na membru man dilinkuente i ha'ånen para u ma apåsi i <u>claims</u> siempre u fan ma nå'i' i <u>collection agency</u> para eyu siha i ma ekstetende i båndan <u>medical</u>:

- >> Siempre ha distrosa i kreditun i membru siha;
- >> Slempre u ma na mutta i membru ni interes sigun gi balansianña i dibina.
- » Siempre ti u ma aksepta na para u ma åmte i membru gi fisilidåt.
- » I membru siempre a chogue i ligåt na aksion kontra i prugråma yangen ti malagu u apasi i ligåt na <u>claims</u>.

> ) mañánten i prugråma yan mangachon-ña siha ma ekspresa na imidiamente u mana påra u ma ekspekta i membru gi hálom este na prugráma anai para u ma atmiti ya u risibi i setbisun <u>medical</u>.

- » Un mayot na hospität giya Hawaii man nä<sup>3</sup>i' notisia na Junio na mes 2002, ti sina i man malangu genin i CNMI u ma aksepta gi fisilidat solo guaha satesfecho na areklamento put para u fan ma apasi imidiamente i man mampos siha na <u>claims</u>.
- >> Ottro na fasilidåt hospitat, yan palu <u>private</u> na mañånte parehu ha na aksion u ma chogue yangen ti ma apåsi i setbisun-niha.
- >> 1 membru siha sina ha ti ma risibi i proplu yan nisisariu na medical treatment taimanu ha diputse i prugrama u ekstiende i ginagagao na setbisun-niha para u ma asiste i membru.

>> I prugrama yan i gobietnamento hu fan responsåble yangen ti ma kumple i obligasion-niha.

Debidl u mahátáhi i interes pupbliku gi bándan piniligru eyu na debi na i 1 CMC Sek. 9104 (b) hu konsiste yan este siha na regulasion ni para u fan ma adopta antes di u kabales trenta (30) dias na notisia para u efektibu insigidas.

Linaknos as: aures

THOMAS I. SAURES, SEGUNDON KABESIYUN (VICE CHAIRMAN) **Board of Trustees NMI Fundon Ritirao** Group Health & Life Insurance **Trust Fund** 

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Karl T. Reyes Atministradot **NMI Fundon Bitirao Group Health & Life Insurance Trust Fund** 

Ma rihksa ni para u fotma yan ligat sufisienti genin i NMIRF/GHLITF:

hat her to fulle

Fecha: 17 June 02

Fecha: 6-17-02

Fecha: 6/17/02

Kathleen Troy-Rucket, Pinagat Ligat (Legal Counsel) NMI Fundon Bitirao Group Health & Life Insurance Trust Fund

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Pinelo' as:

Fecha: 4.17.02

Rehistradoran Kotporasion Commonwealth Gi Sankattan Siha Na Islas Marianas (CNMI)

Rebisan Abugådan Heneråt:

Sigun gi 1 CMC Sek. 2153 ni ma amenda genin Lai Pupbliku 10-15, i imidianti na regulasion ni checheton guine esta ma ribisa yan ma apreba gi fotma yan sufisienti na ligåt genin i Ofisinan I Abugádan Henerát gi Commonwealth Sankattan Siha Na Islas Mariánas.

Cour 7. 2

Robert Torres, Abugådan Heneråt Commonwealth Gi Sankattan Siha Na Islas Mariånas

Ma risibi gi Oli sinan Gobietno genin as:

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Delegådon I Gobietno Commonwealth Gi Sankattan Siha Na Islas Mariánas Fecha: 6. 17 . 02

Fecha: 17 Jun 02

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l. Babauta, Gobietno nmonwealth Gi Sankattan (Con Siha Na Islas Mariánas

Fecha: 6/13/02

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## ARTICLE 1 – INTRODUCTION

The Government of the Commonwealth of the Northern Mariana Islands provides its eligible Employees, Retirees and their eligible family members with an optional group health insurance Plan. The purpose of the Plan is to provide financial assistance to Enrollees to help them pay for necessary health care. Public Law 10-19 transferred the administrative functions of the Plan, existing inventory and staff to the NMI Retirement Fund effective June 21, 1996. This Plan Document sets forth the terms and conditions of the Government's Program beginning on the effective date of these regulations.

The Program is underwritten exclusively by the CNMI Government and is administered by the Board of Trustees of the NMI Retirement Fund and the NMI Retirement Fund's Administrator. The Program's Covered Benefits, eligibility and enrollment requirements, and administrative procedures are governed by this Plan Document.

These Rules and Regulations govern the Program and repeal Parts I, II, III, IV, V, VI, VII and IX of the Rules and Regulations published in the Commonwealth Register, Volume 19, Number 2, on February 15, 1997, and adopted by the Notice and Certification of Adoption appearing in the Commonwealth Register, Volume 19, Number 5, on May 15, 1997. To the extent that they are not inconsistent with the provisions of Public Law 8-31, the Program, and these Rules and Regulations, shall apply to all Retirees who are covered by the provisions of Public Law 8-31.

The CNMI Legislature has the right to modify or terminate the Program at any time. The Board has the right to modify or amend the Program at any time, with or without notice. However, no such modification or amendment by the Board will adversely affect any claim for any benefit that was incurred before the effective date of such modification or termination.

Questions about enrollment, benefits or claims and all Application Forms, Enrollment Change Forms, Claims Forms and correspondence should be directed to the Administrator, CNMI Group Health Insurance Program, NMI Retirement Fund, 1<sup>st</sup> Floor, Retirement Fund Building, Capitol Hill, P.O. Box 501247, Saipan, MP 96950-1247, telephone (670) 664-8026, fax (670) 664-8074.

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Vicente C. Camacho Chairman, Board of Trustees NMI Retirement Fund

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Karl T. Reyes Administrator NMI Retirement Fund

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## **ARTICLE 2 – DEFINITIONS**

Where a word or phrase used in this Plan Document has a meaning specifically defined by this Article, it appears italicized and with its first letter or letters in capitalized form.

- 2.01. "Act" means Public Law 10-19, An Act to Transfer the Administration of the Government Health Insurance Programs to the Northern Mariana Islands Retirement Fund, which was enacted into law effective June 21, 1996, and all subsequent amendments.
- 2.02. **"Administrator"** means the Administrator of the NMI Retirement Fund or his or her designee. If the Fund has contracted with a Third Party Administrator to provide Services under the Plan, the term "Administrator" may, at times, refer to the Third Party Administrator.
- 2.03. **"Allowable Expense"** means any expense which the Board or Administrator determines to be reasonable and appropriate for administering the Program and for providing Covered Benefits in accordance with this Plan Document.
- 2.04. **"Annual Maximum"** means the dollar limitation on the total amount that the Program will pay for all Covered Benefits provided to any Enrollee in any Plan Year.
- 2.05. **"Application Form"** means the form prescribed by the Administrator and required to be submitted to the Administrator by any person wishing to enroll himself or herself and/or his or her Dependents in the Program.
- 2.06. "Board" means the Board of Trustees of the NMI Retirement Fund.
- 2.07. "Child" means a Subscriber's unmarried
  - a. natural child;
  - b. legally adopted child or child placed for adoption;
  - c. stepchild living with the Subscriber in a normal parent/child relationship; or
  - d. child under his or her court-appointed legal guardianship;

so long as such Child is under the age of 18 and primarily supported by the Subscriber. If a court of competent jurisdiction has ordered that the Subscriber provide health insurance coverage for such Child, the Child need not be primarily supported by the Subscriber.

2.08. **"Claim Form"** means the form prescribed by the Administrator, or any Third Party Administrator contracted by the Program, and required to be submitted to the Program or Third Party Administrator for payment of Covered Benefits.

- 2.09. **"Coinsurance"** means the percentage of the cost of Covered Benefits that must be paid by either the Enrollee or the Program.
- 2.10. **"Contribution"** means the share of the Premium required to be paid by the Government or the Subscriber.
- 2.11. **"Co-payment"** means the specified portion or percentage of the Eligible Charge that an Enrollee must pay to the Provider of Services.
- 2.12. "Covered Benefits" means the health care Services covered under the Program.
- 2.13. "Dependent" means a Subscriber's
  - a. Spouse;
  - b. Eligible Child(ren).
- 2.14. **"Disease"** means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the vital functions, and causing or threatening pain and weakness. Other common terms for Disease and which may be considered to be a Disease are malady, affliction, illness, sickness and disorder.
- 2.15. **"Dispense" or "Fill"** means the counting, measuring, compounding, pouring, packaging and labeling required to prepare a drug for either direct or indirect delivery to a patient when authorized by a valid prescription from a licensed Practitioner.
- 2.16. **"Doctor"** means a duly licensed doctor of medicine (M.D.), medical officer (M.O.), or doctor of osteopathy (D.O.). Doctors of Optometry (O.D.) and Podiatry (D.P.M.) will also be considered a Doctor for purposes of the Plan, but only for the provision of services as stated to be allowed to be performed by the appropriate licensing board or agency in the location in which the service is performed, and only for the provision of services covered under the Plan. A doctor of dentistry (D.D.M. or D.D.S.) is also considered a Doctor for purposes of the dental work and oral surgery covered by the Program. Types of practitioners not specifically mentioned in this paragraph are not considered Doctors for purposes of the Program.
- 2.17. **"Drug" or "Medication"** means articles recognized in the official United States Pharmacopoeia, the official Homeopathic Pharmacopoeia of the United States, or official national Formula, or any supplement to any of them, being and labeled in accordance with the Federal Drug Administration requirements; or articles and devices intended for use in the diagnosis, cure, mitigation, treatment or prevention of diseases in humans; or articles intended for use as a component of

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any article specified in this definition; or controlled substances as defined in the Rules and Regulations of the CNMI Medical Profession Licensing Board.

- 2.18. **"Effective Date"** means the date on which a person is accepted as a Subscriber, as established and recorded by the Administrator, and is the date, subject to all applicable waiting periods provided under this Plan, on which such Subscriber's eligibility for benefits under this Plan begins.
- 2.19. "Eligible Charge" means
  - a. the charge described in Article 11.10 below and is the charge used to calculate the Plan's benefit payment for most covered Services;
- 2.20. "Emergency" means the sudden and unexpected onset of a severe medical condition that, if not treated immediately, would be, in the opinion of a Doctor, life-threatening or result in a permanent disability; for example, a heart attack, severe hemorrhaging, poisoning, loss of consciousness or respiration, and convulsions are considered Emergencies.
- 2.21. **"Employee"** means a person who is receiving salary or wages from the Government and who is (a) employed by the Government and regularly scheduled to work 20 or more hours per week, or (b) an elected or appointed Government official. However, as to any period, the term "Employee" will not include any individual who, during such period, is classified or treated by the Government as an independent contractor, a consultant, a leased employee, or an employee of an employment agency or any entity other than the Government, even if such individual is subsequently determined to have been a common law employee of the Government during such period. This definition also excludes any individual who serves on a Government board or commission, but is not otherwise a Government employee, and any individual employed by the Government in violation of applicable law. Nothing in this definition will be construed to affect Retirees who are authorized by law to draw their retirement benefits while working for the Government in a non-employee classification. This definition is effective as of the Plan's original effective date.
- 2.22. **"Enrollee"** means any Employee, Retiree, Survivor, or Dependent whose enrollment in the Program has been approved by the Administrator and for whom all Premium payments are current, unless otherwise required by law or specifically approved by the Administrator if the failure to make Premium payments was no fault of the Subscriber.
- 2.23. **"Enrollment Change Form"** means the form prescribed by the Administrator and required to be submitted to the Administrator by any person wishing to change his or her benefit or enrollment option or to add or delete coverage of Dependents.

- 2.24. **"Experimental"** means any experimental, investigational or unproven Service which is considered by the HCFA Medicare Coverage Issues Manual to be not reasonable and necessary and, therefore, not approved for payment under U.S. Medicare.
- 2.25. "Fiscal Year" means any October 1 through the following September 30.
- 2.26. **"Formulary"** means a listing of prescription drugs and medications that are covered under the Plan and for which the Plan will either pay the appropriate portion of co-insurance or for which the Plan will reimburse the Enrollee the appropriate portion of co-insurance. Providers that are legally permitted and authorized to dispense medications will be reimbursed for medications prescribed from the Formulary, based upon the rate established by the Plan's Pharmacy Benefit Manager.
- 2.27. "Fund" means the NMI Retirement Fund.
- 2.28. **"Generic"** means a drug or medication prescribed by a Doctor that contains the chemical name for the drug, and is usually a lower cost equivalent to a Name Brand drug or medication. The active ingredient in the generic drug is the same \_\_\_\_\_\_ as the active ingredient in the equivalent name-brand drug, even though the exact formula for the two drugs may not be identical.
- 2.29. **"GHLI Trust Fund"** means the CNMI Government Group Health and Life Insurance Trust Fund. The GHLI Trust Fund shall be segregated from other funds and held in trust and administered by the Administrator under the fiduciary supervision of the Board.
- 2.30. **"Government"** means the CNMI Government, its departments, agencies, instrumentalities, public corporations, municipal governments, and other CNMI Government entities and autonomous agencies.
- 2.31. "Hospital" means any inpatient acute care institution which:
  - a. is not other than incidentally, a nursing home, rest home, or Skilled Nursing Facility; and
  - b. is primarily engaged in providing facilities for surgery and for medical diagnosis and treatment of injured or ill persons by or under the supervision of Doctors; and
  - c. has registered nurses always on duty; and
  - d. is certified or licensed as a hospital by the proper governmental authority.
- 2.32. **"Injury"** means a wound or physical trauma resulting from an external force (such as a blow, collision, or impact) that is of sufficient magnitude to require the Services of a physician within a reasonable time. Subjective symptoms that occur spontaneously or from trivial movement or exercise and that are

physiological, pathological, toxic, or infective in origin are not to be considered the result of external force and therefore shall not be considered an injury. The fact that an ailment or condition may not fit this definition of "Injury" does not necessarily mean that the ailment or condition is not covered under the Plan.

- 2.33. "Lifetime Maximum" means the dollar limitation on the total amount that the Program will pay for all Covered Benefits provided to an Enrollee during the Enrollee's lifetime.
- 2.34. "Medical Director" means a medical doctor, medical officer, and other medical professional employed by the Plan or its Third Party Administrator, if any, to review claims and determine medical necessity of Services.
- 2.35. "Medically Necessary" means, with respect to each Service, that the Service meets all of the tests listed below. The fact that a Doctor prescribes, orders, recommends or approves a Service does not, of itself, make it Medically Necessary.
  - a. **Health-Related.** The Service is provided for the diagnosis or treatment of an injury, illness, disease, ailment or condition, including pregnancy, and birth and congenital defects.
  - b. **Appropriate.** The Service is (i) appropriate for the symptoms, (ii) consistent with the diagnosis, (iii) in accordance with generally accepted medical practice and professionally recognized standards in the geographic location where Services are provided, and (iv) expected to result in a meaningful and substantial improvement in the Subscriber's condition.
  - c. **Adequate.** The Service does not exceed the supply, level of Service or amount of Service needed to provide safe and appropriate care.
  - d. **Not for Convenience.** The Service is not provided mainly for the convenience or desire of the Enrollee, Enrollee's family, Enrollee's Provider, or other person or entity.
  - e. **Not Experimental.** The Service is not Experimental.
  - f. As further described in Article 11.09 of this Plan Document.
- 2.36. **"Mental or Nervous Disorders"** include the following conditions: neurosis, psychoneurosis, psychopathy, psychosis, and emotional disorders of every kind, irrespective of cause, except substance abuse and/or dependency.

- 2.37. **"Name-Brand"** means any drug or medication prescribed by a Doctor that contains a specific copyrighted name assigned to it by the drug's manufacturer. There may or may not be a generic equivalent for name-brand medications.
- 2.38. **"Non-Participating or Non-Preferred Provider"** means a provider of services who, when rendering a service covered by the Plan to an enrollee, does not have an agreement with the Plan or the Plan's Third Party Administrator, if any, to collect a specified amount.
- 2.39. **"Non-Preferred Prescription"** means any drug or medication prescribed by a Doctor that exceeds a certain dollar limit as established in the Plan's formulary, or as specified in this Plan.
- 2.40 **"Off-island"** means a location other than the Commonwealth of the Northern Mariana Islands. For example an Off-island hospital or provider refers to a hospital or medical provider located outside the CNMI, such as a provider located in Guam, Hawaii or the U.S. mainland.
- 2.41 **"On-island"** means a location in the Commonwealth of the Northern Mariana Islands. For example, an On-island provider or hospital refers to a provider or facility located within the CNMI, such as the Commonwealth Health Center.
- 2.42. **"Open Season"** means that period of time, designated by the Administrator, during which Employees may apply for enrollment in the Program for themselves and their Dependents and during which Subscribers may apply to change their benefit and enrollment options in the Program. Generally, an Open Season will be held in November each year.
- 2.43. **"Out-Of-Pocket Maximum"** means the total dollar amount of Eligible Charges that must be paid by the Subscriber for his or her family in a Plan Year toward eligible medical expenses. The out-of-pocket maximum only applies to Eligible Charges and the Subscriber must still pay for any non-eligible charges in addition to the out-of-pocket maximum.
- 2.44. **"Participating or Preferred Provider"** means a Provider of Services who, when rendering a Service covered by this Plan to an Enrollee, agrees with the Plan or the Plan's Third Party Administrator or Pharmacy Benefit Manager, if any, to collect not more than (a) a specified amount paid by the Plan and (b) the Enrollee's Copayment or Coinsurance as specified in this Plan.
- 2.45. **"Pharmacist"** means one who is Registered, Certified or Licensed by the appropriate licensing and regulatory authority in the jurisdiction in which the Services is being performed, and who legally may compound and dispense medications, following prescriptions issued by a duly licensed Doctor or Physician, or other authorized medical practitioner; and one who legally weighs, measures and mixes drugs and/or other medicinal compounds, and fills bottles or

capsules with correct quantities and compositions or the preparation; and one who legally dispenses prescription medications and advises self-diagnosing and self-medicating patients, or provides information on potential drug interactions, potential adverse drug reactions, and elements of patient's history which might bear on prescribing decisions when in an advisory capacity to a Physician; or as otherwise described and defined in the CNMI Medical Profession Licensing Board Rules and Regulations.

- 2.46. "Pharmacy" means a location properly licensed by the CNMI Medical Profession Licensing Board or the appropriate licensing and regulatory authority in the jurisdiction in which the facility is located, where prescription drugs are legally stored or possessed and dispensed or sold at retail, or displayed for sale at retail, or where prescriptions are compounded or dispensed.
- 2.47. "Pharmacy Benefit Manager (PBM)" means a company or firm that provides prescription benefit management services including, but not limited to, formulary development and management, prescription pre-authorization, prescription utilization review, prescription claims processing and payment, prescription cost controls.
- 2.48. "Physician" See "Doctor", above.
- 2.49. **"Physician Assistant"** means a duly certified or licensed Physician Assistant, properly certified or licensed pursuant to the Rules and Regulations promulgated by the CNMI Medical Profession Licensing Board, or all criteria established in the jurisdiction in which the Physician Assistant is rendering services, including but not limited to certification requirements as established by the National Commission on Certification of Physician Assistants (NCCPA).
- 2.50. **"Plan"** means the group health insurance plan, which the Government offers to its Employees and Retirees and includes this Program and any and all Prior Programs. This term may be used interchangeably with the term "Program", as defined herein.
- 2.51. **"Plan Document"** means this CNMI Group Health Insurance Program Plan Document as amended by the Board from time to time. The term "Plan Document" includes any currently effective rules and regulations amending or interpreting this Plan Document, any supplements issued by the Program or Riders providing any supplemental coverage, if any.
- 2.52. **"Plan Year"** means the calendar year (January 1 through December 31), except that the "first" Plan Year will be the effective date of these regulations through the following December 31 in the year of first implementation of these regulations or any published revisions to these regulations. For a new Enrollee, the Plan Year begins when such Enrollee's coverage begins and continues through the following December 31.

- 2.53. **"Premium"** means the total amount of Contributions required to be paid into the GHLI Trust Fund for participation in the Program.
- 2.54. **"Prescription"** means a written order given individually for the person for whom prescribed or named, issued by a licensed Doctor, Physician, or other legally qualified medical practitioner, for a drug or medication, to be compounded, filled, dispensed or furnished by a legally qualified individual or Pharmacist. In addition, a Prescription may be for durable medical equipment. Prescription does not include medications or drugs for which a prescription is not required or that are lawfully obtainable without a prescription, such as "over-the-counter" remedies.
- 2.55. **"Prior Program"** means any Government Employee group health insurance program in effect prior to the effective date of this Program.
- 2.56. **"Program"** means the CNMI Government Employee group health insurance program described in this Plan Document. This term may be used interchangeably with the term "Plan", as defined herein.
- 2.57. **"Provider"** means a Doctor, Physician, Physician Assistant, Hospital, Skilled Nursing Facility, Pharmacy, or any other duly licensed person, institution or other entity qualified to provide the relevant Covered Benefits under the Program.
- 2.58. **"Retiree"** means a former Employee who is receiving annuity payments through the Northern Mariana Islands Retirement Fund as a result of service, age or disability. The term "Retiree" does not include a spouse or former spouse of a Retiree receiving an annuity as a result of a domestic relations court order.
- 2.59. **"Services"** means health care treatments, procedures, supplies, equipment, and products, and includes prescription drugs.
- 2.60. **"Skilled Nursing Facility"** means a licensed institution, other than a Hospital, which is not, other than incidentally, a custodial care Provider, and which, at a minimum, provides the following:
  - a. inpatient medical care and treatment to convalescing patients;
  - b. full-time supervision by at least one Doctor or registered nurse;
  - c. 24-hour nursing care by licensed professional nurses; and
  - d. complete medical records for each patient.
- 2.61. **"Special Enrollment"** means the rights conferred on any person by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 2.62. "Spouse" means an Employee's or Retiree's current:

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- legal husband or wife from whom the Employee or Retiree is not legally a. separated; or
- common-law husband or wife, provided the marriage is recognized as b. valid and lawful in the jurisdiction where it was made.
- 2.63. "Subscriber" means any Employee, Retiree or Survivor who is enrolled in the Program and in whose name the enrollment is registered.
- 2.64. "Surgical Services" means professional Services necessarily and directly performed by a physician in the treatment of an Injury or illness requiring cutting; suturing; diagnostic and therapeutic endoscopic procedures; debridement of wounds including burns; surgical management or reduction of fractures and dislocations; orthopedic casting; manipulation of joints under general anesthesia; or destruction of localized surface lesions by chemotherapy (excluding silver nitrate), cryotherapy, or electrosurgery.
- 2.65. "Survivor" means the Spouse of a deceased Retiree who is receiving Survivor's annuity benefits under the laws governing the NMI Retirement Fund and who has not remarried.
- 2.66. "Third Party Administrator" means an individual or company with particular expertise in the administration of health plans, typically tasked with utilization review (examining claims to detect and/or determine eligibility, accuracy, fraud, double billings, diagnosis and treatment consistency), case management, claims processing, and claims payment, in addition to any other responsibilities contracted for by a health plan or insurance company.

# **ARTICLE 3 – ELIGIBILITY**

- 3.01. **Employees Generally.** All Employees are eligible to apply to enroll themselves and their Dependents in the Program.
- 3.02. **Dependent Children.** Any Child of a Subscriber who meets the definition of "Child" as defined in Article 2.07 and the definition of Dependent as defined in Article 2.13, and who is 18 years of age or younger and unmarried is eligible for coverage under this Plan.
  - a. If a Child, upon reaching the age of 18 years, is incapable of selfsustaining employment because of mental retardation or physical handicap, is chiefly dependent upon the Subscriber for support and maintenance, and is unmarried, the Child shall be allowed continued coverage under this Plan so long as the Child continues to be so incapacitated, dependent, and unmarried. The Subscriber must furnish written evidence of such incapacity, dependency, and marital status to the Plan within 31 days of the Dependent's attaining the age of 18, and at any time thereafter upon request by the Plan but not more frequently than annually after the two year period following Child's attainment of the limiting age. The Child's coverage shall terminate when the Subscriber's coverage terminates or when the Child marries or is no longer incapacitated and dependent.
  - b. A Dependent Child may remain eligible through age 24 provided said Dependent is unmarried, financially dependent upon the Subscriber, and is regularly attending an accredited educational institution as a "full time" student, maintaining at least twelve (12) units, or the definition of full-time as used by the accredited learning institution, whichever is greater. Proof of enrollment by means of a letter from the Registrar's Office of the school and signed by the Registrar for the appropriate semester is required at the beginning of each semester. Coverage for the Dependent shall continue during semester breaks, or times when school is not in session, pursuant to the institution's official schedule. However, if the Dependent does not enroll in the next semester or session immediately following said break, coverage shall terminate as of the last official class day of the semester or session immediately prior to the break, or on the last official day of the session in which the Dependent was last enrolled.
  - c. A Child identified in a Qualified Medical Child Support Order as an eligible Dependent will be accepted upon submission of a certified copy of the Court Order.
- 3.03. **Notice of Enrollment Rights.** If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance

coverage, you may in the future be able to enroll yourself or your Dependents in this Program, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

- 3.04. **Retiring Employees.** An Employee who was enrolled in the Program on the day immediately preceding his or her date of retirement is eligible to continue enrollment in this Program for himself or herself, as a Retiree, and to continue the enrollment of any Dependents who were enrolled as of the last day of the Employee's employment.
- 3.05. **Retirees and Their Dependents in Prior Program.** A Retiree and his or her Dependents are eligible to enroll in the Program if they:
  - a. were enrolled in a Prior Program on the effective date of this Program; and
  - b. had no break in coverage under the Prior Program between the effective date of this Program and the effective date of coverage under this Program.
- 3.06. **Retirees Not Enrolled in Government Plan.** A Retiree who is not enrolled in a CNMI Government group health insurance Plan is eligible to apply for enrollment in this Program, provided he or she is enrolled 30 days from the effective date of his/her retirement. Enrollment will be effective on the day after the first annuity payment following approval.
- 3.07. **Spouse Enrolled in this Program on Death of Retiree.** A Spouse, upon becoming a Survivor, is eligible to continue enrollment in the Program for himself or herself and the deceased Subscriber's Dependents, provided such Survivor and Dependents were enrolled in the Program at the time of the Subscriber's death.
- 3.08. **Survivors and Dependents in Prior Program.** A Survivor who was enrolled in a Prior Program on the effective date of this Program, together with any of the deceased Retiree's Dependents, who were also enrolled in the Prior Program on that date, are eligible to enroll in this Program, provided they had no break in coverage under the Prior Program between the effective date of this Program and the proposed effective date of coverage under this Program.
- 3.09. **Survivors and Dependents Not Enrolled in Government Plan.** A Survivor of a deceased Retiree together with any of the Dependents of a deceased Retiree not enrolled in a CNMI Government group health insurance Plan are eligible to enroll in this Program.

- 3.10. **Newly Acquired Dependents.** An Employee or a Retiree may apply to enroll his or her newly acquired Dependents. A Survivor may apply to enroll a newborn Child provided the newborn is a natural Child of the deceased Subscriber.
- 3.11. Eligibility for Special Enrollment. An Employee or a Retiree and his or her Dependents may be eligible for Special Enrollment under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 3.12. **Proof of Eligibility.** The Administrator may require such documentation as he or she deems necessary to verify the eligibility of any person. If satisfactory documentation is received by the deadline specified by the Administrator, the person will be considered eligible as of the date of application for enrollment or enrollment change, whichever is applicable. If satisfactory documentation is received after the specified deadline, the person will be eligible as of the date of receipt of the documentation.
- 3.13 **Eligibility of Disabled Child.** Sufficient medical and/or legal proof of total disability and dependence must be submitted to the Administrator within thirty (30) days of the Child's attainment of the limiting age and every year after that.
- 3.14. **No Guarantee of Enrollment.** Being eligible for enrollment does not guarantee that the application for enrollment will be approved. Employment by or retirement from the Government does not guarantee enrollment or continued enrollment. The enrollment requirements detailed in Article 4 must be met.

# **ARTICLE 4 – ENROLLMENT**

#### 4.01. Enrollment Options and Categories.

- A. Options for coverage available under the Plan are as follows:
  - 1. High Option 80/20 coverage. The Plan pays 80% of Eligible Charges, and the Enrollee pays 20%.
  - 2. Low Option 70/30 coverage. The Plan pays 70% of Eligible Charges and the Enrollee pays 30%.
- B. Categories of coverage.
  - 1. Available Category and Option selections:
    - a. Self Only, High Option
    - b. Self Plus One, High Option
    - c. Self Plus Four, High Option
    - d. Self Plus Five Plus, High Option
    - e. Self Only, Low Option
    - f. Self Plus One, Low Option
    - g. Self Plus Four, Low Option
    - h. Self Plus Five Plus, Low Option
  - 2. Category explanations:
    - a. **"Self Only"** refers to the Subscriber only. Only one Enrollee may be covered under this category of the Plan.
    - b. **"Self Plus One"** refers to a Subscriber with one (1) Dependent. The Dependent may be a Spouse or eligible Child, but a maximum of two (2) total Enrollees (including the Subscriber) may be covered under this category of the Plan.
    - c. "Self Plus Four" refers to a Subscriber with up to four (4) Dependents. The Dependents may be a Spouse and eligible Children or all eligible Children, but a maximum of five (5) total Enrollees (including the Subscriber) may be covered under this category of the Plan.
    - d. **"Self Plus Five Plus"** refers to a Subscriber with five (5) or more Dependents. The Dependents may be a Spouse and eligible Children or all eligible Children, but this category

must be selected in order to cover six (6) or more Enrollees (including the Subscriber) in the Plan.

3. Category Examples:

Self Only	Employee only	1 total Enrollee
Self Plus One	Employee + Spouse	2 total Enrollees
	OR	OR
	Employee + eligible Child	2 total Enrollees
Self Plus Four	Employee + Spouse + up to 3 eligible Children	Up to 5 total Enrollees
	OR	OR
	Employee + up to 4 eligible Children	Up to 5 total Enrollees
Self Plus Five Plus	Employee + Spouse + 4 or more eligible Children	No limit to the number of eligible Enrollees
	OR	OR
	Employee + 5 or more eligible Children	No limit to the number of eligible Enrollees

- 4.02. **Forms.** A person wishing to enroll himself or herself and/or his or her Dependents in the Program must file an Application Form with the Administrator. A Subscriber wishing to change his or her enrollment or that of his or her Dependents must file an Enrollment Change Form with the Administrator. Both forms are available from the Fund and any other office designated by the Administrator.
- 4.03. **New Employee Enrollment Period and Effective Date of Coverage.** A new Employee may apply, for himself or herself and his or her Dependents, to enroll in the Program within 30 days after his or her date of hire. Enrollment will be effective as of the first day of the pay period following approval of the application. However, no waiting period will be imposed if prohibited by law, such as the

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Uniformed Services Employment and Reemployment Rights Act of 1993 and the Family and Medical Leave Act of 1993.

- 4.04. Other Employee Enrollment Period and Effective Date of Coverage. Employees and their Dependents who are already enrolled in a Prior Program on the original effective date of this Plan are automatically enrolled in this Program. All other Employees who are not new Employees may only apply to enroll during an Open Season unless they are entitled to special enrollment under the Health Insurance Portability and Accountability Act of 1996. If an Employee applies to enroll during an Open Season, such enrollment will be effective as of the date specified by the Administrator unless the Employee is entitled to special enrollment under the Health Insurance Portability and Accountability Act of 1996. If an Employee is so entitled, then the Health Insurance Portability and Accountability Act of 1996's special enrollment rules will apply.
- 4.05. Special Enrollment Periods Following Loss of Other Coverage / Employees and Their Dependents. An Employee who is eligible for Special Enrollment under the Health Insurance Portability and Accountability Act of 1996 is required to request enrollment, by filing a written application form with the Administrator, for himself or herself and/or his or her Dependents not later than 30 days after the exhaustion of COBRA coverage, termination of other coverage as a result of the loss of eligibility for the other coverage or following the termination of employer contributions toward that other coverage. Enrollment in this Program is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.
- 4.06. **Rules for Persons Retiring from Government Employment.** Enrollment in the Program will be automatically continued for an Employee who retires from Government employment and who was an Enrollee in the Program on the day before his or her date of retirement. Enrollment will also be automatically continued for such Retiree's Dependents, who were Enrollees as of the day before the Retiree's date of retirement. Retirees may elect not to have their enrollment and/or their Dependent's enrollment automatically continued by signing a form prescribed by the Administrator acknowledging that he or she understands the consequences as specified in this Article.
- 4.07. Rules for Retirees and Their Dependents in Prior Program. A Retiree whose last day of Government employment was before the effective date of this Program, and who has been covered under a Prior Program continuously since the effective date of this Program, may enroll himself or herself in this Program and may also enroll his or her Dependents, provided such Dependents were enrolled in the Prior Program on the day before the proposed date of enrollment in this Program. Application may be made at any time by filing an approved application form with the Administrator. Enrollment will be effective on the day after the first annuity payment date following approval. However, if such Retiree

later terminates his or her enrollment from this Program, he or she will never be allowed to re-enroll unless he or she otherwise becomes eligible.

- 4.08. **Rules for Retirees Not Enrolled in Government Plan.** A Retiree not enrolled in a CNMI Government group health insurance Plan may elect to enroll himself or herself and any of his or her Dependents, provided the Retiree applies for enrollment within 30 days from the effective date of his/her retirement. Enrollment will be effective on the day after the first annuity payment date following approval.
- 4.09. **Rules for Survivors and Dependents of Deceased Retirees.** A Survivor may elect to enroll or to continue enrollment for himself or herself and any of the former Subscriber's Dependents, provided the Survivor applies for enrollment within 30 days following (a) the date the Administrator approves the Survivor's application for Survivor annuity benefits or (b) the original effective date of this Plan Document. Enrollment will be effective on the day after the first annuity payment date following approval. A Survivor may apply to enroll any newly acquired Dependent only if such Dependent is a Child of the Subscriber.
- 4.10. **Rules That Apply When New Spouse Acquired.** An Employee or a Retiree enrolled in the Program who newly acquires a Spouse may apply to enroll such Spouse by filing an Enrollment Change Form within 30 days after the date of marriage. Enrollment of the Spouse will be effective as of the first day of the pay period following approval of the application. If such Spouse is not enrolled when first eligible, the Employee or Retiree may not apply to enroll the Spouse in the Program until an Open Season unless the Employee or Spouse is entitled to special enrollment under the Health Insurance Portability and Accountability Act of 1996. If an Employee is so entitled, then the Health Insurance Portability and Accountability Act of 1996's special enrollment rules will apply.
- 4.11. **Rules That Apply When New Child Acquired.** An Employee or a Retiree enrolled in the Program who newly acquires a Child may apply to enroll such Child by filing an Enrollment Change Form within 30 days after the Child is newly acquired. The Child's enrollment will be effective as of the date of birth or other acquisition, provided all past Contributions, from date of acquisition, are made at the time of application. If such Child is not enrolled when first eligible, the Employee or Retiree may not apply to enroll the Child in the Program until an Open Season unless the Employee or Child is entitled to special enrollment under the Health Insurance Portability and Accountability Act of 1996. If an Employee or Child is so entitled, then the Health Insurance Portability and Accountability Act of 1996's special enrollment rules will apply. This provision also applies to a newborn Child of a Survivor, provided the newborn is a natural Child of the deceased Subscriber.
- 4.12. Special Enrollment Periods Due to Acquisition of Dependent / Employees, Retirees and Their Dependents. An Employee, Retiree and/or their eligible

Dependents who are eligible for Special Enrollment under the dependency rules of the Health Insurance Portability and Accountability Act of 1996 are required to request enrollment, by filing a written application form with the Administrator, not less than 30 days from the date of the marriage, birth, or adoption or placement for adoption. Such Special Enrollment period does not begin earlier than the date the Plan makes Dependent coverage generally available.

- 4.13. **Dependent Child Over Age 18.** Enrollment for a Dependent Child over age 18, whose medical insurance under another group plan is being continued beyond the termination date of coverage under that plan by an extension of benefits provision, will be postponed until the date such extended coverage terminates.
- 4.14. **Special Enrollment Under Qualified Medical Child Support Orders.** A Child identified in a Qualified Medical Child Support Order as an eligible Dependent will be accepted upon submission of a Certified copy of the Court Order without regard to any Enrollment season restrictions.
- 4.15. **Medicare Part A / Mandatory Enrollment.** It is a condition of enrollment in the Program that if any Enrollee, including a Retiree, Spouse of a Retiree, or an Enrollee who has met Medicare's waiting period for end stage renal disease (ESRD), is eligible for Medicare Part A at no cost, such Enrollee must enroll in Medicare Part A.
- 4.16. **Failure to Enroll.** A non-retiring Employee whose last day of Government employment was on or after the effective date of this Program, and who was not an Enrollee in the Program on such last day of employment, will not be allowed to enroll in the Program unless he or she otherwise becomes eligible.
- 4.17. Voluntary Termination of Enrollment / Retirees. If a Retiree continues enrollment in this Program pursuant to Article 3, Section 3.02 and later terminates the enrollment, or if a Retiree elects not to continue enrollment in this Program, such Retiree will not be allowed to re-enroll unless he or she otherwise becomes eligible.
- 4.18. Voluntary Termination of Enrollment / Survivors. If a Survivor continues enrollment in the Program pursuant to Article 3, Section 3.04 and later terminates the enrollment, or if a Survivor elects not to continue enrollment in this Program, such Survivor will not be allowed to re-enroll unless he or she otherwise becomes eligible.
- 4.19. Election to Terminate / Form for Retirees and Survivors. Any Retiree or Survivor wising to terminate his or her enrollment may do so by signing a form prescribed by the Administrator acknowledging that he or she understand the consequences as specified in this Article 4.

- 4.20. **Identification Cards.** The Administrator, or Third Party Administrator, if any, will provide each Enrollee with one identification card. If an Enrollee requires additional cards, a charge of \$10 per card will be made by the Administrator, or the Third Party Administrator, if any, who shall deposit the money into the GHLI Trust Fund. Enrollees must return all identification cards to the Administrator on termination of enrollment.
- 4.21. **Retroactive Enrollments and Termination.** Retroactive enrollments and terminations are not allowed unless specifically provided for in the Plan.
- 4.22. **Approval of Enrollment or Enrollment Change.** Notwithstanding any other section of this Plan Document, no enrollment or enrollment change will become effective without the approval of the Administrator. If the Administrator has not acted on an Application Form or Enrollment Change Form within 30 days of its receipt, the application for enrollment or enrollment change shall be deemed denied.
- 4.23. **No Guarantee of Enrollment.** Employment by or retirement from the Government does not guarantee enrollment or continued enrollment.
- 4.24. **Enrollment Denied.** The Administrator may deny an application for enrollment because the applicant is ineligible, has exhausted his or her Lifetime Maximum under the Plan, has filed fraudulent claims or other documents with the Program or Prior Program or for any other reason the Administrator deems in the best interest of the Program.

# **ARTICLE 5 – BENEFITS**

- 5.01. **Basics.** Only Eligible Charges for Medically Necessary Covered Benefits may be reimbursed, subject to the limitations and maximums imposed by Article 7 of this Plan Document. A procedure or Service may meet the definition of Medically Necessary but not be a fully Covered Benefit because it is subject to the limitations or maximums imposed by Article 7 of this Plan Document. A procedure or Service may meet the definition of Medically Necessary in this Plan Document. A procedure or Service may meet the definition of Medically Necessary in this Plan Document but not be a Covered Benefit because it is excluded from coverage by Article 8 of this Plan Document.
- 5.02. **Chart.** The chart below is a brief summary of the major Covered Benefits. Enrollees should not rely only on this outline. Enrollees must review this entire Plan Document to fully understand the Covered Benefits including the limitations, maximums and exclusions that are detailed in Articles 6, 7 and 8 of this Plan Document.

	HIGH OPTION PLAN	LOW OPTION PLAN
A. All Hospital, surgical, medical,	Program pays 80% of the first \$20,000	Program pays 70% of the first \$20,000
laboratory, and other Services,	per Enrollee of Eligible Charges incurred	per Enrollee of Eligible Charges
except for those Services specified in	during a Plan Year, and 100% of Eligible	incurred during a Plan Year, and 100%
5.02B through F below.	Charges thereafter.	of Eligible Charges thereafter.
B. Office Visits	Program pays 80% of the Eligible	Program pays 70% of the Eligible
	Charges incurred during a Plan Year.	Charges incurred during a Plan Year.
C. Prescription drugs	Enrollee pays the following for each	Enrollee pays the following for each
	medication prescribed: \$3 for generic,	medication prescribed: \$3 for generic,
	\$7 for name brand and \$15 for non-	\$7 for name brand and \$15 for non-
	preferred prescriptions dispensed by a	preferred prescriptions dispensed by a
	participating provider OR \$5 for generic,	participating provider OR \$5 for
	\$10 for name brand and \$20 for non-	generic, \$10 for name brand and \$20
	preferred prescriptions dispensed by a	for non-preferred prescriptions
	non-participating provider, for a 30-day	dispensed by a non-participating
	supply from a pharmacy or a 90-day	provider, for a 30-day supply from a
	supply from the Plan's mail-order Rx	pharmacy or a 90-day supply from the
	service, or a pharmacy (pharmacy or	Plan's mail-order Rx service, or a
	Enrollee will be reimbursed at the mail	pharmacy (pharmacy or Enrollee will
	order reimbursement rate). Certain	be reimbursed at the mail order
	medications may have a 30-day supply	reimbursement rate). Certain
	maximum and may not be eligible for the	medications may have a 30-day supply
	90-day supply or available under the mail	maximum and may not be eligible for
	order program.	the 90-day supply or available under
		the mail order program.
D. Hospital room and board	Off-island: Program pays 80% of Eligible	Off-island: Program pays 70% of
	Charges.	Eligible Charges.
	On-island: Program pays 80% of Eligible	On-island: Program pays 70% of
	Charges, with a maximum of \$300 per	Eligible Charges with a maximum of
	day.	\$250 per day.

## A BRIEF SUMMARY OF COVERED BENEFITS

E.	Intensive Care Unit room and board	Off-island: Program pays 80% of Eligible Charges. On-island: Program pays 80% of Eligible Charges, with a maximum of \$900 per day.	Off-island: Program pays 70% of Eligible Charges. On-island: Program pays 70% of Eligible Charges with a maximum of \$750 per day.
F.	Skilled Nursing Facility room and board	Off-island: Program pays 80% of Eligible Charges On-island: Program pays 80% of Eligible Charges with a maximum of \$150 per day.	Off-island: Program pays 70% of Eligible Charges On-island: Program pays 70% of Eligible Charges with a maximum of \$125 per day.
G.	Family Out-of-pocket Maximum	Maximum family out-of-pocket expense per category each Plan Year: Self Only - \$4,000 Self Plus One - \$8,000 Self Plus Four - \$12,000 Self Plus Five Plus - \$16,000	Maximum family out-of-pocket expense per category each Plan Year: Self Only - \$6,000 Self Plus One - \$12,000 Self Plus Four - \$18,000 Self Plus Five Plus - \$24,000
H.	Annual Maximum	Program pays a maximum of \$100,000 per Enrollee.	Program pays a maximum of \$50,000 per Enrollee.
Ī.	Lifetime Maximum	Program pays a maximum of \$500,000 per Enrollee.	Program pays a maximum of \$250,000 per Enrollee.

### 5.03. Inpatient Hospital Room and Board Benefits.

- A. Allowable Charges. Subject to the definitions, limitations, maximums and exclusions of the Program, Eligible Charges for the following Hospital room and board charges are Allowable Expenses:
  - 1. Room and board at the average semi-private rates, including meals, special diets and general nursing care.
  - 2. Charges made by the Hospital as a condition of occupancy, such as those for identification bracelets and medical records.
  - 3. Intermediate care unit, isolation unit, and intensive care or coronary care unit. Must be equipped and operated according to generally recognized Hospital standards acceptable to the Plan.
- B. **Private Room Benefits.** Regardless of the reason a private room is used, the difference between its cost and the cost of the Hospital's average semi-private accommodation is not an Allowable Expense. If the Hospital has private rooms only, the Program will pay the average semi-private room rate based on the charges of a comparable Hospital in the same or a similar geographic area up to the maximum Hospital room and board Allowable Expense.
- C. Except where otherwise stated, benefits are subject to the Plan's Schedule of Benefits. If Services are rendered by a non-participating Provider, the Enrollee also owes any difference between actual and Eligible Charges.

5.04. **Other Benefits.** Subject to the definitions, limitations, maximums and exclusions of the Program, Eligible Charges for the following Services, in or out of a Hospital, are Allowable Expenses:

- 1. Hospital Services.
  - a. Services (other than room and board) furnished by the Hospital for treatment in the Hospital or its outpatient department, such as drugs, medicines, laboratory work, use of operating and recovery rooms, surgical supplies, Hospital anesthesia Services and supplies, dressings, oxygen, antibiotics, Hospital blood transfusion Services, and diagnostic and therapy benefits for which the Hospital charges on its own behalf.

### 2. Surgical and Medical Services.

a. **Surgical Services.** Except where otherwise stated, benefits are subject to the Plan's Schedule of Benefits for surgical Services required for the diagnosis or treatment of an Enrollee's illness, Disease, condition or Injury. If Services are rendered by a Non-Participating Provider, the Enrollee also owes any difference between actual and Eligible Charges;

**Non-cutting Surgical Services.** For surgical Services that do not require cutting, benefits are subject to the Plan's Schedule of Benefits on the same basis as surgical benefits above. If Services are rendered by a Non-Participating Provider, the Enrollee also owes any difference between actual and Eligible Charges;

b. **Professional Services.** Professional Services of Doctors such as surgery, consultations and home, office and Hospital visits;

**Physician Assistants.** Professional Services of Physician Assistants, to the extent permitted by Law and the Medical Profession Licensing Board, or similar licensing board or agency for medical professionals in the jurisdiction in which the service is being rendered.

**Registered Nurses.** Professional Services of registered nurses, diagnostic x-rays and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other Medically Necessary tests that reveal need for treatment or are made because of definite symptoms of diseases or injury;

c. **Anesthesiology.** When an attending physician requires anesthesiology Services for a hospitalized patient, other than those provided by the Hospital, that benefit is subject to the Plan's Schedule of Benefits. If Services are rendered by a non-participating Provider, the Enrollee also owes any difference between actual and Eligible Charges.

Anesthetic, oxygen, intravenous injections and solutions, blood (and blood derivatives) not donated or replaced, and administration of these.

- d. **X-Ray.** X-ray, radium and radioactive isotope therapy, including materials and the Services of a technician;
- e. **Surgical Items.** Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations;
- f. **Prosthetic Devices.** Prosthetic devices, other than dental, which replace all or part of an internal body organ, including replacement of such devices;
- g. **Durable Medical Equipment.** Rental or purchase, as decided by the Administrator, for the initial provision or replacement of the following standard durable medical equipment:
  - i. wheelchairs
  - ii. crutches/walkers, braces, trusses, casts, splints
  - iii. suction machines
  - iv. hospital beds/commodes
  - v. oxygen and oxygen accessories
  - vi. respirators
  - vii. hearing aids (one device per ear every five (5) years)
  - viii. cardiac pacemakers
  - ix. artificial limbs, eyes, and hips, and similar non-experimental appliances
  - x. iron lung, artificial kidney machine, pulmonary resuscitator and similar special medical equipment
  - xi. muscle stimulators/regenerators

All such appliances and/or durable medical equipment must be for Services covered under this Plan and must be ordered by the attending physician. However, the Administrator or Medical Director must agree that the ordered item is Medically Necessary for the treatment of the Enrollee's illness or Injury. The Plan will not pay for any convenience items;

- h. **Ambulance Service.** In Emergencies only, professional surface ambulance Service to the first Hospital where the Enrollee is treated and from that Hospital to another Hospital if Medically Necessary Services are not available at the first Hospital;
- i. **Sterilization Services.** Tubal ligations;
- j. **Reconstructive Surgery.** The Plan will pay benefits for reconstructive surgery only when it is required to restore, reconstruct and correct any bodily function that was lost, impaired, or damaged as a result of an illness or Injury. Reconstructive surgery for congenital anomalies (i.e., defects present from birth) are payable only when the defect severely impairs or impedes normal, essential bodily functions.
- k. Mental Health Services. Services of a licensed Psychiatrist or Psychologist for treatment of mental, psychoneurotic or personality disorders. If services are provided by a psychologist, such services must be in accordance with a referral and specific instructions as to treatment type and duration by a doctor of medicine (M.D.).

Inpatient mental health services for room and board and other inpatient diagnostic and laboratory services shall be covered by the Plan on the same basis as other inpatient hospital and medical and surgical benefits and subject to the same limitations, except as otherwise stated herein.

- i. The Plan shall pay eligible and covered charges for up to thirty (30) calendar days of eligible facility charges per year per enrollee
- ii. Each day of inpatient hospital or facility charges, or equivalent services exchanged therefore, shall count against the 365 days per Calendar year maximum inpatient hospital benefits allowed under the Plan
- iii. All co-payments for any services are the responsibility of the Enrollee. If services are rendered or provided by a nonparticipating provider, the Enrollee owes any difference between the actual charges and Eligible Charges
- iv. Each day of inpatient hospital services may be exchanged for two (2) days of non-hospital residential services, two (2) days of partial hospitalization, or two (2) days of day treatment services in a Qualified Treatment Facility, provided that such exchange services include not less than four (4) hours of treatment per day. Each day of inpatient services may also be exchanged for two (2) outpatient visits, provided the Enrollee's condition is strictly that hospitalization would

become imminent if the outpatient services were interrupted and the outpatient services would reasonably preclude hospitalization. The Plan shall not, however, pay more for two (2) days of exchange services than if the services had been provided through one (1) day of hospital inpatient services.

v. A Qualified Treatment Facility is an inpatient or outpatient facility for the treatment of Mental Illness that has been accredited as such by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), or the Commission on Accreditation of Rehabilitation Facilities and, if the facility is residential, has been licensed as a special treatment facility by the proper governmental authority in the locale or jurisdiction in which the facility is located.

#### 3. **Outpatient Services.**

- a. **Physical Therapy and Chiropractic.** Services of licensed physical therapists or licensed chiropractors for administration of physical therapy in accordance with a referral and specific instructions as to treatment type and duration by a doctor of medicine (M.D.) with a maximum of 15 visits at a maximum of \$25 per visit, per Enrollee per Plan Year. Any person employed by CHC, the Rota Health Center or the Tinian Health Center as a physical therapist will be considered a licensed physical therapist;
- b. **Durable Medical Equipment/Items.** Braces, such as leg, arm, back and neck braces, and artificial body parts, such as legs, arms and eyes, including replacements, if required, because of a change in the Enrollee's physical condition. All such appliances and/or durable medical equipment must be for Services covered under this Plan and must be ordered by the attending physician. However, the Administrator or Medical Director must agree that the ordered item is Medically Necessary for the treatment of the Enrollee's illness or Injury. The Plan will not pay for any convenience items;
- c. **Prescriptions.** Drugs and medicines which may be purchased only with a Doctor's prescription and as described in the Plan's formulary. Any prescription drug or medication that is excluded, or not contained, in the Plan's formulary shall not be covered under the Plan. Non-preferred prescriptions shall be covered at a different rate than generic or lower cost name-brand prescriptions. Beginning with the partial Plan year commencing in June 2002, and every plan year thereafter, a non-preferred prescription is any medication with a cost that exceeds \$60.00. Any such medication will require the Enrollee to pay the highest level prescription drug

co-payment, as outlined in the Chart in Section 5.02 of this Plan Document;

- d. **Birth Control/Contraception.** Vasectomies, tubal ligations, and prescription contraceptives;
- e. **Home Health Care.** Services of home health agencies licensed as such by the applicable jurisdiction or approved by the Administrator.

Subject to any limitations listed in this Plan and the Plan's Schedule of Benefits, an Enrollee is entitled to a maximum of 150 home health care visits per Plan Year. If Services are rendered by a nonparticipating Provider, the Enrollee also owes any difference between actual and Eligible Charges.

- i. The attending physician must certify in writing that the Enrollee:
  - 1. is homebound due to an Injury or illness,
  - 2. requires part-time skilled health Services, and
  - 3. would require inpatient Hospital and Skilled Nursing Facility care if there were no home health care visits. The Federal Medicare definition of homebound shall apply.
- ii. If an Enrollee requires home health care visits for more than 30 days, the physician must recertify that additional visits are required and must provide a continuing plan of treatment at the end of each such 30-day period of care.
- lii. Visits must be provided by a qualified home health agency.
- iv. No payment will be made for home health care Services furnished primarily to assist the Enrollee with personal, family, or domestic needs, such as general household Services, meal preparations, shopping, bathing, or dressing.
- f. **Mental Health Care.** Subject to the limitations and maximums as otherwise provided in the Plan (See Article 7), Services of a licensed Psychiatrist or Psychologist for treatment of mental, psychoneurotic or personality disorders. If services are provided by a psychologist, such services must be in accordance with a referral and specific instructions as go treatment type and duration by a doctor of medicine (M.D.).

Enrollee owes any co-payments or co-insurance as set forth in the Plan's Schedule of Benefits for covered outpatient facility, physician, psychologist, clinical social worker or registered nursing services. If services are provided by a non-participating provider, the Enrollee also owes any difference between the actual and Eligible Charges.

### 4. Dental Work and Oral Surgery Services.

Subject to the provisions of this Plan and the Plan's Schedule of Benefits, an Enrollee is entitled to limited benefits for oral surgery as listed below. For the purposes of this Article, a Dentist means a doctor of dentistry (D.D.M.) or dental surgery (D.D.S.) who is appropriately licensed to practice by the proper government authority and who renders Services within the lawful scope of such license.

- a. Dental work, including dental materials (such as fillings, crowns and false teeth) and oral surgery, for the following treatments, as a result of an accident or injury:
  - i. prompt emergency repair of accidental injury to sound, natural teeth;
  - ii. reduction of fractures of the jaw or facial bones as a result of accidental Injury;
  - iii. surgical correction of congenital anomalies;
  - iv. removal of stones from salivary ducts;
  - v. excision of impacted teeth that are not completely erupted, bony cysts of the jaw, torus palatinus, leukoplakia, or malignant oral tissue;
  - vi. freeing of oro-facial muscle attachments; and
  - vii. other surgery on tissues of the mouth, other than the gums, when not performed in connection with the extraction or repair of teeth.
- b. In connection with all other dental work and oral surgery, the only Covered Benefits are for Hospital room and board as specified in Section 5.03.A. Benefits as provided in this Article for oral Surgical Services performed by a dentist shall be payable only when the dentist is performing emergency or Surgical Services that could also be performed by a physician (M.D. or D.O.). Hospital inpatient benefits as provided in Article 5 are available for dental Services only when a physician certifies in writing that the Enrollee has a separate medical condition that makes hospitalization necessary for the Enrollee to safely receive dental Services or that the oral surgery itself requires hospitalization.

### 5. Licensed Practical Nurses' Services.

- a. Licensed Practical Nurse Service. Licensed practical Nursing services are covered if:
  - i. the relevant Hospital uses licensed practical nurses; or
  - ii. the attending Doctor has prescribed nursing Service, including Services of licensed practical nurses.
  - iii. The Administrator may determine that licensed practical nurses are covered in other cases, such as when the attending Doctor certifies in writing (i) that Services of a registered nurse were Medically Necessary but unobtainable, (ii) the names of the licensed practical nurses employed, and (iii) the time period for which the Services were prescribed.

#### 6. **Maternity Services.**

- a. **Prenatal Care.** Standard Prenatal care, as recommended by The American College of Obstetricians and Gynecologists, and the ensuing childbirth or miscarriage, and any medical conditions relating thereto. Diagnostic tests related to the unborn child are eligible for payment or reimbursement only when medically necessary and ordered by a Doctor or Physician.
- b. **Midwife Services.** Services by a nurse-midwife will be eligible for coverage on the same basis as physician coverage. To be eligible for coverage, however, the Services must be rendered by a certified nurse-midwife who is properly licensed, is certified by the American College of Nurse-Midwives, and is formally associated with a physician for purposes of supervision and consultation.
- c. **Birthing Centers.** Hospital benefits described in this Plan Document are also available for Services of a properly licensed birthing center approved by the Plan when such birthing center is used instead of regular Hospital facilities for childbirth. Benefits for birthing center Services are in lieu of payment for inpatient Hospital Services.
- d. **Hospital Stays.** In connection with childbirth, mothers and newborn Children are entitled to Hospital and/or Birthing Center stays up to 48 hours following vaginal delivery and 96 hours following cesarean section. Extension of stays beyond those periods requires prior Plan review to determine medical necessity or appropriateness.

- e. **Post Partum Care.** One routine post partum Doctor visit, per delivery is provided under the Plan.
- f. **Newborn Child.** Nursery charges for days in which the mother and newborn are both confined are considered Hospital room and board expenses of the mother and not expenses of the newborn. All other expenses of the newborn will be considered his or her own and will only be considered Covered Benefits if such newborn meets the definition of Child and is enrolled by the Subscriber pursuant to Article 4, and if such charges are for Hospital and Doctor services provided in connection with routine newborn or nursery care. If properly enrolled pursuant to Article 4, all benefits provided elsewhere in this Plan are available to the Newborn Child from the date of birth including medical services for premature birth, illness, Injury, disease or birth defect.
- g. **Child of Non-Spouse Dependent.** A newborn Child of a non-Spouse Dependent is not an Enrollee unless such Child meets the definition of Child and is enrolled by the Subscriber pursuant to Article 4.

### 7. **Preventive Care Services.**

- a. Annual Physical Check-Up. One (1) annual physical exam, except as excluded in Article 8, including, but not necessarily limited to one:
  - i. blood pressure check
  - ii. chest x-ray
  - iii. cholesterol screening for Enrollees over 25 years of age
  - iv. mammogram in accordance with the American Cancer Society's recommended schedule
  - v. PAP smear
  - vi. vision screening
  - vii. hearing screening
- b. **Family Planning.** One (1) family planning counseling session, per lifetime;
- c. **Childbirth.** Pre-natal care and one post partum visit per delivery;
- d. **Smoking Cessation.** One (1) counseling session on smoking cessation per Enrollee, per lifetime; and
- e. **Well-Child Care.** Well-child care program through age five (5), including immunizations for DPT, typhoid, cholera, polio, small pox,

mumps, measles, rubella, hepatitis, influenza, whooping cough, typhus, tetanus, chicken pox and any other immunizations required by the laws of the jurisdiction in which the child is domiciled, and screening for anemia, tuberculosis, and hearing and vision problems.

Subject to the Plan's Schedule of Benefits, covered well-child care visits are limited to three (3) routine well-baby visits during the first twelve (12) months of a Child's life, two (2) visits during the second (next) twelve (12) months, and one (1) annual visit during ages three (3), four (4) and five (5).

- 8. **Skilled Nursing Facility Services.** An Enrollee, confined in a Skilled Nursing Facility, shall be eligible for the same room and board and general nursing care benefits as if confined in a Hospital, if:
  - a. the Enrollee was admitted upon the authorization of a Doctor;
  - b. the Enrollee is attended by a Doctor while confined; and
  - c. the Enrollee's confinement in the Skilled Nursing Facility is not primarily for comfort, convenience, rest cure or domiciliary care.
  - d. an Enrollee remains in such facility more than 30 days, the attending physician must submit to the Administrator an evaluation report concerning the Enrollee at the end of each such 30-day period of confinement.
- 9. **Cancer Treatment Services.** Chemotherapy and Other U.S. Federal Government Approved Cancer Treatments.
- 10. **Diabetes Related Services.** Dialysis and Supplies.
- 11. **Birth Control Services.** Prescription contraceptives and birth control devices.
- 12. Transplant Services.
  - A. **Recipient Services.** Subject to compliance with each of the conditions set forth below, the following transplants are eligible for benefits:
    - i. Cornea;
    - ii. Heart;
    - iii. heart-lung;
    - iv. kidney;

- v. kidney-pancreas;
- vi. lung;
- vii. pancreas;
- viii. bone marrow, excluding high does chemotherapy with bone marrow transplants or peripheral stem cell infusion for epithelial ovarian cancer, primary intrinsic tumors of the brain;
- ix. liver, excluding liver transplants for metastatic malignancies to the liver or transplants necessitated by or related to substance abuse and Hepatitis B e antigen or core antibody positive;

All other transplants, including artificial or animal organ transplants, are not eligible for benefits under the Plan.

Transplant Evaluations. No benefits will be paid in connection with any covered transplant evaluation(s) without prior approval from the Administrator. Transplant evaluation means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations, which a Hospital or facility uses in evaluation a potential transplant candidate.

Transplant Conditions and Approval. No benefits will be paid in connection with any covered Transplant Services without the prior approval of the Administrator. No transplant benefits will be approved unless each of the following conditions are met:

- i. Both the Enrollee and the specific transplant must meet the "Medical Necessity" criteria set forth in Article 2, Section 2.39;
- ii. The transplant must be performed at a transplant facility that is under contract with the Plan or the Plan's Third Party Administrator for that type of transplant and the contracted transplant facility has accepted the Enrollee as a transplant candidate;
- iii. Any transplant that is classified as "experimental" or "investigative" in the circumstance presented, or as not proven to be safe and effective, will not be covered.
- B. **Donor Services.** Eligible medical and hospital expenses of the donor, or services of an organ bank, will be paid or reimbursed only when the Enrollee is the recipient. Covered expenses for screening of donors shall be limited to expenses associated with the actual

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donor. If the donor is covered under another medical plan, that other plan shall be the primary plan and its benefits shall be applied before benefits under this plan apply. If the Donor is not covered under another medical plan and this Program is the primary plan, any benefits paid for Services provided to the Donor will count against the Annual and Lifetime Maximums of the Recipient Enrollee.

- 13. **Speech Therapy Services.** Speech therapy services from a speech therapist holding a Certificate in Clinical Competence from the American Speech and Hearing Association, or equivalent association or agency in the location the service is being rendered. Speech therapy services must be ordered by a Doctor or Physician under an individual treatment plan, must be medically necessary to restore an Enrollee's speech or hearing function which was lost or impaired due to illness or injury, and must be reasonably expected to improve the patient's condition through short-term care. (Long- term maintenance programs are NOT covered under the Plan). Speech therapy for children with developmental learning disabilities (development delay) is not a covered benefit.
- 14. **Allergy Testing and Treatment.** Allergy testing is limited to one series of tests per Calendar year. Allergy treatment and medication is covered on the same basis as other medical conditions under the Plan.
- 15. **Blood and Blood Products.** Blood and blood products (except when donated) and blood bank service charges are a covered benefit under the Plan, on the same basis as other medical care, if the blood being administered into the Enrollee is done so as part of a medically necessary procedure. Any additional charges for autologous blood (reserved for the Enrollee who donated the blood) are excluded as a benefit.
- 16. **Sleep Disorder Treatment.** Subject to the limitations and maximums as otherwise provided in the Plan (See Article 7), Services of a licensed, certified, registered or Plan approved Sleep Center, Clinic, Hospital Unit or Facility for the diagnosis and treatment of sleep disorders are a covered benefit, only if referred by a duly licensed Physician.

For purposes of this provision of the Plan, a sleep disorder shall be defined as any disorder that affects, disrupts or involves sleep, including, but not necessarily limited to chronic snoring, insomnia, sleep apnea, obstructive sleep apnea, sleep disordered breathing (SDB), restless leg syndrome, and sleepwalking.

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# **ARTICLE 6 – COINSURANCE AND COPAYMENTS**

- 6.01. The office visit Coinsurance must be paid by the Enrollee for each visit, including preventive care visits, made to or by a Doctor, physical therapist, chiropractor, psychologist, home health agency or other Provider while the Enrollee is not confined in a Hospital as an inpatient. The Coinsurance does not cover any ancillary costs that may be associated with such office visit, such as prescription drugs, diagnostic tests or x-rays.
- 6.02. The prescription drug Co-payment must be paid by the Enrollee for each prescription filled or refilled. Such Co-payment will cover a maximum of a one-month supply of the prescription drug if filled at a pharmacy and a ninety-day supply if ordered from the Plan's mail order Prescription Service. If more than one prescription drug is needed, a separate Co-payment will apply to each prescription drug. If the prescription is for more than a one-month supply, and filled at a pharmacy, an additional Co-payment will apply to each additional month or part thereof.
- 6.03. Except as otherwise specifically provided in Article 7, Enrollees in the "High Option Plan" must pay a Coinsurance amount of 20% of Eligible Charges for all Covered Benefits specified in Article 5, Section 5.02.
- 6.04. Except as otherwise specifically provided in Article 7, Enrollees in the "Low Option Plan" must pay a Coinsurance amount of 30% of Eligible Charges for all Covered Benefits specified in Article 5, Section 5.02.
- 6.05. The Enrollee (and not the Program) is responsible for paying the Provider the amount of any Co-payments, Coinsurance, charges that exceed Eligible Charges, charges that exceed maximum amounts payable by the Program, and charges for non-Covered Benefits.
- 6.06. If an Enrollee is officially referred by the CHC Medical Referral Committee for Services outside the CNMI, the Enrollee must pay the Provider any Coinsurance or other amount due from the Enrollee under the Program. The Enrollee may then seek reimbursement from the CNMI Medical Referral Program.
- 6.07. Notwithstanding any other provision of this Plan Document, the Subscriber has ultimate responsibility for paying any amounts required by the Program for himself or herself and all of his or her enrolled Dependents.

# **ARTICLE 7 – LIMITATIONS AND MAXIMUMS**

#### 7.01. Inpatient Limitations.

- A. **On-Island Hospital Room and Board.** The "High Option Plan" limits to \$300 per day, and the "Low Option Plan" limits to \$250 per day, the maximum amounts the Program will pay for room and board and general nursing care while an Enrollee is confined in an On-Island Hospital, unless the Enrollee is confined in a Hospital intensive care unit.
- B. **On-Island Intensive Care Room and Board.** The "High Option Plan" limits to \$900 per day, and the "Low Option Plan" limits to \$750 per day, the maximum amounts the Program will pay for room and board and general nursing care while an Enrollee is confined in an On-Island Hospital intensive care unit.
- C. **On-Island Skilled Nursing Facility Room and Board.** The "High Option Plan" limits to \$150 per day for 60 days, and the "Low Option Plan" limits to \$125 per day for 30 days, the maximum amounts the Program will pay for room and board and general nursing care while an Enrollee is confined in an On-Island Skilled Nursing Facility.
- 7.02. **Physical Exam Limitation.** The maximum amount the Program will pay for physical exams is limited to \$150 per Enrollee per Plan Year.
- 7.03. **Physical and Occupational Therapy and Chiropractic Limitations.** The Program will pay the maximum amount of \$25 per physical and occupational therapy visit or chiropractic visit for a maximum of 15 such visits per Enrollee per Plan Year.
- 7.04. **Surface Ambulance Limitation.** The maximum amount the Program will pay for any surface ambulance trip is \$150 for ambulance service provided in the CNMI, and 80% of Eligible Charge in a location other than the CNMI.
- 7.05 **Home Health Limitation.** The maximum number of home health visits covered per Enrollee per Plan Year is limited to 150 visits.
- 7.06 **Mental Health Limitations.** Both the High Option Plan and Low Option Plan have a limit of \$1000.00 per Enrollee per plan year as the maximum amount the Program will pay for Doctors' and/or Psychologists' Services in connection with inpatient or outpatient treatment of mental or nervous disorders. No mental health services shall be eligible for reimbursement hereunder unless

- i. the Enrollee has a nervous or mental disorder classified as such in the current (at the time of diagnosis) version of the Diagnostic and Statistical Manual of the American Psychiatric Association, and
- ii. the services are provided under an individualized treatment plan approved by a Physician, Psychologist, clinical social worker or advanced practice registered nurse.
- iii. Epilepsy, senility, mental retardation or other developmental disabilities do not in and of themselves constitute a mental disorder.
- 7.07. **Sleep Disorder Limitations.** Upon Physician referral, the Plan will pay for a maximum of two (2), one-night visits, lifetime, per Enrollee, to a licensed and/or approved Sleep Center, for diagnosis and/or treatment of a Sleep Disorder.
  - A. The High Option Plan will cover the first such visit at Eighty percent (80%), with the Enrollee paying the twenty percent (20%) coinsurance;
  - B. The Low Option Plan will cover the first such visit at Seventy percent (70%), with the Enrollee paying the thirty percent (30%) coinsurance;
  - C. Both the High Option Plan and the Low Option Plan will cover fifty percent (50%) of a second visit, with the Enrollee paying fifty percent (50%) coinsurance for the second visit.
  - D. The maximum dollar benefit the Plan will pay in any case is \$2,000.00, per Enrollee, per visit.

### 7.08. Family Out-of-Pocket Maximums.

- A. The family out-of-pocket maximum is the total aggregate maximum amount that a Subscriber must pay in Allowable Expenses for Covered Benefits, specified in Article 5, Section 5.02, incurred during a Plan Year for all Enrollees in that Subscriber's family unit combined. Once a family's out-of-pocket maximum is reached, all Enrollees in such family will be considered to have reached their Coinsurance maximum, and the Program will pay 100% of Allowable Expenses for Covered Benefits, specified in Article 5, Section 5.02, up to the Annual and Lifetime Maximums.
- B. For Enrollees in the "High Option Plan", the family out-of-pocket maximums per category are defined in Article 5, Section 5.02.G.
- C. For Enrollees in the "Low Option Plan", the family out-of-pocket maximums per category are defined in Article 5, Section 5.02.G.

#### 7.09. Annual Maximums.

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The total benefits provided to an Enrollee under this Plan shall not exceed \$50,000 or \$100,000, Lifetime, depending on the Option chosen. The maximum shall apply to any and all benefits provided an Enrollee in the aggregate during the Plan Year under this Plan, whether such Enrollee derives such benefits as an Enrollee or as a Dependent or whether there is any interruption in the continuity of his or her coverage under this Plan.

- A. Under the "High Option Plan", the Annual Maximum that the Program will pay per Enrollee for all Covered Benefits, specified in Article 5, Sections 5.04. 1 through 11 (combined), incurred during a Plan Year is \$100,000.
- B. Under the "Low Option Plan", the Annual Maximum that the Program will pay per Enrollee for all Covered Benefits, specified in Article 5, Sections 5.04. 1 through 11 (combined), incurred during a Plan Year is \$50,000.
- C. Once the Program has paid out the total amount of the Annual Maximum for an Enrollee, the Enrollee will not be entitled to coverage under the Program for the remainder of that Plan Year.

#### 7.10. Lifetime Maximums.

The total benefits provided to an Enrollee under this Plan shall not exceed \$250,000 or \$500,000, depending on the Option chosen. The maximum shall apply to any and all benefits provided an Enrollee in the aggregate during his or her lifetime under this Plan, whether such Enrollee derives such benefits as an Enrollee or as a Dependent or whether there is any interruption in the continuity of his or her coverage under this Plan.

- A. Under the "High Option Plan", the Lifetime Maximum that the Program will pay is \$500,000 per Enrollee for all Covered Benefits, specified in Article 5, Sections 5.04. 1 through 11 (combined), incurred during the Enrollee's lifetime.
- B. Under the "Low Option Plan", the Lifetime Maximum that the Program will pay is \$250,000 per Enrollee for all Covered Benefits, specified in Article 5, Sections 5.04. 1 through 11 (combined), incurred during the Enrollee's lifetime.
- C. If an Enrollee terminates the Program and later re-enrolls, his or her Lifetime Maximum will be that amount remaining as of the last day the Enrollee was enrolled in the Program, including all reductions for payments of Covered Benefits, specified in Article 5, Sections 5.02A through F (combined), which were incurred prior to the date of termination and paid either before or after such date.

- D. Once the Program has paid out the total amount of the Lifetime Maximum for an Enrollee, the Enrollee will not under any circumstances be entitled to coverage or indemnification under the Program for the remainder of his or her life.
- 7.11. **Full-Time Student Coverage Limitation.** A statement or certification is required from the Registrar's Office or school representative stating that the Dependent is enrolled for a minimum of twelve (12) semester units. Certifications must be submitted no later than thirty (30) days after commencement of such semester. Coverage for the Dependent shall continue during semester breaks, or times when school is not in session, pursuant to the institution's official schedule. However, if the Dependent does not enroll in the next semester or session immediately following said break, coverage shall terminate as of the last official class day of the session in which the Dependent was last enrolled.

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# **ARTICLE 8 – EXCLUSIONS**

- 8.01. The limitations and exclusions provided under this Article shall be in addition to any limitations and exclusions provided elsewhere in this Plan.
  - A. The Plan will not pay benefits for any Services when the Enrollee is entitled to receive disability benefits or compensation (or forfeits his or her rights thereto) under any Workers' Compensation or Employer's Liability Law for Injury or illness. In the event the Enrollee formally appeals the denial of a claim for Workers' Compensation, the Enrollee shall notify the Administrator of such appeal. The Plan will then provide benefits under this Plan, but such benefits shall be considered an advance or loan to the Enrollee. If the claim is declared eligible for benefits under Workers' Compensation or Employer's Liability Law or if the Enrollee reaches a compromise settlement of the Workers' Compensation claim, the Enrollee agrees to repay the advance or loan the Plan has the Right of Subrogation.
  - B. The Plan will not pay benefits for any Services:
    - 1. When Services for an Injury or illness are provided without charge to the Enrollee by any federal, state, territorial, municipal, or other government instrumentality or agency, or
    - 2. When Services for an Injury or illness would have been provided without charge or collection but for the fact that the person is an Enrollee under this Plan.
  - C. The Plan will not pay any benefits, to the extent that such benefits are payable, by reason of any false statement or other misrepresentation made in an application for membership or in any claims for benefits. If the Plan pays such benefits before learning of any false statement, the Subscriber agrees to reimburse the Plan for such payment.
  - D. The Plan is not an insurer against nor liable for the negligence or other wrongful act or omission of any Provider, Provider's Employee, or other person or for any act or omission of any Enrollee.
  - E. The Plan does not guarantee the availability or quality of or undertake to provide any Services of any third party including the availability of Preferred or Participating Providers.
  - F. The Plan will not pay benefits for Services required in the treatment of an Injury or illness that results from an act of war or armed aggression,

whether or not a state of war legally exists, or that occurs during a period of active duty of any armed force of any state or nation.

G. The following charges and Services are not Covered Benefits under the Program. The fact that a Service may be Medically Necessary or that a Doctor may prescribe, recommend or approve a Service does not, of itself, make the charge for such Service an Allowable Expense under the Program, even though the Service is not specifically listed as an exclusion.

#### 1. Charges.

- a. The portion of any charge that exceeds the Eligible Charge or the Allowable Expense for the Service provided.
- b. The portion of any charge that exceeds the maximum amount payable by the Program.
- c. The portion of any charge that exceeds the charge that would have been made if the Enrollee had no insurance or were not enrolled in the Program.

### 2. Services.

- a. Any drugs, medicines, or supplies available without a Doctor's prescription, or "over-the-counter" items, even if prescribed by a Doctor.
- b. Any inpatient Service provided by an institution that is not a Hospital or Skilled Nursing Facility.
- c. Any Service not recommended and approved by a Doctor who is practicing within the scope of his or her license.
- d. Any Service for which the Enrollee has no legal obligation to pay.
- e. Any Service for which the government of the jurisdiction in which the Service was provided prohibits payment.
- f. Any Service rendered because of occupational disease or injury for which benefits are payable under Workers' Compensation or similar laws or voluntary workers' compensation programs, if proper claim were made.

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- g. Any Service rendered because of war, or an act of war, occurring after the effective date of the Enrollee's coverage in the Program.
- h. Any Service rendered by an immediate relative or member of the Enrollee's household. (The term "immediate relative" refers to the Enrollee's Spouse, parent, Child or sibling whether by blood, marriage or adoption). This exclusion does not apply to the charges made by a Provider that employs such relative or household member.
- i. Any Service rendered by a practitioner who is not a Doctor, except as otherwise specifically provided in the Plan Document.
- j. Any Service if a material statement made is false and would otherwise have rendered the Service ineligible.
- k. Any Service not provided by, or directly supervised by, a Hospital or Doctor duly licensed to provide that Service in the jurisdiction where the Service was provided.
- I. Any Service which is not Medically Necessary, except as otherwise specifically provided in the Plan Document.
- m. Any Service, including Hospital, surgical, medical, laboratory, and x-ray Services, rendered in connection with an excluded Service.
- n. Any Service for which no charge was made.
- o. Any Service rendered or received while the individual was not enrolled in the Program.
- p. Any Service for which the Enrollee has coverage through a public health program, CHAMPUS or other government or military program.
- q. Any Services rendered to a Subscriber's dependent parent.
- r. Any service related to treatment for any complications as a result of previous cosmetic, experimental, investigative services or other services not covered by the Plan, regardless of how long ago such service or procedure was performed.

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- s. Abortions (elective).
- t. Acupuncture.
- u. Air ambulance.
- v. Air conditioners, humidifiers, dehumidifiers and purifiers.
- w. Biofeedback and similar forms of self-care or self-help training, and any other related diagnostic testing.
- x. Chiropractic care, except as otherwise specifically provided in the Plan Document.
- y. Circumcision, ritual. Routine circumcision rendered at the time of, or shortly after birth, in conjunction with maternity and Newborn Child.
- z. Consultations with Doctors by telephone, facsimile, e-mail or any other form of electronic transmission, or a Doctor's stand-by or waiting time.
- a1. Eye refractions, contact lenses, eyeglasses and refractive surgery, such as radial keratotomy or Lasik, to correct vision problems.
- b1. Cosmetic surgery and all cosmetic services.
- c1. Custodial, domiciliary and convalescent care, including nutritional supplements and/or formulas used for nutritional supplement.
- d1. Dental appliances.
- e1. Dental care.
- f1. Dental work or oral surgery, including endontic (root canal) and periodontic Services, except as otherwise specifically provided in the Plan Document.
- g1. Dental Services, except for Services and surgical procedures as otherwise specifically provided in the Plan Document.

- h1. Exercise equipment and other similar non-medical products or supplies. Vitamins, steroids, muscle-enhancing powders, muscle stimulation devices and other related items used solely for the purpose of exercise are also not covered, even if prescribed by a Doctor.
- i1. Experimental Services, including any clinical visits, inpatient stays, drugs, laboratory testing, x-rays, and other Services related to such Experimental Services.
- j1. Fertility / Infertility Services, including diagnosis or treatment of infertility, fertilization by artificial means, such as artificial insemination, in-vitro fertilization and embryo transplants, and any and all other drugs or Services intended to induce pregnancy.
- k1. Foot reflexology, or orthotics, except as related to specific diabetic conditions.
- I1. Gastric bypass, stomach, or other organ stapling or reversal.
- m1. Growth hormone therapy, except replacement therapy services due to hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy.
- n1. Hansen's Disease.
- o1. Heat lamp treatments, except as provided in conjunction with covered maternity and delivery services.
- p1. Hospice care.
- q1. Implants, and any related services, supplies and drugs, sought for cosmetic purposes or to enhance or improve physical appearance.
- r1. Liposuction.
- s1. Living expenses.
- t1. Massage treatments.
- u1. Maternity Services for non-Spouse Dependent.

v1. Military service-connected disabilities for which the Enrollee is legally entitled to care from military medical facilities and for which military medical facilities are reasonably available to the Enrollee.

- w1. Occupational therapy, except as otherwise specifically provided in the Plan Document.
- x1. Orthopedic shoes, insoles and other similar external supportive devices for the feet.
- y1. Other health and accidental insurance coverage and third party liability settlements.
- z1. Palliative treatments.
- a2. Parkinson's Disease.
- b2. Personal comfort and convenience items, such as telephones, radios, televisions, and barber and beauty services.
- c2. Physical exams, when required for obtaining or continuing employment, insurance, schooling, government licensing, or sporting activities.
- d2. Physical therapy, except as otherwise specifically provided in the Plan Document.
- e2. Private duty nursing.
- f2. Rehabilitation therapy, except as otherwise specifically provided herein.
- g2. Replacement of joints.
- h2. Rest cures.

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- i2. Rest homes, sanitariums and other institutions that are not Hospitals or Skilled Nursing Facilities.
- j2. Reversal of voluntary sterilization.
- k2. Services rendered for drugs, food substitute or supplement or any other product which is primarily for weight reduction

even if it is prescribed by a physician, including weight loss or weight control programs, services and food products.

- I2. Services of an injury or illness resulting from the Enrollee's attempted suicide.
- m2. Services for an injury or illness resulting from major natural disaster or from act of war (whether or not a state of war legally exists).
- n2. Services for an injury sustained because of the Enrollee's participation, either as a driver or passenger, in racing, pace making or speed testing of any motor vehicle (including boats), whether such activity is formal and organized or informal and spontaneous.
- o2. Services for an injury sustained because of the Enrollee's commission of a criminal act including driving under the influence of alcohol or other controlled substance.
- p2. Services for an intentionally self-induced illness or selfinflicted injury, while the Enrollee was sane or insane.
- q2. Services not Medically Necessary.
- r2. Services or supplies for treatment or diagnosis of Temporomandibular Joint (TMJ) disorders or other conditions involving joints or muscles related to TMJ.
- s2. Services or supplies not specifically described as covered in this Plan Description. (Example: Subscriber's grandchild for which no Court Ordered legal guardianship exists)
- t2. Services and supplies provided to a Dependent of a non-Spouse Dependent. Dependents of non-Spouse Dependents are not eligible for coverage. When a Dependent, other than a Spouse of the insured, has a Child, that Child is a Dependent of a non-Spouse Dependent and is not eligible to become covered under this Plan.
- u2. Services for sexual dysfunction or inadequacies.
- v2. Substance Abuse Services. Any service related to alcohol, drug or intoxicating substance abuse, dependence or addiction. Hospital, treatment facility, medication,

counseling and other related charges for these Services are also excluded.

- w2. Telephone calls to or from a Doctor or a Doctor's office even if a Doctor charges for such calls.
- x2. Training for custodial care or self-care such as for personal hygiene.
- y2. Transportation, except as otherwise specifically provided herein. No benefits will be paid in connection with airfare and transportation from the Commonwealth to off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. (travel expenses and/or subsistence).
- z2. Transportation of the remains of any deceased person will in no way be paid by the Government Health Insurance.
- a3. Transsexual Services, to include sex transformations or sex change operations and any and all prosthetic devices related to sexual transformations or sex change operations, or treatment of sexual dysfunction regardless of cause.
- b3. Treatment of baldness, including hair transplants and topical ointments, concoctions, shampoos or other remedies.
- c3. Tuberculosis.
- d3. Excluded Prescription services:
  - i. Non-FDA-approved prescriptive contraceptive drugs or devices,
  - ii. Drugs and medicines for which a prescription from a Doctor is not required under U.S. federal law, or those excluded from coverage in any formulary selected, adopted, or implemented by the Plan.
  - iii. Drugs or medicines which may be lawfully obtained without a prescription order of a physician or doctor or dentist, except insulin,
  - iv. Therapeutic devices or appliances, including hypodermic needles or syringes, support garments, and other non-medical substances or items,

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regardless of their intended use, except for insulin syringes and insulin needles,

- v. Administration of prescription drugs or injections,
- vi. Drugs labeled: "Caution: Limited by Federal Law to Investigational Use," or, experimental drugs, even though a charge may be made to the Enrollee,
- vii. Medication which is to be taken or administered to the Enrollee in whole or in part, while a patient (inpatient or outpatient) in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on it premises a facility for dispensing pharmaceuticals. (Medication administered while an inpatient is submitted as a hospital expense and will be covered under the inpatient hospital benefit),
- viii. Filling or refilling a prescription in excess of the amount, number or quantity of medication prescribed or specified by the Doctor or Physician, or any refill dispensed without the Doctor of Physician's authorization, or any refill dispensed after one year from the date of the written order of the Doctor or Physician,
- ix. Prescription charges incurred after termination of coverage of the Enrollee
- x. Appliances, devices, bandages, heat lamps, braces or splints, except as otherwise specifically covered under this Plan,
- xi. Vitamins, cosmetics, dietary supplements, health and Beauty aids, or smoking cessation aids,
- xii. Drugs or medications dispensed by a Doctor or Dentist who is not a Registered Pharmacist, or otherwise permitted by law to legally dispense medications,
- xiii. Weight control medications, supplements or concoctions,

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- xiv. Retin A for Subscribers or dependents over the age of 24 years;
- xv. Drugs, medications, solutions of concoctions for treatment of hair loss;
- xvi. Viagra, or other impotency drugs, medications, solutions or concoctions;
- xvii. Injectable medications, unless ore-authorized as an eligible benefit, except insulin;
- xviii. Any and all drugs or medications related to the treatment of infertility and/or sexual dysfunction.
- H. The Plan shall not be required to pay any claim until it determines that the Enrollee was provided Services covered by this Plan. Payment will not be made for Services not actually rendered.
- I. The Plan will not pay benefits when confinement in a Hospital or in a Skilled Nursing Facility is primarily for custodial or domiciliary care. Custodial or domiciliary care includes that care which consists of training of personal hygiene, routine nursing Services, and other forms of self-care or supervisory Services by a physician or nurse for a person who is not under specific medical, Surgical, or psychiatric treatment to reduce such person's disability and to enable such person to live outside an institution providing such care. However, benefits for confinement in a Hospital or Skilled Nursing Facility will be paid if such confinement is required because of a concurrent Injury or illness (whether related or not) which requires medical or Surgical Services otherwise provided as benefits under this Plan.

## **ARTICLE 9 – HEALTH CARE PROVIDERS**

- 9.01. Any Provider world-wide is eligible to provide Covered Benefits to Enrollees, provided such Provider has not been eliminated as a Provider by the Administrator pursuant to Article 11, Section 11.11.A.
- 9.02. The Program does not maintain an employment or other relationship with any Provider.
- 9.03. The Program is not responsible for the negligence, intentional misconduct or any other action or inaction of any Provider.
- 9.04. The Program, as long as the Program has contracted with a Third Party Administrator, shall maintain a network of Preferred or Participating Providers. These providers will offer a variety of Services to Enrollees, including, but not necessarily limited to, routine medical care, specialty Services, in-patient and outpatient Services and Pharmaceutical Services.
- 9.05. The Program, as long as the Program has contracted with a Third Party Administrator that maintains contracts for services with Health Care Providers, will maintain and periodically update, a Provider Directory that lists all Preferred or Participating Providers in the Plan's network, and On-Island Providers that are qualified or approved to provide Services to Enrollees.

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# **ARTICLE 10 – PREMIUMS**

- 10.01. Premiums consist of Contributions from the Government and the Subscriber.
- 10.02. The amount of the Subscriber Contributions will be based on the Premium rates as determined by the Board.
- 10.03. The amount of the Government Contributions will be based on the Premium rates as determined by the Board.
- 10.04. Retroactive changes to the Premium rates are not permitted.
- 10.05. All Employee Contributions shall be made through deductions from the Employee's paycheck, except that Employees on leave without pay shall pay 100% of the Premium to the GHLI Trust Fund and deliver it to the Fund on a monthly basis in advance.
- 10.06. All Retiree and Survivor Contributions shall be paid through deductions from their pension annuity payments. Government Contributions for Retirees and Survivors shall be made by the Fund.
- 10.07. Within five working days following the close of each pay period, each autonomous agency, public corporation and other Government entity that processes its own payroll shall remit to the Fund the total Premiums, including Contributions deducted from Employees' paychecks for all enrolled, active Employees under their supervision. Also within such five working days, the Department of Finance shall remit to the Fund the total Premiums, including Contributions deducted from Employees' paychecks for all other enrolled, active Employees. Payment shall be made to the GHLI Trust Fund and delivered to the Administrator. If such Premiums are not received by the Fund by the 10<sup>th</sup> working day following each pay period, interest will be charged on the amount due at a rate determined by the Board.
- 10.08. With each Premium remittance, each autonomous agency, each public corporation, any other Government entity that processes its own payroll, and the Department of Finance shall submit to the Administrator a list of all enrolled Employees for whom Premium is being paid. This list will be the definitive identification of all active Employees enrolled in the Program.
- 10.09. With each Premium remittance, the Administrator shall prepare a list of enrolled Retirees, Survivors and Employees on leave without pay, for whom Premiums were paid. This list will be the definitive identification of all those Retirees, Survivors and Employees on leave without pay enrolled in the Program.
- 10.10. The Administrator shall maintain a current list of all enrolled Dependents.

Category	Option	Government Contribution	Total Premium		
Self Only	High	\$11.14	\$43.93		
	Low	\$ 7.00	\$27.63		
Self Plus One	High	\$20.16	\$79.50		
	Low	\$11.90	\$47.04		
Self Plus Four	High	\$29.20	\$115.08		
	Low	\$16.80	\$66.45		
Self Plus Five	High	\$38.34	\$150.72		
	Low	\$21.70	\$85.86		

- 10.11. It is the responsibility of each applicable person or paying entity to make certain that Premiums are fully and timely paid.
- 10.12. The Administrator will issue a receipt of payment to each person or entity submitting Premiums to the GHLI Trust Fund.
- 10.13. The Administrator shall cause all Premiums received to be deposited into the GHLI Trust Fund.
- 10.14. The Board shall, at least annually, engage an experienced health insurance actuary or underwriter to review the financial status of the Program, to review this Plan Document, and to make such recommendations for changes as the Board deems necessary. Based on such recommendations, the Board may revise, as it deems necessary, (a) the Premium rates for the Program, (b) the Contributions required of Subscribers and the Government, and (c) this Plan Document.
- 10.15. The Chart below details the bi-weekly Contributions required from Subscribers and the Government, and the total Premium, beginning on the effective date of this Plan Document, which effective date is January 2, 2002.

Beginning with the partial Plan Year that commences June 1 2002, the Government Contribution and total Premium for each category and option of coverage shall be as follows:

Unless determined otherwise by actuarial study and recommendation, the Government Contribution to Premiums shall increase by five percent (5%) annually, each such increase to become effective at the beginning of the Plan Year, with the first such increase being effective in January 2003. Said automatic increases shall continue annually until such time the Government's Contribution is equal to the Subscriber's Contribution.

### Contribution Rates Rates Effective June 1, 2002

Type of Enrollment	Enrollment Code Number		Bi-weekly Cost \$ 11.14 <u>\$ 32.79</u> \$ 43.93		
Self Only High Option	201	Government Contribution Subscriber Contribution Total Premium			
Self Plus One High Option	202	Government Contribution Subscriber Contribution Total Premium	\$ 20.16 <u>\$ 59.34</u> <b>\$ 79.50</b>		
Self Plus Four High Option	203	Government Contribution Subscriber Contribution Total Premium	\$ 29.20 <u>\$ 85.88</u> \$11 <b>5.08</b>		
Self Plus Five Plus High Option	204	Government Contribution Subscriber Contribution Total Premium	\$ 38.34 <u>\$112.42</u> \$1 <b>50.76</b>		
Self Only Low Option	205	Government Contribution Subscriber Contribution Total Premium	\$ 7.00 <u>\$ 20.63</u> \$ 27.63		
Self Plus One Low Option	206	Government Contribution Subscriber Contribution Total Premium	\$ 11.90 <u>\$ 35.14</u> <b>\$ 47.04</b>		
Self Plus Four Low Option	207	Government Contribution Subscriber Contribution Total Premium	\$ 16.80 <u>\$ 49.65</u> \$ <b>66.45</b>		
Self Plus Five Plus Low Option	208	Government Contribution Subscriber Contribution Total Premium	\$ 21.70 <u>\$ 64.16</u> <b>\$ 85.86</b>		

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# **ARTICLE 11 – CLAIMS AND PAYMENT FOR SERVICES**

11.01. Only Services provided by clinical laboratories, home health agencies, Hospitals, physicians (M.D., D.O., O.D., D.P.M., D.D.M., or D.D.S.), Skilled Nursing Facilities, Doctors of Chiropractic, Physician Assistants, advanced practice registered nurses and physical or occupational therapists who qualify as such under the requirements of the Federal Medicare Program, are certified or licensed by the proper government authority, render Services within the lawful scope of the respective licenses, and are approved by the Plan will be covered. Benefits may be available for Services rendered by other Providers as shown in specific sections of this Plan.

### 11.02. Filing of Claims (General Rules).

- A. All claims must be filed on Claim Forms as prescribed by the Administrator except as otherwise provided in this Article 11.
- B. All claims must be accompanied by a Provider billing acceptable to the Administrator. Such billing must be itemized and must show at least the following:
  - 1. Name of Enrollee.
  - 2. Name, address, telephone number and professional license number of Provider.
  - 3. Dates Services were received or rendered.
  - 4. Nature of illness or injury and specific diagnosis.
  - 5. Services and/or treatment provided.
  - 6. Prescriptions filled, if applicable.
  - 7. Physician's or Authorized Representative's Signature.

### 11.03. Payment of Claims (General Rules).

A. All claims eligible for reimbursement of Eligible Charges and Allowable Expenses, less any required Co-payment or Coinsurance, will be paid by the Administrator or by the Program's Third Party Administrator, if any, from the GHLI Trust Fund, or other claims payment account as established by the Program and/or its Third Party Administrator, if any, to either the Provider or the Subscriber as specified in this Plan Document,

- B. Should any claim overpayment to a Provider be discovered, the Administrator will attempt to recover it. However, regardless of whether recovery is made, the amount of such overpayment will not be charged to the Enrollee's Annual Maximum or Lifetime Maximum.
- C. Should any claim underpayment be discovered, the Administrator shall pay the shortfall when possible, and charge the amount of such payment against the Enrollee's Annual Maximum and Lifetime Maximum.
- D. All claims and accompanying documentation will be retained by the Administrator.
- E. The Trust Fund reserves the Right to utilize the Services of a Third Party Administrator to handle and process payment of claims. In the event the Trust Fund employs such Service, any reference, herein in this Article 11, to the Administrator shall refer to that Third Party Administrator, to the extent permissible under this Plan Document and any contract or agreement for Services between the GHLI Trust Fund and the Third Party Administrator ("TPA").

### 11.04. Filing of Claims by Providers.

- A. Claims incurred at Government health facilities, including the Commonwealth Health Center, the Rota Health Center, and the Tinian Health Center, shall be filed directly with the Administrator by such facility on the Enrollee's behalf, except, if the Program has contracted with a Third Party Administrator, all claims must be filed directly with that Third Party Administrator.
  - B. Private sector Providers and Providers outside the CNMI may file claims directly with the Administrator on the Enrollee's behalf, except, if the Program has contracted with a Third Party Administrator, all claims must be filed directly with that Third Party Administrator.
  - C. Providers filing claims may file Claim Forms on their own insurance forms, provided such other forms are acceptable to the Administrator, or Providers may file claims electronically in accordance with the requirements of the Administrator, or the requirements as established with the Program's Third Party Administrator, if any.

### 11.05. Payment of Claims to Providers.

A. Claims filed by Government health facilities will be paid to such facilities. Claims filed by other Providers will be paid to the applicable Subscriber unless payment has been assigned to the Provider as specified in Section 11.05.B below.

- B. A Subscriber or the Subscriber's enrolled Spouse may assign payment of his or her benefits, or those of the Subscriber's enrolled Children, to a Provider by signing a written statement authorizing the Administrator, or the Program's Third Party Administrator, to pay the Provider rather than the Subscriber.
- C. If a claim is paid to a Provider, the Administrator, or the Program's Third Party Administrator, will notify the Subscriber in writing of such payment.
- D. **Preferred and Participating Providers.** When covered Services are rendered by a Preferred or Participating Provider, the Plan will pay benefits directly to the said Provider. Preferred and Participating Providers have agreed to limit their charges to Enrollees to not more than a specified amount. In addition, Preferred and Participating Providers have agreed not to collect from any Enrollee an amount exceeding the Enrollee's Copayment or Coinsurance in this Plan.

**Non-Participating Providers.** The Plan has no agreement with nonpreferred or non-participating Providers and they may charge the Plan's Enrollees more than the Eligible Charge for any Service. The Plan's benefit payments for Services rendered by non-preferred or nonparticipating Providers will be a specified portion or percentage of the Eligible Charge for the Service. The Enrollee is responsible for paying the specified Copayments or Coinsurance plus any amount by which the Provider's charge exceeds the Eligible Charge. Payment of claims for Services covered by this Plan and rendered by a non-preferred or nonparticipating Provider:

- 1. are not assignable;
- 2. shall be made by the Administrator, or the Program's Third Party Administrator, in its sole discretion, directly to the Provider or to the Subscriber or to the Dependent or, in the case of the Subscriber's death, to his or her executor, administrator, Provider, Spouse, or relative; and
- 3. shall in no event exceed the amount which the Plan would pay to a comparable Participating Provider for like Services rendered.

### 11.06. Filing of Claims by Enrollees/Dependents.

- A. Claim Forms for reimbursement must be completed by the Subscriber or the Subscriber's enrolled Spouse and delivered to the Administrator.
- B. Enrollees eighteen (18) years of age and over at the time of Service are required to sign each claim submitted unless they are incapable of doing<sub>3</sub>

so rather than stamping a claim form with the phrase "SIGNATURE ON FILE".

C. Claims submitted for Dependents under eighteen (18) years of age at the time of Service must be signed by the Subscriber who is the parent or legal guardian.

### 11.07. Payment of Claims to Subscribers.

- A. Claims will be paid to the Subscriber for all claims filed by the Subscriber, or on his or her behalf, or for any of the Subscriber's Dependents, unless payment to the Provider has been assigned pursuant to Section 11.04.B above.
- B. In the case of a deceased Subscriber, payment of claims filed by the Subscriber will be made to the Subscriber's estate, or otherwise as ordered by a Court of competent jurisdiction.
- C. Any claim for benefits with respect to a Child covered by a Qualified Medical Child Support Order ("QMCSO") may be made by the Child or by the Child's custodial parent or court-appointed guardian. Any benefits otherwise payable to the Subscriber with respect to any such claim shall be payable to the Child's custodial parent or court-appointed guardian.
- 11.08. **Timely Filing.** Claims must be filed promptly. The Administrator, or the Program's Third Party Administrator, will not accept claims filed more than one year following the date on which the Service was rendered.
- 11.09. **Medical Necessity of Services.** This Plan covers only medically necessary Services; the Plan will not cover any unnecessary Services nor will the unnecessary portion of any charge be paid. The fact that a physician may prescribe, order, recommend, or approve a Service does not in itself constitute medical necessity or make a charge an allowable expense under this Plan. An Enrollee may ask a physician to write to the Administrator for a determination regarding the medical necessity of a Service before it is performed. The Administrator will determine the medical necessity of the test or treatment based on the criteria and guidelines of the Federal agencies. To be considered medically necessary, a Service must meet all of the following criteria:
  - A. The Service or treatment must follow standard medical practice and be essential and appropriate for the diagnosis or treatment of an illness or Injury. Standard medical practice, with respect to a particular illness or Injury, means that the Service was given in accordance with generally accepted principles of medical practice in the United States at the time furnished.

- B. The Service or treatment must not be "Experimental" (e.g., used in research or on animals), or "investigative" (e.g., used only on a limited number of people or where the long term effectiveness of the treatment has not been proven in scientific, controlled settings, and, where applicable, has not been approved by the appropriate government agency).
- C. If there is more than one medically appropriate method of treating an Enrollee, the Plan's benefit will be based on the least expensive method, even if the health care Provider elects to treat the Enrollee by a more expensive method. Similarly, if the Services could be provided in more than one type of facility or setting (e.g., Hospital or physician's office), the Plan's benefits will be based on the least expensive facility or setting.
- 11.10. **Eligible Charges.** The Plan's benefit payments and the Enrollee's Copayments for most Services are based on the Eligible Charges for the Services (i.e., the Enrollee pays a specified percentage or portion of the Eligible Charge for each Service). The Plan will not pay the portion of any charge that exceeds the Eligible Charge. General excise or other tax is not included in the Eligible Charge. An Enrollee is responsible for paying all taxes.
  - The Eligible Charge for a covered Service is, in most Α. Definition. instances, the lower of the actual charge on the claim, the discounted charge negotiated by the Plan, the standard current reimbursement rate established by United States Medicare, or the charge listed for the Service in the Plans Schedule of Maximum Allowable Charges. For a covered Service which does not have a charge listed in the Schedule, the Plan will establish the Maximum Allowable Charge. The Plan also reserves the right to annually adjust the charges listed in the Schedule of Allowable Charges. In adjusting charges, the Plan will consider increases in the cost of medical and non-medical Services over the previous year, the relative difficulty of the Service compared to similar Services, changes in technology which may have affected the difficulty of the Service, payment for the Service under federal, state and other private insurance programs and the impact of changes in the charge on the Plan's health plan rates.

### B. Claims for Routine Services Provided by Off-island Providers.

1. **Non-Preferred or Non-Participating Providers.** Benefit payments for covered Services rendered outside the CNMI by Providers who are not participating Providers under a third party administration contract are based on the Eligible Charges for the same or comparable Services rendered by Providers in the CNMI, or the geographic location where the Service is provided if the Service is not offered in the CNMI. 2. **Preferred or Participating Providers.** Benefits payments for covered services rendered outside the CNMI by Providers who are Participating Providers under a third party administration contract are based on the Eligible Charges and paid in accordance with the agreement between the Third Party Administrator and the Provider.

### C. Claims for Routine Services Provided by On-island Providers

- 1. **Non-Preferred or Non-Participating Providers.** Benefits payments for covered services that are routinely provided by the Commonwealth Health Center will be reimbursed to independent practicing physicians in the CNMI based upon the current U.S. Medicare rate.
- 2. **Preferred or Participating Providers.** Benefits payments for covered services that are routinely provided by the Commonwealth Health Center will be reimbursed to independent practicing physicians in the CNMI based upon the current U.S. Medicare rate.

### D. Claims for Specialty Services Provided by Off-island Providers.

- 1. **Non-Preferred or Non-Participating Providers.** Benefits payments for covered services that are considered to be specialty or sub-specialty services and not routinely provided by the Commonwealth Health Center will be reimbursed to independent practicing physicians outside the CNMI based on an eligible charge as established by the Plan and based upon the reimbursement rate for the same or similar procedure in a location where the procedure is performed on a more routine basis.
- 2. **Preferred or Participating Providers.** Benefits payments for covered services that are considered to be specialty or sub-specialty services, and are not routinely provided by the Commonwealth Health Center, by Providers who are Participating Providers under a third party administration contract are based on the Eligible Charges and paid in accordance with the agreement between the Third Party Administrator and the Provider.

### E. Claims for Specialty Services Provided by On-island Providers.

1. **Non-Preferred or Non-Participating Providers.** Benefits payments for covered services that are considered to be specialty or sub-specialty services and not routinely provided by the Commonwealth Health Center will be reimbursed to independent practicing physicians outside the CNMI based on an eligible charge

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as established by the Plan and based upon the reimbursement rate for the same or similar procedure in a location where the procedure is performed on a more routine basis.

- 2. **Preferred or Participating Providers.** Benefits payments for covered services that are considered to be specialty or sub-specialty services, and are not routinely provided by the Commonwealth Health Center, by Providers who are Participating Providers under a third party administration contract are based on the Eligible Charges and paid in accordance with the agreement between the Third Party Administrator and the Provider.
- F. **Claims for Prescription Services.** Claims for Prescription Services will be reimbursed at the rates and under the guidelines established by the Program's Third Party Administrator or Pharmacy Benefit Manager (PBM).
  - 1. **Preferred or Participating Providers.** Benefit payments to Participating Providers will be based upon the reimbursement amounts as agreed in any contract between the Provider and the Third Party Administrator or Pharmacy Benefits Manager.
  - 2. **Non-Preferred or Non-Participating Providers.** Benefit payments to properly Registered or Licensed Pharmacies that are not Participating Providers shall include the amount established under the Third Party Administrator's or Pharmacy Benefits Manager's reimbursement rate schedule for both the medication and dispensing or filling costs, which rates are derived from the Average Wholesale Price (AWP) for prescription medications.
  - 3. **Physician Dispensing.** Benefit payments to Physician's who conduct what is commonly referred to as "Physician dispensing" shall include the amount established under the Pharmacy Benefit Manager's reimbursement rate schedule for the medication, derived from the Average Wholesale Price (AWP) for prescription medications. No dispensing or filling fee shall be reimbursed to a Provider who conducts Physician dispensing of medications unless the Physician is authorized under the law to dispense the medication or fill the prescription. No reimbursement shall be made for Professional samples.

### 11.11. False Claims.

A. The Administrator may discontinue covering the Services of any Provider who submits a false claim. The Administrator will make reasonable best efforts to notify all Enrollees of such change. Thereafter, claims for Services received through such former Provider will not be paid. The Administrator will maintain a list of all such ineligible Providers.

B. The Administrator may terminate the enrollment of any Enrollee who submits a false claim, immediately upon the discovery and verification of such false claim. Coverage will seize on the day the Administrator terminates enrollment of the Subscriber and/or the Enrollee, and any claims submitted by the Subscriber or Enrollee after the date the Administrator terminates enrollment shall be denied for lack of coverage, and the Program shall have no obligation for payment of any such claims.

### 11.12. Claims Auditing.

- A. The Administrator will audit a reasonable sample of claims each month.
- B. Should errors in claim payments be discovered, they shall be corrected in accordance with Sections 11.02.B and 11.02.C.
- C. Should errors in claim payments be discovered, the Administrator shall provide the applicable claims processor with the necessary remedial instructions.

### 11.13. Review and Arbitration.

- A. The Administrator shall have discretionary authority to determine all questions of eligibility of Enrollees, to determine the amount and type of benefits payable to any Enrollee or Provider in accordance with the terms of this Plan, and to interpret the provisions of this Plan as is necessary to determine benefits.
  - 1. **Review.** Any preliminary determination that a Service or charge is unnecessary or otherwise not payable shall be reviewed at the Subscriber's request and approved or corrected by such review committees as are appointed or approved by the Administrator. A Subscriber has one year from the date the Plan processed the Subscriber's claim to request this review. Any determination made by such review committees, acting in good faith, shall be conclusive upon all interested parties, subject to review and redetermination by the Board, whose decision shall be final. Such final decision may be submitted to arbitration.
  - 2. **Arbitration.** If a Subscriber is dissatisfied with the results of a review as defined in paragraph (1) above, the Subscriber may request a further appeal by arbitration, provided that such request must be submitted to the Administrator in writing within ninety (30) days of the final decision. If a Subscriber shall make such written

demand, the Subscriber and the Fund shall promptly agree upon a single arbitrator and if they shall fail to so agree within 30 days of the written demand, either party may apply to the Superior Court of the CNMI for appointment of an arbitrator. The questions for the arbitrator shall be whether, in the particular instance, the Board was in error upon an issue of law, acted arbitrarily or capriciously in the exercise of its discretion, or whether the Fund's findings of fact were supported by substantial evidence. The dispute shall be promptly decided and judgment may be entered upon the award of the arbitrator with the Superior Court of the CNMI. The judgment of the arbitrator shall be final and binding upon all interested parties and no further court action may be taken. The fee payable to the arbitrator shall be borne equally by the Subscriber and the Plan; all other expenses of the arbitration, such as cost of reporter and transcript, shall be paid in the share and manner ordered by the arbitrator, except that any attorney or witness fees of a party shall be borne by that party.

### 11.14. Provider Signature.

- A. Claims submitted by Providers must include the signature of the physician or authorized representative in the correct block on the Health Insurance Claim Forms. (HCFA 1500, UB92, HFCA 1450)
- B. Statements of Account must be accompanied by a Claim Form signed by the physician or authorized representative in the correct block on the Claim Form, otherwise it will be rejected or sent back for proper documents, and substantiation.

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## ARTICLE 12 – MANAGED CARE

- 12.01. **Managed Care Program Reviews.** A prior review must be obtained from the Administrator for certain types of medical Services. The Administrator's prior review, often referred to as pre-certification or pre-authorization, is required before admission to a Hospital, or before receiving certain Surgical or diagnostic Services. The Plan may pay reduced benefits in cases where its prior review of otherwise covered Services is required, but is not obtained.
- 12.02. **Benefits Reductions.** Any benefits that would have been paid in connection with a Hospital admission, surgical procedure, or diagnostic Services may be reduced by \$300 if a required review is not requested and obtained. This \$300 benefit reduction will also be applied if the Plan is not notified of an emergency or maternity admission within 48 hours of the event or by the next working day, whichever is later.

Additional expenses incurred by an Enrollee because of any reduction of benefits made by the Plan pursuant to this Article 12 shall not count toward the Annual or Lifetime Maximum.

- A. **Preferred and Participating Providers.** When the Services are recommended or provided by a Preferred or Participating Provider, that Provider is responsible for obtaining any required Managed Care Reviews on the Enrollee's behalf. The Preferred or Participating Provider is responsible for obtaining pre-admission certification for the Enrollee, and failure to do so will not impose a penalty on the beneficiary.
- B. **Non-participating Providers.** When the Services are recommended or provided by a non-participating Provider, the Enrollee must assume responsibility for requesting any required review and for any reduction in benefits resulting from failure to do so.

### 12.03. Preadmission Review.

A. Before admission to a hospital, for any treatment that can be scheduled in advance, the Enrollee or the Enrollee's physician shall notify the Administrator and request a Preadmission Review (pre-certification or pre-authorization). If a Preadmission Review is not obtained, the Enrollee will have additional expenses as indicated in this Article 12.

Where the admission cannot be scheduled in advance, e.g., in cases of emergency or maternity, the Enrollee or the Enrollee's physician shall notify the Administrator as soon as practical after admission but in no event later than 48 hours or one working day after the admission, whichever is later.

- B. Approval of benefits for a Hospital admission will be based on whether the Hospital admission recommended by the physician is medically necessary and whether the care can be provided safely and effectively out of the Hospital.
- C. The Administrator will notify the Enrollee and the Enrollee's physician in writing if the Plan approves payment of benefits for the admission. The Enrollee shall present the written notification to the Hospital upon admission. The Enrollee and the Enrollee's physician will also be notified if payment of benefits for the admission is not approved. The Subscriber shall be responsible for all charges related to any Hospital admission for which the Plan has indicated it will not pay benefits.

### 12.04. Surgical Review.

- A. The Plan has identified certain kinds of Surgical Services which are sometimes performed even though non-surgical treatment may be equally effective. Before scheduling any Surgical Services, the Enrollee or the Enrollee's physician shall notify the Administrator and request a Surgical Review. Where the admission cannot be scheduled in advance, e.g., in cases of emergency or maternity, the Enrollee shall notify the Administrator as soon as practical after the surgery, but in no event later than 48 hours or one working day after the surgery, whichever is later.
- B. The Administrator will notify the Enrollee and the Enrollee's physician of the results of its Surgical Review. The Administrator may approve or deny payment of benefits for the surgery, or may condition the payment of such benefits on the Enrollee's receiving a second opinion on the necessity of surgery. An Enrollee may receive a second opinion at no cost to the Enrollee if the second opinion is arranged by the Administrator. After receiving a second opinion, the Enrollee and the Enrollee's physician may decide whether to proceed with the surgery. The second opinion does not need to confirm the recommended surgery, however, the Enrollee shall be responsible for all charges related to Surgical Services for which the Plan has indicated it will not pay benefits. If a Surgical Review is not obtained, the Enrollee will have additional expenses as indicated in Article 12.02 above.

### 12.05. Inpatient Review.

A. The Administrator will periodically review each Enrollee's Hospital medical records for the appropriateness of the inpatient care provided to the Enrollee and the appropriateness of continuing hospitalization. This review will occur within 48 hours after admission and at set intervals, until

the Enrollee is discharged from the Hospital. The Administrator will also review discharge plans for the appropriateness of after-hospital care.

- B. The review of the appropriateness of inpatient care and after-hospital care is for benefit payment purposes. If the Administrator has a question regarding the appropriateness of the continuing hospitalization or after-hospital care, or if the Administrator determines that benefits are not payable, the Enrollee and the Enrollee's physician will be notified. If the Administrator decides that the continuation of any Service or care is not medically necessary or appropriate, the Enrollee and the Enrollee and
- 12.06. **Benefits Management Program.** The Administrator may assist an Enrollee by providing benefits for alternative Services that are medically appropriate but may not otherwise be covered under this Plan. Benefits for any alternative Services for an Enrollee's illness or Injury will be paid in lieu of benefits for regularly covered Services and will not exceed the total benefits otherwise payable for regularly covered Services.

These alternative Services will be paid at the Administrator's discretion as long as the Enrollee and the Enrollee's physician agree that the recommended alternative Services are medically appropriate for the illness or Injury. Payment for alternative Services in one instance does not obligate the Plan to provide the same or similar benefits for the same or any other Enrollee in any other instance. Payment of these alternative benefits is made as an exception and in no way changes or voids the Plan benefits, terms and conditions, or the Plan Document.

12.07. If an Enrollee does not agree with a benefit determination made under the Preadmission Review, Surgical Review, Benefit Management Review, or Inpatient Review provisions above, the Enrollee may ask for a second review by the Plan's Administrator or Medical Director. The Administrator will notify the Enrollee of the results of such second review.

# ARTICLE 13 – COORDINATION OF BENEFITS AND DOUBLE COVERAGE

- 13.01. When an Enrollee is covered by another group health insurance plan, including Medicare, the Coordination of Benefits Guidelines established by the National Association of Insurance Commissioners (NAIC) will be used to determine whether the Program will be the primary or secondary payor. These guidelines have included the following provisions:
  - A. The plan covering the Enrollee as an active employee will be the primary payor.
  - B. If a Child is covered under two plans, the plan of the parent whose birthday occurs first in the calendar year will be the primary payor.
  - C. If other guidelines fail to establish which plan is the primary payor, the plan covering the Enrollee for the longer time will be the primary payor.
- 13.02. If the Program is the primary payor, it will pay for Covered Benefits in accordance with this Plan Document. If the Program is the secondary payor, it will pay a reduced amount, so that, when added to the amount payable by the other plan, the total amount paid by both plans will not exceed the Provider's charges for Covered Benefits. In no event will the amount paid by the Program exceed the Allowable Expenses it would have paid had it been the primary payor. Also, in no event will the Program pay for non-Covered Benefits.
- 13.03. The double coverage provision applies whether or not a claim is filed under the other plan. As a condition of enrollment, a Subscriber authorizes the Administrator to obtain information as to benefits available from the other plan, and to recover overpayment, should they occur, from the other plan, on behalf of the Subscriber and any of his or her enrolled Dependents.

For purposes of enforcing or determining the applicability of this Article, the Subscriber, on his or her own behalf or on behalf of his or her Dependents:

- A. will disclose all coverage under any other plan;
- B. consents to the Plan's releasing to any party or obtaining from any party any information which the Plan deems necessary for such purposes;
- C. authorizes direct reimbursement to or from any other Plan when such direct payment is appropriate and necessary to facilitate the coordination and adjustments of the Plan's and other plan's payments under this section; and

- D. will, upon request, execute and deliver such instruments or documents as may be required to satisfy the intent of this section.
- 13.04. Special Provisions Regarding Medicare and No-Fault Motor Vehicle Insurance Coverage.
  - A. The Federal Medicare Program will be considered the primary plan unless the Enrollee is an active Employee covered under this Plan. Where an Employee or Dependent is covered by both Medicare and this Plan, applicable Federal statutes will determine which plan is primary.
  - B. Any no-fault motor vehicle insurance coverage will be considered the primary plan and its benefits will be applied first. Before the Plan pays benefits under this Plan for any Injury covered by no-fault insurance, the Plan will list the medical expenses that no-fault covers according to the date on which the expenses were incurred. The Plan will add up the no-fault expenses for each successive day until the day when the no-fault benefit maximum is exhausted. From that day on, covered Services received by the Enrollee will be eligible for payment under this Plan. The Plan will follow this procedure even when the no-fault insurer pays all of its benefits for non-medical expenses or when the actual order of payment differs.
  - C. If another person caused the motor vehicle accident and the Enrollee may recover damages from that person, any benefits for which the Enrollee may be eligible shall be subject to the provisions of Article 13. The Plan is not liable to pay any benefits for injuries caused by another person, but may assist the Enrollee by providing coverage he or she would have received as a benefit after the no-fault benefits have been exhausted as described in subparagraph B above, subject to the right of subrogation.
- 13.05. An Enrollee may not seek Double Coverage by being a Subscriber, and also being the Dependent of another Subscriber under this Plan. Only one category of enrollment and coverage will be permitted.

## **ARTICLE 14 – SUBROGATION**

- 14.01. If an Injury or illness of an Enrollee is or may have been caused by another person or party and the Enrollee has or may have a right to recover damages therefore against that person or party, the Plan shall not be liable to pay any benefits provided under this Plan. However, upon the execution and delivery to the Plan of all papers it requires to secure its rights of reimbursement, the Plan may pay benefits in connection with such Injury or illness. If an Enrollee is injured or infected through the act or omission of another person or entity and recovers damages from the other person or entity, the Enrollee shall reimburse the Plan for the cost of the benefits provided by the Program in treating such condition. The amount of such reimbursement must equal the amount of the recovery or the Program's cost for such benefits, whichever is less. If the Plan pays any benefits because of such Injury or illness, the Plan shall have a lien against any recovery to the extent of such payments. Such lien may be filed with such other person or party, his or her agent or insurance company, or the court; and such lien shall be satisfied from any recovery received by the Enrollee.
- 14.02. If there is no recovery of damages, the Plan shall be subrogated to the Enrollee's rights against the wrongdoer to the extent of the cost of the benefits provided by the Plan, including the right to sue in the Enrollee's name and to compromise the claim in order to indemnify the Plan for amounts paid.
- 14.03. It is a condition of enrollment in the Plan that each Enrollee agrees that he or she, his or her guardian, his or her Survivor, and his or her estate will execute and deliver an assignment of claim payment form, and any other necessary forms prescribed by the Administrator, to the Administrator upon request, and shall render all necessary assistance, other than pecuniary, to enable the Plan to secure the rights provided by this Article.

# **ARTICLE 15 – CHANGING BENEFITS AND ENROLLMENT**

15.01. The benefit options under the Program are the "High Option Plan" or the "Low Option Plan". The enrollment options under the Program are "self only", "self plus one", "family plus four" or "family plus five plus". The following table summarizes some basic rules for changing benefit or enrollment options:

(SEE CHART ON NEXT PAGE)

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### **CHART ON CHANGING ENROLLMENT / BENEFITS**

Events which permit enrollment or change in enrollment	Changes permitted by Subscriber or prospective Subscriber						Time during which an application form must be filed with the Administrator		
	From not enrolled to ENROLLED	From SELF only to Self Plus One	From SELF only to Plus Four	From SELF only to Plus Five Plus	From Plus Four OR Plus Five Plus to SELF only	From Plus Four or Plus Five Plus to Self Plus One	From Plus Four to Plus Five Plus	From one OPTION to another	
Open Season	YES	YES	YES	YES	YES	YES	YES	YES	November of each year or as otherwise specified by the Administrator.
Acquisition of Spouse or Child	NO (unless special enrollment permitted)	YES	YES	YES	NO	NO	NO	NO	Within 30 days of acquisition (or according to HIPAA rules for special enrollment)
Loss of other coverage	NO (Unless special enrollment permitted)	YES	YES	YES	N/A	N/A	N/A	N/A	According to HIPAA rules of special enrollment.
Divorce, legal separation, annulment, death of a Spouse or Child, a Child's loss of Dependent Status	NO (Unless special enrollment permitted)	NO (Unless special enrollment permitted)	NO <sup>°</sup> (Unless special enrollment permitted)	NO (Unless special enrollment permitted)	YES	YES	YES	NO	Within 30 days of event (or according to HIPAA rules for special enrollment)
Change in status from Spouse to Survivor of former Retiree	YES	YES	YES	YES	YES	YES	YES	NO	Within 30 days of (a) the date the Administrator approves the Survivor's application for survivor annuity benefits, or (b) the original effective date of this Plan Document.

The chart in 15.01 above is a summary of some basic rules for changing benefit or enrollment options and is not an all inclusive listing of all possible situations. Subscribers should not rely only on this chart, but must also review this entire Plan Document, including Article 3 on eligibility and Article 4 on enrollment to fully understand these rules.

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- 15.02. In addition to the rules outlined in Section 15.01, the following rules also apply to changing benefit options:
  - A. If the Subscriber changes from one benefit option to another, such change is also applicable to all of the Subscriber's enrolled Dependents.
  - B. The new benefit option will apply only to Services received after the change is effective.
  - C. Plan Year limitations and maximums for each Enrollee under the new benefit option will be reduced by the amount paid by the Program for the Enrollee for that Plan Year under the former benefit option.
  - D. Any amount remaining under the Lifetime Maximum under the former benefit option will be transferred to the new benefit option, however in no event will a transfer result in a Lifetime Maximum which exceeds the limits as specified in this Plan Document.
  - E. The effective date of the change will be the first day of the Government's next pay period or, for Retirees and Survivors, the date of the next annuity installment payment, unless the change is made during an Open Season, in which case the change will be effective as the date specified by the Administrator.
- 15.03. In addition to the rules outlined in Section 15.01, the following rules also apply to changing enrollment options:
  - A. A Subscriber may cancel his or her enrollment and that of any of his or her enrolled Dependents at any time.
  - B. Enrollment changes made pursuant to a change in family status must be consistent with such change in status, and the Enrollee must provide any documentation required by the Administrator to substantiate such change in status.
- 15.04. To change benefit or enrollment options, the Subscriber must file an Enrollment Change Form with the Administrator.
- 15.05. No change in benefit or enrollment options will be effective without the approval of the Administrator. If the Administrator has not acted upon an application for change in benefit or enrollment option within 30 days of its receipt, the application shall be deemed denied.

### **ARTICLE 16 – ADMINISTRATION**

- 16.01. The Board has ultimate and fiduciary responsibility for the administration and management of the Program and the GHLI Trust Fund. The Board will administer and manage the Program in accordance with this Plan Document and the Act. The Board may promulgate administrative or interpretive rules and/or regulations governing the Program, provided that such rules must be consistent with this Plan Document, the Act and other applicable law. Any such rules shall be applied as if they were part of the Plan Document.
- 16.02. The Administrator has the authority to make decisions, as necessary for the optimal functioning of the Program, within the authority granted him by the Act, this Plan Document and Board directives.
- 16.03. The Administrator is responsible for the daily functions of the Program including, but not limited to, receiving and depositing Premiums, receiving and processing claims, communicating and explaining the Program to current and prospective Enrollees, responding to inquiries, and guarding against Enrollee and Provider fraud.
- 16.04. The Administrator will create and maintain all necessary Program records including Premiums received, enrollment, claims processed, claims paid, and amounts accumulated toward each Enrollee's Coinsurance maximum, family out-of-pocket maximum, Annual Maximum, Lifetime Maximum, and any other maximums.
- 16.05. The Board, through the Administrator, has the authority to contract with private sector third party administrators to administer medical care within and outside the CNMI.
- 16.06. The Board, through the Administrator, has the authority to contract with private sector, third party insurers and/or administrators to insure and/or administer the Program.
- 16.07. Subject to the review and oversight of the Board, the Administrator shall have all discretionary powers necessary to administer the Program and control its operation in accordance with the terms of this Plan Document and applicable law, including but not limited to the power to (a) interpret the provisions of this Plan Document, (b) to determine any question relating to the administration or operation of the Program subject to Article 19, and (c) make and enforce decisions regarding who is eligible for benefits and the amount of benefits payable in any particular case. All decisions of the Administrator, any actions taken or omitted by the Administrator in respect of the Program and within the powers granted by the Act or under this Plan Document, and any interpretation of this Plan Document by the Administrator shall be conclusive and binding on

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all persons other than the Board, and shall be given the maximum possible consideration allowed by law, subject to Article 20.

### 16.08. Annual Budget.

- A. By September 30 each year, unless otherwise directed by the Board, the Administrator will prepare an annual budget for the operation of the Program to include the expected Premiums, claims, administrative costs, and other Allowable Expenses for approval by the Board. Such budget shall be for the next Fiscal Year.
- B. The annual operating budget shall be approved, or revised and approved, by the Board on or before the beginning of each Fiscal Year. The approved budget will be transmitted by the Board to the Office of Management and Budget and to the Office of the Governor for informational purposes only.
- C. In the event of a shortfall occurring during any Fiscal Year, the Administrator will prepare a revised budget to cover the shortfall. However, the total budget shall not exceed the estimated Premiums to be received during that Fiscal Year.

### 16.09. GHLI Trust Fund.

- A. The GHLI Trust Fund was established in accordance with Section 5 of the Act for holding Premiums and any investment earnings thereon.
- B. Moneys in the GHLI Trust Fund are to be expended for the payment of claims, premiums to third party health insurance companies (if any), reasonable costs of administration, and other Allowable Expenses related to the Program.
- C. The Administrator shall maintain the GHLI Trust Fund at any recognized financial institution whose deposits are insured by an agency of the U.S. Federal Government. However, the full amount of money held in the GHLI Trust Fund need not be so insured.
- D. The Administrator, under the direction of the Board, shall have sole and exclusive expenditure authority over the GHLI Trust Fund.
- E. The Administrator shall establish an accounting system for the GHLI Trust Fund in accordance with Generally Accepted Governmental Accounting Standards and issue accounting reports to the Board as required but at least semiannually.

- F. The Administrator shall report to the CNMI Legislature and Governor on the financial status of the GHLI Trust Fund within 60 days after the end of each Fiscal Year.
- G. When the GHLI Trust Fund reaches \$3 million dollars in excess of the amount estimated to cover obligations for one full year, the Board may invest such excess funds in other appropriate investment programs consistent with the fiduciary standards and procedural rules for investment of the NMI Retirement Fund assets.

### **ARTICLE 17 – AMENDMENTS**

- 17.01. The CNMI Legislature has the power to abolish the Program or amend the law creating and governing the Program at any time. The Board has the authority change or modify the Program or amend any and all provisions of the Program at any time by rule and/or regulation pursuant to Public Law 10-19, and the Administrative Procedure Act at 1 CMC 9101, *et. seq.* However, no action by the Board in making such change, modification or amendment shall adversely affect any claim for any Covered Benefit, which was incurred before the effective date of such amendment.
- 17.02. Significant amendments by the Legislature or by the Board, through rule making or regulation, will be communicated by the Administrator in accordance with Article 18, Section 18.02.

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## **ARTICLE 18 – COMMUNICATIONS**

- 18.01. Communications from Enrollees and any other interested persons regarding the Program should be addressed to the Administrator, CNMI Group Health Insurance Program, NMI Retirement Fund, 1<sup>st</sup> Floor, Retirement Fund Building, Capitol Hill, P.O. Box 501247, Saipan, MP 96950-1247, telephone (670) 664-8026, fax (670) 664-8074.
- 18.02. Any significant amendments to the Act or this Plan Document and any other pertinent information regarding the Program shall be communicated to Enrollees in accordance with the Administrative Procedure Act. In addition, they shall be posted in the Fund/GHLI offices as well as directly provided to Enrollees through Employees' pay checks and Retirees' annuity checks. The Administrator will make reasonable best efforts to notify Survivors, employees on leave without pay and other interested parties.
- 18.03. Workshops explaining the Program will be conducted periodically, usually during "new employees orientations", which are usually held at least once every quarter. Similar workshops will also be held upon request by any Government department, agency or other entity.
- 18.04. Employee meetings will be held during Open Seasons during working hours through coordination between the Administrators and department and agency heads to explain the Program. All Employees may attend such meetings and ask any questions about the Program.

# **ARTICLE 19 – TERMINATION**

19.01. Enrollment in the Program will terminate:

- A. for an Enrollee if he/she no longer meets the definition of "Enrollee";
- B. for an Enrollee if such individual files a "false claim" pursuant to Article 11, Section 11.11.B;
- C. for an Enrollee if the Enrollee dies;
- D. for all Enrollees if the Government terminates the Program;
- E. for a Subscriber if the Subscriber terminates he or her enrollment;
- F. for a Dependent if the Subscriber's enrollment terminates;
- G. for a Dependent if the Subscriber terminates the enrollment of the Dependent;
- H. for a Survivor and all Dependents of the former Subscriber if the Survivor remarries;
- I. for an Employee 30 days after the Employee ceases to be employed by the Government, unless the former Employee qualifies as a Retiree.
- 19.02. Except as specified in Section 19.01.I above, all terminations of enrollment will be effective as of the first day of the pay period or semi-monthly annuity period following the event causing the termination.
- 19.03. If a Subscriber's enrollment terminates, coverage for all of such Subscriber's enrolled Dependents also terminates as of the Subscriber's date of termination except as specifically provided for Survivors in Article 4. A Subscriber whose enrollment has terminated will not be eligible to re-enroll until an Open Season is declared or unless the Subscriber otherwise becomes eligible. Notwithstanding the previous sentence, if the Subscriber's enrollment terminates because of non-payment or untimely payment of Subscriber Contributions while the Subscriber is on leave without pay pursuant to the Family and Medical Leave Act of 1993, or if the Subscriber qualifies under the Uniformed Services Employment and Reemployment Rights Act of 1993, the provisions of those acts will govern.
- 19.04. If an enrolled Dependent no longer meets the definition of "Dependent", the Subscriber must ensure that the Administrator is notified within 30 days of the date the change occurred. If the Administrator is not so notified, payment of

benefits for such Dependent will be denied retroactively to the date the change occurred, even though Premiums were paid, and Premiums will not be refunded. Also, any claim filed on behalf of such Dependent may be considered a "false claim" pursuant to Article 11, Section 11.11.B.

- 19.05. Except as specifically provided in Section 19.04 above, the Administrator will refund any pre-paid Subscriber Contributions within 60 days following termination of enrollment. Pre-paid Government Contributions will not be refunded.
- 19.06. The CNMI Legislature has the power to abolish the Program or amend the law creating and governing the Program at any time.

## **ARTICLE 20 – RECONSIDERATION AND APPEALS**

- 20.01. If a claim for benefits, application for enrollment, enrollment change or continued enrollment is denied in whole or in part for reasons other than for failing to meet a stated time deadline, or if adverse action is otherwise taken against the claimant, the claimant or the claimant's representative may submit a written request for reconsideration to the Administrator within 20 days after the notice of denial is issued or other adverse action is taken. The claimant or claimant's representative must state the reason he or she believes the denial was inappropriate and may submit any supporting data. An Enrollee has the right to be represented by an attorney of his or her choosing or by any person, including the Enrollee's Service Provider or a representative of the Enrollee's Service Provider.
- 20.02. The Administrator will discuss the request for reconsideration with the claimant or claimant's representative at an informal conference either by telephone or in person at the option of the claimant or the claimant's representative. Such informal conference will be held within 30 days following the Administrator's receipt of the written request for reconsideration if at all possible. The Administrator shall require the written consent of the claimant or his or her authorized representative before discussing privileged or confidential medical information to any non-privileged third party.
- 20.03. The Administrator's decision on reconsideration shall be in writing and sent to the claimant or claimant's representative, within 20 days of the informal conference. The Administrator shall state the specific reasons for his or her decision and refer to the provisions in the Act, the Plan Document or other rules or regulations on which the decision is based.
- 20.04. If the claimant is adversely affected by the Administrator's decision on reconsideration, the claimant or claimant's representative may appeal to the Board within 20 days of the Administrator's decision on reconsideration, pursuant to the Administrative Procedures Act and other applicable law, rules and regulations. Such appeal must be in writing and sent to the Chairman, Board of Trustees, NMI Retirement Fund, P.O. Box 501247, Saipan, MP 96950-1247. The claimant shall also serve a copy of the appeal on the Administrator within the same time period.
- 20.05. Upon receipt of a notice of appeal, the Board may appoint a hearing officer to hold a hearing on the record or, in an appropriate case, the Board may itself conduct a hearing on the record. The hearing shall be conducted according to the procedures set forth in the Administrative Procedures Act and the claimant shall have all rights guaranteed thereunder.

Any further appeal or review of the Board's decision shall be made to the Commonwealth Superior Court in accordance with 1 CMC Section 9112(b) and 9113. If the Court finds in favor of the Plan, the claimant shall be liable for attorney's fees and other costs incurred by the Plan in its defense. If the Court finds in favor of the Claimant, the Plan shall pay its own attorney's fees and other costs and those of the Claimant.

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# **ARTICLE 21 – GOVERNING LAWS**

- 21.01. Notwithstanding any other provision of this Plan Document, the Program will be administered in accordance with applicable CNMI and U.S. Federal Government laws, except in cases in which the CNMI has the authority to and has chosen to opt-out of such laws. Such laws include the Retirement Fund Act, the Public Health Service Act, the Health Insurance Portability and Accountability Act of 1996, the Mental Health Parity Act of 1996, the Family and Medical Leave Act of 1993, the Uniformed Services Employment and Re-employment Rights Act of 1993, the Americans with Disabilities Act of 1990, and the Pregnancy Discrimination Act of 1979.
- 21.02 In case of conflict between this Plan Document and any CNMI or U.S. Federal law, the law will govern.
- 21.03 Pursuant to Section 146.180 of the Public Health Service Act (PHSA), the Program will not participate in the Mental Health Parity Act (MHPA). Under the MHPA, mental health coverage, if provided as a covered benefit, is required to be provided on the same basis as medical and surgical coverage. Certain provisions of the PHSA permit self-funded government plans to opt-out of this requirement. In order to provide mental health benefits to members, in a manner the Plan can reasonably afford, the Plan has opted-out of the MHPA, and is therefore, if it meets all continuing requirements, exempt from providing mental health coverage on the same basis as medical coverage. Under such exemption, the Plan may limit the amount of coverage provided for mental health benefits to members.

To meet the requirements to maintain this exemption, the Plan must:

A. Elect the exemption in writing;

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- B. Attach a copy of the Notice to Plan Participants;
- C. Identify the portions of the plan that will not be funded through insurance;
- D. State the name and address of the Plan Administrator;
- E. Re-elect the exemption on an annual basis; and
- F. provide notice to all enrollees at the time of enrollment, and on an annual basis, after the initial notice. Said notice is deemed properly given if printed prominently in the Summary Plan Description.

The Plan's election for exemption must be sent to:

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Health Care Financing Administration Department of Health & Human Services Insurance Reform Implementation Task Force Attn: David Holstein, Room SLL-17 7500 Security Blvd. Baltimore, MD 21244-1850 Phone: (410) 786-1564 Fax: (410) 786-8001

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# **ARTICLE 22 – AMENDMENTS AND EFFECTIVE DATE**

- 22.01. These rules and regulations may be amended from time to time as the Board of Trustees deems appropriate.
- These rules and regulations shall be effective 10 days following final publication 22.02. in the Commonwealth Register pursuant to the Administrative Procedure Act at 1 CMC 9101, et. seq.

# Summary of Comments Received from General Public re GHLI Proposed Amendments

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# COMMENT NO. 1:

Date		10/09/01
From	:	Michelle Foltz, M.D. / Orthopedic Service – CHC
Concern(s)	:	Limitation and Coverage of Physical Therapy (P.T.)

#### **GHLI Response / Comments:**

This comment was duly noted, discussed and seriously considered. However, based on research of other plans and prior abuse of this and the chiropractic benefit, it was determined that the amounts paid and number of visits allowed under the Plan must be restricted. This issue may be re-visited in the future, however an increase in premiums would be required to accommodate any increased benefit.

# COMMENT NO. 2:

Date:10/16/01From:Laura L. Post, MD / Marianas Psychiatric ServicesConcern(s):Service Exclusions (Dialysis, Off-Island Surgical Repairs, E-mailed/FaxedConsultations, Dental Restorations, HIV Testing, HIV/AIDSTreatment, Implants, Maternity Services for Non-Spouse, Occupational Therapy,Joint Replacements, Medicines for Parkinson's Disease, Mental Health Disorders

#### **GHLI Response / Comments:**

Many of Dr. Post's assertions were inaccurate, leading to much confusion among Members and the Public, and much frustration among staff.

1. Dialysis has never been excluded under the Plan, and was not ever considered as an Exclusion;

2. Babies born with congenital defects are entitled to some coverage, however the Plan cannot afford to cover all defects;

3. The Plan has never paid for e-mail or fax consultations, conversations or communications and will not, as it is simply too easy to abuse such a benefit;

4. The Plan is a MEDICAL plan and does not cover any dental items unless related to an injury - this is nothing new;

5. The Plan had considered removing HIV/Aids coverage, but based in part on Dr. Post's concerns and information this Exclusions was reconsidered;

6. Implants due to loss resulting from disease or injury have never been, and are not now excluded. Dr. Post failed to accurately interpret the Plan which states that such implants are not covered if for purely cosmetic/image enhancement reasons;

7. Maternity services for non-spouse Dependents does not relate to the wife, common-law or otherwise of a Subscriber. To be a Dependent, a valid legal relationship must exist - another inaccurate interpretation by the author of the comments;

8. Occupational therapy will usually be covered under worker's compensation laws if the injury is sustained in relation to employment, and the Plan does not supplement this;

9. Joint replacements, at this time, are simply to costly for the Plan;

10. Parkinson's disease has never been covered under the Plan, but the Exclusions failed to properly state this, so this was clarified;

11. Mental health coverage was considered as an Exclusion due to the requirements of the MHPA, however research revealed that the Plan could opt out of these requirements and place mental health coverage back in the Plan, so Dr. Post's concern has been addressed, as this coverage has been reinstated and increased.

Dr. Post continued to comment that underwriters in the U.S. are being required to provided equivalent mental health and medical services in Plans. What she failed to state is that there is no requirement to provide mental health benefits and that the provision of these benefits is the option of the carrier.

## COMMENT NO. 3:

Date	:	10/18/01
From	:	Coryleen B. Gilbert
Concern(s)	:	Exclusions

#### **GHLI Response / Comments:**

11/09/01 – Response Letter from Chairman Camacho; Ms. Gilbert's information came only from the newspapers, which often did not accurately reflect plan changes. Her comments were considered and responded to.

# COMMENT NO. 4:

Date	:	10/24/01
From	:	Teresa Olesch, PT
Concern(s)	:	Physical Therapy

#### **GHLI Response / Comments:**

11/30/01 – Response Letter from Chairman Camacho; These comments were duly considered, but due to prior abuses, no changes were made to the amendments.

# COMMENT NO. 5:

Date:11/28/01From:Herbert D. Soll, Attorney General / Office of the Attorney<br/>GeneralConcern(s):GHLI Open Enrollment Period Extension to Allow Plan<br/>Participants the Opportunity to Review Proposed Changes.

#### GHLI Response / Comments:

The Attorney General's request was granted and the comment period extended.

# COMMENT NO. 6:

Date : 12/05/01

From : Dr. Joaquin A. Tenorio, Secretary - DLNR Concern(s) : New Class of Members (Self Plus Five Plus), Change in Cap after which Benefits are Paid, Change in Co-payments for Office Visits and Prescriptions, Drops in Coverage for Intensive Care Room and Board, Out-of-Pocket Maximums, Mental Health Service, and Longer List of Exclusions

#### GHLI Response / Comments:

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Dr. Tenorio's comments were reviewed and considered. However, it appears that he was unaware that notices and information regarding changes had been provided to Departments/Agencies by GHLIP. For the good of the Plan, the Board must act when it deems it necessary and appropriate and cannot restrict its actions based on the timeframes of private insurance carriers or their enrollment periods. The private carriers in the CNMI time their enrollments intentionally to compete with the GHLIP.

# COMMENT NO. 7:

Date:12/12/01From:Vicente Sablan Aldan, MD / Saipan Health Clinic, Inc.Concern(s):Third Party Administrator, Rule 2.02, Rule 2.03, Rule 2.15,Rule 2.16 (Eligible Charges Definition), Rule 2.36, Article 11.09, Rule 2.30(Medical Director Definition), Rule 2.28 (Injury Definition), Rule 2.34 (Non-<br/>Participation Provider), Rule 3.02 (Eligibility), Article 4, Section 4.05, Article 5(Brief Summary of Covered Benefits – Prescriptions), Rule 5.02(A) & (B), Rule5.03, Rule 7.06, Article 11, Section 11.05 D2 and Rule 16.09c and 16.09d

#### GHLI Response / Comments:

While Dr. Aldan did have some comments of value that were considered, unfortunately, many of these were overshadowed by his incessant belief that the Board is being manipulated by the Third Party Administrator.

- The GHLIP re-designed its regulations. Yes, the TPA was consulted as were many other sources before any decisions were made;
- Re: Rule 2.02: The Board cannot impose its fiduciary duty onto the TPA, as the TPA has its own duties to the Program;
- Re: Rule 2.03: Allowable expense has been removed, so this comment is moot;
- Re: Rule 2.15: different dates apply depending on hire date and the Board does not determine hire date, therefore does not determine effective date of coverage for most members;
- Re: Rule 2.16: Comment considered, usual and customary will no longer be the standard, and the Board changed this to the Medicare reimbursement rate; definition of medically necessary was considered and will remain the same and be evenly applied to all members – this was the original definition and was not changed in the proposed amendments – SHC is not a Medicare facility, and chooses not to meet those requirements and standards, yet wants to impose them on the Plan; the Administrator makes decision based on the Plan and is not subject to any separate liability for any decision made in reliance on the Plan Document, therefore the Board felt this comment was ill-conceived and designed to impose additional liability on the TPA;
- Re: Rule 2.30: The TPA is perfectly qualified to enlist the services of a Medical Director and employs a duly licensed physician for the post; simply because something is not "customary in the CNMI" does not mean that it should not be implemented in the CNMI – a need for change away from the "customary" has been perceived by the Board and the Board is acting accordingly;
- Re: Rule 2.28: GHLIP analyzed several definitions of the term "injury" and as the definition states, just because an ailment does not meet this specific definition, does not mean the ailment is not covered; this was not

a "gimmick" by the TPA, but a concern of the Board due to prior abuses of the Plan;

- Re: Rule 2.34: different reimbursement rates for preferred and nonpreferred providers are very common in most plans in existence – the additional change to the Plan calls for the Medicare reimbursement rate for all routine services;
- Re: Rule 3.02: As a governmental plan, the Board cannot entertain the option of allowing non-government employees to participate at the present time;
- Re: Art. 4, Sec. 4.05: Dr. Aldan is mistaken ... HIPAA applies in the CNMI, and even though COBRA does not directly apply, any loss of COBRA coverage results in a special enrollment situation which the Plan must honor – no change will be made to this provision to ensure compliance with federal law;
- Re: Art. 5: Dr. Aldan objects to the mail order RX service, and states this will be an economic drain on the CNMI; these options are very common in modern plans and save the member the duplicate cost of co-pays for more prescriptions – a benefit rather than a drain; this benefit is offered in many plans and is offered by the PBM, not the TPA – again DR. Aldan unnecessarily attacks the TPA for doing its job, which is trying to better manage the Program and save the Plan and patients money;
- Re: Rule 5.03: The Plan will not reduce its expectations of standards of care for patients, and expects quality care from providers; the last portion of this comment regarding "dynamic" reviews "keeping the patient inhouse" and "esoteric payables" could not be deciphered;
- Re: Rule 16.09: The TPA has no access to the GHLI Trust Fund; and, not only would the Board not turn over the Fund & Program to Enron, but likewise the Board will not allow the Program to be run by the providers.

## COMMENT NO. 8:

Date : 12/19/01

From : Herbert D. Soll, Attorney General / Office of the Attorney General

**Concern(s) :** Request to Extend Comment Period on GHLI Proposed Amendments to Allow AGO more time to analyze and prepare comments on changes.

#### GHLI Response / Comments:

This request was granted.

# COMMENT NO. 9:

Date : 12/19/01 From : Ruth L. Tighe, WordWorks

**Concern(s)** : Rule 2.16 (Eligible Charge), Rule 2.24 (Generic), Rule 2.26 (Injury), Rule 2.30 (Medical Director), Rule 2.38 (Participating Provider), Rule 5.04.3(a) (Outpatient Services), Rule 7.02 (Mental Health Benefits), Rule 7.08 (Coinsurance Maximums), Rule 7.06 (Out-of Pocket Maximums), Rule 8.01.B(35) (Exclusion of Hearing Aids), Rule 8.01.G(2) (Exclusions), Rule 11.09 (Medical Necessity of Services), Article 12 (Managed Care), Rule 12.03 (Preadmission Review) and Rule 12.04 (Surgical Review)

#### GHLI Response / Comments:

Many good comments that the Board considered. Not all were adopted, but the suggestion regarding hearing aids was. Many others indicated a confusions about some things that have been further clarified.

# COMMENT NO. 10:

Date:12/20/01From:Antony Glad, CFO and Treasurer / Island Medical CenterConcern(s):EligibleCharge,FeeSchedules,Article5.02(c)(Prescription),Article10.07 (Premiums), and Article11.09 (Medical Necessity of<br/>Services)

#### GHLI Response / Comments:

The term eligible charge is sufficiently defined, and most services will now be reimbursed at Medicare rates; If local providers wish to prescribe a 90-day supply of a drug, they must meet the cost provided by the PBM to best serve the Plan and patient. Medical Necessity has been addressed.

# COMMENT NO. 11:

Date	:	01/09/02
From	:	Janet L. McCullough, Ph.D. / Licensed Clinical Psychologist
Concern(s)	:	Mental Health Benefits

GHLI Response / Comments:

Mental Health benefits have been reinstated to the Plan.

# COMMENT NO. 12:

Date:01/09/02From:Anne V. Erhard, Ph.D. / Licensed Clinical PsychologistConcern(s):Mental Health Benefits

#### GHLI Response / Comments:

Mental health benefits have been reinstated to the Plan.

# COMMENT NO. 13:

#### Date

**From :** James J. Benedetto, Acting Attorney General / Office of the Attorney General

**Concern(s) :** Review and Appeal, Medically Necessary, Rule 2.28 (Injury), Rule 2.30 (Medical Director), 5.04.2(k) (Reconstructive Surgery), 8.01(G) (Covered Benefits – Services that are preventive in nature, AIDS and HIV-related testing and treatment, mental illness, tuberculosis, congenital defects, mental health treatment and substance abuse) 11.10 (Eligible Charges), Article 12 (Managed Care), 16.09 (GHLI Trust Fund)

#### GHLI Response / Comments:

01/10/02 – Response from Fund Legal Counsel Kathleen Troy-Rucker. All comments were thoroughly reviewed and considered and all are well taken. Many were thought very beneficial and prompted some changes; a few were, unfortunately, just not feasible at this time, such as IMR, due to the cost to the Plan, even though the Board did like the idea Many of the changes recommended are being considered for the future, as the Plan can evolve into a more comprehensive, private-type Program.

## COMMENT NO. 14:

Date	:	01/29/02 and 02/08/02
From	:	Felipe Litulumar
Concern(s)	:	Exclusion (Joint Replacement)

#### **GHLI Response / Comments:**

Joint replacement is simply cost prohibitive to the Plan at this time, in light of the low premiums and government contribution rate.

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# COMMENT NO. 15:

Date	:	02/01/02
From	:	Ivan Groom
Concern(s)	:	Insurance Coverage Policy

#### **GHLI Response / Comments:**

*Mr.* Groom's comments, while well taken, are not for the Program to address, but rather the CNMI government.

# COMMENT NO. 16:

Date:05/27/02From:Tony Stearns, MD, FAAFP / Marianas Medical CenterConcern(s):On-island Health Care Providers, and HPMR ProviderAgreement.

#### **GHLI Response / Comments:**

Positive comments from Dr. Stearns, which were most appreciated. In the future, the Board may be able to approve higher reimbursement rates. This must be done a step at a time and the Board has taken the necessary steps to begin this process by raising the previously granted CHC rate to the Medicare rate.

# COMMENT NO. 17:

Date	:	05/28/02
From	:	Dr. Richard W. Ludders, Clinic Director / Saipan SDA
Concern(s)	:	HPMR Participating Provider Agreement

#### **GHLI Response / Comments:**

Dr. Ludders' comment has been considered and the TPA will ensure timely payment of claims, as long as the government ensures timely payment of premiums.



ETIRENENTFUN D

"Investing For The Future Financial Security Of Our Members"

# ADMINISTRATIVE SERVICE AGREEMENT

DATE: August 1, 2001

<u>PARTIES</u>: First Party: CNMI Government Health and Life Insurance Trust Fund, hereinafter referred to as "GHLITF".

Second Party: HPMR, Hawaii Pacific Medical Referral, Inc., hereinafter referred to as the "Contractor".

# RECITALS:

GHLIP, by and through the Northem Mariana Islands Retirement Fund ("NMIRF") as the designated Plan Administrator and Fiduciary for its benefit plan, desires to provide certain medical benefits for its beneficiaries, said benefits which are described in the NMI Retirement Fund Group Health and Life Insurance Program Plan Description, attached hereto as Appendix C (The Plan).

It is the intent of the parties to implement a third party administration contract for both on-island and off-island health care to better serve the Plan members by providing discounted medical services through HPMR's medical provider network, case management, utilization review and claims processing services. It is the further intent of the parties that such discounted services shall result in significant savings to GHLITF. It is the intention of the parties to implement these services in the following stages:

1 August 2001: contract implementation - system set-up to begin;

1 September 2001: off-island provider claims processing and payment to begin (only for claims submitted on or after 1 September 2001 by off-island {outside CNMI} providers); claims for charges for patients admitted to or confined in a hospital, clinic or other healthcare facility prior to September 1, 2001 and still so confined on or after September 1, 2001 will not be the responsibility of Contractor, except that this exception applies only to the illness for which the patient was originally confined or admitted, as claims for any treatment for any other illness, condition and/or disorder diagnosed or treated on or after September 1, 2001 shall be the responsibility of Contractor, even if said condition is discovered or treatment rendered while the patient is confined for a prior illness or condition;

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1 January 2002: on-island provider claims processing and payment to begin (only for claims for service dates on or after January 1, 2001 by CNMI providers).

#### AGREEMENT:

NOW, THEREFORE, it is agreed as follows:

1. <u>ENGAGEMENT OF CONTRACTOR</u>. GHLITF hereby engages the Contractor and the Contractor hereby accepts such engagement to perform those services specified in this Agreement required in connection with the operation of the medical benefit plans ("Plan") of the GHLITF, upon the terms and subject to the conditions provided in this Agreement, which Plan is intended to be an integral component of GHLITF's responsibility. Said plan is attached as Appendix C. This Agreement is not the Plan document; it is a collateral service agreement between GHLITF and Contractor.

2. <u>DUTIES AND RESPONSIBILITIES OF CONTRACTOR</u>. The Contractor shall provide, with respect to GHLITF's Plan, the following services:

a. Utilize necessary forms provided by GHLITF in order that Contractor may enroll and terminate individuals pursuant to GHLITF's qualification and eligibility instructions.

b. GHLITF, as part of its duties set forth in Paragraph 4, shall furnish Contractor with current plan participant information as set forth in Paragraph 4 (a), in order that the Contractor may create and maintain a current list of participants to which all new participants are added and from which all terminated participants are deleted. Contractor shall rely upon GHLITF's eligibility determinations to create said lists.

c. Receive, adjudicate, verify, pay or deny all claims for benefits, based upon the claim receipt date, under and pursuant to said Plan(s), including such communications with dentists, physicians, hospitals and/or other individuals and firms as may be necessary to verify claims as submitted, pursuant to generally accepted claims practices. Claim runs shall be a minimum of twice (2 times) per month.

d. Utilize enrollment materials and supplies provided by GHLITF necessary for administration of the Plan.

e. Respond to Plan participants with respect to questions regarding benefits, claims and other non-Plan administrator duties. Any said responses regarding benefits shall be coordinated with GHLITF management and staff to ensure appropriate responses are given to plan participants.

f. Provide utilization and case management services, within the parameters of the Plan.

g. Develop administrative guidelines/procedures for the following processes: medical referral; utilization management; billing for administrative and case management services; claims adjudication; and financial reporting. These procedures will be subject to review and approval by the GHLITF before implementation.

h. Use its best efforts to negotiate, secure and maintain discount medical service contracts with all major hospital facilities and medical providers in as many specialties as is praticable, in the State of Hawaii and on Guam to provide medical treatment to CNMI patients.

All claim settlements made by Contractor shall be binding upon GHLITF, subject to the terms of this Agreement.

3. <u>COMPENSATION</u>. For the administration services provided by the Contractor, GHLITF agrees to pay monthly fees in accordance with the fee schedules attached hereto as Appendix "A" and "B" as amended from time to time and approved by GHLITF; provided that no increase in fees shall apply with respect to any month which commenced prior to the date of approval of the revised schedule of fees submitted by the Contractor. Any additional fees for contract services elected are set forth in Appendix "A" and "B". Said fees are deemed reasonable by GHLITF.

4. <u>DUTIES AND RESPONSIBILITIES OF GHLITF</u>. The NMIRF is the Plan Administrator and Fiduciary pursuant to Public Law 10-19, codified in the CNMI Code at 1 CMC §8424. NMIRF has the sole discretionary authority and responsibility in the administration of the Plan.

NMIRF retains all duties of the Plan Administrator and it shall be the duty and obligation of NMIRF, through GHLITF Administrator and staff, to take the following actions with respect to the Act described in this Agreement to facilitate administration thereof by the Contractor:

a. Supply to Contractor all participant eligibility information, completed enrollment forms, and other information evidencing GHLITF's determinations of participant eligibility. Contractor shall utilize the forms supplied by GHLITF and as adopted by GHLITF's Plan.

b. Advise the Contractor promptly upon any acquisition of any insurance contract or contracts purchased to fund any benefit or benefits payable under said Plan and receipt of any information with respect to changes in the status of any contract or contracts previously purchased.

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c. Provide the Contractor with such additional information with respect to matters incidental to the Plan, as may be requested from time to time by GHLITF, in order for GHLITF to satisfy its contractual responsibilities.

Upon commencement of this Agreement, Contractor shall open a d. claims disbursement Trust account. This account shall be initially funded by GHLITF, with \$350,000.00 to be deposited by 1 September 2001, \$50,000 to remain in a reserve account and \$300,000 to be placed in a revolving account to process claims. Should the account balance in the revolving account be reduced to \$150,000.00 or less, GHLITF shall promptly provide the funds necessary to maintain the account at \$300,000.00, upon notification by Contractor of the amount needed. In addition, the GHLITF shall forward \$50,000.00 per month to be placed in the reserve account until such time as the reserve account reaches \$450,000 or an amount equal to one and a half months of utilization. Disbursements will be made to fund claims liability in a manner acceptable to the GHLITF, and including such documentation as the GHLITF may require. Interest, if any, shall accrue to the benefit of the GHLITF. The minimum funding may be subject to increase, based upon the number of hospital admissions. The initial funding and deposit requirements are based upon an average of ten (10) admissions per month.

For purposes of this Paragraph d, "promptly" shall mean within seven (7) working days.

GHLITF assumes full responsibility for failure to fund the claims disbursement account and GHLITF agrees to indemnify Contractor from liability, disclosure of information to Plan participants as a result of any such failure, and such other relief as Contractor may be legally entitled to receive. Should GHLITF fail to promptly fund its claim disbursement account, Contractor shall notify plan beneficiaries and service providers of GHLITF's failure to fund, but only in the event such failure to timely fund results in the inability to pay claims. Repeated failure to timely fund (failure to fund the account for a period exceeding 30 days, and such failure occurring four or more times in one calendar year) resulting in the inability to pay claims may be grounds for immediate termination of this Agreement. Any remaining funds in the Trust Account shall be utilized first to pay outstanding medical charges. Any remaining funds upon payment of said charges less Contractor fees pursuant to Appendix "A" and "B" shall be returned to GHLITF.

5. <u>RECORDS AND REPORTS</u>. The Contractor shall supply GHLITF with full and complete records concerning all services performed by the Contractor pursuant to the terms of this Agreement in the following formats:

a. All original claims records (including forms UB-92 and HICFA 1500), copies of administration documents and related correspondence,

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including the Explanation of Benefits (EOB) issued to plan participants. Additional copies will be provided for a reasonable fee, to be agreed upon in writing by the parties, but not to exceed fifteen cents (\$.15) per page. Original claim records (forms UB-92 and HICFA 1500 and copies of the EOB) shall be submitted to GHLITF on a quarterly basis. Originals of the Explanation of Benefits shall be sent directly to the Plan member, with a copy submitted to GHLITF.

b. One copy of the following standard reports shall be provided on the following basis:

#### Report Name

#### Frequency of Report

- 1. Check Register
- 2. Employee Claim Report
- 3. Spouse Claim Report
- 4. Dependent Claim Report
- 5. Claimant Age Analysis
- 6. Claim Lag Report
- 7. Incurred Claim Analysis
- 8. Top Provider Report
- 9. Major Diagnosis Category Summary
- 10. Benefit Code Year to Date Summary
- 11. Unpaid Claims Inventory

c. Programming of special reports shall be at \$125.00 per hour. Special reports are those reports that are not listed in the FACTS, Fully Automated Claims Transaction System, Reports and Listings Manual.

6. <u>CONTRACT RECORDS MAINTENANCE</u>. Contractor shall maintain at its principal administrative office, for the duration of this Agreement:

a. Adequate books and records of all transactions between and among Contractor and GHLITF and any reinsurer and covered persons. Such books and records shall be maintained in accordance with prudent standards of administrator record keeping. At the expiration or termination of this Agreement all books and records shall be returned to GHLITF within fifteen (15) days without necessity of formal request, via U.S. Postal Service Express Mail at GHLITF's expense. Contractor shall maintain such records for a longer period if required by statute.

b. GHLITF, at its expense, shall have the right, during Contractor's regular business hours, to examine, inspect, and copy such books and records relating to the services which Contractor is performing for GHLITF, allowing a two (2) working day advance notice to Contractor for records less than

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GHLITF/HPMR/ASAGMT/KTF	R/072001	Page 5 of 11		• • • •	• .		

At least 2x/mo Monthly Monthly Monthly Monthly At least 2x/mo Monthly Monthly Monthly Monthly Monthly Monthly two (2) years old and a five (5) working day advance notice for records older than two (2) years old.

c. Pursuant to 1 CMC §7845, the Public Auditor of the Northern Mariana Islands shall have access and the right to examine and copy any record data or papers relevant to this agreement. This right shall continue for a period of three (3) years after final payment is made under this agreement.

d. Contractor shall release to GHLITF, on demand, any such books and records which may be required by GHLITF to answer inquiries from plan participants or from regulatory authorities, and as necessary to provide for Contractor's defense in any legal action regarding the plan or administration of the Plan.

7. <u>LIMITS OF CONTRACTOR RESPONSIBILITIES</u>. The Contractor does not assume any responsibility, risk, liability, or obligation for the general policy direction of GHLITF, the adequacy of the funding thereof, or any act or omission or breach of duty by parties other than the Contractor, its agents, servants and authorized representatives. The Contractor is not in any way to be deemed an insurer, underwriter guarantor, Plan Fiduciary or Plan Administrator with respect to any benefits payable under the Plan.

8. <u>INDEMNIFICATION</u>. Each party agrees to indemnify and hold the other harmless from and against all claims, including reasonable Attorney's fees, arising out of the performance of this Agreement, but only in proportion to and to the extent such claims are caused by or result from the unintentional negligence or honest mistake of a party. Each party reserves the right to hold the other party liable for the other party's gross negligence or willful misconduct of its officers, agents or employees.

# 9. TERMINATION.

a. <u>FOR BREACH</u>: In the event that either party shall default in the performance of the duties and obligations imposed upon it pursuant to the terms of this Agreement or materially breach any of the provisions contained herein, with the exception of a failure to fund as set forth in Section 4(d), the other party shall be entitled to terminate this Agreement upon delivery of thirty (30) days written advance notice of such termination to the defaulting party without prejudice to any other rights or remedies available to such party by reason of such fault or breach. The party in receipt of such notice of breach shall have fifteen (15) days in which to remedy such breach and conform to the provisions of this Agreement. If the breach is remedied within fifteen (15) days, this Agreement shall continue uninterrupted. Otherwise, it will terminate in accordance with the notice provided.

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b. OFF-ISLAND SERVICES: Contractor agrees to use its best efforts to secure discounts of the highest possible level on behalf of the Plan. In the event that Contractor is unable to secure and maintain off-island discount contracts with all necessary providers at an overall average discount of a minimum of twenty percent off of billed charges (including, but not limited to hospital and urgent care facilities, primary care and specialized care physicians, pharmacies or prescription drug providers) to provide comprehensive medical care and treatment to Plan members for off-island medical services; or if Contractor's provider network is diminished to a degree that it is not able to or fails to provide all necessary off-island medical treatment to members; or if GHLITF does not realize a minimum of a ten percent (10%) overall reduction in claims cost by the end of the first year of this contract, GHLITF reserves the right to seek modification of, or terminate this Agreement upon 60 days prior written notice to Contractor.

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c. ON-ISLAND SERVICES: Contractor agrees to use its best efforts to negotiate discount contracts with CNMI health care providers and CNMI prescription drug providers, and/or to seek the addition of mail-order or other alternative prescription drug services for Plan members. Contractor cannot guarantee any success in securing said services, but in the event that Contractor fails to initiate and actively pursue such negotiations, GHLITF reserves the right to seek modification of, or terminate the on-island portion of this Agreement upon 60 days prior written notice to Contractor.

d. SEVERABILITY: GHLITF reserves the right to seek modification or termination of either segment of this Agreement (on-island and off-island segments), if only that segment should fail to meet GHLITF's expectations as outlined in items "9b" and "9c", above. Should GHLITF seek to modify or terminate only one segment of this Agreement, all terms and conditions herein regarding that segment only shall be affected, and all terms and conditions stated herein shall continue to apply to the remainder of this Agreement. GHLITF may only seek the above remedy if GHLITF is not in default of any of its obligations under this Agreement, or if any default of GHLITF resulted in the failure.

10. <u>TERM OF AGREEMENT</u>. This Agreement shall become effective on August 1, 2001, and continue for a period of three years. This Agreement may be renewed, extended or re-negotiated at the end of the initial three (3) year period on terms mutually agreed upon by the parties. In the event that this Agreement is terminated:

a. GHLITF agrees to pay all fees, commitments and obligations incurred by the Contractor on behalf of the Plan and all valid claims incurred up to the date of termination of this Agreement.

b. In the absence of any special transfer arrangements, the Contractor agrees to process all claims that have been received prior to the termination date without further charge to the GHLITF.

c. Contractor shall have no obligation to process claims received after the termination date, or to issue drafts after the termination date for payment of claims based on conditions which exist after the termination date (Claims Run Out) unless a separate administration fee has been agreed to for services performed by the Contractor after the termination date.

11. <u>JURISDICTION</u>. This Agreement will be governed by the laws of the Commonwealth of the Northern Mariana Islands, in accordance with the Plan, and the parties agree that the federal and local court in the Commonwealth of the Northern Mariana Islands shall be the appropriate venue for any dispute or disagreement with respect to this Agreement.

12. <u>OMISSION OF FAILED PROVISION/SEVERABILITY</u>. In the even that any provision of this Agreement shall be void or contrary to applicable state or federal law, it is agreed that such provision shall be deemed omitted from this Agreement and the remainder thereof shall be enforceable as if such provision had not been included.

ARBITRATION. If any dispute shall arise between the Contractor 13. and the GHLITF, except as set forth in Section 18, either before or after termination of this Agreement, with reference to the interpretation of this Agreement or the rights of either party with respect to any transaction under this Agreement, the dispute shall be referred to three (3) arbitrators; one to be chosen by each party and the third by the two so chosen. If either party refuses or neglects to appoint an arbitrator within thirty (30) days after the receipt of written notice from the other party requesting it to do so, the requesting party may nominate two arbitrators who shall chose the third. In the event the two arbitrators have been named, then the third arbitrator shall be selected pursuant to the commercial arbitration rules of the American Arbitration Association. The arbitration shall take place in the state of Hawaii, city of Honolulu, and the arbitration proceedings are to be governed by the American Arbitration Laws. The arbitrators shall consider this Agreement an honorable engagement in addition to a legal obligation; they are relieved of judicial formalities and may abstain from following the strict rules of law. The decision of a majority of the arbitrators shall be binding and final on both the Contractor and the GHLITF, and

arbitration proceedings shall be equally divided between the Contractor and the GHLITF.

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14. <u>AMENDMENTS</u>. No amendment to this Agreement will be effective unless it is in writing and signed by duly authorized representatives of GHLITF and Contractor.

15. <u>NOTICES</u>. Any notice to be given pursuant to the terms of this Agreement must be in writing and may be given either by personal delivery or by mail, registered or certified, with postage prepaid and return receipt requested. Mailed notices shall be addressed to the parties at their respective addresses shown beneath their signatures in this Agreement.

16. <u>ASSIGNMENT</u>. This Agreement shall not be assigned by either party without the written consent of the other.

# 17. CONFIDENTIALITY/PROPRIETARY INFORMATION.

a. Each party recognizes that it will be exposed to, have access to, and be engaged in the development of confidential information regarding the trade secrets, processes, fee structures and business of the other party (all such information shall be collectively referred to as the "Proprietary Information").

b. All Proprietary Information, whether presently existing or developed after the Effective Date of this Agreement, shall be the sole property of the party that developed such Proprietary Information, with the exception of any and all plan participant information and data which shall always be the proprietary information of GHLITF.

c. At all times, both during the term of this Agreement and after its termination, each party will keep in confidence and trust all Proprietary Information of the other party and shall not use or disclose any such Proprietary Information or anything related to such information without the written consent of the other party except as may be required in the ordinary course of performing services under this Agreement.

d. Each party understands that the other party has received, and in the future will receive, from third parties information that is confidential or proprietary ("Third-Party Information") and subject to a duty to maintain the confidentiality of such information and to use it only for certain limited purposes pursuant to this Agreement. During the term of this Agreement, and thereafter. The parties will hold Third-Party Information in the strictest confidence and will not disclose or use Third-Party Information, except as permitted by the agreement with such third party, unless expressly authorized in writing to act otherwise by the other party.



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e. Upon termination of this Agreement for any reason, each party shall promptly surrender and deliver to the other party all documents and other materials of any nature belonging to the other party and any documents of any description containing or pertaining to any Proprietary Information.

f. In the event of an actual or threatened breach of the provisions of this Section 18, and notwithstanding the provisions of Section 14 relating to arbitration, the aggrieved party may bring an action in court of competent jurisdiction seeking damages and/or equitable relief and reasonable attorney fees and costs against the other party.

18. <u>CURRENCY</u>. Currency shall be in U.S. dollars.

19. <u>PARTY CERTIFICATIONS</u>. It is a breach of ethical standards for any party to this contract to offer or agree to offer, to give or agree to give, to receive or agree to receive any form of consideration or gift, financial incentive or benefit, or personal incentive or benefit for the award or implementation of this contract, with the exception of the contract benefits and fees as contemplated and stated in the appendices herein. By executing this Agreement, the parties hereby certify that no such unethical actions have taken place and that this contract is in compliance with Sections 6-203, 6-204 and 6-205 of the CNMI Procurement Regulations, as adopted by the NMI Retirement Fund.

For purposes of this clause, "party" refers to and encompasses each contracting party, it agents, representatives, officers, board members, employees and any and all associated persons in any capacity.

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IN WITNESS WHEREOF, the parties, acting with authorization and appropriate granted authority, have executed this Agreement as of the dates shown by each signature below.

Northern Mariana Islands Government Health & Life Insurance Trust Fund

Vicente C. Camacho Chairman, Board of Trustees Northern Mariana Islands **Retirement Fund and Group Health** And Life Insurance/Trust Fund Date:

S. Torres Administrator Northern Mariana Islands **Retirement Fund and Group Health** And Life Insurance Trust Fund Date:

Hawaii Pacific Medical Referral, Inc.

Bv Title:

19374

737 Bishop Street, Suite 1800 Honolulu, Hawaii 96813 Date: \_\_\_\_ 01 8

Reviewed and Approved for Legal Sufficiency:

Kathleen Troy-Rucker Legal Counsel Northern Mariana Islands **Retirement Fund and Group Health** 

And Life Insurance Trust Fund Date: 10 /ugust

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# APPENDIX A

# OFF-ISLAND FEE SCHEDULE For Services Rendered Outside of the CNMI

To the Administrative Services Agreement between GHLITF and Contractor, effective 1August 2001, and forming **a** part of that Agreement.

## FEE SCHEDULE

CONTRACTOR hereby agrees to provide contract administration services specified in the Agreement for the fee amounts specified below, for an initial period of three years.

Services Covered By This Agreement	Thirteen Percent (13%) of paid claims (Defined as claims paid after the effective date.) Administration fees do not include Run- In Services (i.e. claims incurred prior to the effective date of this Agreement).
Peer Review/Case Mgmt:	Included with above fee. Peer Review includes Case Management as an added feature, and pre-certification services. Pre-certification for various Plan procedures will be conducted by the Contractor in accordance with the Plan.
Set-Up Fee:	\$20,000.00 one time set-up fee.

It is understood and agreed that the above-stated fees apply to the services set forth in the Administrative Services Agreement. Any additional services not expressly specified in this Agreement and not necessary incidental to Administration shall be at additional expense to GHLITF, with the reasonable expense agreed upon, in writing, by the parties.

Furthermore, the above-described fees do not account for plan revisions, changes, or other modifications, except those anticipated to take effect January 1, 2002. Any further plan changes shall be made by Contractor for an additional charge to be agreed upon, in writing, by the parties at the time said changes are requested.

# APPENDIX B

#### ON-ISLAND FEE SCHEDULE For Services Rendered Inside of CNMI

To the Administrative Services Agreement between GHLITF and Contractor, effective 1 August 2001, this "on-island" portion (solely for services rendered in the CNMI) anticipated to become effective 1 January 2002, and forming a part of that Agreement.

#### FEE SCHEDULE

CONTRACTOR hereby agrees to provide contract administration services specified in the Agreement for the fee amounts specified below, for an initial period of three years.

Services Covered By this Agreement

Peer Review/Case Mgmt:

\$7.29 per member\* per month, payable at the beginning of each month.

\* "member" includes both subscribers and dependents

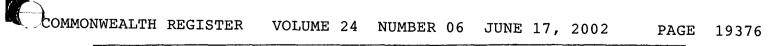
No additional fee. Peer Review includes Retrospective Review, Case Management as an added feature, and Pre-certification Services. Pre-certification for various Plan procedures will be conducted by the Contractor in accordance with the Plan.

Set-Up Fee:

\$20,000.00 one time set-up fee.

It is understood and agreed that the above-stated fees apply to the services set forth in the Administrative Services Agreement Agreement. Any additional services not expressly specified in this Agreement and not necessary incidental to Administration shall be at additional expense to GHLITF, with the reasonable expense agreed upon, in writing, by the parties.

Furthermore, the above-described fees do not account for plan revisions, changes, or other modifications, effected after 1 January 2002. Any such planchanges shall be made by Contractor for an additional charge to be agreed upon, in writing, by the parties at the time said changes are requested.





# Commonwealth of the Northern Mariana Islands COMMONWEALTH DEVELOPMENT AUTHORITY

Wakin's Bldg., Gualo Rai, Tel. 234-7145 / 7146 / 6293 / 6245 Saipan, MP 96950-2149

MAILING ADDRESS: P.O. BOX 502149 SAIPAN, MP 96950-2149 FAX (670) 234-7144 (670) 235-7147 Email: cda@itecnmi.com

#### PUBLIC NOTICE

# NOTICE AND CERTIFICATION OF ADOPTION OF THE AMENDED RULES AND REGULATIONS OF THE DEVELOPMENT CORPORATION DIVISION OF THE COMMONWEALTH DEVELOPMENT AUTHORITY

We, Juan S. Tenorio, Chairman of the Board of Directors and Maria Lourdes Seman Ada, Executive Director of the Commonwealth Development Authority, which is promulgating the Amended Rules and Regulations of the Development Corporation Division (DCD) of the Commonwealth Development Authority (CDA), published in the Commonwealth Register, Volume 24, Number 01, on January 29, 2002, at pages 18813 through and including page 18851, by our signatures below, do hereby certify that the final Amended Rules and Regulations of the DCD were adopted by the CDA Board of Directors at its regular meeting on May 29, 2002 without modification or changes. We hereby request and direct that this Public Notice and Certificate of Adoption be immediately published in the Commonwealth Register.

We declare under penalty of perjury that the aforementioned rules and regulations are true and correct and that this declaration was executed on the 30<sup>th</sup> of May, 2002, Saipan, Commonwealth of the Northern Mariana Islands.

Juan S. Tenorio, Chairman CDA Board of Directors

Marta Lourdes S. Ada, Executive Director, CDA

Date:

DATE:

Soledad B. Sasamoto Registrar of Corporations COMMONWEALTH REGISTER VOLUME 24

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Robert Torres

Attorney General

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TINIAN CASINO GAMING CONTROL COMMISSION Commonwealth of the Northern Mariana Islands



Esther H. Barr **Executive Director** 

Martin DLG San Nicolas Chairman

#### NOTICE AND CERTIFICATION OF ADOPTION OF TINIAN CASINO GAMING CONTROL COMMISSION PERSONNEL RULES AND REGULATIONS

Jose P. San Nicolas William M. Cing Serafina King-Nabors

> I, Martin DLG. San Nicolas, Chairman of the Tinian Casino Gaming Control Commission which is promulgating the Tinian Casino Gaming Control Commission Personnel Rules and Regulations published in the Commonwealth Register Volume 24, No. 4 on the 29th day of April 2001 at pages 19047 through 19114, inclusive by signature below hereby certify that as published such Rules and Regulations are a true, complete and correct copy of the Tinian Casino Gaming Control Commission Personnel Rules and Regulations previously proposed by the Tinian Casino Gaming Control Commission which, after the expiration of the legally required time for public comment have been adopted with the following minor modification or amendment .:

> > 1. Section 8-109(1)(B) at the bottom of page 19080, Commonwealth Register Vol. 24, No. 4, April 29, 2002 is deleted as incomplete and redundant. Section 8-109(1)(B) commencing at the top of page 19081 is unaffected by this amendment.

I further request and direct that this Notice and Certification of Adoption be published in the CNMI Commonwealth Register.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on the 4th day of June, 2002 at Tinian, Commonwealth of the Northern Mariana Islands.

Martin DLG. San Nicolas Chairman

VOLUME 24 NUMBER 06 JUNE 17, 2002 PAGE 19378 COMMONWEALTH REGISTER P.O. Box 143 San Jose Village Tinian, MP 96952 \* Tel: (670) 433-9288/9292 \* Fax: (670) 433-9290

TINIAN CASINO GAMING CONTROL COMMISSION Municipality of Tinian and Aguiguan

Municipality of Tinian and Aguiguan Commonwealth of the Northern Mariana Islands



# PUBLIC NOTICE

Esther H. Barr **Executive Director** 

Martin DLG San Nicolas Chairman

# PROPOSED AMENDMENT TO RULES AND REGULATIONS

Jose P. San Nicolas William M. Cing Serafina King-Nabors

> The Tinian Casino Gaming Control Commission, (TCGCC) in order to both accommodate its unique needs in regulating gaming in the Second Senatorial District while also encouraging the development of the casino industry in the Second Senatorial District proposes to amend the existing TCGCC Rules and Regulations by decreasing the monetary payment required as the "initial deposit against licensing costs" (i.e. investigation fee) paid by an applicant.

> Written comments regarding the Proposed Amendment to the TCGCC Rules and Regulations are to be submitted, not later than thirty (30) days of publication of this Notice in the Commonwealth Register, to Esther Hofschneider-Barr, Executive Director, TCGCC, P.O. Box 143, San Jose Village, Tinian, MP 96952.

By: Martin DLG. San Alicolas Chairman	6/4/02
By: Registrar of Corporations By: Registrar of Corporations	6.13.02
By: Special Assistant for Administration Date:	6/12/02

Pursuant to 1 CMC §2153 as amended by PL 10-50, the Proposed Amendment to the TCGCC Rules and Regulations attached hereto have been reviewed and approved by the CNMI Attorney General's Office.

ROBERT T. TORRES Attorney General By: Assistant Attorney General

Jerne 12, 2002 Date:

COMMONWEALTH REGISTER ONWEALTH REGISTER VOLUME 24 NUMBER 06 JUNE 17, 2002 PAGE 19379 P.O. Box 143 San Jose Village Tinian, MP 96952 \* Tel: (670) 433-9288/9292 \* Fax: (670) 433-9290 TINIAN CASINO GAMING CONTROL COMMISSION

Commonwealth of the Northern Mariana Islands



# **NOTISIAN PUBLIKU**

Esther H. Barr **Executive Director** 

Martin DLG San Nicolas Chairman

# **MAPROPONE NA AMENDASION PARA AREKLU YAN REGULASION I TCGCC**

Jose P. San Nicolas William M. Cing Serafina King-Nabors

> I Tinian Casino Gaming Control Commission, (TCGCC) pot para u kubre I especiat na nesisidadña ni para u establesi areklu pot bandan Gaming gi halom I Segundo na Destriton Senadot, yan gi mismo tiempo pot para u probeniye yan para u adelanta mas developmentu gi halum I industrian casino gi halum I Segundo na Distriton Senadot ha propone na u amenda I presente na areklu yan regulasion anai para una guaha marebahan apas pot bandan salape ne ma nesesita kumo I ginagagao gi halum I primet na para uma deposita na gusto pot para uma Lisensia (tat kumo I apas ni para uguaha investigasion) ni para uma apase nui applikante antes de umalisensia para casino.

> I TCGCC ha sen agradesi opinion yan fotmat na ineppi siha asino rekumendasion ni para uresibe, pot este ima propone na RULES AND REGULATIONS para I TCGCC. Todo recomendasion masen agradesi na uma submite gihalom tirenta dias na tiempo osino menus para si Esther Hofschneider-Barr, Executive Director, TCGCC, P.O.Box 143, San Jose Village, Tinian, MP 96952.

Tinian Casino Gaming Control Commission By: Martin DLG. San Nicolas Chairman NMI (Registrar of Corporations OllAIAN By: egistrar of Corporations ernor's Office By: Special Assistant for Administration

Date:

6.13.02 Date:

Date:

Pursuant to 1CMC§2153 as amended by PL 10-50, the proposed TCGCC Rules and Regulations attached hereto have been reviewed and approved by the CNMI Attorney General's Office.

> Robert T. Torres Attorney General

By:

Assistant Attorney General

Date:

COMMONWEALTH REGISTER IONWEALTH REGISTER VOLUME 24 NUMBER 06 JUNE 17 2002 PAGE 193 P.O. Box 143 San Jose Village Tinian, MP 96952 \* Tel: (670) 433-9288/9292 \* Fax: (670) 433-9290

TINIAN CASINO GAMING CONTROL COMMISSION Municipality of Tinian and Aguiguan Commonwealth of the Northern Mariana Islands



Martin DLG San Nicolas Chairman

Esther H. Barr **Executive Director** 

# NOTICE

# **PURSUANT TO GOVERNOR'S DIRECTIVE NO. 183**

Jose P. San Nicolas William M. Cing Serafina King-Nabors

Statutory Authority:	The Tinian Casino Gaming Control Commission (TCGCC) has promulgated this Proposed Amendment to the TCGCC Rules and Regulations pursuant to the powers granted it through the constitutional initiative process set forth in NMI Constitution Article XXI as implemented by and the Revised Tinian Casino Gaming Control Act of 1989; in particular Sections 5(8), and 121 thereof.
Statement of Goals and Objectives:	The Proposed Amendment to the TCGCC Rules and Regulations is promulgated to encourage the development of the casino industry in the Second Senatorial District by decreasing the monetary payment required as the "initial deposit against licensing costs" (i.e. investigation fee) paid by the applicant.
Brief Summary of the Proposed Amendments:	The Proposed Amendment to the TCGCC Rules and Regulations is promulgated to encourage the development of the casino industry in the Second Senatorial District by decreasing the monetary payment required as the "initial deposit against licensing costs" (i.e. investigation fee) paid by the applicant.
Citation of Related and/or Affected Regulations:	The Proposed Amendment to the TCGCC Rules and Regulations submitted herewith specifically amends Section 1:8.5 "Casino License Fees and Deposits" published in the CNMI Commonwealth Register Volume 14 No. 02 February 15, 1992 at Page 8766.
For Further Information Contact:	Esther Hofschneider-Barr, TCGCC Executive Director via phone at 433-9292, or via fax at 433-9290; or in writing at P.O. Box 143. Tinian, MP 96952.

COMMONWEALTH REGISTER VOLUME 24 NUMBER 06 JUNE 17, 2002 PAGE 19381 P.O. Box 143 San Jose Village Tinian, MP 96952 \* Tel: (670) 433-9288/9292 \* Fax: (670) 433-9290

#### TCGCC AMENDMENTS TO RULES AND REGULATIONS

#### 1:8.5 Casino License Fees and Deposits

(a) No application for the issuance of a casino license shall be accepted for filing by the Commission unless a nonrefundable application fee of \$200,000 and an initial deposit against licensing costs of \$100,000 shall first have been paid, in full, to the Commission.

(b) No conditional or plenary casino license shall be issued or renewed unless an annual license fee of \$500,000 or the prorated portion thereof for an initial license issuance, shall first have been paid, in full, to the Commission.

By signature below the Tinian Casino Gaming Control Commission certifies that the above Amendment to Rules and Regulations was adopted by the Commission at its Board Meeting held June  $4^{2}$ 2002.

Martin DLG. San Nicolas Chairman

William M. Cing Vice-Chairman

Serafina R. King-Member

#### CERTIFICATION BY TCGCC COUNSEL

Pursuant to the instruction and direction of the Chairman and the members of the Tinian Casino Gaming Control Commission, this amendment to the rules and regulations has been drafted, reviewed, revised and approved as to form and legal sufficiency by the undersigned TCGCC Legal Counsel.



Elliott A. Sattler, Sr. Chief Legal Counsel TCGCC

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