Prescribed By: **Judiciary of Guam**	**REQUEST FOR HEALTH PROPOSAL** (SERVICE CONTRACT)	Page No. 1	Number of Pages

Issued By: **JOSHUA F. TENORIO, Administrator of the Courts**	Address:	**JUDICIARY OF GUAM GUAM JUDICIAL CENTER PROCUREMENT SECTION 120 WEST OBRIEN DRIVE HAGÅTÑA GUAM 96910 Tel: (671)475-3175/3393 Fax: (671)477-8009**
Date Issued: April 28, 2015	**Request For Health Proposal No.: 15 - 01**	

Sealed Proposals **(1) original and (6) copies**, SUBJECT TO THE TERMS AND CONDITIONS OF THIS PROPOSAL, ITS SCHEDULE AND THE ATTACHED GENERAL PROVISIONS, will be received at the above office until: **2:00 o'clock p.m., May 26, 2015 (Chamorro Standard Time).**

General information and instructions to offerors are contained in the terms and conditions attached.

SCHEDULE

Item No.	Supplies or Services	Quantity (No. of Units)	Unit	Unit Price	Amount
1.	**Group Medical & Dental Insurance** **See attachment for Scope of Services**	**Please leave this space blank when submitting proposals.** ********** **See General Terms for instructions.**			

Proposal	**Date**

Offers providing less than sixty (60) calendar days for Government acceptance after the date offers are due will not be considered and will be rejected.

Indicate Whether: ( ) Individual ( ) Partnership	( ) Corporation Incorporated in the state of:
NAME AND ADDRESS OF OFFEROR: (Type or Print) _____ _____ _____ _____	SIGNATURE AND TITLE OF PERSON AUTHORIZED TO SIGN THIS PROPOSAL: _____

AWARD:	CONTRACT NO.:		DATE:

Accepted as to items numbered Amount $_____	By: Contracting Officer
Invoice for payment should be mailed to: _____ Payment will be made by:	_____ Accounting and Appropriation Date

Judiciary of Guam

Administrative Office of the Courts
Guam Judicial Center • 120 West OBrien Dr • Hagatna Gu 96910
Tel: (671) 475-3544/3278 • Fax: (671) 477-3184

HON. ROBERT J. TORRES
CHIEF JUSTICE

HON. ALBERTO C. LAMORENA III
PRESIDING JUDGE

JOSHUA F. TENORIO
ADMINISTRATOR OF THE COURTS

April 28, 2015

REQUEST FOR HEALTH PROPOSAL (RFHP) NO. 15-01

Dear Prospective Offeror:

Buenas yan Hafa Adai!

We would like to thank you for your interest in submitting a proposal to provide health insurance services to the Judiciary of Guam Group Health Insurance Program.

The Judiciary is seeking proposals for health insurance coverage for the Judiciary of Guam's employees and their dependents. The Judiciary of Guam issuing a Request for Health Proposal (RFHP) to interested health insurance companies licensed to do business on Guam, to provide group health insurance coverage to Judiciary of Guam employees, and their dependents. Therefore, we invite your company to submit a proposal to this RFHP. Negotiations are scheduled for mid-July.

To register as an interested company, you must complete and email the "Acknowledgement of Receipt of RFHP" form to the Judiciary of Guam at mantonio@guamcourts.org. In the event any amendments to the RFHP are issued, the acknowledgement will ensure that all interested parties are informed of such change(s).

Thank you in advance for your response and we look forward to working with your company.

JOSHUA F. TENORIO
Administrator of Courts

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ADMINISTRATOR OF THE COURTS

ACKNOWLEDGEMENT OF RECEIPT OF RFHP

Procurement for Health Insurance - RFHP No.: 15-01

Attention: Procurement & Facilities Management Division

From: _____

Subject: Registration of Interest to Provide Health Insurance Services

FY 2016 Health Insurance Program

To register as an interested party, you must complete and email the following information to the Judiciary of Guam at mantonio@guamcourts.org, **no later than 4:00 P.M., May 13, 2015, Chamorro Standard Time**. The Judiciary of Guam cannot guarantee that you will receive any amendments or notices to the RFHP that may be issued unless the information below is completed and submitted as provided herein.

Date:	
Company Name:	
Contact Person & Title:	
Contact Information:	Telephone No.: ( )
	Facsimile No.: ( )
	E-Mail address:
	E-Mail address:
Mailing address:	
Street address:	

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ADMINISTRATOR OF THE COURTS

Procurement No.: **RFHP 15-01**

Description: **FY 2016 Health Insurance Program**

Request for Health Proposal (RFHP)

SPECIAL REMINDER TO PROSPECTIVE OFFERORS

Offerors shall carefully read all sections of this Request for Health Proposal (RFHP) and be informed of all its terms and conditions. Offerors are especially alerted to the sections entitled **"Proposal Contents and Requirements"** in the RFHP, and are asked to ensure that all required documents and information are included in their proposal.

Compliance with the following is mandatory, but not inclusive of all the requirements of the RFHP:

1. Each offeror shall submit an original proposal and six (6) copies to the Procurement & Facilities Management Division at the Judiciary of Guam at the address indicated in this RFHP. Offerors are required to submit electronic copies of all required documents in CD format and in Excel format where required in addition to the copies.

2. The Judiciary of Guam will contract with one Health Insurance Provider to provide its enrollees up to three different plan designs.

3. Each proposal must be organized, fully assembled and complete.

4. All offerors must submit their cost proposal within the original response.

5. All offerors must submit five (5) different Affidavit Forms and one (1) Declaration Form, found in **Exhibit K**:
    a. Form A, Affidavit Disclosing Ownership and Commissions must be made between the dates of issuance of this RFHP and the dates that proposals are due, so long as the ownership listing mentioned in the Affidavit is for the 365 day period preceding the date the offeror submits the proposal.

6. One original of each form and six (6) copies of each form must be submitted. The original form shall be submitted with the original proposal and the copies shall be submitted with the proposal copies.

7. The Questionnaire and Pricing information provided in Excel format with the RFHP package, must be completed and returned in Excel format, **as well as in PDF format** to ensure no changes were mistakenly made to the Excel file during our analysis phase.

8. Copies of the Judiciary of Guam's desired plan design alternatives are included with this RFHP. Offerors must specify in their proposal any requested features with which they cannot comply.

   Pursuant to Title 4 GCA § 4302(g), health insurance carriers contracted with the Judiciary of Guam must provide specific claim level detail to the Judiciary of Guam. This information is to be distributed to interested health insurance carriers to aid in their bid for the Judiciary of Guam's business. Due to the large size of such files, this information will be made available via CD or DVD media to only those interested parties who have registered by returning an Acknowledgment Form to the Judiciary of Guam by the deadline. Instructions will then be emailed to the email addresses listed on the Forms. In addition, in **Exhibit F** is provided a monthly claims summary by coverage.

For Insured and Reinsurance Proposals:

9. All reinsurers that assume accident and health risks ceded by the offeror must be licensed to transact reinsurance business in Guam. A copy of the current certificate of authority of the insurer and the reinsurer and a summary of each reinsurance treaty(ies) must be submitted together with the proposal.

10. The offeror must submit a copy of the reinsurance agreement or reinsurance treaty that transfers the risks for accident and health insurance. The submitted reinsurance agreement or reinsurance treaty must be duly authenticated by the reinsurer as the entire agreement between the offeror and the reinsurance company.

For Administration and Reinsurance Proposals:

11. All proposers must be licensed to transact reinsurance business in Guam. A copy of the current certificate of authority of the administrator and the reinsurer must be submitted together with the proposal.

For all Proposers:

12. Adherence to the Administrative Procedures and the Marketing Guidelines is required.

13. Offerors must read and review the Marketing Guidelines **(Exhibit M)** and sign and submit the Marketing Guidelines along with their proposal.

14. Offerors must read and review the Reporting Guidelines **(Exhibit O)** and sign and submit the Reporting Guidelines along with their proposal.

15. Offerors must read and review the Affirmation that Plan Designs are consistent in all Material Respects **(Exhibit T**). A signed copy must be submitted along with their proposal.

16. Premium, Claims, enrollment and demographic information are included in the RFHP as **Exhibits D, E, and F**, respectively.

17. This request for proposals does not commit the Judiciary of Guam, for any cause shown, to enter into negotiations, award a contract to pay costs incurred, or contract for any services.

18. The Judiciary of Guam conducts the health insurance program in compliance with all applicable Federal and local statutes.

19. Prospective offerors are required to register as an interested party by completing the "Acknowledgement of Receipt of RFHP" and submitting the Acknowledgement no later than **4:00 P.M., May 13, 2015, Chamorro Standard Time.**

20. All questions regarding this RFHP must be submitted in writing or email and received by the Judiciary of Guam, Procurement & Facilities Management Division no later than **4:00 P.M., May 18, 2015, Chamorro Standard Time.**

Proposal due dates:

21. All hard copies of proposals, including a printed copy of the Excel file, must be received by the Procurement & Facilities Management Division at the Judiciary of Guam no later than **2:00 P.M., May 26, 2015, Chamorro Standard Time**. Hard copies of the entire proposal (including hard copies of the Questionnaire and Pricing portions) must be received by this due date and will be the determining factor for the purpose of timely submission. Hard copies of proposals received after this time and date will not be accepted.

22. RFHP packages are available online for information purposes only at the Judiciary of Guam's website at www.guamcourts.org and at the Office of Procurement & Facilities Management, Judiciary of Guam, First Floor, 120 West O'Brien Drive, Hagåtña, Guam.

Judiciary of Guam

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JUDICIARY OF GUAM

REQUEST FOR HEALTH PROPOSAL (RFHP) NO. 15-01

FOR

FY2016 GROUP HEALTH INSURANCE PROGRAM

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I. GENERAL INFORMATION

A. Purpose and background

Pursuant to 4 GCA § 4302(c) and Judicial Council of Guam Procurement Regulations Section 2, the Judiciary of Guam is authorized to enter into contracts with and reject proposals from one or more insurance companies for group insurance including but not limited to hospitalization, medical care, life and accident. In connection with such group benefits, the Judiciary of Guam (Judiciary) is accepting proposals from interested and qualified health insurance companies (including health maintenance organizations) licensed under applicable Guam laws, to provide health insurance coverage for eligible Judiciary of Guam employees and their dependents. All health insurance companies must be licensed and comply with all regulatory requirements as promulgated by the Guam Insurance Commissioner, pursuant to the Insurance Law of Guam and other applicable laws.

The intent, pursuant to 4 GCA §4302(c) (as amended by P.L. 31-197), is to present to the Administrator of the Courts a negotiated proposed contract for the requested services. The Administrator of the Courts will then choose to enter into a separate contract for the requested services or not award a contract under this RFHP.

Selection procedures for award of the contract will be guided by the Judicial Council of Guam Procurement Regulations Section 6(G), as amended on May 23, 2013, is attached as **Exhibit L**.

The benefits derived from the executed contract will be offered to active employees and may be offered to retirees of the Judiciary, and their dependents.

Currently, the Judiciary of Guam has two (2) health insurance plans: HSA eligible high deductible health plan ($2000 deductible) and a Preferred Provider Organization (PPO) Plan ($1000 deductible) which both offer an optional dental plan. Both plans are preferred provider organizations. Carriers must refer to the required plan designs and options for the description of FY2015 desired plan designs. PLEASE NOTE! The required plan designs for FY2016 have changed from the FY2015 plans.

There are approximately 400 employees of the Judicial Branch. Approximately 299 employees are current subscribers, who cover an additional 396 dependents, for approximately 695 covered lives. Please refer to enrollment census data for those enrolled in the medical and dental plans listed in Exhibits D.

B. General authority for procurement

The Judiciary is issuing this Request for Health Proposal (RFHP) subject to the procedures set forth in "Requests for Proposal for the Procurement of Health Services," found in the Judicial Council of Guam Procurement Regulations Section 6(G) and 4 GCA 4301(c) which authorizes the Judicial Branch to separately contract for group health insurance.

The Guam Code Annotated (GCA) and the Judicial Council of Guam Procurement Regulations are available on www.guamcourts.org

Nothing in this RFHP or any process carried out pursuant to this RFHP is meant to confer a right to any offeror to be awarded a contract or a right to enter into a contract with the Judiciary.

C. Determination to use competitive selection procedure

The following written determination is required by law prior to the announcement for the need of the services described in this RFHP:

By issuing this RFHP, the Judiciary of Guam has determined (a) that the services to be acquired are a type of service specified in the Judicial Council of Guam Procurement Regulations Sections 2 and 6(G), forrequests for proposals for health care services; (b) that a reasonable inquiry has been conducted on the availability of health care services, and the Judiciary of Guam does not provide this type of service.

D. All parties to act in good faith

Guam Law and the Judicial Council of Guam Procurement Regulations require that all parties involved in the preparation of proposals, the preparation of the RFHP, the evaluation and negotiation of proposals, and the performance or administration of contracts, are to act in good faith.

E. Liability for costs to prepare proposal

The Judiciary of Guam is not liable for any costs incurred by any offeror in connection with the preparation of its proposal. By submitting a proposal, the offeror expressly waives any right it may have against the Judiciary of Guam for any expenses incurred in connection with the preparation of its proposal.

F. Applicability of Judicial Council of Guam Procurement Regulations and Guam Group Benefits Law

If any part of this RFHP is contrary to Judicial Council of Guam Procurement Regulations Sections 2 and 6(G) or Guam Group Benefits Law (4 GCA §§ 4301 – 4308) or contains ambiguous terms, then such portion of the RFHP shall be interpreted or resolved in favor of or according to the provisions of these regulations and laws.

G. Licensing and other statutory requirements

All offerors must comply with Guam laws and procurement regulations and should provide a copy of a current Certificate of Authority issued by the Insurance Commissioner of Guam at the time of proposal submission but not later than prior to award. In the event any risks for accident and health is reinsured or transferred by the offeror to a reinsurance company, the reinsurer that assumes the risk must also have a current Certificate of Authority to transact reinsurance business on Guam. Any offeror that submits a proposal without the required copy of Certificate(s) of Authority and insurance license must submit it prior to award. The requirements of having a Certificate of Authority by an insurance company and insurance licenses shall be continuous and shall be maintained during the period the carrier maintains an insurance service contract with the Judiciary of Guam.

H. Registration as interested party or offeror

The RFHP is available on-line at the Judiciary of Guam's web site at www.guamcourts.org or at the Procurement & Facilities Management Office, Judiciary of Guam, First Floor, 120 West O'Brien Drive, Hagåtña, Guam. Interested parties are cautioned that to participate in this RFHP, registration is required in accordance with instructions described in this RFHP and below.

All parties who received an RFHP packet and who are possibly interested in submitting a proposal must register as an interested party by filling out the "Acknowledgment of Receipt of RFHP" form and delivering it to the Judiciary of Guam. Only registered companies are assured of receiving any amendments from the Judiciary of Guam and responses to inquiries.

I. Restrictions against sex offenders

If a contract is awarded, then the offeror must warrant that no person in its employment who has been convicted of a sex offense under the provisions of Title 9 GCA Chapter 25 or of an offense defined in Title 9 GCA Chapter 28 Article 2, or who has been convicted in any other jurisdiction of an offense with the same elements as heretofore defined, or who is listed on the Sex Offender Registry, shall provide services on behalf of the offeror while on Government of Guam property, with the exception of public highways.

If any employee of an offeror is providing services on Government property and is convicted subsequent to an award of a contract, then the offeror warrants that it will notify the Judiciary of Guam of the conviction within 24 hours of the conviction, and will immediately remove such convicted person from providing services on Government property.

If the offeror is found to be in violation of any of the provisions of this section, then the Judiciary of Guam will give notice to the offeror to take corrective action. The offeror shall take corrective action within 24 hours of such notice, and the offeror shall notify the Judiciary of Guam when action has been taken. If the offeror fails to take corrective steps within 24 hours of notice, then the Judiciary of Guam in its sole discretion may suspend temporarily the contract until corrective action has been taken. The offeror shall indemnify the Judiciary for any costs or expenses resulting from the failure of offeror to take corrective action.

J. Duration of contract

The duration of any contract resulting from this RFHP shall be for one year from October 1, 2015 through September 30, 2016.

K. Confidentiality and proprietary information

Pursuant to the procurement law, after an award of a services contract, the contract and proposal become public record. Proposals that are not awarded a contract remain private and the Judiciary of Guam may not disclose them to the public. The full procurement record also becomes public record, including the proposals of awarded offerors except for those portions designated as confidential. Offerors must identify in their cover letter what items they deem proprietary and/or confidential and request that those items be maintained in confidence in addition to marking those specific items in their proposal. The Judiciary will not be responsible for any disclosure unless willful or grossly negligent.

L. Time is of the essence

The Judiciary of Guam intends for the services requested by the RFHP to go into effect on October 1, 2015. An offeror awarded a contract must file the health insurance policy with the Insurance Commissioner of Guam at least forty-five (45) days prior to the policy's effective date of October 1, 2015 and pay the applicable fees. No health insurance policy or endorsement shall become effective unless filed with the Insurance Commissioner for approval at least forty-five (45) days prior to its effective date. According to Title 22 GCA § 18311, failure to follow this time frame is a crime. Section 18311 provides:

> Any person violating any of the provisions of this article shall be guilty of a misdemeanor, and shall, upon conviction be subject to a fine of not more than one thousand dollars ($1,000.00) if the person convicted is not a natural person, or if the person convicted is a natural person, a fine of not more than five hundred dollars ($500.00) or imprisonment of not more than six (6) months, or both such fine and imprisonment.

Furthermore, the insurance laws prohibit advertisement of any rates unless the rates are filed with the Insurance

Commissioner at least forty-five (45) days prior to the effective date of the rates or the advertisement of the rates, whichever comes first. Persons violating this provision are subject to a civil fine of up to $5,000.00 pursuant to Title 22 GCA § 18504.

Therefore, time is of the essence, and all registered interested parties and potential offerors are asked to keep the applicable laws in mind and to act accordingly. The Judiciary of Guam will provide time frames and deadlines for contract drafting, review and signing by the awarded offeror to allow for timely submissions.

M. Type of contract

The contract to be awarded is a Fixed Price contract.

N. Protest Procedure

Judicial Council of Guam Procurement Regulations Section 10, "Protest," will apply to any protests to this bid:

1. Any aggrieved party who may be aggrieved in connection with the method of source selection, solicitation or award of a contract, and who wishes to pursue a protest shall file a written protest with the Purchasing Officer. The protest shall be submitted in writing within fourteen (14) days after such aggrieved person knew or should have known of the facts giving rise to the protest.

2. The Purchasing Officer shall have the authority to settle and resolve a protest.

3. If the protest is not resolved by mutual agreement, the Purchasing Officer shall issue a decision in writing within thirty (30) days of receipt of the protest. If no written decision has been issued by the Purchasing Officer at the expiration of the thirty (30) day period, such shall be considered an adverse decision.

4. Upon the issuance of an adverse decision by the Purchasing Officer, or upon the Expiration of the thirty (30) day period after filing of the complaint, the aggrieved party may file an action in the Superior Court of Guam for appropriate relief within fourteen (14) days of such adverse decision or expiration of time.

O. Other Information

1. This solicitation may be cancelled as provided for in the Judicial Council of Guam Procurement regulations.

2. Any proposal may be rejected in whole or in part when in the best interest of the Judiciary of Guam in accordance with its procurement regulations.

P. Minimum Wage as Determined by U.S. Department of Labor

The offeror awarded a contract under this solicitation agrees to comply with Title 5 GCA §§ 5801 and 5802. In the event that the offeror employs persons whose purpose, in whole or in part, is the direct delivery of service contracted by the Government, then the offeror awarded a contract under this solicitation shall pay such employees, at a minimum, in accordance with the U.S. Department of Labor Wage Determination for Guam and the Northern Mariana Islands in effect on the date of a contract. In the event that the contract is renewed by the Government, the offeror awarded a contract under this solicitation shall pay such employees in accordance with the Wage Determination for Guam and the Northern Mariana Islands promulgated on a date most recent to the renewal date.

The offeror awarded a contract under this solicitation agrees to provide employees whose purpose, in whole or in part, is the direct delivery of service contracted by the Government those mandated health and similar benefits having a minimal value as detailed in the U.S. Department of Labor Wage Determination for Guam and the Northern Mariana Islands, and guarantee such employees a minimum of ten (10) paid holidays per annum per employee.

The current U.S. Department of Labor Wage Determination for Guam and the Northern Mariana Islands is attached hereto as **Exhibit K**.

Q. Patient Protection and Affordable Care Act Benefits to Continue

It is the intent of this RFHP, and the contract to result from it, to enter into an agreement that provides for all of the benefits, rights and responsibilities afforded as a result of the Patient Protection and Affordable Care Act (PPACA) (U.S. Public Law 111-148), and the regulations promulgated under the authority of the Act.

R. Experience Participation Ratio

Consistent with Guam law, for purposes of any contract entered into as a result of this RFHP, Target Experience means the amount calculated by multiplying (1) the total premiums earned by the Health Insurance Provider for the full twelve (12) month Plan Year ending the last day of the fiscal year under the Participating Policies issued to the Government of Guam with respect to such Plan Year, by (2) **a percentage not lower than eighty-six percent (86%)**; Actual Experience means an amount calculated by subtracting from the Target Experience all claims incurred during such Plan Year by the Health Insurance Provider under all the Participating Policies; and Experience Refund means a positive Actual Experience. See Title 4 GCA §4302.3(g).

II. PROPOSAL CONTENTS, REQUIREMENTS AND INSTRUCTIONS

A. Proposal contents and requirements

All proposals must be in writing and contain the following information in the order listed below:

1. **Cover letter**. Include the name of the offeror, the location of the offeror's principal place of business and type of business. The offeror shall designate a contact person and include his or her address and contact numbers, including e-mail address, if different from the offeror's. The designated person must be knowledgeable to answer any questions asked by the Judiciary of Guam regarding the offeror's proposal. Obligations committed by such signatures must be fulfilled.

2. **Acknowledgment of receipt of amendments**. If the Judiciary of Guam issues any amendments to the RFHP, the offeror must acknowledge receipt of each individual amendment in its cover letter.

3. **Acknowledgement of responses**: If the Judiciary of Guam issues any responses to questions received about the RFHP, the offeror must acknowledge receipt of each individual response in its cover memo.

4. **Description of company**. The offeror must provide a brief description of its company, its capabilities and other information which illustrates to the Judiciary of Guam the level of expertise with which the company can provide the services requested.

5. **Authorized signature**. **Exhibit T** must be signed with the firm name and by an authorized officer, representative, agent, or employee of the offeror. Proof of authority may be requested by the Judiciary of Guam.

6. **Administrative and Marketing Guidelines**. All offerors are required to review and sign the Administrative and Marketing Guidelines and submit such with their proposal. See **Exhibit M**.

7. **Consistency with Judicial Council of Guam Procurement Regulations, Section 6(G)(3)(c), describes the minimum evaluation factors the Judiciary of Guam must evaluate in proposals**. Those minimum factors are:

   (A) the plan for performing the required services to include timelines to conduct the services, and explaining how the services will be performed;
   (B) ability to perform the services as reflected by technical training and education, general experience, specific experience in providing the required services, and the qualifications and abilities of personnel proposed to be assigned to perform the services;
   (C) the personnel, equipment, and facilities to perform the services currently available or demonstrated to be made available at the time of contracting and during the term of any resulting contract;
   (D) number of years offeror's business has been in existence and a record of past performance of similar work; and
   (E) A fair and reasonable price to the Judiciary of Guam for the services to be provided taking into consideration the nature and complexity of the requirements.

All offerors must substantiate their ability to provide the insurance services requested in this RFHP consistent with the minimum factors described in Section 6 (G)(3). See **Exhibit L**.

8. **Financially Stable**. The offeror must demonstrate that it is financially capable to perform the scope of services under the RFHP. At a minimum, a proposal must contain satisfactory responses to the following:
   (A) Each offeror must provide the most recent audited financial statements for the healthcare insurance business only for the underwriting insurance company.
   (B) Each offeror must provide the most recent Annual Statement and Risk-Based Capital Report that has been filed with the National Association of Insurance Commissioners.
   (C) The insurance company or third party administrator must also provide proof that it has errors and omissions insurance that will suitably protect the Judiciary of Guam, or proof in the form of a written statement indicating that it is willing to obtain the errors and omissions insurance.
   (D) If some part or all of the funds of the plan are to be held by an administrator, the administrator must also provide its most recent audited financial statements and proof that it has errors and omissions insurance, or proof in the form of a written statement indicating that it is willing to obtain the errors and omissions insurance.
   (E) Each offeror must also indicate the amount of any payment obligations for eligible services rendered by the Guam Memorial Hospital, other hospitals, physicians, and other health service providers which are outstanding. The information for each must be separate.
   (F) Each offeror must indicate the amount of any potential payment obligations which are unpaid pending utilization review.
   (G) If the offeror contracts with a third party for utilization review services, the offeror must indicate the cost of such services.

9. **Submission of Guam business license**. All offerors, to include reinsurers and underwriters, must submit a copy of a current Guam business license. If a current license or licenses have not been obtained yet, then they must be obtained and copies submitted prior to conclusion of negotiations, and the cover letter must explain that the offeror does not have a current Guam business license or

licenses. If copies of the required business licenses are not submitted by the time and date that all the terms and conditions of a contract are agreed to between the parties, then negotiations shall terminate and the offeror will be disqualified on the basis of being non-responsible.

10. **Submission of cost proposal**. All offerors must submit a cost proposal. Please see **Exhibit N**. All offerors are required to submit fully insured medical and dental premiums and rates at a minimum. This information will be used along with current enrollment information to assist the Judiciary of Guam in analyzing the cost portion of the proposal. To assist with the offeror's preparation of its proposal, the Judiciary of Guam has provided certain information attached to this RFHP and designated as **Exhibits D, E, F, G, H, I, and J**.

11. **Proposed plan design**. Copies of the Judiciary of Guam's desired plan designs and alternatives are included with this RFHP. Offerors must specify in their proposal any component to which they cannot comply and any changes they desire to the proposed plan design. Offerors must execute **Exhibit T** and submit it with their proposal.

12. **Responses to all questions in Exhibit B.** All offerors must answer questions found in **Exhibit B** and attach the responses to their proposal. These answers need to be submitted on the enclosed Microsoft Excel file format provided in the RFHP package, as well as in PDF format, within the formal response.

13. **Submission of disclosure forms**. Guam law requires each offeror to make a number of disclosures. Some of the disclosures are required for an offeror to qualify to submit a bid or a proposal. For the ease of making these required disclosures, the Judiciary of Guam is providing sample disclosure forms. There are six (6) disclosure forms labeled Forms A through F, and they are found in **Exhibit K.** They must be completed and included with the offeror's proposal. Note that a qualified proposal requires submission of only one set of disclosure forms from an offeror. Failure to complete and submit the forms may disqualify the offeror's proposal as being non-responsive.

    (A) **Affidavit Disclosing Ownership and Commissions (Form A).** As a condition of bidding and doing business with the Judiciary of Guam, an offeror must disclose in the form of an affidavit the names of all persons owning more than ten percent of the outstanding interest of the offeror's business during the twelve-month period immediately preceding the date the proposals are due, including the percentage owned by each such person or entity. The affidavit must be made between the date of issuance of this RFHP and the date that proposals are due, so long as the ownership listing mentioned in the affidavit is for the 365-day period preceding the date the offeror submits the proposal.

    The same affidavit must also disclose the identity of anyone who has received or is entitled to receive a commission, gratuity, percentage, brokerage or other compensation or contingent arrangement for procuring a contract with the Judiciary of Guam or for assisting the offeror in obtaining business related to this RFHP, and the value or amounts. Please note that commissions, gratuities, percentages, contingency fees, or other compensation for the purposes stated herein are prohibited by Guam law, except that this prohibition does not apply to fees payable by the offeror upon contracts or sales secured or made through bona fide established commercial or selling agencies maintained by the offeror for the purpose of securing business.

    (B) **Affidavit re Non-Collusion (Form B).** The offeror must represent that the offer is genuine and not a sham and that the offeror is not in collusion with others, that the offeror has not

colluded, conspired, connived or agreed, directly or indirectly, with any other person to put in a sham proposal, to fix the cost of the contract, to secure any advantage against the Judiciary of Guam or any person interested in the contract.

(C) **Affidavit re No Gratuities or Kickbacks (Form C).** The offeror must represent that it has not violated, is not violating, and promises that it will not violate, the prohibition against gratuities and kickbacks set forth in Guam Law. The prohibition is as follows: It is a breach of ethical standards for any person to offer, give, or agree to give any Judiciary of Guam employee or former Judiciary of Guam employee, or for any Judiciary of Guamemployee or former Judiciary of Guam employee to solicit, demand, accept, or agree to accept from another person, a gratuity or an offer of employment in connection with any decision, approval, disapproval, recommendation, preparation of any part of a program requirement or a purchase request, influencing the content of any specification or procurement standard, rendering of advice, investigation, auditing, or in any other advisory capacity in any proceeding or application, request for ruling, determination, claim or controversy, or other particular matter, pertaining to any program requirement or a contract or subcontract, or to any solicitation or proposal thereof. Further, it shall be a breach of ethical standards for any payment, gratuity, or offer of employment to be made by or on behalf of a subcontractor under a contract to the prime contractor or higher tier subcontractor or any person associated therewith, as an inducement of the award of a contract or order.

(D) **Affidavit re Ethical Standards (Form D).** The offeror must represent that it has not knowingly influenced, and promises that it will not knowingly influence, a Judiciary of Guam employee to breach any of the ethical standards set out in Guam's procurement code or regulations pertaining to ethics in public contracting.

(E) **Affidavit re Contingent Fees (Form E).** The offeror must represent as a part of its proposal that such offeror has not retained any person or agency to solicit or secure a Judiciary of Guam contract upon an agreement or understanding for a commission, percentage, brokerage, or other contingent fee or arrangement, except for retention of bona fide employees or bona fide established commercial selling agencies for the purpose of securing business.

(F) **Declaration for Compliance with U.S. DOL Wage Determination (Form F).** Offerors are required to declare in non-affidavit form that they are in compliance with Title 5 GCA § 5801 and § 5802 regarding wage determination, and the current applicable US DOL Wage Determination must be attached to the declaration.

14. Submission of Contract and Certificate of Insurance Changes and Additions. The Judiciary of Guam Group Health Insurance Contract (FY2015) is attached as **Exhibit V**. **PLEASE NOTE: Each offeror is required to submit with its proposal any changes it desires to the proposed contract and to the proposed certificate of insurance.** Without notice of requested changes from an offeror, the Judiciary of Guam will assume and rely upon the proposed contract and the proposed certificate of insurance as the basis of any agreement reached during negotiations. Notwithstanding, the Judiciary of Guam reserves the right to make changes to the language in **Exhibit V**.

B. Proposal instructions

1. Inquiries. All questions regarding this RFHP must be submitted in writing and received by the

Administrator of the Courts, ATTN: Procurement & Facilities Management Division no later than 4:00 P.M., May 18, 2015 Chamorro Standard time. Only potential offerors who have obtained an RFHP and registered may submit written questions. The Judiciary of Guam will not respond to inquiries received after the deadline. Oral statements made by the Judiciary of Guam are not binding. The Judiciary of Guam will respond in writing and send the response via facsimile or electronic mail. Delivery of inquiries to the Judiciary of Guam must be in one of the following forms:

Hand-delivered to:
Administrator of the Courts, ATTN: Procurement & Facilities Management Division
Guam Judicial Center, First Floor
120 West O'Brien Drive
Hagåtña, Guam 96910

Mailed to:
Administrator of the Courts, ATTN: Procurement & Facilities Management Division
120 West OBrien Drive
Hagåtña, Guam 96910

Electronic message (e-mail) to:
mantonio@guamcourts.org

If an inquiry requires an interpretation of the RFHP, then the Judiciary of Guam shall prepare a response in the form of an amendment to the RFHP. All registered interested parties shall be provided the amendment. For responses which merely guide the inquirer, the Judiciary of Guam has the discretion to provide the response to only the inquirer, or to all registered interested parties, depending on the content of the inquiry and response.

2. Sufficiency of proposals. Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective proposal are not desired. Elaborate artwork, expensive visual or other presentations are neither necessary nor desired. The Judiciary of Guam will look instead for the quality of the information provided. The onus will be on the offeror to convince the Judiciary of Guam of the offeror's capability to perform services through the documentation enumerated above in this paragraph. As each offeror will have its own unique operation, its financial ability will be assessed individually based on its audited financial statements, convention form, A. M. Best or similar financial rating report, and reinsurance treaties, as may be applicable. Factors that will be taken into consideration include, but are not limited to, the following:

   (A) Any qualified audit opinion.
   (B) The ratio of current assets to current liabilities.
   (C) Adequacy of reserves.
   (D) Ability to generate underwriting gains.
   (E) History of overall profits or losses.
   (F) A. M. Best or similar financial rating report.
   (G) Reinsurance.
   (H) Experience in health insurance or HMO underwriting.
   (I) Experience in Third Party Administration.
   (J) Risk-based capital report.

3. Multiple representations of an insuring company. For the purposes of negotiating the costs and

contractual terms, the insurance company shall designate a company representative who shall have full authority to make plan design and rating decision at the negotiation table on behalf of the company.

4. Late proposals. No proposal will be accepted after the deadline for submitting proposals. If a proposal is delivered to the Judiciary of Guam after the deadline for submission, it will be time-stamped and dated by the Judiciary of Guam. However, late proposals are considered non-responsive and will not be considered by the Judiciary of Guam.

5. Form and number of proposals. Each offeror shall prepare an original and six (6) hard copies of its proposal. Handwritten proposals are not acceptable. Each proposal must be organized, fully assembled and complete. Offerors are required to submit electronic copies of all required documents in CD format and in Excel format where required in addition to the hard copies.

6. Where and how to submit proposals. Proposal packages must be sealed and mailed or delivered to the following names and addresses. The Judiciary of Guam is not responsible for any delivery costs or postage due. Proposals will not be accepted via facsimile or electronic mail (email) as these formats do not allow for the proposal to be sealed or submitted in an original form with multiple copies as required by law. Proposals should be marked "confidential."

   The original and six (6) copies shall be sent to:
   Hand-delivered to:
   Administrator of the Courts, ATTN: Procurement & Facilities Management Division
   Guam Judicial Center, First Floor
   120 West O'Brien Drive
   Hagåtña, Guam 96910

   Mailed to:
   Administrator of the Courts, ATTN: Procurement & Facilities Management Division
   120 West O'Brien Drive
   Hagåtña, Guam 96910

7. Due date and time for proposals. All hard copies of proposals, including a printed copy of the Excel file, must be received by the Administrator of the Courts, Procurement & Facilities Management Division **no later than 2:00 P.M., May 26, 2015, Chamorro Standard Time**. Hard copies of the entire proposal (including hard copies of the Questionnaire and Pricing portions) must be received by this due date and will be the determining factor for the purpose of timely submission. Hard copy of proposals received after this time and date will not be accepted.

   Completed proposals must be in both Excel and PDF formats.

   Please note that Guam is UTC/GMT +10 hours, or 17 hours ahead of Pacific Daylight Time. The offeror is responsible for submitting the proposals in a timely manner regardless of choice of delivery method. The offeror's transfer of its proposal to a U.S. Post Office or to a delivery company does not constitute receipt by the Judiciary of Guam.

III. GENERAL PROCEDURES

A. Receipt and registration of proposals

Proposals (both electronic and hard copies) and modifications to proposals will be time-stamped upon receipt and held in a secure place until the established due date. The Judiciary of Guam will keep a Register of Proposals Received identifying the proposals, the names of the offerors, and the number of modifications received, if any, by each offeror. The Register is not open for public inspection until after award of a contract. Proposals of offerors not awarded contracts do not become public records.

B. Opening of proposals

After the deadline for submission of proposals and as soon as practical, the proposals will be unsealed by at least two authorized Judiciary of Guam representatives who shall be procurement administrators for purposes of this RFHP as assigned by the Administrator of the Courts. They shall at all times conduct the administration of this procurement together in the presence of each other. Proposals will not be opened publicly, nor disclosed to unauthorized persons.

C. Proposal evaluation and discussion procedure

Evaluation procedures are guided by the Judiciary of Guam Procurement Regulations Section 6(G) and the RFHP contract. Should there be a question or conflict with the instructions below and the Judiciary of Guam Procurement Regulations, the Regulations shall prevail.

1. The Judiciary will review all proposals prior to beginning of discussions and classify them into one of three categories (Acceptable, Potentially Acceptable and Unacceptable). Proposals determined to be unacceptable will be removed from consideration and the Offerors will be notified promptly.

2. The Judiciary will prepare a list of discussion items based on review of the proposals for each proposal submitted. Proposals initially categorized as "Potentially Acceptable" must be made to address all items of concerns, issues, details, clarifications, etc., that led to their proposal being categorized as Potentially Acceptable.

3. Discussions may be conducted with each offeror separately to promote an understanding of the Judiciary's requirements and the offeror's proposal that would facilitate arriving at a contract that will be most advantageous to the Judiciary taking into consideration price and other evaluation factors set forth in the RFHP.

4. Modification, withdrawal, confirmation, and mistakes in proposals shall be governed by Judiciary of Guam Procurement Regulations 6(G)(3)(a)(5).

5. The Purchasing Officer shall establish a common date and time for the submission of best and final offers. Best and final offers shall be submitted only once; provided, however, the Purchasing Officer may make a written determination that it is in the Judiciary's best interest to conduct additional discussions or change the Judiciary's requirements and require another submission of best and final offers. Otherwise, no discussion of or changes in the best and final offers shall be allowed prior to award. Offerors are advised that if they do not submit a notice of withdrawal or another best and final offer, their immediate previous offer will be construed as their best and final offer.

6. Upon receipt of best and final offers the Judiciary will evaluate the best and final offers based on the criteria shown below along with their assigned points. A more detailed breakdown for assigning points to each criterion can be viewed at **Exhibit C** (Request for Proposal Evaluation Procedure and Evaluation Form). The proposal that receives the highest number of total points will be recommended to the Administrator of the Courts for award.

EVALUATION CRITERIA	POINTS
Part 1	**30**
-Plan design features -Rating methodology, including trends -Administrative loading -Provider reimbursement methodology and processes -Claim reserve policies and calculation methodology -Prompt payment to providers -Marketing cost, open enrollment strategies -Value added features specific to Vendor -Provider network, disruption to current Judiciary network -Usual and Customary definition and application -Performance guarantee proposal -Guaranteed discount rates -Disease Management and Wellness Incentive Program -Fully insured plan for Medicare eligible retirees	
Part 2	**30**
-Customer service office on Guam -Administrative ability to process transactions -Online access to information and services -Claims payment procedures and fraud detection ability -Reporting capabilities -Coordination of benefits process -Emergency benefit payment policies -Off island referral process and eligibility -Financial stability of Vendor -Organization structure and experience of key personnel -Number of lives insured	
Part 3	**40**
Price. A fair and reasonable price to the Judiciary of Guam for the services to be provided taking into consideration the nature and complexity of the requirements.	
Total Points:	**100**

7. The Administrator of the Courts shall make a written determination showing the basis on which the award was found to be most advantageous to the Judiciary.

   After a contract award is entered into, notice of award shall be posted in the Administrator of the Courts office and the Judiciary's website.

D. Cancellation of RFHP or solicitation

The Judiciary of Guam may cancel this RFHP or solicitation, in whole or in part, at any time, or may reject all proposals so long as the Judiciary of Guam makes a written determination that doing so is in the best interest of the Judiciary of Guam and a contract has not yet been fully signed. In the event of cancellation or rejection of all proposals, proposals that have been unsealed shall remain the property of the Judiciary of Guam and not returned to the respective offerors. A proposal that has not been unsealed (such as late proposals) will be returned to the offeror upon request of the offeror.

E. Rejection of individual proposals

The Judiciary of Guam shall have the prerogative to reject proposals in whole or in part when doing so is in the best interest of the Judiciary of Guam as provided for in the Judicial Council of Guam Procurement Regulations.

_____
JOSHUA F. TENORIO
Administrator of the Courts
Judiciary of Guam

Date: _____

EXHIBIT A

Proposal Review Checklist

YES	NO	Description
		1) All components of the proposal received within the timeframe
		2) Offeror registered as an interested party by submitting the "Acknowledgement of Receipt of RFP" within timeframe
		3) Cover letter w/authorized signature, name of offeror location, type of business, and designated person with contact information.
		4) Original with 6 numbered copies and printed copy of Excel file delivered to the Judiciary of Guam.
		5) Acknowledgement of Amendments issued, if any.
		6) Acknowledgement of questions and responses issued, if any.
		7) Description of company, capabilities, level of expertise the company can provide.
		8) Current Certificate of Authority for insurer.
		9) Current Certificate of Authority for reinsurer.Submitted copy of the reinsurance agreement or reinsurance treaty that transfers the risks for accident and health insurance.
		10) If Offeror marked any item as confidential: • If Negotiating Team does not agree, Negotiating Team must issue written determination explaining its position. • Offerors must identify the items deemed as proprietary or trade secret as confidential in their cover letter and in the proposal.
		11) Signed and executed exhibits: • Exhibit B (Questions for Offerors), hard copy and CD
		• Exhibit K(Disclosure Affidavits) with original seal: _____ Form A: Disclosing Ownership and Commissions. The affidavit must be made between the date of issuance of this RFP and the date that proposals are due. _____ Form B: Non-Collusion _____ Form C: No Gratuities and Kickbacks _____ Form D: Ethical Standards _____ Form E: Contingent Fees _____ Form F: Declaration for Compliance with U.S. DOL Wage Determination, with current Wage Determination attached.
		• Exhibit M (Marketing Guidelines)
		• Exhibit N (Premium and Retention Quotation), hard copy and CD
		• Exhibit O (Reporting Guidelines)
		• Exhibit T (Statement that Plan Designs Are Consistent In All Material Respects with RFHP)

EXHIBIT B

Questions for Offerors

1. Detail any additional plan design features (not already included in this request) and their cost differentials which you feel would increase the benefit value of the current FY2015 Judiciary of Guam health care plans with minimal cost increase.

2. What type of rating do you propose for the Judiciary of Guam in FY2016: 100% Community Rating by Class (CRC), 100% Experience Rating (ACR) or a blended CRC/ACR Rating? If a blended rating please provide the percentages for the CRC and ACR components and the criteria used to determine the percentages. Clearly explain in detail the rating methods you are proposing.

3. How do you calculate your medical trend factors? What components are considered and used for your calculations? What are your current published and experience trends?

4. How will you reimburse non-participating providers of medical care? At a minimum, your answer should separately address reimbursements to hospitals, physicians, pharmacies, and off-island providers.

5. Are your IBNR reserves actuarially certified? If yes, provide the name of the individual responsible for certification and his/her credentials.

6. What is your average claims payment lag for your medical/PPO book of business?

    a. On Guam?
    b. Outside of Guam?

7. Are there any other charges other than rates, i.e. marketing costs, printing costs, site meetings, etc., assessed to the Judiciary of Guam?

8. Describe how you would assist the Judiciary of Guam in communicating your plan to its employees. Describe how you will assist the Judiciary of Guam with the open enrollment process.

9. Explain how the Judiciary of Guam would benefit by contracting with your company.

10. Provide a list of all participating network providers by specialty area and facility type on Guam, the Philippines, Hawaii and the U.S. Mainland that will be available to Judiciary of Guam employees, including centers of excellence and their specialties. If applicable, add a link to all your network providers.

    a. Please provide current list of your contracted providers and explain how any changes to the provider network are communicated to subscribers and dependents.
    b. Please describe how your benefit plan coverage is communicated to participating providers.

11. How do you define usual, customary and reasonable (UCR) charges? How do you assign UCR values on Guam? How do you assign UCR values to different geographic areas? How frequently are your UCR charges updated?

12. Under what circumstances do you apply usual, customary and reasonable charges? Please provide clear and detailed examples, including calculations of a facility claim and a physician claim applying UCR charges as defined in each plan proposed.

13. How are your rates impacted by enrollment threshold? For example, will rates, retention, etc. change with the number of lives in the plan?

14. Disruption Report: A list of the top 50 utilized providers by Judiciary employees is included as **Exhibit R**. Please provide a network disruption analysis based on the availability of these providers in your network.

15. Provide and define in detail your performance standards for which your will provide a guarantee subject to financial penalty. Include a description of the reporting format which measures these standards.

16. Will you provide a guaranteed overall provider discount rate? Please provide details of any guarantee and the penalty for non-compliance.

17. Offerors must provide a proposal that includes a Disease Management and Wellness Incentive Program. The Judiciary of Guam has a legal requirement, pursuant to 4 GCA §4301, to provide an incentive program that promotes wellness, promotes primary care and preventive care, and manages and coordinates care for persons with chronic health conditions or acute illness. See **Exhibit U** for additional requirements. Please provide in detail your proposal for all of these services as well as how each will be administered.

18. If awarded the contract, will you have a customer service office on Guam?

19. Provide references of three other employers for whom services similar in scope, size or discipline to the required services have been provided by the offeror. The response to this question should be limited to the name, address, contact person, and telephone number(s) of each reference.

20. Provide the name of the insurance company or companies, including reinsurers, through which this policy will be underwritten. Provide proof that all such insurance companies underwriting the risks are licensed to do business on Guam pursuant to the Insurance Laws of Guam. If any part of the plan would be reinsured, please provide a copy of the face sheet to the reinsurance agreement.

21. The offeror must demonstrate that it has the organizational and technological structure necessary to perform the claim processing and administrative required services. Insurance companies and administrators, if applicable, must submit documentation that there exists an adequate mechanism for maintaining records on enrollees. Demonstrate that there exists an effective program for containing costs for medical services (i.e. Disease Management program administered by the carrier/vendor), hospital confinement, and any other benefits that shall be provided. The Judiciary of Guam requires detailed claim information be remitted to them and their consultants on a monthly basis. Please refer to **Exhibit P** for a list of data requirements.

22. The offeror must demonstrate its experience and expertise in providing the required services.

    a. Describe claim paying procedures including review of questionable claims and internal fraud controls.
    b. Indicate the location where claims incurred under the proposed contract would be processed.
    c. Provide samples of utilization and claims reports, enrollment reports, premium payment reports, large claim reports, and any other reports you can produce which may be of benefit to the Judiciary of Guam in assessing the experience of the plan. Describe custom reporting capabilities, indicating whether the Judiciary of Guam will have the ability to create reports using an online tool. In the situation where a special data request cannot be fulfilled using an online data tool, will you generate a special report for the Judiciary of Guam – at what cost? And how quickly could the report be available?

d. Provide responses to the following questions about your company's online website/portal:

   i. Is accessible online 24 hours a day, 7 days a week?
   ii. Coordinates and authorizes pre-certification for covered persons and providers?
   iii. Allows covered person access to Patient Health Record?
   iv. Allows covered person access to individual medical, dental and drug claims?
   v. Allows providers to verify eligibility?
   vi. Allows covered person to submit deductible claims and claims eligible for reimbursement?
   vii. Allows providers to submit claims for payment?
   viii. Allows employer group enrollment and disenrollment?
   ix. Allows covered persons and providers to download Schedules of Benefits, Member Handbooks and Provider Network information?

e. Demonstrate that a mechanism exists for coordinating benefits when a person is insured by more than one health insurance plan for the same condition.

23. The offeror must provide a fully-insured but participating contract rate quote for the current plans and the individually requested benefits in **Exhibit G**. Please refer to Section I. R. Experience Participation Ratio under General Information.

24. The offeror must outline its plan for performing the required services.

    a. Describe the manner in which you propose to handle medical costs and services on-island.
    b. Also, the manner in which you propose to handle medical costs and services in the event of an accident or illness which occurs while off-island.
    c. Further, describe your practice for sending enrolled members off-island for evaluation and treatment not obtainable on Guam.

25. The offeror must show evidence of the ability of the personnel of the principal insurance company and its local agent, if any, to perform the services required. The technical training, education, experience, and the qualifications and abilities of personnel proposed to be assigned to perform the services should be included.

26. Provide a detailed organizational chart that includes all personnel to be assigned to this project.

27. Provide the offeror's most recent financial rating status for the following rating agencies: A.M. Best, Standard & Poor's, Fitch, and Moody's. If the offeror's financial rating has changed within the past 12 months for any of the rating agencies, indicate the new rating and the date received. If the rating has not changed within the past 12 months, please indicate.

28. For how many enrollees do you provide medical and/or dental coverage other than for the Government of Guam and the Judiciary of Guam?

EXHIBIT C

Request for Health Proposal Evaluation Procedure and Evaluation Form

Evaluation procedures are guided by the Judiciary of Guam Procurement Regulations Section 6(G) and the RFHP contract. Should there be a question or conflict with the instructions below the Judiciary of Guam Procurement Regulations shall prevail/supersede.

1. The Judiciary will review all proposals prior to beginning of discussions and classify them into one of three categories (Acceptable, Potentially Acceptable and Unacceptable). Proposals determined to be unacceptable **will be removed** from consideration and the offerors will be notified promptly.

2. The Judiciary will prepare a list of discussion items based on review of the proposals for each proposal submitted. Proposals initially categorized as "Potentially Acceptable" must be made to address all items of concerns, issues, details, clarifications, etc., that led to their proposal being categorized as Potentially Unacceptable.

3. Discussions may be conducted with each offeror separately to promote an understanding of the Judiciary's requirements and the offeror's proposal that would facilitate arriving at a contract that will be most advantageous to the Judiciary taking into consideration price and other evaluation factors set forth in the RFHP.

4. Modification, withdrawal, confirmation, and mistakes in proposals shall be governed by Judiciary of Guam Procurement Regulations 6(G) (3)(a)(5).

5. The Purchasing Officer shall establish a common date and time for the submission of best and final offers. Best and final offers shall be submitted only once; provided, however, the Purchasing Officer may make a written determination that it is in the Judiciary's best interest to conduct additional discussions or change the Judiciary's requirements and require another submission of best and final offers. Otherwise, no discussion of or changes in the best and final offers shall be allowed prior to award. Offerors are advised that if they do not submit a notice of withdrawal or another best and final offer, their immediate previous offer will be construed as their best and final offer.

6. Upon receipt of best and final offers the Judiciary will evaluate the best and final offers based on the criteria shown below along with their assigned points. A more detailed breakdown for assigning points to each criterion can be viewed further in this exhibit, Request for Health Proposal Evaluation Form Parts 1-3. The proposal that receives the highest number of total points will be recommended to the Administrator of the Courts for award.

EVALUATION CRITERIA	POINTS
Part 1	**30**
-Plan design features -Rating methodology, including trends -Administrative loading -Provider reimbursement methodology and processes -Claim reserve policies and calculation methodology -Prompt payment to providers -Marketing cost, open enrollment strategies -Value added features specific to Vendor -Provider network, disruption to current Judiciary network -Usual and Customary definition and application -Performance guarantee proposal -Guaranteed discount rates -Disease Management and Wellness Incentive Program -Fully insured plan for Medicare eligible retirees	
Part 2	**30**
-Customer service office on Guam -Administrative ability to process transactions -Online access to information and services -Claims payment procedures and fraud detection ability -Reporting capabilities -Coordination of benefits process -Emergency benefit payment policies -Off island referral process and eligibility -Financial stability of Vendor -Organization structure and experience of key personnel -Number of lives insured	
Part 3	**40**
Price. A fair and reasonable price to the Judiciary of Guam for the services to be provided taking into consideration the nature and complexity of the requirements.	
Total Points:	**100**

7. The Administrator of the Courts shall make a written determination showing the basis on which the award was found to be most advantageous to the Judiciary.

   After a contract award is entered into, notice of award shall be posted in the Administrator of the Courts office and the Judiciary's website.

EXHIBIT C (continued)

Proposal Evaluation Form - Part 1 (30%)

This Evaluation Form is Only a Sample

All offerors must answer questions found in Exhibit C, Parts 1, 2 and 3. These answers need to be submitted on the Excel format provided in the RFP package, as well as in PDF format, within the formal response.

Rater No.:_____ Date:_____

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
0 - 5	1. Detail any additional plan design features (not already included in this request) and their cost differentials which you feel would increase the benefit value of the current FY2015 Judiciary of Guam health care plans with minimal cost increase.	1						
0 - 5	2. What type of rating do you propose for the Judiciary of Guam in FY2016: 100% Community Rating by Class (CRC), 100% Experience Rating (ACR) or a blended CRC/ACR Rating? If a blended rating please provide the percentages for the CRC and ACR components and the criteria used to determine the percentages. Clearly explain in detail the rating methods you are proposing.	1						
0 - 5	3. How do you calculate your medical trend factors? What components are considered and used for your calculations? What are your current published and experience trends?	1						

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
0 - 5	4. How will you reimburse "Non-par" providers of medical care? At a minimum, your answer should separately address reimbursements to hospitals, physicians, pharmacies, and off-island providers.	1						
0 - 5	5. Are your IBNR reserves actuarially certified? If yes, provide the name of the individual responsible for certification and his/her credentials.	1						
0 - 5	6. What is your average claims payment lag for your medical/PPO book of business? a) On Guam? b) Outside of Guam?	1						
0 - 5	7. Are there any other charges other than rates, i.e. marketing costs, printing costs, site meetings, etc., assessed to the Judiciary of Guam?	1						
0 - 5	8. Describe how you would assist the Judiciary of Guam in communicating your plan to its employees. Describe how you will assist the Judiciary of Guam with the open enrollment process.	1						
0-5	9. Explain how the Judiciary of Guam would benefit by contracting with your company.	1						

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
0-5	10. Provide a list of all participating network providers by specialty area and facility type on Guam, the Philippines, Hawaii and the U.S. Mainland that will be available to Judiciary of Guam employees, including centers of excellence and their specialties. If applicable, add a link to all your network providers. (a) Please provide current list of your contracted providers and explain how any changes to the provider network are communicated to subscribers and dependents.(b) Please describe how your benefit plan coverage is communicated to participating providers.	1						
0 - 5	11. How do you define usual, customary and reasonable (UCR) charges? How do you assign UCR values on Guam? How do you assign UCR values to different geographic areas? How frequently are your UCR charges updated?	1						
0 - 5	12. Under what circumstances do you apply usual, customary and reasonable charges? Please provide clear and detailed examples, including calculations of a facility claim and a physician claim applying UCR charges as defined in each plan proposed.	1						
0 - 5	13. How are your rates impacted by enrollment threshold? For example, will rates, retention, etc. change with the number of lives in the	1						

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
	plan?							
0 - 5	14. Disruption Report: A list of the top 50 utilized providers by Judiciary employees is included as Exhibit R. Please provide a network disruption analysis based on the availability of these providers in the Vendor's network.	2						
0 - 5	15. Provide and define in detail your performance standards for which you will provide a guarantee subject to financial penalty. Include a description of the reporting format which measures these standards.	1						
0 - 5	16. Will you provide a guaranteed overall provider discount rate? Please provide details of any guarantee and the penalty for non-compliance.	1						
0 - 5	17. Offerors must provide a proposal that includes a Disease Management and Wellness Incentive Program. The Judiciary of Guam has a legal requirement, pursuant to 4 GCA §4301, to provide an incentive program that promotes wellness, promotes primary care and preventive care, and manages and coordinates care for persons with chronic health conditions	2						

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
	or acute illness. See Exhibit U for additional requirements. Please provide in detail your proposal for all of these services as well as how each will be administered.							
	Cumulative Relative Total	19						
	Weight of Part 1	30%		X 30%		X 30%		X 30%
	Total Weighted Points							

EXHIBIT C (continued)

Proposal Evaluation Form - Part 2 (30%)

This Evaluation Form is Only a Sample

All offerors must answer questions found in ExhibitC, Parts 1, 2 and 3. These answers need to be submitted on the Excel format provided in the RFP package, as well as in PDF format, within the formal response.

Rater No.:_____ Date:_____

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
0 – 5	1. If awarded the contract, will you have a customer service office on Guam?	1						
N/A	2. Provide references of three other employers for whom services similar in scope, size or discipline to the required services have been provided by the offeror. The response to this question should be limited to the name, address, contact person, and telephone number(s) of each reference.	N/A						
N/A	3. Provide the name of the insurance company or companies, including reinsurers, through which this policy will be underwritten. Provide proof that all such insurance companies underwriting the risks are licensed to do business on Guam pursuant to the Insurance Laws of Guam. If any part of the plan would be reinsured, please provide a copy of the face sheet to the reinsurance agreement.	N/A						
0 – 5	4. The offeror must demonstrate that it has the organizational and technological structure necessary to perform the claim processing and administrative required services. Insurance companies and administrators, if applicable, must submit	1						

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
	documentation that there exists an adequate mechanism for maintaining records on enrollees. Demonstrate that there exists an effective program for containing costs for medical services (i.e. Disease Management program administered by the carrier/vendor), hospital confinement, and any other benefits that shall be provided. The Judiciary of Guam requires detailed claim information be remitted to them and their consultants on a monthly basis. Please refer to Exhibit P for a list of data requirements.							
N/A	5. The offer must demonstrate its experience and expertise in providing the required services.	N/A						
0 – 5	a. Describe claims paying procedures including review of questionable claims and internal fraud controls.	1						
N/A	b. Indicate the location where claims incurred under the proposed contract would be processed.	N/A						
0 - 5	c. Provide samples of utilization and claims reports, enrollment reports, premium payment reports, large claim reports, and any other reports you can produce which may be of benefit to the Judiciary of Guam in assessing the experience of the plan. Describe custom reporting capabilities, indicating whether the Judiciary of Guam will have the ability to create reports using an online tool. In the situation where a special data request cannot be fulfilled using an online data tool, will you generate a special report for the Judiciary of Guam – at what cost? And how quickly could the report be available?	2						

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
0 - 5	d. Provide responses to the following questions about your company's online website/portal: (i) Is accessible online 24 hours a day, 7 days a week? (ii) Coordinates and authorizes pre-certification for covered persons and providers? (iii) Allows covered person access to Patient Health Record? (iv) Allows covered person access to individual medical, dental and drug claims? (v) Allows providers to verify eligibility? (vi) Allows covered person to submit deductible claims and claims eligible for reimbursement? (vii) Allows providers to submit claims for payment? (viii) Allows employer group enrollment and disenrollment? (ix) Allows covered persons and providers to download Schedules of Benefits, Member Handbooks and Provider Network information?	2						
0 - 5	e. Demonstrate that a mechanism exists for coordinating benefits when a person is insured by more than one health insurance plan for the same condition.	1						

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
0 - 5	6. The offeror must provide a fully-insured but participating contract rate quote for the current plans and the individually requested benefits in Exhibit G. Please refer to Section R. Experience Participation Ratio under General Information.	1						
N/A	7. The offeror must outline its plan for performing the required services.	N/A						
0 - 5	a. Describe the manner in which you propose to handle medical costs and services on-island.	1						
0 - 5	b. Also, the manner in which you propose to handle medical costs and services in the event of an accident or illness which occurs while off-island.	1						
0 - 5	c. Further, describe your practice for sending enrolled members off-island for evaluation and treatment not obtainable on Guam.	1						
0 - 5	8. The offeror must show evidence of the ability of the personnel of the principal insurance company and its local agent, if any, to perform the services required. The technical training, education, experience, and the qualifications and abilities of personnel proposed to be assigned to perform the services should be included.	1						

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
0 - 5	9. Provide a detailed organizational chart that includes all personnel to be assigned to this project.	1						
0 - 5	10. Provide the offeror's most recent financial rating status for the following rating agencies: A.M. Best, Standard & Poor's, Fitch, and Moody's. If the offeror's financial rating has changed within the past 12 months for any of the rating agencies, indicate the new rating and the date received. If the rating has not changed within the past 12 months, please indicate.	1						
0 - 5	11. For how many persons do you provide medical and/or dental coverage other than for the Judiciary of Guam?	1						
	Cumulative Relative Total	16						
	Weight of Part 1	30%		x 30%		x 30%		x 30%
	Total Weighted Points							

EXHIBIT C (continued)

Proposal Evaluation Form - Part 3 (40%)

This Evaluation Form is Only a Sample

All offerors must answer questions found in Exhibit C, Parts 1, 2 and 3. These answers need to be submitted on the Excel format provided in the RFP package, as well as in PDF format, within the formal response. Costs will be evaluated by the Judiciary of Guam Evaluation Committee. This portion is worth 30% of the total score.

Process for evaluation of costs:

1. For each plan requested, the total annual premium will be evaluated on a scale of 0 to 5.The total annual premium will be provided by each bidder. The annual premium will be determined by the quoted insured premiums times the current enrollment figures times 12. The lowest cost for each item will receive the highest score from each evaluator, the next lowest cost will receive the second highest score from each evaluator, etc.
2. For each alternative plan design component requested, the cost impact will be evaluated on a scale of 0 to 5. The total annual cost will be determined in the same manner as noted above for fully insured plans. The lowest cost for each item will receive the highest score from each evaluator, the next lowest cost will receive the second highest score from each evaluator, etc.
3. In the event that there are greater than six (6) offerors to be evaluated, the "possible POINTS" will be increased so that there are a correct number of integers with which to score.

Rater No.:_____ Date:_____

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
0 - 10	1. Proposed FY15 PPO1000 deductible plan: evaluation for total annual premium	10						
0 - 5	2. Proposed FY15 HSA2000 deductible plan: evaluation for total annual premium.	4						
0 - 5	3. Dental plan: evaluation for total annual premium.	2						
	4. Provide the percentage of guaranteed							

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
	retention for the following fully insured, but participating, contracts: (The lowest retention would receive the highest score.)							
0 - 5	a) PPO1000	0.9						
0 - 5	b) HSA2000	0.9						
0 - 5	c) Dental	0.2						
	5. Alternative Plan Design: Proposal for the same plan details as the proposed FY15 PPO1000 plan, but with a $750 annual individual deductible and $1,500 annual family deductible – all other plan details remain the same.	1						
0 - 5	6. Alternative Plan Design: Proposal for the same plan details as the proposed FY15 PPO1000 plan, but with a $500 annual individual deductible and $1,000 annual family deductible – all other plan details remain the same	1						
	7. Alternative Plan Design: Proposal for the same plan details as the Proposed FY15 PPO1000 and HSA2000 plans but with organ transplant coverage for heart, liver, lung, pancreas, intestinal, bone marrow, cornea, and kidney.							
0 - 5	a) PPO1000 (1000/2000)	0.5						
0 - 5	b) HSA2000 (2000/4000)	0.5						

POSSIBLE POINTS		RELATIVE WEIGHT	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL	EVALUATOR SCORE	RELATIVE TOTAL
		(A) X	(B) =	(C)	(B) =	(C)	(B) =	(C)
			OFFEROR:		**OFFEROR:**		**OFFEROR:**	
	8. Alternative Plan Design: Proposal for the same plan details as the Proposed FY15 PPO1000 and HSA2000 plans but with a combined in-network and out-of-network deductible where out-of-network claims accumulate at the in-network reimbursement rate for the same procedure.							
0 - 5	a) PPO1000 (1000/2000)	0.5						
0 - 5	b) HSA2000 (2000/4000)	0.5						
	9. Impact of removing the limitation that results in the suspension of coverage after 90 days outside the coverage area. Vendors must be clear exactly how proposed rates will be impacted or what the new rates will be		-	-	-	-	-	-
0 - 5	a) PPO1000 (1000/2000)	0.5	-	-	-	-	-	-
0 - 5	b) HSA2000 (2000/4000)	0.5	-	-	-	-	-	-
	Cumulative Relative Total	23						
	Weight of Part 1	40%		x 40%		x 40%		x 40%
	Total Weighted Points							

SCORING	TOTAL POINTS
Part 1 Total Weighted Points	
Part 2 Total Weighted Points	+
Part 3 Total Weighted Points	+
Cumulative Total Weighted Points	=

Only for initial ranking: total premiums will be reduced by 4% Business Privilege Tax (BPT) for those organizations not benefiting from a BPT abatement.

EXHIBIT C (continued)

Proposal Evaluation Form

Evaluation Summary Worksheet

Total points earned by individual offeror

Offerors	Part 1	Part 2	Part 3	Total:
Offeror #1				
Offeror #2				
Offeror #3				
Offeror #4				
Offeror #5				

Recommended firm based on evaluation factors (Firm with the highest number of points):

Name of Firm: _____

_____

Chairperson, Evaluation Committee

Attachments:

All Evaluation Sheets

Certification:

_____

Marissa C. Antonio, Asst. Procurement Administrator

EXHIBIT D

Judiciary of Guam FY2015 Medical and Dental Insurance Rates

PPO 1000

CLASS		MONTHLY TOTAL COST	MONTHLY EMPLOYEE RATE	MONTHLY EMPLOYER RATE	EMPLOYEE AMT	EMPLOYER AMT.	TOTAL
Class I	Employee	$209.86	$45.20	$164.66	$20.86	$76.00	$96.86
Class II	Employee + Spouse	$461.69	$159.60	$302.09	$73.66	$139.43	$213.09
Class III	Employee & Children	$377.75	$115.59	$262.16	$53.35	$121.00	$174.35
Class IV	Employee & Family	$629.58	$232.01	$397.57	$107.08	$183.50	$290.58

HSA 2000

CLASS		MONTHLY TOTAL COST	MONTHLY EMPLOYEE RATE	MONTHLY EMPLOYER RATE	EMPLOYEE AMT	EMPLOYER AMT.	TOTAL
Class I	Employee	$105.85	$7.41	$98.44	$3.42	$45.43	$48.85
Class II	Employee + Spouse	$232.87	$73.60	$159.27	$33.97	$73.51	$107.48
Class III	Employee & Children	$190.53	$58.39	$132.14	$26.95	$60.99	$87.94
Class IV	Employee & Family	$317.55	$112.00	$205.56	$51.69	$94.87	$146.56

DENTAL

CLASS		MONTHLY TOTAL COST	MONTHLY EMPLOYEE RATE	MONTHLY EMPLOYER RATE	EMPLOYEE AMT	EMPLOYER AMT.	TOTAL
Class I	Employee	$30.96	$13.85	$17.12	$6.39	$7.90	$14.29
Class II	Employee + Spouse	$68.11	$47.84	$20.27	$22.08	$9.36	$31.44
Class III	Employee & Children	$55.73	$39.07	$16.67	$18.03	$7.69	$25.72
Class IV	Employee & Family	$92.88	$64.59	$28.29	$29.81	$13.06	$42.87

EXHIBIT E

Additional information will be provided at a later date. Interested parties should register no later than May 13, 2015 to ensure that they receive any updated information related to this Request for Health Proposal.

ENROLLMENT DATA (employee count only)
ENROLLMENT AS OF MARCH 2015

	PPO1000	HSA2000	Dental
Class I	104	40	131
Class II	18	6	22
Class III	21	5	26
Class IV	85	24	107
Total	228	75	286

Exhibit E (continued)

ENROLLMENT DATA

JUDICIARY OF GUAM HEALTH INSURANCE PROGRAM										
MEDICAL & DENTAL	SUBSCRIBER & MEMBER MONTHS									
	PLTYPE	PLAN	SINGLE	2PARTY	SUBCHILD	FAMILY	TOTAL SUBSCRIBER MONTHS	TOTAL MEMBER MONTHS	AVG. CONTRACT SIZE	AVG. FAMILY SIZE
12 MONTHS FY2014										
	M	HSA2000	673	98	168	200	1,139	2,220	1.95	3.67
	M	PPO1000	978	146	689	455	2,268	5,537	2.44	3.73
			1,651	244	857	655	3,407	7,757	2.28	3.72
	D		1,482	214	836	598	3,130	7,282	2.33	3.75
6 MONTHS FY2015										
	M	HSA2000	233	35	33	144	445	963	2.16	3.73
	M	PPO1000	609	105	131	508	1,353	3,217	2.38	3.75
			842	140	164	652	1,798	4,180	2.32	3.75
	D		763	128	164	640	1,695	4,041	2.38	3.76

JUDICIARY OF GUAM HEALTH INSURANCE PROGRAM										
MEDICAL & DENTAL	AVERAGE SUBSCRIBER & MEMBER MONTHS									
	PLTYPE	PLAN	SINGLE	2PARTY	SUBCHILD	FAMILY	AVERAGE SUBSCRIBER MONTHS	AVERAGE MEMBER MONTHS	AVG. CONTRACT SIZE	AVG. FAMILY SIZE
12 MONTHS FY2014										
	M	HSA2000	56	8	14	17	95	185	1.95	3.65
	M	PPO1000	82	12	57	38	189	461	2.44	3.74
			138	20	71	55	284	646	2.28	3.72
	D		124	18	70	50	261	607	2.33	3.75
6 MONTHS FY2015										
	M	HSA2000	39	6	6	24	74	161	2.16	3.73
	M	PPO1000	102	18	22	85	226	536	2.38	3.75
			140	23	27	109	300	697	2.32	3.75
	D		127	21	27	107	283	674	2.38	3.76

Exhibit F
Judiciary of Guam FY2014 Claims Data

Additional information will be provided at a later date. Interested parties should register no later than May 13, 2015 to ensure that they receive any updated information related to this Request for Health Proposal.

HSA2000 PAID CLAIMS

MEDICAL CLAIMS PAID (NO PATIENT SHARE)

CLAIM_TYPE	**MEDICAL**
PLAN_CODE	**HSA 2000**

	PAID DATE																		
SRV DATE	**2013-10**	**2013-11**	**2013-12**	**2014-01**	**2014-02**	**2014-03**	**2014-04**	**2014-05**	**2014-06**	**2014-07**	**2014-08**	**2014-09**	**2014-10**	**2014-11**	**2014-12**	**2015-01**	**2015-02**	**2015-03**	**Grand Total**
2013-10	$0.00	$1,508.56	$194.81	$1,642.84	$131.47			$65.60				$0.00			$0.00				$3,543.28
2013-11		$0.00	$1,122.85	$1,719.81	$282.15	$0.00	$272.12	$24.80	$186.80		$0.00								$3,608.52
2013-12			$0.00	$2,094.89	$903.52	$11.24	$0.00	$0.00			$84.06								$3,093.71
2014-01				$0.00	$921.69	$2,805.60	$252.20	$374.04	$0.00	$10.00	$0.00		$0.00						$4,363.53
2014-02					$0.00	$1,053.21	$1,907.73	$245.20	$137.57				$146.16						$3,489.88
2014-03						$0.00	$1,317.89	$691.76	$424.29	$36.41	$411.38		$146.16						$3,027.90
2014-04							$0.00	$185.36	$2,782.57	$343.32		$0.00			$20.00				$3,331.25
2014-05								$0.00	$66.41	$2,233.72	$288.82	$404.12			$40.00				$3,033.08
2014-06									$0.00	$0.00	$910.81	$507.59	$0.00	$0.00	$126.71				$1,545.11
2014-07										$0.00	$0.00	$2,626.01	$2,160.86	$0.00	$86.38		$0.00		$4,873.25
2014-08											$0.00	$2,614.18	$2,389.34	$1,474.65	$358.94	$20.00			$6,857.11
2014-09												$0.00	$1,061.91	$5,864.67	$2,047.13	$84.65	$0.00	$0.00	$9,058.36
Grand Total	**$0.00**	**$1,508.56**	**$1,317.66**	**$5,457.54**	**$2,238.83**	**$3,870.05**	**$3,749.94**	**$1,586.76**	**$3,597.65**	**$2,623.45**	**$1,695.07**	**$6,151.90**	**$5,904.43**	**$7,339.31**	**$2,679.17**	**$104.65**	**$0.00**	**$0.00**	**$49,824.98**

HOSPITAL CLAIMS (NO PATIENT SHARE)

CLAIM_TYPE	**FACILITY**
PLAN_CODE	**HSA 2000**

	PAID DATE																		
SRV DATE	**2013-10**	**2013-11**	**2013-12**	**2014-01**	**2014-02**	**2014-03**	**2014-04**	**2014-05**	**2014-06**	**2014-07**	**2014-08**	**2014-09**	**2014-10**	**2014-11**	**2014-12**	**2015-01**	**2015-02**	**2015-03**	**Grand Total**
2013-10	$0.00		$1,554.48																$1,554.48
2013-11		$0.00		$0.00				$3,563.44											$3,563.44
2013-12			$0.00		$1,830.81														$1,830.81
2014-01				$0.00	$1,086.10														$1,086.10
2014-02					$0.00	$533.07													$533.07
2014-03						$0.00													$0.00
2014-04							$0.00												$0.00
2014-05								$0.00											$0.00
2014-06									$0.00										$0.00
2014-07										$0.00	$0.00	$16,625.63							$16,625.63
2014-08											$0.00								$0.00
2014-09												$0.00	$0.00	$1,034.06	$0.00	$979.78	$0.00	$0.00	$2,013.84
Grand Total	**$0.00**	**$0.00**	**$1,554.48**	**$0.00**	**$2,916.91**	**$533.07**	**$0.00**	**$3,563.44**	**$0.00**	**$0.00**	**$0.00**	**$16,625.63**	**$0.00**	**$1,034.06**	**$0.00**	**$979.78**	**$0.00**	**$0.00**	**$27,207.37**

HSA2000 PAID CLAIMS

PRESCRIPTION DRUG CLAIMS (NO PATIENT SHARE)

PLAN_CODE	**HSA 2000**

	PAID DATE																		
SRV DATE	**2013-10**	**2013-11**	**2013-12**	**2014-01**	**2014-02**	**2014-03**	**2014-04**	**2014-05**	**2014-06**	**2014-07**	**2014-08**	**2014-09**	**2014-10**	**2014-11**	**2014-12**	**2015-01**	**2015-02**	**2015-03**	**Grand Total**
2013-10	$33.84	$25.95																	$59.79
2013-11		$170.25																	$170.25
2013-12			$49.91																$49.91
2014-01				$73.27															$73.27
2014-02					$169.23														$169.23
2014-03						$127.53	$0.00												$127.53
2014-04							$109.89	$0.00											$109.89
2014-05							$0.00	$271.19	($140.27)										$130.92
2014-06									$184.06	$0.00									$184.06
2014-07										$85.08	$0.00								$85.08
2014-08											$219.85								$219.85
2014-09											$21.38	$203.67	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$225.05
Grand Total	**$33.84**	**$196.20**	**$49.91**	**$73.27**	**$169.23**	**$127.53**	**$109.89**	**$271.19**	**$43.79**	**$85.08**	**$241.23**	**$203.67**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$1,604.83**

PPO1000 PAID CLAIMS

MEDICAL CLAIMS PAID (NO PATIENT SHARE)

CLAIM_TYPE	**MEDICAL**
PLAN_CODE	**PPO 1000**

	PAID DATE																		
SRV DATE	**2013-10**	**2013-11**	**2013-12**	**2014-01**	**2014-02**	**2014-03**	**2014-04**	**2014-05**	**2014-06**	**2014-07**	**2014-08**	**2014-09**	**2014-10**	**2014-11**	**2014-12**	**2015-01**	**2015-02**	**2015-03**	**Grand Total**
2013-10	$217.00	$7,808.93	$13,281.88	$2,458.69	$531.94	$0.00	$590.61	$1,561.82	$20.04	$0.00		$128.05	$0.00				$0.00		$26,598.95
2013-11		$0.00	$6,925.42	$12,478.19	$1,512.26	$620.30	$484.79	$2,695.08	$4,445.00	$82.04	$339.37	$308.12	$90.00						$29,980.57
2013-12			$0.00	$13,348.11	$17,170.33	$3,854.52	$199.02	$1,660.38	$6,368.95	$131.72	$0.00	$597.30	$217.00						$43,547.33
2014-01				$0.00	$9,881.97	$9,484.26	$426.81	$3,616.42	$145.60	$0.00		$171.62	$258.29	$168.30	$312.00		$371.01	$0.00	$24,836.28
2014-02					$0.00	$13,565.79	$9,753.19	$1,798.57	$1,227.74	$440.65	$215.84	$213.24		$248.07	$52.00				$27,515.10
2014-03						$704.40	$9,053.67	$15,843.47	$3,399.58	$1,587.33	$127.37	$636.08	$803.40	$16.41	$547.35				$32,719.06
2014-04							$0.00	$4,249.24	$17,873.31	$6,011.25	$4,675.45	$704.31	$66.41	$120.00				$414.17	$34,114.13
2014-05								$0.00	$2,794.04	$13,768.48	$5,624.47	$2,746.99	$259.92	$149.42	$23.92				$25,367.25
2014-06									$0.00	$243.99	$11,395.09	$7,892.07	$584.48	$3,971.58		$100.62	$2,458.45		$26,646.28
2014-07										$0.00	$1,012.19	$11,115.78	$2,509.25	$966.93	$287.87	$0.00	$229.66		$16,121.68
2014-08											$0.00	$7,400.89	$9,837.11	$15,366.72	$3,775.82	$91.60	$10,820.71		$47,292.85
2014-09												$490.90	$4,521.09	$13,129.34	$11,243.87	$294.02	$4,992.86	$11,539.93	$46,212.00
Grand Total	**$217.00**	**$7,808.93**	**$20,207.29**	**$28,284.98**	**$29,096.49**	**$28,229.28**	**$20,508.09**	**$31,424.97**	**$36,274.26**	**$22,265.47**	**$23,389.78**	**$32,405.35**	**$19,146.94**	**$34,136.78**	**$16,242.83**	**$486.24**	**$18,872.69**	**$11,954.10**	**$380,951.48**

HOSPITAL CLAIMS (NO PATIENT SHARE)

CLAIM_TYPE	**FACILITY**
PLAN_CODE	**PPO 1000**

	PAID DATE																		
SRV DATE	**2013-10**	**2013-11**	**2013-12**	**2014-01**	**2014-02**	**2014-03**	**2014-04**	**2014-05**	**2014-06**	**2014-07**	**2014-08**	**2014-09**	**2014-10**	**2014-11**	**2014-12**	**2015-01**	**2015-02**	**2015-03**	**Grand Total**
2013-10	$0.00	$32.43	$562.94	$0.00		$0.00													$595.37
2013-11		$0.00	$152.31	$0.00	$216.94	$20.80		$5,372.12	$0.00										$5,762.17
2013-12			$0.00		$6,894.08	$459.29	$0.00	$107.67	$192.74										$7,653.78
2014-01				$0.00		$2,908.67		$2,012.24	$0.00										$4,920.91
2014-02					$0.00	$1,712.88		$0.00			$0.00								$1,712.88
2014-03						$45.28	$449.57	$730.61	$189.12	$0.00	$271.74	$65.42	$694.76						$2,446.50
2014-04							$0.00	$180.95	$13,863.87		$0.00								$14,044.82
2014-05								$0.00	$251.84	$1,864.49									$2,116.33
2014-06									$0.00	$0.00									$0.00
2014-07										$0.00		$3,304.26			$0.00				$3,304.26
2014-08											$0.00	$1,794.44	$12,762.29			$1,507.52			$16,064.25
2014-09												$0.00	$4,295.22	$3,197.44	$0.00	$482.40	$0.00	$0.00	$7,975.06
Grand Total	**$0.00**	**$32.43**	**$715.25**	**$0.00**	**$7,111.02**	**$5,146.92**	**$449.57**	**$8,403.59**	**$14,497.57**	**$1,864.49**	**$271.74**	**$5,164.12**	**$17,752.27**	**$3,197.44**	**$0.00**	**$1,989.92**	**$0.00**	**$0.00**	**$66,596.33**

PPO1000 PAID CLAIMS

PRESCRIPTION DRUG CLAIMS (NO PATIENT SHARE)

PLAN_CODE	**PPO 1000**

	PAID DATE																		
SRV DATE	**2013-10**	**2013-11**	**2013-12**	**2014-01**	**2014-02**	**2014-03**	**2014-04**	**2014-05**	**2014-06**	**2014-07**	**2014-08**	**2014-09**	**2014-10**	**2014-11**	**2014-12**	**2015-01**	**2015-02**	**2015-03**	**Grand Total**
2013-10	$6,722.90	($348.44)																	$6,374.46
2013-11	$9.10	$4,573.47	($4.54)																$4,578.03
2013-12		$18.39	$3,956.59	($105.95)															$3,869.03
2014-01				$6,155.68															$6,155.68
2014-02				$159.28	$4,249.99														$4,409.27
2014-03					$223.49	$4,680.94	($21.33)												$4,883.10
2014-04						$46.34	$5,353.05	($31.95)											$5,367.44
2014-05							$27.40	$5,209.67											$5,237.07
2014-06								$140.77	$4,939.89	($16.21)									$5,064.45
2014-07									$64.67	$6,763.65	$0.00								$6,828.32
2014-08										$17.79	$5,199.58	($15.23)							$5,202.14
2014-09											$39.46	$9,248.87	($422.39)	$0.00	$0.00	$0.00	$0.00	$0.00	$8,865.94
Grand Total	**$6,732.00**	**$4,243.42**	**$3,952.05**	**$6,209.01**	**$4,473.48**	**$4,727.28**	**$5,359.12**	**$5,318.49**	**$5,004.56**	**$6,765.23**	**$5,239.04**	**$9,233.64**	**($422.39)**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$66,834.93**

DENTAL PAID CLAIMS

DENTAL CLAIMS PAID (NO PATIENT SHARE)

	PAID DATE																		
SRV DATE	**2013-10**	**2013-11**	**2013-12**	**2014-01**	**2014-02**	**2014-03**	**2014-04**	**2014-05**	**2014-06**	**2014-07**	**2014-08**	**2014-09**	**2014-10**	**2014-11**	**2014-12**	**2015-01**	**2015-02**	**2015-03**	**Grand Total**
2013-10	$0.00	$2,873.84	$12,754.60	$519.95	$1,762.64	$957.13	$2,000.00	$118.48	$0.00	$296.10		$69.60		$0.00					$21,352.34
2013-11		$0.00	$6,002.50	$9,473.73	$2,078.08		$1,030.30	$274.00		$248.85									$19,107.46
2013-12			$372.37	$3,274.97	$10,654.23		$671.68			$88.20		$232.00				$296.00			$15,589.45
2014-01				$1,582.44	$9,017.55	$15,638.12	$2,020.47	$516.00	$1,032.02			$213.00							$30,019.60
2014-02					$788.17	$8,316.08	$8,142.77	$2,134.29	$0.00	$745.80									$20,127.11
2014-03						$0.00	$8,709.70	$13,615.52	$1,705.00	$0.00									$24,030.23
2014-04							$0.00	$3,630.10	$10,220.57	$116.00									$13,966.67
2014-05								$0.00	$1,667.54	$7,475.25	$2,127.00			$41.80					$11,311.59
2014-06									$0.00	$4,370.20	$9,627.40	$1,813.00	$233.00	$724.06					$16,767.66
2014-07										$0.00	$6,817.78	$13,998.67		$0.00		$0.00			$20,816.45
2014-08											$0.00	$11,806.64	$2,669.60	$2,492.90		$477.60	$582.12		$18,028.86
2014-09												$916.00	$4,174.40	$20,080.50	$7,165.58	$714.40	$796.66	$0.00	$33,847.54
2014-10															$0.00				$0.00
2014-11																$0.00			$0.00
2015-01																	$0.00		$0.00
Grand Total	**$0.00**	**$2,873.84**	**$19,129.47**	**$14,851.09**	**$24,300.67**	**$24,911.33**	**$22,574.92**	**$20,288.38**	**$14,625.13**	**$13,340.40**	**$18,572.18**	**$29,048.91**	**$7,077.00**	**$23,339.26**	**$7,165.58**	**$1,488.00**	**$1,378.78**	**$0.00**	**$244,964.96**

EXHIBIT G

Medical and Dental Plan Designs

The following outlines the current core level of benefits with updates required for PPACA required changes, plus the additional alternative plan features requested.

The Judiciary of Guam requests a quote for the following current plan options:

1. HSA Plan with a $2,000 annual deductible /$4,000 annual family deductible;
2. PPO Plan with a $1,000 annual deductible /$2,000 annual family deductible;
3. Dental

Disease management program which provides at a minimum quarterly reporting on disease states.

HSA2000		
Important Information about your coverage	**PARTICIPATING Providers**	**NON-PARTICIPATING Providers**
Deductible per individual member	**$2,000**	**$4,000**
Deductible Per Family **The entire family deductible amount of $4,000 must be satisfied by one or more family members before the plan begins to pay for any covered expense**	**$4,000**	**$12,000**
Member Cost-Sharing Preventive Services Outpatient Phys. Copays, after deductible Primary Care Specialists Pharmacy (Retail), after deductible Generic Formulary Brand Non-Formulary Brand Other Medical, after deductible	 **0%, no deductible** **$20** **$40** **$15** **$30** **$30** **20%**	 **Not covered** **50%** **50%** **50%** **50%** **50%** **50%**
Coverage Maximums Individual member annual maximum	**None**	
Out-of-Pocket Maximums (including accumulated deductible) Per Individual member per policy year Per Family per policy year	 **$4,000** **$11,900**	 **No Maximum** **No Maximum**
Any Services in The Philippines, Hawaii & the U.S. Mainland (Pre-Certification required)	**Requires Referral from your Doctor and approval in advance from Plan**	

PPO1000		
Important Information about your coverage	**PARTICIPATING Providers**	**NON-PARTICIPATING Providers**
Deductible per individual member	**$1,000**	**$2,000**
Deductible Per Family **If a member meets their $1,000 deductible, the plan begins to pay for covered services for that individual**	**$2,000**	**$6,000**
Member Cost-Sharing Preventive Services Outpatient Phys. Copays Primary Care Specialists Pharmacy (Retail) Generic Formulary Brand Non-Formulary Brand Other Medical	 **0%, no deductible** **$20, no deductible** **$40, no deductible** **$15, no deductible** **$30, no deductible** **$30, no deductible** **20%, after deductible**	 **Not covered** **30%, after deductible** **30%, after deductible** **30%, after deductible** **30%, after deductible** **30%, after deductible** **30%, after deductible**
Coverage Maximums Individual member annual maximum	**None**	
Out-of-Pocket Maximums (including accumulated deductible) Per Individual member per policy year Per Family per policy year	 **$3,000** **$9,000**	 **No Maximum** **No Maximum**
Any Services in The Philippines, Hawaii & the U.S. Mainland (Pre-Certification required)	**Requires Referral from your Doctor and approval in advance from Plan**	

PPO750		
Important Information about your coverage	**PARTICIPATING Providers**	**NON-PARTICIPATING Providers**
Deductible per individual member	**$500**	**$1,000**
Deductible Per Family **If a member meets their $750 deductible, the plan begins to pay for covered services for that individual**	**$1,500**	**$3,000**
Member Cost-Sharing Preventive Services Outpatient Phys. Copays Primary Care Specialists Pharmacy (Retail) Generic Formulary Brand Non-Formulary Brand Other Medical	 **0%, no deductible** **$20, no deductible** **$40, no deductible** **$15, no deductible** **$30, no deductible** **$30, no deductible** **20%, after deductible**	 **Not covered** **30%, after deductible** **30%, after deductible** **30%, after deductible** **30%, after deductible** **30%, after deductible** **30%, after deductible**
Coverage Maximums Individual member annual maximum	**None**	
Out-of-Pocket Maximums (including accumulated deductible) Per Individual member per policy year Per Family per policy year	 **$2,000** **$6,000**	 **No Maximum** **No Maximum**
Any Services in The Philippines, Hawaii & the U.S. Mainland (Pre-Certification required)	**Requires Referral from your Doctor and approval in advance from Plan**	

PPO500		
Important Information about your coverage	**PARTICIPATING Providers**	**NON-PARTICIPATING Providers**
Deductible per individual member	**$500**	**$1,000**
Deductible Per Family **If a member meets their $500 deductible, the plan begins to pay for covered services for that individual**	**$1,000**	**$3,000**
Member Cost-Sharing Preventive Services Outpatient Phys. Copays Primary Care Specialists Pharmacy (Retail) Generic Formulary Brand Non-Formulary Brand Other Medical	 **0%, no deductible** **$20, no deductible** **$40, no deductible** **$15, no deductible** **$30, no deductible** **$30, no deductible** **20%, after deductible**	 **Not covered** **30%, after deductible** **30%, after deductible** **30%, after deductible** **30%, after deductible** **30%, after deductible** **30%, after deductible**
Coverage Maximums Individual member annual maximum	**None**	
Out-of-Pocket Maximums (including accumulated deductible) Per Individual member per policy year Per Family per policy year	 **1,500** **$4,500**	 **No Maximum** **No Maximum**
Any Services in The Philippines, Hawaii & the U.S. Mainland (Pre-Certification required)	**Requires Referral from your Doctor and approval in advance from Plan**	

DENTAL

BENEFITS	When you go to PARTICIPATING Providers	When you to NON-PARTICIPATING Providers
Diagnostic & Preventive Care 1. Caries Susceptibility Test 2. Exams (Once every 6 months) 3. Fluoride treatment (Annually for children age 19 &under) 4. Prophylaxis (Cleaning of teeth once every 6 months) 5. Sealants (For permanent molars of children age 15 & under) 6. Space maintainers (For children age 15 & under) includes adjustments within 6 months of installation 7. Study Models 8. Treatment Plan 9. X-rays (Bite Wing Maximum of 4 per Plan Year) 10. X-rays (Full Mouth, once every 3 years)	**100% of Eligible Expenses**	**70% of Eligible Expenses (Covered Persons pay excess above Eligible Expenses)**
Basic & Restorative Care **General Services** 1. Emergency Care (During office hours) 2. Pulp Treatment 3. Routine Fillings (Silver & composite resin) **Oral Surgery** 1. Simple Extractions 2. Complicated Extractions 3. Impactions **Periodontal Care** 1. Periodontal Prophylaxis (Cleaning once every 6 months) 2. Periodontal Treatment Conscious Sedation and Nitrous Oxide for children under the age of 13. **Pulpotomy & Root Canals/Endodontic Surgery & Care**	**80% of Eligible Expenses**	**70% of Eligible Expenses (Covered Persons pay excess above Eligible Expenses)**
Major & Replacement Care **Fixed Prosthetics** 1. Crowns 2. Gold Inlays & Onlays 3. Replacement of Crown Restoration (Once every 5 years) **Removable Prosthetics**	**50% of Eligible Expenses**	**35% of Eligible Expenses (Covered Persons pay excess above Eligible Expenses)**

1. Full Dentures (Once every 5 years) 2. Partial Dentures (Once every 5 years) 3. Each Additional Tooth 4. Relines		
Deductible	**None**	**None**
Registration Fee Per Visit To Dentist	**None**	**None**
Coverage Maximum Per Member per Plan Year	**$2,000**	

Terms:

1. Unused balances are not transferable to the following year.
2. Charges for Non-participating Providers are limited to the lesser of actual charges of the Company's determination of the usual, customary and reasonable charge in geographic location where the service was rendered, unless otherwise provided in the agreement. The covered member pays any excess above Eligible Charges.
3. There is to be a single out-of-pocket maximum for all plan coverage, including medical, prescription drug, and mental health and substance use disorder benefits. All in-network copays, coinsurance, and deductibles across all categories of covered expenses under the plan must apply towards the out-of-pocket maximum.

See Exhibits G and H for further details on the current plan designs and required provisions.

Alternative Plan Designs Requested

In addition to the current two benefit plans, the Judiciary of Guam is considering offering a third option with less member cost sharing. Please provide the cost and price for the following plan design (on the provided Excel file).

- Additional Plan Option #1: The same plan details as the $1,000 deductible plan but with a $750 deductible ($1,500 family maximum) and a $2,000 out of pocket maximum ($6,000 family maximum). Deductibles and out of pocket maximums for non-participating providers of twice the aforementioned values. All copayments and coinsurance values remain the same.
- Additional Plan Option #2: The same plan details as the $1,000 deductible plan but with a $500 deductible ($1,000 family maximum) and a $1,500 out of pocket maximum ($4,500 family maximum). Deductibles and out of pocket maximums for non-participating providers of twice the aforementioned values. All copayments and coinsurance values remain the same.

Additionally, the Judiciary of Guam would like to consider modifying the offered plans as indicated below. Please confirm your ability to administer such plans, and provide the percent change in premium rates that would apply to each plan, as applicable, (on the provided Excel file).

Medical

- Modification #1: Proposal for the same plan details as the Proposed FY2015 PPO1000 and HSA2000 plans but with organ transplant coverage for heart, liver, lung, pancreas, intestinal, bone marrow, cornea, and kidney to include donor and recipient.
- Modification #2: Proposed FY15 PPO1000 and HSA2000 plans but with a combined in-network and out-of-network deductible where out-of-network claims accumulate at the in-network reimbursement rate for the same procedure.
- Modification #3: Remove the limitation that results in the suspension of coverage after 90 days outside the coverage area.

Notes:

1. The above is intended to broadly define all medical and dental plans. In case of discrepancies between the request for health proposal and the contract, the contract shall govern.
2. Where no limitation or maximum is specified, none may be imposed.

EXHIBIT H

Plan Design Notes

1. For participating providers, the enrollee will not be balance billed. The level of coverage of the benefits for non-participating providers must be based on Usual, Customary, and Reasonable (UCR) charges. Enrollees may be assessed copayments and/or deductibles according to plan design.
2. No limitations may be imposed besides those stated herein.
3. Carriers must submit their rate calculation approach and substantiating data along with proposals.
4. Offerors must specify any desired contractual changes to the proposed contract. Offerors must submit a proposed certificate of insurance.
5. The audited financial statements must also be submitted along with proposals.
6. In addition to other bona fide legal dependents, the plan must cover children under legal guardianship of the subscriber who meet all other plan requirements. However, the plan may require a court order granting guardianship to the subscriber, but should allow for such children to be enrolled regardless of whether it is an open enrollment period. Additionally, in accordance with the Patient Protection and Affordable Care Act, dependents must be covered up to age 26. For the plan years beginning October 1, 2014, the plan cannot limit dependent children eligibility by their access to other healthcare.
7. The provider network must include Guam, the Philippines, Hawaii, and the U.S. Mainland.
8. The plan shall accept the exclusions as outlined in the suggested contractual language only; or may include coverage for a listed excluded item as the plan desires.
9. The plan must include coverage for enrolled employees and their enrolled dependents, to the end of the plan year, if the employee is laid off due to workforce reduction by the Judiciary of Guam, provided the employee pays full premium in accordance with the rules applicable to employees on leave without pay.
10. If a carrier does not contract with the provider of any sole source service on Guam, it must reimburse for the sole source provided by such Guam provider as if sole source provider were a participating provider.
11. Nothing in the carrier's proposal will be incorporated into any contract with the Judiciary of Guam unless specifically agreed to by the Judiciary of Guam.
12. The plan must include the PPACA requirements first applicable to plan years beginning on or after January 1, 2014.
13. The Judiciary requests an additional plan feature for FY2015 of transferability of deductibles of insured persons who separate from non-Judiciary government entities and begin working at the Judiciary of Guam, thus becoming eligible to participate in the Judiciary of Guam Health Insurance program for FY2015.
14. In addition to Wellness and Disease Management benefits offerors are required to provide Eligible Subscribers aged 18 years of age and older, enrolled under one of the plans offered by the Judiciary, are eligible to participate in this program by selecting a gym of their choice and notifying the Judiciary's Human Resource Department and the Selected Offeror of their choice. By participating, Subscribers will qualify for the Judiciary's dollar per month gym subsidy either through direct membership payment to the chosen gym by the Company or reimbursement by the ubscriber. Actual gym membership expenses in excess of the dollar per month subsidy are the Subscriber's responsibility. The Judiciary will pay Selected Offeror the selected subsidy amount times the individual participating on a monthly basis. Selected Offeror will administer the payment of the subsidy to the gyms selected. Nothing in the carrier's proposal will be incorporated into any contract with the Judiciary of Guam unless specifically agreed to by the Judiciary of Guam.

15. The following preventive care requirements apply: Additions in September 2013 regarding coverage tamoxifen and raloxifene for women athigh risk of breast cancer starting 10/1/2014; Additions in December 2013 regarding certain preventive coveragesuch as BRCA-gene riskassessment and counseling for women who have family members with breast,ovarian, tubal, or peritoneal cancer, and lung cancer CT scans forindividuals ages 55-80 with a 30-pack year smoking history starting 10/1/15 (beginning of first plan year beginning atleast 12 months after items and services were added to the preventive care).
16. Wards under a court-ordered guardianship will be eligible for health insurance coverage outside the open enrollment period.

EXHIBIT I

Medical Exclusions

Please see the following for a list of the requested medical exclusions. Please indicate if any are not applicable to your proposed plans, or if there are any additional exclusions in your proposed plans.

1. No benefits will be paid for Injury or Illness, (a) when the Covered Person is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such Injury or Illness or (b) when Services for an Injury or Illness are rendered to the Covered Person by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (c) when such Services would have been rendered without charge but for the fact that the person is a Covered Person under the Plan.
2. No benefits will be paid if any material statement made in an application for coverage, enrollment of any Dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall give the Covered Person at least 30 days'notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage shall be effective no earlier than the date of the suspension. The Covered Person may dispute any termination of coverage by filing a claim under the grievance procedure provided for in the Agreement. If a grievance is filed, the resolution of the matter shall be in accordance with the outcome of the grievance proceedings. If no grievance is filed for any retroactive termination and the Company paid benefits prior to learning of any such false statement, the Subscriber must reimburse the Company for such payment. Terminations of coverage shall be handled in accordance with the applicable claims procedure requirements of Section 2719 of the PHSA, as added by PPACA. Retroactive terminations of coverage shall not violate the applicable prohibitions on rescissions of Section 2712 of the PHSA, as added by PPACA, and rescissions shall be handled in compliance with PPACA's applicable claim denial requirements.
3. No benefits will be paid for confinement in a Hospital or in a Skilled Nursing Facility if such confinement is primarily for custodial or domiciliary care. (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self-care. Custodial or domiciliary care also includes supervisory services by a Physician or Nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.) Company and not Covered Person shall be liable if the Company approves the confinement, regardless of who orders the service.
4. No benefits will be paid for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
5. No benefits will be paid for private Duty Nursing. This provision does not apply to Home Health Care.
6. No benefits will be paid for special medical reports, including those not directly related to treatment of the Member. (e.g., Employment or insurance physicals, and reports prepared in connection with litigation.)
7. No benefits will be paid for services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage,

travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

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

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

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

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

12. Unless otherwise specifically provided in the Agreement, no benefit will be paid for, or in connection with, airfare and the Company will not pay for the transportation from Guam to any off-island facility, or for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person.

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

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

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

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

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

18. No benefits will be paid for:

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

    b) Drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury.

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

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

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

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

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

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

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

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

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

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

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

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

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

26. No benefits will be paid for vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision), lasik, keratoplasty, and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the Covered Benefits section of the Group Health Insurance Certificate.
27. Except as otherwise provided in this Request for Health Proposal, no benefits will be paid for eyeglasses or contact lenses or for Services and supplies in connection with surgery for the purpose of diagnosing or correcting errors in refraction.
28. No benefits will be paid in connection with any injuries sustained while the Covered Person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.
29. No benefits will be paid for personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies.
30. No benefits will be paid for hypnotherapy.
31. No benefits will be paid for religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
32. No benefits will be paid for cosmetic Surgery, or other services intended primarily to improve the Member's appearance or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion does not apply to:
    a) Medically Necessary reconstructive surgery as described in the Covered Benefits sections Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery.
    b) surgery to correct the results of injuries causing an impairment;
    c) surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;
    d) surgery to correct congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
33. No benefits will be paid for routine foot/hand care, including routine reduction of nails, calluses and corns.
34. Except as otherwise provided in this agreement, no benefit will be paid for specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
35. No benefits will be paid for Services and supplies associated with growth hormone treatment unless the Covered Person is proven to have growth hormone deficiency using accepted stimulated growth hormone analyses and also show an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency.
36. No benefits will be paid for Services and supplies provided for liposuction.
37. No benefits will be paid for weight reduction programs, or dietary supplements, except as pre-authorized by Company for the Medically Necessary treatment of morbid obesity.
38. No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction unless medically necessary.

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

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

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

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

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

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

    d) Home ovulation prediction kits;

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

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

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

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

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

    j) Reversal of sterilization surgery; and

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

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

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

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

    c) CPAP machine under DME benefit.

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

44. No benefits will be paid for outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, and elastic stockings.
45. No benefits will be paid for Services and supplies provided for penile implants of any type.
46. No benefits will be paid for Services and supplies to correct sexual dysfunction.
47. Except as specifically provided, if a benefit is excluded, all Hospital, surgical, medical treatments, prescription drugs, laboratory services, and x-rays in relation to the excluded benefits are also excluded as of the time it is determined that the benefit is excluded.
48. Except as specifically provided in this Agreement, no benefits will be provided for Services and supplies not ordered by a Physician or not Medically Necessary.
49. No benefits will be paid for temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the Covered Benefits Section
50. Except as specifically provided in this Agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment.
51. No benefits will be paid for Services for which the Covered Person or Subscriber is not legally obligated to pay.
52. No benefit will be paid for ambulance services when used for routine and convenience transportation to receive outpatient or inpatient services, unless deemed medically necessary with prior authorization obtained from Company.
53. Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a Physician.
54. No benefits will be paid for hospital take-home drugs.
55. No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the Covered Person.
56. No benefits will be paid for educational services. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
57. No benefits will be paid for Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.
58. No benefits will be paid for Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms or whether providing or receiving the Service.
59. No benefits will be paid for non-medically necessary services, including but not limited to, those services and supplies:
    a) Which are not Medically Necessary for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
    b) That do not require the technical skills of a medical, mental health or a dental professional;
    c) Furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member's family, or any Provider;

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

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

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

EXHIBIT J

Dental Exclusions

Please see the following for a list of the current dental exclusions. Please indicate if any are not applicable to your proposed plans, or if there are any additional exclusions in your proposed plans.

1. Work in progress on the effective date of coverage. Work in progress is defined as:
   - A prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered, or
   - A crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered, or
   - Root canal therapy, if the pulp chamber was opened before the patient was covered.
2. Services not specifically listed in the agreement, services not prescribed, performed or supervised by a dentist; services which are not medically or dentally necessary or customarily performed; services that are not indicated because they have a limited or poor prognosis; or services for which there is a less expensive, professionally acceptable alternative.
3. Any service unless required and rendered in accordance with accepted standards or dental practice.
4. A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement or modification of a crown, cast restoration, denture or bridge installed less than 5 years ago, or one that replaces a tooth that was missing before the date the enrollee became eligible for services under the plan (including previously extracted or missing teeth).
5. Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable.
6. Precision attachments, interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth-borne and/or prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stress.
7. Replacement of lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.
8. Any service for which the Covered Person received benefits under any other coverage offered by the company.
9. Spare or duplicate prosthetic devices.
10. Services included, related to or required for:
    - Implants;
    - Cosmetic purposes;
    - Services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to equilibrium, full mouth rehabilitation and restoration for malalignment of teeth;
    - Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction or harmful habits;
    - Experimental procedures; and
    - Intentionally self-inflicted injury unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.

11. Any over the counter drugs or medicine, unless prescribed by a dentist or physician.
12. Fluoride varnish.
13. Charges for finance charge, broken appointments, completion of insurance forms or reports, providing records, oral hygiene instruction, pit and fissure sealants and dietary instruction, or lack of cooperation on the part of the patient.
14. Charges in excess of the amount allowed by the plan for a covered service.
15. Any treatment, material, or supplies which are for orthodontic treatment, including extractions for orthodontics.
16. Services for which no charge would have been made had the agreement not been in effect.
17. Surgical grafting procedures.
18. General anesthetic, conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein, unless deemed medically necessary by patient's dentist or physician and pre-authorized by Company.
19. Services paid for by Workers' Compensation.
20. Charges incurred while confined as an inpatient in hospital unless such charges would have been covered had treatment been rendered in dental office.
21. Treatment and/or removal of oral tumors.
22. All surgical procedures except for surgical extractions of teeth and periodontal surgeries performed by a dentist.
23. Panoramic x-ray or full mouth x-ray if provided less than 3 years from the covered person's last full mouth x-ray; and full mouth x-rays if provided less than three years from Covered Person's last panoramic x-ray.

EXHIBIT K

Form A

AFFIDAVIT DISCLOSING OWNERSHIP AND COMMISSIONS

CITY OF _____)

_____) ss.

STATE OF _____)

A. I, the undersigned, being first duly sworn, depose and say that I am an authorized representative of the offeror and that [*please check only one*]:

[ ] The offeror is an individual or sole proprietor and owns the entire (100%) interest in the offering business.

[ ] The offeror is a corporation, partnership, joint venture, or association known as _____[*please state name of offeror company*], and the persons, companies, partners, or joint ventures who have held more than 10% of the shares or interest in the offering business during the 365 days immediately preceding the submission date of the proposal are as follows [*if none, please so state*]:

NameAddress	% of Interest	
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Further, I say that the persons who have received or are entitled to receive a commission, gratuity or other compensation for procuring or assisting in obtaining business related to the bid or proposal for which this affidavit is submitted are as follows [*if none, please so state*]:

Name Address		Compensation
_____	_____	_____

C. If the ownership of the offering business should change between the time this affidavit is made and the time an award is made or a contract is entered into, then I promise personally to update the disclosure required by 5 GCA §5233 by delivering another affidavit to the Judiciary of Guam.

_____

Signature of one of the following:
Offeror, if the offeror is an individual;
Partner, if the offeror is a partnership;
Officer, if the offeror is a corporation.
Officer, if the offeror is a limited liability company.

Subscribed and sworn to before me

this ____ day of _____, 201__.

_____

NOTARY PUBLIC

My commission expires: _____

EXHIBIT K (continued)

Form B

AFFIDAVIT RE NON-COLLUSION

CITY OF _____)

) ss.
STATE OF _____)

_____[*state name of affiant signing below*], being first duly sworn, deposes and says that:

1. The name of the offering company or individual is [*state name of company*] _____.

2. The proposal for the solicitation identified above is genuine and not collusive or a sham. The offeror has not colluded, conspired, connived or agreed, directly or indirectly, with any other offeror or person, to put in a sham proposal or to refrain from making an offer. The offeror has not in any manner, directly or indirectly, sought by an agreement or collusion, or communication or conference, with any person to fix the proposal price of offeror or of any other offeror, or to fix any overhead, profit or cost element of said proposal price, or of that of any other offeror, or to secure any advantage against the Judiciary of Guam or any other offeror, or to secure any advantage against the Judiciary of Guam or any person interested in the proposed contract. All statements in this affidavit and in the proposal are true to the best of the knowledge of the undersigned. This statement is made pursuant to 2 GAR Division 4 § 3126(b).

3. I make this statement on behalf of myself as a representative of the offeror, and on behalf of the offeror's officers, representatives, agents, subcontractors, and employees.

_____

Signature of one of the following:
Offeror, if the offeror is an individual;
Partner, if the offeror is a partnership;
Officer, if the offeror is a corporation.
Officer, if the offeror is a limited liability company.

Subscribed and sworn to before me

this _____ day of _____, 201__.

_____
NOTARY PUBLIC
My commission expires _____, _____.

EXHIBIT K (continued)

Form C

AFFIDAVIT RE NO GRATUITIES OR KICKBACKS

CITY OF _____)

) ss.
STATE OF _____)

_____[*state name of affiant signing below*], being first duly sworn, deposes and says that:

1. The name of the offering firm or individual is [*state name of offeror company*] _____. Affiant is _____ [*state one of the following: the offeror, a partner of the offeror, an officer of the offeror*] making the foregoing identified bid or proposal.

2. To the best of affiant's knowledge, neither affiant, nor any of the offeror's officers, representatives, agents, subcontractors, or employees have violated, are violating the prohibition against gratuities and kickbacks set forth in 2 GAR Division 4 § 11107(e). Further, affiant promises, on behalf of offeror, not to violate the prohibition against gratuities and kickbacks as set forth in 2 GAR Division 4 § 11107(e).

3. To the best of affiant's knowledge, neither affiant, nor any of the offeror's officers, representatives, agents, subcontractors, or employees have offered, given or agreed to give, any Judiciary of Guam employee or former Judiciary of Guam employee, any payment, gift, kickback, gratuity or offer of employment in connection with the offeror's proposal.

4. I make these statements on behalf of myself as a representative of the offeror, and on behalf of the offeror's officers, representatives, agents, subcontractors, and employees.

_____

Signature of one of the following:
Offeror, if the offeror is an individual;
Partner, if the offeror is a partnership;
Officer, if the offeror is a corporation.
Officer, if the offeror is a limited liability company.

Subscribed and sworn to before me

this _____ day of _____, 201____.

_____
NOTARY PUBLIC
My commission expires _____, _____.

EXHIBIT K (continued)

Form D

AFFIDAVIT RE ETHICAL STANDARDS

CITY OF _____)

) ss.
STATE OF _____)

_____[*state name of affiant signing below*], being first duly sworn, deposes and says that:

The affiant is _____ [*state one of the following: the offeror, a partner of the offeror, an officer of the offeror*] making the foregoing identified bid or proposal. To the best of affiant's knowledge, neither affiant nor any officers, representatives, agents, subcontractors or employees of offeror have knowingly influenced any Judiciary of Guam employee to breach any of the ethical standards set forth in 5 GCA Chapter 5, Article 11. Further, affiant promises that neither he or she, nor any officer, representative, agent, subcontractor, or employee of offeror will knowingly influence any Judiciary of Guam employee to breach any ethical standards set forth in 5 GCA Chapter 5, Article 11. These statements are made pursuant to 2 GAR Division 4 § 11103(b).

_____
Signature of one of the following:
Offeror, if the offeror is an individual;
Partner, if the offeror is a partnership;
Officer, if the offeror is a corporation.
Officer, if the offeror is a limited liability company.

Subscribed and sworn to before me
this _____ day of _____, 201__.

_____
NOTARY PUBLIC
My commission expires _____, _____.

EXHIBIT K (continued)

Form E

AFFIDAVIT RE CONTINGENT FEES

CITY OF _____)

) ss.
STATE OF _____)

_____[*state name of affiant signing below*], being first duly sworn, deposes and says that:

1. The name of the offering company or individual is [*state name of company*] _____.

2. As a part of the offering company's bid or proposal, to the best of my knowledge, the offering company has not retained any person or agency on a percentage, commission, or other contingent arrangement to secure this contract. This statement is made pursuant to 2 GAR Division 4 11108(f).

3. As a part of the offering company's bid or proposal, to the best of my knowledge, the offering company has not retained a person to solicit or secure a contract with the Judiciary of Guam upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies for the purpose of securing business. This statement is made pursuant to 2 GAR Division 4 11108(h).

4. I make these statements on behalf of myself as a representative of the offeror, and on behalf of the offeror's officers, representatives, agents, subcontractors, and employees.

_____

Signature of one of the following:
Offeror, if the offeror is an individual;
Partner, if the offeror is a partnership;
Officer, if the offeror is a corporation.
Officer, if the offeror is a limited liability company.

Subscribed and sworn to before me

this _____ day of _____, 201__.

_____
NOTARY PUBLIC
My commission expires _____, _____.

EXHIBIT K (continued)

Form F

DECLARATION RE COMPLIANCE WITH U.S. DOL WAGE DETERMINATION

Procurement No.: _____

Name of Offeror Company: _____

I, _____ hereby **certify under penalty of perjury**:

(1) That I am _____ [*please select one: the offeror, a partner of the offeror, an officer of the offeror*] making the bid or proposal in the foregoing identified procurement;

(2) That I have read and understand the provisions of 5 GCA § 5801 and § 5802 which read:

§ 5801. Wage Determination Established.

In such cases where the Judiciary of Guam enters into contractual arrangements with a sole proprietorship, a partnership or a corporation ("contractor") for the provision of a service to the Judiciary of Guam, and in such cases where the contractor employs a person(s) whose purpose, in whole or in part, is the direct delivery of service contracted by the Judiciary of Guam, then the contractor shall pay such employee(s) in accordance with the Wage Determination for Guam and the Northern Mariana Islands issued and promulgated by the U.S. Department of Labor for such labor as is employed in the direct delivery of contract deliverables to the Judiciary of Guam.

The Wage Determination most recently issued by the U.S. Department of Labor at the time a contract is awarded to a contractor by the Judiciary of Guam shall be used to determine wages, which shall be paid to employees pursuant to this Article. Should any contract contain a renewal clause, then at the time of renewal adjustments, there shall be made stipulations contained in that contract for applying the Wage Determination, as required by this Article, so that the Wage Determination promulgated by the U.S. Department of Labor on a date most recent to the renewal date shall apply.

§ 5802. Benefits.

In addition to the Wage Determination detailed in this Article, any contract to which this Article applies shall also contain provisions mandating health and similar benefits for employees covered by this Article, such benefits having a minimum value as detailed in the Wage Determination issued and promulgated by the U.S. Department of Labor, and shall contain provisions guaranteeing a minimum of ten (10) paid holidays per annum per employee.

(3) That the offeror is in full compliance with 5 GCA § 5801 and § 5802, as may be applicable to the procurement referenced herein;

(4) That I have attached the most recent wage determination applicable to Guam issued by the U.S. Department of Labor.

_____

Signature

_____

Date

EXHIBIT K (continued)

U.S. Department of Labor

Wage Determination List

WD 05-2147 (Rev.-17) was first posted on www.wdol.gov on 12/30/2014

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REGISTER OF WAGE DETERMINATIONS UNDER THE SERVICE CONTRACT ACT By direction of the Secretary of Labor	U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION WAGE AND HOUR DIVISION WASHINGTON D.C. 20210
Diane C. Koplewski Director Division of Wage Determinations	Wage Determination No.: 2005-2147 Revision No.: 17 Date Of Revision: 12/22/2014

Note: Executive Order (EO) 13658 establishes an hourly minimum wage of $10.10 for 2015 that applies to all contracts subject to the Service Contract Act for which the solicitation is issued on or after January 1, 2015. If this contract is covered by the EO, the contractor must pay all workers in any classification listed on this wage determination at least $10.10 (or the applicable wage rate listed on this wage determination, if it is higher) for all hours spent performing on the contract. The EO minimum wage rate will be adjusted annually. Additional information on contractor requirements and worker protections under the EO is available at www.dol.gov/whd/govcontracts.

States: Guam, Northern Marianas, Wake Island

Area: Guam Statewide
Northern Marianas Statewide
Wake Island Statewide

Fringe Benefits Required Follow the Occupational Listing

OCCUPATION CODE - TITLE	FOOTNOTE	RATE
01000 - Administrative Support And Clerical Occupations		
01011 - Accounting Clerk I		12.50
01012 - Accounting Clerk II		13.53
01013 - Accounting Clerk III		15.59
01020 - Administrative Assistant		17.67
01040 - Court Reporter		15.38
01051 - Data Entry Operator I		10.48
01052 - Data Entry Operator II		11.99
01060 - Dispatcher, Motor Vehicle		13.06
01070 - Document Preparation Clerk		12.25
01090 - Duplicating Machine Operator		12.25
01111 - General Clerk I		10.29
01112 - General Clerk II		11.28
01113 - General Clerk III		12.32
01120 - Housing Referral Assistant		17.15
01141 - Messenger Courier		10.12
01191 - Order Clerk I		11.23
01192 - Order Clerk II		12.25
01261 - Personnel Assistant (Employment) I		14.33
01262 - Personnel Assistant (Employment) II		14.90
01263 - Personnel Assistant (Employment) III		16.48
01270 - Production Control Clerk		18.34
01280 - Receptionist		9.67
01290 - Rental Clerk		11.10
01300 - Scheduler, Maintenance		13.75
01311 - Secretary I		13.75
01312 - Secretary II		15.38
01313 - Secretary III		17.15
01320 - Service Order Dispatcher		11.57

01410 - Supply Technician	17.67
01420 - Survey Worker	15.26
01531 - Travel Clerk I	11.61
01532 - Travel Clerk II	12.57
01533 - Travel Clerk III	13.44
01611 - Word Processor I	12.25
01612 - Word Processor II	13.75
01613 - Word Processor III	15.38
05000 - Automotive Service Occupations	
05005 - Automobile Body Repairer, Fiberglass	13.34
05010 - Automotive Electrician	13.06
05040 - Automotive Glass Installer	12.10
05070 - Automotive Worker	12.10
05110 - Mobile Equipment Servicer	8.59
05130 - Motor Equipment Metal Mechanic	13.06
05160 - Motor Equipment Metal Worker	12.10
05190 - Motor Vehicle Mechanic	13.06
05220 - Motor Vehicle Mechanic Helper	10.12
05250 - Motor Vehicle Upholstery Worker	12.10
05280 - Motor Vehicle Wrecker	12.10
05310 - Painter, Automotive	12.37
05340 - Radiator Repair Specialist	12.10
05370 - Tire Repairer	7.81
05400 - Transmission Repair Specialist	12.10
07000 - Food Preparation And Service Occupations	
07010 - Baker	10.47
07041 - Cook I	9.54
07042 - Cook II	11.78
07070 - Dishwasher	7.25
07130 - Food Service Worker	7.78
07210 - Meat Cutter	11.86
07260 - Waiter/Waitress	7.59
09000 - Furniture Maintenance And Repair Occupations	
09010 - Electrostatic Spray Painter	14.38
09040 - Furniture Handler	8.85
09080 - Furniture Refinisher	14.38
09090 - Furniture Refinisher Helper	10.66
09110 - Furniture Repairer, Minor	12.51
09130 - Upholsterer	14.38
11000 - General Services And Support Occupations	
11030 - Cleaner, Vehicles	8.23
11060 - Elevator Operator	8.23
11090 - Gardener	10.99
11122 - Housekeeping Aide	8.33
11150 - Janitor	8.23
11210 - Laborer, Grounds Maintenance	9.14
11240 - Maid or Houseman	7.25
11260 - Pruner	8.23
11270 - Tractor Operator	10.33
11330 - Trail Maintenance Worker	9.14
11360 - Window Cleaner	9.14
12000 - Health Occupations	
12010 - Ambulance Driver	15.81
12011 - Breath Alcohol Technician	15.81
12012 - Certified Occupational Therapist Assistant	21.70
12015 - Certified Physical Therapist Assistant	21.70
12020 - Dental Assistant	13.20
12025 - Dental Hygienist	29.85
12030 - EKG Technician	23.96
12035 - Electroneurodiagnostic Technologist	23.96
12040 - Emergency Medical Technician	15.81

12071 - Licensed Practical Nurse I		14.14
12072 - Licensed Practical Nurse II		15.81
12073 - Licensed Practical Nurse III		17.63
12100 - Medical Assistant		11.54
12130 - Medical Laboratory Technician		14.14
12160 - Medical Record Clerk		11.82
12190 - Medical Record Technician		13.59
12195 - Medical Transcriptionist		14.14
12210 - Nuclear Medicine Technologist		34.75
12221 - Nursing Assistant I		10.03
12222 - Nursing Assistant II		11.30
12223 - Nursing Assistant III		12.31
12224 - Nursing Assistant IV		13.84
12235 - Optical Dispenser		15.81
12236 - Optical Technician		14.14
12250 - Pharmacy Technician		13.41
12280 - Phlebotomist		13.84
12305 - Radiologic Technologist		22.64
12311 - Registered Nurse I		20.70
12312 - Registered Nurse II		25.32
12313 - Registered Nurse II, Specialist		25.32
12314 - Registered Nurse III		30.64
12315 - Registered Nurse III, Anesthetist		30.64
12316 - Registered Nurse IV		36.72
12317 - Scheduler (Drug and Alcohol Testing)		19.59
13000 - Information And Arts Occupations		
13011 - Exhibits Specialist I		15.06
13012 - Exhibits Specialist II		18.66
13013 - Exhibits Specialist III		22.83
13041 - Illustrator I		15.06
13042 - Illustrator II		18.66
13043 - Illustrator III		22.83
13047 - Librarian		20.66
13050 - Library Aide/Clerk		12.00
13054 - Library Information Technology Systems Administrator		18.66
13058 - Library Technician		15.06
13061 - Media Specialist I		13.46
13062 - Media Specialist II		15.06
13063 - Media Specialist III		16.80
13071 - Photographer I		12.82
13072 - Photographer II		14.32
13073 - Photographer III		17.75
13074 - Photographer IV		21.73
13075 - Photographer V		26.30
13110 - Video Teleconference Technician		12.91
14000 - Information Technology Occupations		
14041 - Computer Operator I		13.65
14042 - Computer Operator II		15.76
14043 - Computer Operator III		17.56
14044 - Computer Operator IV		19.50
14045 - Computer Operator V		21.81
14071 - Computer Programmer I	(see 1)	15.73
14072 - Computer Programmer II	(see 1)	19.50
14073 - Computer Programmer III	(see 1)	23.84
14074 - Computer Programmer IV	(see 1)	
14101 - Computer Systems Analyst I	(see 1)	24.23
14102 - Computer Systems Analyst II	(see 1)	
14103 - Computer Systems Analyst III	(see 1)	
14150 - Peripheral Equipment Operator		13.65
14160 - Personal Computer Support Technician		19.50

15000 - Instructional Occupations	
15010 - Aircrew Training Devices Instructor (Non-Rated)	24.23
15020 - Aircrew Training Devices Instructor (Rated)	29.32
15030 - Air Crew Training Devices Instructor (Pilot)	33.30
15050 - Computer Based Training Specialist / Instructor	24.23
15060 - Educational Technologist	22.82
15070 - Flight Instructor (Pilot)	33.30
15080 - Graphic Artist	20.47
15090 - Technical Instructor	17.65
15095 - Technical Instructor/Course Developer	21.58
15110 - Test Proctor	13.87
15120 - Tutor	13.87
16000 - Laundry, Dry-Cleaning, Pressing And Related Occupations	
16010 - Assembler	8.08
16030 - Counter Attendant	8.08
16040 - Dry Cleaner	9.34
16070 - Finisher, Flatwork, Machine	8.08
16090 - Presser, Hand	8.08
16110 - Presser, Machine, Drycleaning	8.08
16130 - Presser, Machine, Shirts	8.08
16160 - Presser, Machine, Wearing Apparel, Laundry	8.08
16190 - Sewing Machine Operator	9.86
16220 - Tailor	10.33
16250 - Washer, Machine	8.46
19000 - Machine Tool Operation And Repair Occupations	
19010 - Machine-Tool Operator (Tool Room)	14.49
19040 - Tool And Die Maker	18.20
21000 - Materials Handling And Packing Occupations	
21020 - Forklift Operator	12.49
21030 - Material Coordinator	18.34
21040 - Material Expediter	18.34
21050 - Material Handling Laborer	10.65
21071 - Order Filler	9.66
21080 - Production Line Worker (Food Processing)	12.49
21110 - Shipping Packer	13.33
21130 - Shipping/Receiving Clerk	13.33
21140 - Store Worker I	13.23
21150 - Stock Clerk	18.58
21210 - Tools And Parts Attendant	12.49
21410 - Warehouse Specialist	12.49
23000 - Mechanics And Maintenance And Repair Occupations	
23010 - Aerospace Structural Welder	20.69
23021 - Aircraft Mechanic I	19.70
23022 - Aircraft Mechanic II	20.69
23023 - Aircraft Mechanic III	21.74
23040 - Aircraft Mechanic Helper	13.70
23050 - Aircraft, Painter	18.50
23060 - Aircraft Servicer	16.09
23080 - Aircraft Worker	17.38
23110 - Appliance Mechanic	14.49
23120 - Bicycle Repairer	9.74
23125 - Cable Splicer	15.43
23130 - Carpenter, Maintenance	13.00
23140 - Carpet Layer	13.55
23160 - Electrician, Maintenance	14.99
23181 - Electronics Technician Maintenance I	14.72
23182 - Electronics Technician Maintenance II	15.05
23183 - Electronics Technician Maintenance III	18.31
23260 - Fabric Worker	12.60
23290 - Fire Alarm System Mechanic	15.43
23310 - Fire Extinguisher Repairer	11.67

23311 - Fuel Distribution System Mechanic	15.43
23312 - Fuel Distribution System Operator	13.01
23370 - General Maintenance Worker	11.95
23380 - Ground Support Equipment Mechanic	19.70
23381 - Ground Support Equipment Servicer	16.09
23382 - Ground Support Equipment Worker	17.38
23391 - Gunsmith I	11.67
23392 - Gunsmith II	13.55
23393 - Gunsmith III	15.43
23410 - Heating, Ventilation And Air-Conditioning Mechanic	15.76
23411 - Heating, Ventilation And Air Contditioning Mechanic (Research Facility)	16.55
23430 - Heavy Equipment Mechanic	15.15
23440 - Heavy Equipment Operator	13.73
23460 - Instrument Mechanic	15.43
23465 - Laboratory/Shelter Mechanic	14.49
23470 - Laborer	10.65
23510 - Locksmith	14.49
23530 - Machinery Maintenance Mechanic	17.38
23550 - Machinist, Maintenance	15.43
23580 - Maintenance Trades Helper	9.92
23591 - Metrology Technician I	15.43
23592 - Metrology Technician II	16.41
23593 - Metrology Technician III	17.37
23640 - Millwright	15.43
23710 - Office Appliance Repairer	14.38
23760 - Painter, Maintenance	13.55
23790 - Pipefitter, Maintenance	15.32
23810 - Plumber, Maintenance	14.38
23820 - Pneudraulic Systems Mechanic	15.43
23850 - Rigger	15.43
23870 - Scale Mechanic	13.55
23890 - Sheet-Metal Worker, Maintenance	15.21
23910 - Small Engine Mechanic	13.55
23931 - Telecommunications Mechanic I	19.01
23932 - Telecommunications Mechanic II	19.76
23950 - Telephone Lineman	18.24
23960 - Welder, Combination, Maintenance	14.66
23965 - Well Driller	15.43
23970 - Woodcraft Worker	15.43
23980 - Woodworker	11.67
24000 - Personal Needs Occupations	
24570 - Child Care Attendant	10.09
24580 - Child Care Center Clerk	12.58
24610 - Chore Aide	12.43
24620 - Family Readiness And Support Services Coordinator	12.44
24630 - Homemaker	16.12
25000 - Plant And System Operations Occupations	
25010 - Boiler Tender	15.43
25040 - Sewage Plant Operator	14.49
25070 - Stationary Engineer	15.43
25190 - Ventilation Equipment Tender	10.73
25210 - Water Treatment Plant Operator	14.49
27000 - Protective Service Occupations	
27004 - Alarm Monitor	10.90
27007 - Baggage Inspector	7.35
27008 - Corrections Officer	12.05
27010 - Court Security Officer	12.05
27030 - Detection Dog Handler	10.90

27040 - Detention Officer		12.05
27070 - Firefighter		12.05
27101 - Guard I		7.37
27102 - Guard II		10.90
27131 - Police Officer I		12.05
27132 - Police Officer II		13.40
28000 - Recreation Occupations		
28041 - Carnival Equipment Operator		9.53
28042 - Carnival Equipment Repairer		10.08
28043 - Carnival Equpment Worker		7.78
28210 - Gate Attendant/Gate Tender		13.18
28310 - Lifeguard		11.01
28350 - Park Attendant (Aide)		14.74
28510 - Recreation Aide/Health Facility Attendant		10.76
28515 - Recreation Specialist		18.26
28630 - Sports Official		11.74
28690 - Swimming Pool Operator		17.71
29000 - Stevedoring/Longshoremen Occupational Services		
29010 - Blocker And Bracer		15.20
29020 - Hatch Tender		15.20
29030 - Line Handler		15.20
29041 - Stevedore I		14.22
29042 - Stevedore II		16.25
30000 - Technical Occupations		
30010 - Air Traffic Control Specialist, Center (HFO)	(see 2)	35.77
30011 - Air Traffic Control Specialist, Station (HFO)	(see 2)	24.66
30012 - Air Traffic Control Specialist, Terminal (HFO)	(see 2)	27.16
30021 - Archeological Technician I		17.49
30022 - Archeological Technician II		19.56
30023 - Archeological Technician III		24.21
30030 - Cartographic Technician		23.18
30040 - Civil Engineering Technician		21.93
30061 - Drafter/CAD Operator I		17.49
30062 - Drafter/CAD Operator II		19.56
30063 - Drafter/CAD Operator III		20.74
30064 - Drafter/CAD Operator IV		24.21
30081 - Engineering Technician I		14.62
30082 - Engineering Technician II		16.41
30083 - Engineering Technician III		18.36
30084 - Engineering Technician IV		22.34
30085 - Engineering Technician V		27.83
30086 - Engineering Technician VI		33.66
30090 - Environmental Technician		21.10
30210 - Laboratory Technician		20.74
30240 - Mathematical Technician		23.34
30361 - Paralegal/Legal Assistant I		19.06
30362 - Paralegal/Legal Assistant II		21.53
30363 - Paralegal/Legal Assistant III		26.35
30364 - Paralegal/Legal Assistant IV		30.80
30390 - Photo-Optics Technician		21.93
30461 - Technical Writer I		22.17
30462 - Technical Writer II		27.10
30463 - Technical Writer III		32.79
30491 - Unexploded Ordnance (UXO) Technician I		22.74
30492 - Unexploded Ordnance (UXO) Technician II		27.51
30493 - Unexploded Ordnance (UXO) Technician III		32.97
30494 - Unexploded (UXO) Safety Escort		22.74
30495 - Unexploded (UXO) Sweep Personnel		22.74
30620 - Weather Observer, Combined Upper Air Or Surface Programs	(see 2)	20.74
30621 - Weather Observer, Senior	(see 2)	23.00

31000 - Transportation/Mobile Equipment Operation Occupations	
31020 - Bus Aide	8.15
31030 - Bus Driver	9.69
31043 - Driver Courier	8.97
31260 - Parking and Lot Attendant	7.25
31290 - Shuttle Bus Driver	9.99
31310 - Taxi Driver	8.21
31361 - Truckdriver, Light	8.97
31362 - Truckdriver, Medium	11.61
31363 - Truckdriver, Heavy	12.48
31364 - Truckdriver, Tractor-Trailer	12.48
99000 - Miscellaneous Occupations	
99030 - Cashier	7.46
99050 - Desk Clerk	9.70
99095 - Embalmer	22.74
99251 - Laboratory Animal Caretaker I	16.24
99252 - Laboratory Animal Caretaker II	17.04
99310 - Mortician	22.74
99410 - Pest Controller	13.28
99510 - Photofinishing Worker	11.95
99710 - Recycling Laborer	10.76
99711 - Recycling Specialist	16.27
99730 - Refuse Collector	10.24
99810 - Sales Clerk	8.95
99820 - School Crossing Guard	15.03
99830 - Survey Party Chief	20.30
99831 - Surveying Aide	11.54
99832 - Surveying Technician	15.00
99840 - Vending Machine Attendant	20.19
99841 - Vending Machine Repairer	23.57
99842 - Vending Machine Repairer Helper	20.19

ALL OCCUPATIONS LISTED ABOVE RECEIVE THE FOLLOWING BENEFITS:

HEALTH & WELFARE: $4.02 per hour or $160.80 per week or $696.79 per month

VACATION: 2 weeks paid vacation after 1 year of service with a contractor or successor; and 4 weeks after 3 years. Length of service includes the whole span of continuous service with the present contractor or successor, wherever employed, and with the predecessor contractors in the performance of similar work at the same Federal facility. (Reg. 29 CFR 4.173)

HOLIDAYS: A minimum of ten paid holidays per year, New Year's Day, Martin Luther King Jr's Birthday, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans' Day, Thanksgiving Day, and Christmas Day. (A contractor may substitute for any of the named holidays another day off with pay in accordance with a plan communicated to the employees involved.) (See 29 CFR 4174)

THE OCCUPATIONS WHICH HAVE NUMBERED FOOTNOTES IN PARENTHESES RECEIVE THE FOLLOWING:

1) COMPUTER EMPLOYEES: Under the SCA at section 8(b), this wage determination does not apply to any employee who individually qualifies as a bona fide executive, administrative, or professional employee as defined in 29 C.F.R. Part 541. Because most Computer System Analysts and Computer Programmers who are compensated at a rate

not less than $27.63 (or on a salary or fee basis at a rate not less than $455 per week) an hour would likely qualify as exempt computer professionals, (29 C.F.R. 541. 400) wage rates may not be listed on this wage determination for all occupations within those job families. In addition, because this wage determination may not list a wage rate for some or all occupations within those job families if the survey data indicates that the prevailing wage rate for the occupation equals or exceeds $27.63 per hour conformances may be necessary for certain nonexempt employees. For example, if an individual employee is nonexempt but nevertheless performs duties within the scope of one of the Computer Systems Analyst or Computer Programmer occupations for which this wage determination does not specify an SCA wage rate, then the wage rate for that employee must be conformed in accordance with the conformance procedures described in the conformance note included on this wage determination.

Additionally, because job titles vary widely and change quickly in the computer industry, job titles are not determinative of the application of the computer professional exemption. Therefore, the exemption applies only to computer employees who satisfy the compensation requirements and whose primary duty consists of:

(1) The application of systems analysis techniques and procedures, including consulting with users, to determine hardware, software or system functional specifications;

(2) The design, development, documentation, analysis, creation, testing or modification of computer systems or programs, including prototypes, based on and related to user or system design specifications;

(3) The design, documentation, testing, creation or modification of computer programs related to machine operating systems; or

(4) A combination of the aforementioned duties, the performance of which requires the same level of skills. (29 C.F.R. 541.400).

2) AIR TRAFFIC CONTROLLERS AND WEATHER OBSERVERS - NIGHT PAY & SUNDAY PAY: If you work at night as part of a regular tour of duty, you will earn a night differential and receive an additional 10% of basic pay for any hours worked between 6pm and 6am. If you are a full-time employed (40 hours a week) and Sunday is part of your regularly scheduled workweek, you are paid at your rate of basic pay plus a Sunday premium of 25% of your basic rate for each hour of Sunday work which is not overtime (i.e. occasional work on Sunday outside the normal tour of duty is considered overtime work).

HAZARDOUS PAY DIFFERENTIAL: An 8 percent differential is applicable to employees employed in a position that represents a high degree of hazard when working with or in close proximity to ordinance, explosives, and incendiary materials. This includes work such as screening, blending, dying, mixing, and pressing of sensitive ordance, explosives, and pyrotechnic compositions such as lead azide, black powder and photoflash powder. All dry-house activities involving propellants or explosives. Demilitarization, modification, renovation, demolition, and maintenance operations on sensitive ordnance, explosives and incendiary materials. All operations involving regrading and cleaning of artillery ranges.

A 4 percent differential is applicable to employees employed in a position that represents a low degree of hazard when working with, or in close proximity to ordance, (or employees possibly adjacent to) explosives and incendiary materials which involves potential injury such as laceration of hands, face, or arms of the employee engaged in the operation, irritation of the skin, minor burns and the like; minimal damage to immediate or adjacent work area or equipment being used. All operations involving, unloading, storage, and hauling of ordance, explosive, and incendiary ordnance material other than small arms ammunition. These differentials are only applicable to work that has been specifically designated by the agency for ordance, explosives, and incendiary material differential pay.

** UNIFORM ALLOWANCE **

If employees are required to wear uniforms in the performance of this contract (either by the terms of the Government contract, by the employer, by the state or local law, etc.), the cost of furnishing such uniforms and maintaining (by laundering or dry cleaning) such uniforms is an expense that may not be borne by an employee where such cost reduces the hourly rate below that required by the wage determination. The Department of Labor will accept payment in accordance with the following standards as compliance:

The contractor or subcontractor is required to furnish all employees with an adequate number of uniforms without cost or to reimburse employees for the actual cost of the uniforms. In addition, where uniform cleaning and maintenance is made the responsibility of the employee, all contractors and subcontractors subject to this wage determination shall (in the absence of a bona fide collective bargaining agreement providing for a different amount, or the furnishing of contrary affirmative proof as to the actual cost), reimburse all employees for such cleaning and maintenance at a rate of $3.35 per week (or $.67 cents per day). However, in those instances where the uniforms furnished are made of "wash and wear" materials, may be routinely washed and dried with other personal garments, and do not require any special treatment such as dry cleaning, daily washing, or commercial laundering in order to meet the cleanliness or appearance standards set by the terms of the Government contract, by the contractor, by law, or by the nature of the work, there is no requirement that employees be reimbursed for uniform maintenance costs.

The duties of employees under job titles listed are those described in the "Service Contract Act Directory of Occupations", Fifth Edition, April 2006, unless otherwise indicated. Copies of the Directory are available on the Internet. A links to the Directory may be found on the WHD home page at http://www.dol.gov/esa/whd/ or through the Wage Determinations On-Line (WDOL) Web site at http://wdol.gov/.

REQUEST FOR AUTHORIZATION OF ADDITIONAL CLASSIFICATION AND WAGE RATE {Standard Form 1444 (SF 1444)}

Conformance Process:

The contracting officer shall require that any class of service employee which is not listed herein and which is to be employed under the contract (i.e., the work to be performed is not performed by any classification listed in the wage determination), be classified by the contractor so as to provide a reasonable relationship (i.e., appropriate level of skill comparison) between such unlisted classifications and the classifications listed in the wage determination. Such conformed classes of employees shall be paid the monetary wages and furnished the fringe benefits as are determined. Such conforming process shall be initiated by the contractor prior to the performance of contract work by such unlisted class(es) of employees. The conformed classification, wage rate, and/or fringe benefits shall be retroactive to the commencement date of the contract. {See Section 4.6 (C)(vi)} When multiple wage determinations are included in a contract, a separate SF 1444 should be prepared for each wage determination to which a class(es) is to be conformed.

The process for preparing a conformance request is as follows:

1) When preparing the bid, the contractor identifies the need for a conformed occupation(s) and computes a proposed rate(s).

2) After contract award, the contractor prepares a written report listing in order proposed classification title(s), a Federal grade equivalency (FGE) for each proposed classification(s), job description(s), and rationale for proposed wage rate(s), including information regarding the agreement or disagreement of the authorized representative of the employees involved, or where there is no authorized

representative, the employees themselves. This report should be submitted to the contracting officer no later than 30 days after such unlisted class(es) of employees performs any contract work.

3) The contracting officer reviews the proposed action and promptly submits a report of the action, together with the agency's recommendations and pertinent information including the position of the contractor and the employees, to the Wage and Hour Division, Employment Standards Administration, U.S. Department of Labor, for review. (See section 4.6(b)(2) of Regulations 29 CFR Part 4).

4) Within 30 days of receipt, the Wage and Hour Division approves, modifies, or disapproves the action via transmittal to the agency contracting officer, or notifies the contracting officer that additional time will be required to process the request.

5) The contracting officer transmits the Wage and Hour decision to the contractor.

6) The contractor informs the affected employees.

Information required by the Regulations must be submitted on SF 1444 or bond paper.

When preparing a conformance request, the "Service Contract Act Directory of Occupations" (the Directory) should be used to compare job definitions to insure that duties requested are not performed by a classification already listed in the wage determination. Remember, it is not the job title, but the required tasks that determine whether a class is included in an established wage determination. Conformances may not be used to artificially split, combine, or subdivide classifications listed in the wage determination.

EXHIBIT L

Judicial Council of Guam Procurement Regulations

Section 6(G)

SECTION 6. PURCHASING ANDCONTRACTING PROCEDURES

. . .

(G) REQUEST FOR PROPOSALS FOR HEALTH CARE SERVICES.

(1) The Purchasing Officer may issue Requests for Health Proposals ("RFHP") fo the procurement of Health Care Services, including the service of providing health insurance or benefits for medical and dental services as a benefit to its employees. Anything in the Judiciary Procurement Regulations to the contrary notwithstanding, the Purchasing Officer shall develop minimum qualifications for proposals to be submitted for health insurance coverage; is authorized to contract for the services of a recognized insurance consultant to advise the Purchasing Officer; shall announce the RFHP for qualified active employees of the Judicial Branch of Guam pursuant to 4 GCA § 4301(c); and shall review the best available proposals by participating healthcare respondents/providers which reflect the most economical and beneficial healthcare insurance proposal plan for Judiciary employees and their dependents. Pursuant to 4 GCA § 4302(d), no health insurance company or health care provider contracted to provide health care to Judiciary employees may deny coverage to the employee or dependents on the basis of a congenital anomaly. No health insurance company or health care provider contracted to provide health care to Judiciary of Guam employees may deny coverage to the employee or dependents on the basis of chronic orthopedic deformities as that term is defined in 4 GCA § 4302(h). Blood and blood derivatives will be covered pursuant to 4 GCA § 4302(i).

(2) Procurement of such Health Care Services shall be conducted pursuant to the steps set forth below. The manner of securing proposals shall be "Request for Health Proposals."

The Request for Health Proposals ("RFHP"). The RFHP shall be prepared in the same manner as provided for preparation of an Invitation to Bid, provided that it shall also include a statement that discussions may be conducted with, and comparative judgmental evaluations may be made regarding, offerors who submit proposals determined to be reasonably susceptible of being selected for award, although proposals may be accepted without such discussions.

(a) Notice. Public notice of the RFHP shall be given in the same manner as provided for notice of an Invitation to Bid.

(b) Pre-Proposal Conferences. A pre-proposal conference may be conducted at the discretion of the Purchasing Officer to explain procurement requirements prior to the date set for submission of proposals. Notice of a pre-proposal conference may be included in the RFHP or sent to the known prospective proposers.

(c) Amendments to RFHP. Amendments to RFHP may be made in accordance with Amendments to Invitations to Bid.

(d) Receipt and Handling of Proposals. Proposals and modifications shall be time-stamped upon receipt and held in a secure place until the established due date. Proposals shall not be opened publicly nor disclosed to unauthorized persons, but shall be opened in the

presence of two or more procurement officials. A Register of Proposals shall be established which shall include, for all proposals, the name of each offeror, the number of modifications received, if any, and a description sufficient to identify the services offered. The Register of Proposals shall be opened to public inspection only after award of the contract. Proposals of offerors who are not awarded the contract shall not be opened to public inspection.

(3) Evaluation Factors in the Request for Health Proposals

The Request for Health Proposals shall state all of the evaluation factors, including price, and their relative importance.

(a) Evaluations

The evaluation shall be based on the evaluation factors set forth in the Request for Health Proposals. Numerical rating systems may be used, but are not required.

1. Classifying Proposals

For the purpose of conducting Discussions with Individual Offerors, proposals shall be initially classified as:

i. Acceptable;

ii. Potentially acceptable, that is, reasonably susceptible of being made acceptable; or

iii. Unacceptable.

Offerors whose proposals are unacceptable shall be so notified promptly.

2. Purpose of Discussions

Discussions are held to:

i. Promote understanding of the Judiciary's requirements and the offerors' proposals; and

ii. Facilitate arriving at a contract that will be most advantageous to the Judiciary, taking into consideration price and the other evaluation factors set forth in the Request for Health Proposals.

3. Conduct of Discussions

Offerors shall be accorded fair and equal treatment with respect to any opportunity for discussions and revisions of proposals. The Purchasing Officer should establish procedures and schedules for conducting discussions. If during discussions there is a need for any substantial clarification of or change in the RFHP, the Request shall be amended to incorporate such clarification or change. Auction techniques (revealing one offeror's price to another) and disclosure of any information derived from competing proposals are prohibited. Any substantial oral clarification of a proposal shall be reduced to writing by the offeror.

4. Best and Final Offers

The Purchasing Officer shall establish a common date and time for the submission of best and final offers. Best and final offers shall be submitted only once; provided, however, the Purchasing Officer may make written determination that it is in the Judiciary's best interest to conduct additional discussions or change the Judiciary's requirements and require another submission of best and final offers. Otherwise, no discussion of or changes in the best and final offers shall be allowed prior to award. Offerors shall also be informed that if they do not submit a notice of withdrawal or another best and final offer, their immediate previous offer will be construed as their best and final offer.

5. Mistakes in Proposals

(a) Modification or Withdrawal of Proposal

Proposals may be modified or withdrawn prior to the established due date. For purposes of this section, the established due date is either the time and date announced for receipt of proposals or receipt of modifications of proposal, if any; or if discussions have begun, it is the time and date by which best and final offers must be submitted, provided that only offerors who submitted proposals by the time announced for receipt of proposals may submit best and final offers.

(b) Confirmation of Proposal

When the Purchasing Officer knows or has reason to conclude before award that a mistake has been made, such officer should request the offeror to confirm the proposal. If the offeror alleges mistake, the proposal may be corrected or withdrawn during any discussions that are held or if conditions set forth in Subsections 6(G)(3)(a)(5)(c)(5)(i-iii) are met.

(c) Mistakes Discovered after Receipt of Proposals but Before Award

(1) This Subsection sets forth procedures to be applied in the following situations in which mistakes in proposals are discovered after receipt of proposals but before award.

(2) During Discussions; Prior to Best and Final Offers. Once discussions are commenced with any offeror or after best and final offers are requested, any offeror may freely correct any mistake by modifying or withdrawing the proposal until the time and date set forth for receipt of best and final offers.

(3) Minor Informalities. Minor informalities, unless otherwise corrected by an offeror as provided in this section, shall be treated as they are under competitive sealed bidding in Section 6(A)(1)(e) above.

(4) Correction of Mistakes. If discussions are not held or if best and final offers upon which award will be made have been received, mistakes may be corrected and the intended correct offer considered only if:

(i) The mistake and the intended correct offer are clearly evident on the face of the proposal, in

which event the proposal may not be withdrawn; or

(ii) the mistake is not clearly evident on the face of the proposal, but the offeror submits proof of evidentiary value which clearly and convincingly demonstrates both the existence of a mistake and intended correct offer, and such correction would not be contrary to the fair and equal treatment of other offerors.

(5) Withdrawal of Proposals. If discussions are not held, or if the best and final offers upon which award will be made have been received, the offeror may be permitted to withdraw the proposal if:

(i) the mistake is clearly evident on the face of the proposal and the intended correct offer is not;

(ii.) the offeror submits proof of evidentiary value which clearly and convincingly demonstrates that a mistake was made, but does not demonstrate the intended correct offer; or

(iii.) the offeror submits proof of evidentiary value which clearly and convincingly demonstrates the intended correct offer, but to allow correction could be contrary to the fair and equal treatment of the other offerors.

(d) Mistakes Discovered after Award

Mistakes shall not be corrected after award of the contract except where the Purchasing Officer finds it would be unconscionable not to allow the mistake to be corrected.

(e) Determinations Required

When a proposal is corrected or withdrawn, or when correction or withdrawal is denied as provided above, a written determination shall be prepared showing that relief was granted or denied in accordance with these Regulations. The Purchasing Officer shall prepare the determination.

(b) Award.

1. The Purchasing Officer shall make a written determination showing the basis on which the award was found to be most advantageous to the Judiciary based on the factors set forth in the RFHP including price.

2. Publicizing Awards. After a contract is entered into, notice of award shall be posted in the Purchasing Officer's office or public information office of the Judiciary.

EXHIBIT M

Marketing Guidelines for Health Insurance Carriers

These marketing guidelines apply to all Health insurance carriers contracting with or intending to contract with the Judiciary of Guam.

A. MARKETING MATERIALS

1. Each carrier shall prepare a Judiciary of Guam plan brochure, setting forth the benefits and conditions of the plan, for distribution to subscribers and prospective subscribers.

2. Each carrier may prepare other marketing materials, including newspaper and other media advertising copy, in addition to those required in paragraphs 1 above.

3. All marketing materials must be submitted to the Judiciary of Guam's Administrator of the Courts or his or her designee with a written statement signed by an appropriate officer of the carrier certifying that the materials have been prepared in accordance with these guidelines.

4. The Judiciary of Guam's Administrator of the Courts of Guam must approve the content of all marketing materials in writing. Such written approval, however, does not guarantee the carrier that its marketing materials will be free from future scrutiny or that the carrier will not attract penalties should the marketing materials later be determined to be out of compliance with these guidelines.

5. Marketing materials which have not been approved for content may not be distributed or displayed. Further, no marketing materials may be distributed or displayed prior to the date specified in writing by the Judiciary of Guam's Administrator of the Courts. No marketing materials will be approved for distribution or display prior to the conclusion of negotiations with all carriers.

6. Once approved for content and distribution and display, all marketing materials, excluding newspaper and other media advertising copy, must be made available to the Judiciary of Guam as quickly as possible.

B. MARKETING STANDARDS

1. All marketing materials, including newspaper and other media advertising and open enrollment presentations, must be truthful and not misleading.

2. All marketing materials must be worded simply, clearly and concisely so that they are readily understandable.

3. All marketing materials must contain sufficient detail to ensure accuracy.

4. At least the plan brochure should contain a statement that full details of the plan are contained in the carrier's contract with the Judiciary of Guam.

5. If an insurance company markets wrongful products, benefits or advertises in their brochure incorrect information, the insurance company must place at least 2 media advertisements, in addition to giving memos to all enrollees, satisfactory to Judiciary of Guam, of correct version. Plans must also prepare an insert of corrected information and include it in all brochures, if not already corrected the language in the brochure.

C. PENALTIES FOR NON-COMPLIANCE

1. Failure to conform to these guidelines may result in corrective action by the Administrator of the Courts. Such corrective action will be appropriate to the circumstances. For example, if a carrier indicates benefits or other plan provisions that are more favorable to enrollees than those specified in the Judiciary of Guam contract, the carrier will be required to provide those more generous benefits or provisions without additional compensation for the entire contract year(s).

2. Interpretation and enforcement of these guidelines shall be at the sole discretion of the Administrator of the Courts. The Judiciary of Guam shall have no liability with regard to the alleged or actual failure to enforce these guidelines.

D. EXPENSES

1. A Personnel/Payroll Officers meeting will be conducted prior to the Open Enrollment Period. The purpose of this meeting is to advise all Judiciary representatives of the benefits available and premiums for the Health insurance program. The insurance company awarded the contract will secure and absorb the cost of the Personnel/Payroll Officers Meeting. Specifications will be provided by the Judiciary of Guam.

2. All expenses involved in the preparation and distribution of marketing materials shall be borne by the respective carrier. The Judiciary of Guam shall have no liability with regard to any marketing materials or any costs which may be incurred because of any alleged or actual delay in the approval or a carrier's marketing materials.

E. AGREEMENT TO MARKETING GUIDELINES

By signing below, the offeror agrees to comply with the Marketing Guidelines.

Insurance Company: _____

Print/Signature/Date _____

EXHIBIT N

Premium and Retention Quotation
For Contract Year October 2015 to September 2016

[Please see Excel File for Pricing Templates – these must be completed and returned via Excel file and PDF file.]

Premium and Retention Quotations

Instructions

1. Each following exhibit has been provided in the Excel file to be completed by the offeror.

2. Compute the expected annual premium, using the monthly premium rates entered on the form and your estimate of the employees in the various classes you enter in space 2.

3. Enter the percent of premiums you expect to use to pay for hospital, surgical, medical and similar services.

4. Subtract the percent in item 2 from 100.

5. Show the percent of total premiums to be used for each of the various expense categories listed. Show if you will incur no expense in a category.

6. A brief explanation of the method of calculating the items shown should be furnished. An additional page may be used if desired. Where the expense has to be charged to the plan based on cost accounting techniques, as in item 4E, the method to allocate significant expense categories to the Judiciary of Guam plan should be explained.

7. Some of the expenses listed in item 4 will not ordinarily change proportionally if the premium is more or less than expected. This question is designed to get an understanding of this effect in your organization.

8. Many companies allow interest to a group policyholder on the difference between premiums received and the total of expenses incurred and claims paid. You should indicate if you would allow this interest and the rate applicable for the contract year you are bidding on. If you will allow interest only on part of the funds, such as an unrevealed claim reserve, you should show what funds you do allow interest on.

EXHIBIT N (continued)

Premium and Retention Quotation
For Contract Year October 2015 to September 2016

Judiciary 1000 Deductible Plan

MONTHLY PREMIUM PROPOSED

Class	Active Employees
I. Employee	
II. Employee and Spouse	
III. Employee and Child(ren)	
IV. Employee and Family	

1	Anticipated total premium in contract year	
2	Percent of premium to be used to pay incurred claims (assumes _____ employees in Class I; _____ employees in Class II; _____ employees in Class III; _____ employees in Class IV or refunds to employees	
3	Balance of premium, in percent	
4	Disposition of balance of premium, in percent:	
	A. Commissions	NONE
	B. Administrative Services or other fees	
	C. Claim payment expense	
	D. Reinsurance expense	
	E. General and overhead Expense	
	F. Gross receipts tax	
	G. Increase in Returnable reserves	
	H. Charges for risks or contingencies	
	I. Profit	
	J. Total (must equal 3 above)	
	K. Gross receipts tax	
	L. Increase in Returnable reserves	
	M. Charges for risks or contingencies	
5	Explain how items 4C, D, E, G, H and I are computed	
6	How will these expenses in percentages be affected if employees covered are 25% more or less than shown in 2?	
7	Will interest be allowed or unrevealed claim reserves and other funds of the Government of Guam held by the undersigned?	
8	If yes, at what rate	
9	Please provide the percentage of guaranteed retention	

EXHIBIT N (continued)

Premium and Retention Quotation
For Contract Year October 2015 to September 2016

Judiciary 2000 Deductible Plan

MONTHLY PREMIUM PROPOSED

Class	Active Employees
I. Employee	
II. Employee and Spouse	
III. Employee and Child(ren)	
IV. Employee and Family	

1	Anticipated total premium in contract year	
2	Percent of premium to be used to pay incurred claims (assumes _____ employees in Class I; _____ employees in Class II; _____ employees in Class III; _____ employees in Class IV or refunds to employees	
3	Balance of premium, in percent	
4	Disposition of balance of premium, in percent:	
	A. Commissions	NONE
	B. Administrative Services or other fees	
	C. Claim payment expense	
	D. Reinsurance expense	
	E. General and overhead Expense	
	F. Gross receipts tax	
	G. Increase in Returnable reserves	
	H. Charges for risks or contingencies	
	I. Profit	
	J. Total (must equal 3 above)	
	K. Gross receipts tax	
	L. Increase in Returnable reserves	
	M. Charges for risks or contingencies	
5	Explain how items 4C, D, E, G, H and I are computed	
6	How will these expenses in percentages be affected if employees covered are 25% more or less than shown in 2?	
7	Will interest be allowed or unrevealed claim reserves and other funds of the Government of Guam held by the undersigned?	
8	If yes, at what rate	
9	Please provide the percentage of guaranteed retention	

EXHIBIT N (continued)

Premium and Retention Quotation
For Contract Year October 2015 to September 2016
Judiciary Dental

MONTHLY PREMIUM PROPOSED

Class	Active Employees
I. Employee	
II. Employee and Spouse	
III. Employee and Child(ren)	
IV. Employee and Family	

1	Anticipated total premium in contract year	
2	Percent of premium to be used to pay incurred claims (assumes _____ employees in Class I; _____ employees in Class II; _____ employees in Class III; _____ employees in Class IV or refunds to employees	
3	Balance of premium, in percent	
4	Disposition of balance of premium, in percent:	
	A. Commissions	NONE
	B. Administrative Services or other fees	
	C. Claim payment expense	
	D. Reinsurance expense	
	E. General and overhead Expense	
	F. Gross receipts tax	
	G. Increase in Returnable reserves	
	H. Charges for risks or contingencies	
	I. Profit	
	J. Total (must equal 3 above)	
	K. Gross receipts tax	
	L. Increase in Returnable reserves	
	M. Charges for risks or contingencies	
5	Explain how items 4C, D, E, G, H and I are computed	
6	How will these expenses in percentages be affected if employees covered are 25% more or less than shown in 2?	
7	Will interest be allowed or unrevealed claim reserves and other funds of the Government of Guam held by the undersigned?	
8	If yes, at what rate	
9	Please provide the percentage of guaranteed retention	

EXHIBIT N (continued)

Premium and Retention Quotation

For Contract Year October 2015 to September 2016

Provide the percentage of guaranteed retention for the PPO1000, HSA2000, and Dental plans - line item for this question has been provided on the previous three tabs as question #9.

EXHIBIT N (continued)

Premium and Retention Quotation
For Contract Year October 2015 to September 2016

Alternative Plan: The same plan details as the proposed FY15 PPO1000 plan, but with a $750 annual individual deductible and $1,500 annual family deductible – all other plan details remain the same.

MONTHLY PREMIUM PROPOSED

Class	Active Employees
I. Employee	
II. Employee and Spouse	
III.Employee and Child(ren)	
IV. Employee and Family	

1	Anticipated total premium in contract year	
2	Percent of premium to be used to pay incurred claims (assumes _____ employees in Class I; _____ employees in Class II; _____ employees in Class III; _____ employees in Class IV or refunds to employees	
3	Balance of premium, in percent	
4	Disposition of balance of premium, in percent:	
	A. Commissions	NONE
	B. Administrative Services or other fees	
	C. Claim payment expense	
	D. Reinsurance expense	
	E. General and overhead Expense	
	F. Gross receipts tax	
	G. Increase in Returnable reserves	
	H. Charges for risks or contingencies	
	I. Profit	
	J. Total (must equal 3 above)	
	K. Gross receipts tax	
	L. Increase in Returnable reserves	
	M. Charges for risks or contingencies	
5	Explain how items 4C, D, E, G, H and I are computed	
6	How will these expenses in percentages be affected if employees covered are 25% more or less than shown in 2?	
7	Will interest be allowed or unrevealed claim reserves and other funds of the Government of Guam held by the undersigned?	
8	If yes, at what rate	

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EXHIBIT N (continued)
Premium and Retention Quotation
For Contract Year October 2015 to September 2016

Alternative Plan: The same plan details as the proposed FY15 PPO1000 plan, but with a $500 annual individual deductible and $1,000 annual family deductible – all other plan details remain the same.

MONTHLY PREMIUM PROPOSED

Class	Active Employees
I. Employee	
II. Employee and Spouse	
III.Employee and Child(ren)	
IV. Employee and Family	

1	Anticipated total premium in contract year	
2	Percent of premium to be used to pay incurred claims (assumes _____ employees in Class I; _____ employees in Class II; _____ employees in Class III; _____ employees in Class IV or refunds to employees	
3	Balance of premium, in percent	
4	Disposition of balance of premium, in percent:	
	A. Commissions	NONE
	B. Administrative Services or other fees	
	C. Claim payment expense	
	D. Reinsurance expense	
	E. General and overhead Expense	
	F. Gross receipts tax	
	G. Increase in Returnable reserves	
	H. Charges for risks or contingencies	
	I. Profit	
	J. Total (must equal 3 above)	
	K. Gross receipts tax	
	L. Increase in Returnable reserves	
	M. Charges for risks or contingencies	
5	Explain how items 4C, D, E, G, H and I are computed	
6	How will these expenses in percentages be affected if employees covered are 25% more or less than shown in 2?	
7	Will interest be allowed or unrevealed claim reserves and other funds of the Government of Guam held by the undersigned?	
8	If yes, at what rate	

EXHIBIT N (continued)

Additional Coverage
For Contract Year October 2015 to September 2016

	Plan Design Alternative	PPO1000 Plan	HSA2000 Plan	750 Plan	500 Plan
1	Cost to add organ transplant coverage for heart, liver, lung, pancreas, intestinal, bone marrow, cornea, and kidney to the Proposed FY15 PPO1000 and HSA2000 plans.				
2	Cost to add a combined in-network and out-of-network deductible where out-of-network claims accumulate at the in-network reimbursement rate for the same procedure to the Proposed FY15 PPO1000 and HSA2000 plans.				
3	Cost, if any, to adjust proposals for removing the limitation that results in the suspension of coverage after 90 days outside the coverage area.				

EXHIBIT O

Reporting Guidelines for Health Insurance Carriers

These reporting guidelines apply to all health insurance carriers (including health insurance companies and health maintenance organizations) contracting with or intending to contract with the Judiciary of Guam.

MONTHLY REPORTING

Each carrier shall provide the following data on a monthly claims paid basis, in electronic format, to the Judiciary of Guam:

1. Paid claims by month, separated by Medical and Rx (not incurred)
2. Enrollment by month, by plan, by class/tier (employees only, and also including dependents) and any other subgroup levels as needed by the Judiciary of Guam
3. Total paid premium by month
4. Large claim information (dollar amounts, by plan, and diagnosis, not including any personal identifiers)
5. Claims by type of service (i.e. hospital, physician, ER, etc.)
6. Top Rx usage (highest utilized drugs)
   Utilization information (average cost of hospital stay, # of physician visits, etc.)

QUARTERLY REPORTING

In addition, quarterly data submissions are required. The penalty for non-compliance is 2.5% of monthly premiums. This amount will be refunded to the Judiciary of Guam for each quarter the above data is not provided as specified in 4 GCA §4302(g).

AGREEMENT TO REPORTING GUIDELINES

By signing below, the offeror agrees to comply with the reporting guidelines and that this agreement will be incorporated as an addendum into the contract.

Health Plan:_____

Signature:_____

Title:_____

Date:_____

EXHIBIT P

Data Requirements

The Offeror must satisfy at a minimum the annual data requirements outlined below:

1. A unique contract identifier that links detailed demographic, claims utilization, and cost information(system generated or manually generated number that links subscriber data from all claim types and demographic data)
2. Enrollment by Plan, Tier/Class, Employment Status, and other Subgroups as required by the Judiciary of Guam
3. Patient demographics including date of birth, gender, and relationship to subscriber
4. Medical, Dental, and Vision claims by line detail, including:
    a. Diagnosis code (ICD9 or ICD10)
    b. Procedure codes (CPT, HCPC, CDT)
    c. Revenue codes
    d. Service dates
    e. Service provider, including:
        i. Name
        ii. Tax ID
        iii. Provider ID
        iv. Specialty code
        v. City
        vi. State
        vii. Zip code
    f. Plan payments
    g. Member payment responsibility, including:
        i. Copay
        ii. Coinsurance
        iii. Deductible
    h. Claim paid date
    i. Type of bill
    j. Facility type
    k. Claim ID number
    l. Claim ID number suffix
5. Prescription Drug claims by line detail, including:
    a. NDC codes
    b. Formulary tier identifier
    c. Pharmacy, including:
        i. Name
        ii. Provider ID
        iii. City
        iv. State
        v. Zip code
    d. Plan payments
    e. Member payment responsibilities, including:
        i. Copay
        ii. Coinsurance
        iii. Deductible
    f. Claim paid date
    g. Injectable drug indicator
    h. GPI number
    i. Ingredient cost

j. Dispensing fee
k. Rebate

6. Any other detailed demographic, claims utilization, or cost information requested by the Invitation to Bid (ITB) negotiation team for the fiscal year following the current fiscal year.

EXHIBIT Q

FY2015 Schedule of Benefits

HSA2000

JUDICIARY OF GUAM HSA2000

YOUR BENEFITS: WHAT NETCARE COVERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
DEDUCTIBLE PER INDIVIDUAL MEMBER	$2,000	$4,000
DEDUCTIBLE PER FAMILY If a member meets their $2,500 individual deductible, NetCare begins to pay for covered services for that individual member.	$4,000	$12,000
COVERAGE MAXIMUMS Individual member annual maximum	Unlimited	
OUT-OF-POCKET MAXIMUMS (Includes accumulated deductible and copays) Per Individual member per plan year Per Family per plan year	$4,000 $11,900	No Maximum No Maximum
OUT OF AREA SERVICES Any service in the Philippines, Hawaii & the U.S. Mainland	Pre-certification and approval from NetCare is required prior to services rendered at out of area services	

YOUR DEDUCTIBLE AND CO-PAY DO NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
PREVENTIVE SERVICES (Outpatient Only) In accordance with guidelines established by USPSTF, Grades A & B, and CDC. • Annual Physical Exam • Immunizations/Vaccinations • Laboratory • Counseling and Health Screenings	Plan Pays 100%	Not Covered
PRE-NATAL CARE Including routine labs and 1st ultrasound	Plan Pays 100%	Not Covered
WELL-BABY / WELL-CHILD CARE • For children 0 to 17 years • Maximum of 7 visits per year for ages 0 to 4 years • Maximum of 1 visit per year for ages 5 to 17 years	Plan Pays 100%	Not Covered
WELL-WOMAN CARE In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA) and the Women's Health and Cancer Act	Plan Pays 100%	Not Covered
STERILIZATION PROCEDURES (Prior authorization required) 1. Tubal Ligation 2. Vasectomy (Outpatient Only)	Plan Pays 100%	Not Covered

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)		NON-PARTICIPATING PROVIDERS (After Deductible is Met)
ACUPUNCTURE	Plan pays 80%; Member pays 20%		Not Covered
AIDS TREATMENT Exclusive of Experimental drugs	Plan pays 80%; Member pays 20%		Not Covered
AIRFARE BENEFIT TO CENTERS OF CARE Members must meet qualifying conditions. Plan provides roundtrip airfare upon required Plan approval.	Plan pays 100%		Not Covered
ALLERGY TESTING $500 per member per plan year	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
AMBULATORY SURGI-CENTER CARE (Pre-Certification Required)	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
ANNUAL EYE REFRACTION/EXAM (Refer to the Vision Rider benefit for eye hardware coverage)	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Not Covered
BLOOD & BLOOD DERIVATIVES	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
BREAST RECONSTRUCTIVE SURGERY In accordance with 1998 W.H.C.R.A.	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CARDIAC SURGERY	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CATARACT SURGERY (OUTPATIENT) Includes Lens Implants	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CHEMICAL DEPENDENCY	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CHEMOTHERAPY BENEFIT	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CHIROPRACTIC CARE	Plan pays 80%; Member pays 20%		Not Covered

EXHIBIT Q (continued)

FY2015 Schedule of Benefits

HSA2000

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)		Judiciary HSA2000 NON-PARTICIPATING PROVIDERS (After Deductible is Met)
CLINICAL TRIALS In relation to treatment of cancer or other life-threatening disease or condition as approved by the National Institute of Health or in case of cancer, the National Cancer Institute. 1. Outpatient Clinical Trial 2. Inpatient Clinical Trial	$40 Member Co-payment Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50% Plan pays 50%*, Member pays 50%
CONGENITAL ANOMALY DISEASES COVERAGE	Plan pays 80%; Member pays 20%		Not Covered
DIAGNOSTIC TESTING (Pre-Certification Required) • MRI, CT Scan, and other diagnostic procedures	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
DURABLE MEDICAL EQUIPMENT (DME) The lesser amount between the purchase or rental when prescribed by a Physician. (Pre-Certification Required) • Accessories • Hospital Beds • Walkers • CPAP Machine • Suction Machine • Wheelchairs • Crutches • Oxygen	Plan pays 80%; Member pays 20% of the total rental cost or purchase		Not Covered
ELECTIVE SURGERY (Pre-Certification Required)	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
EMERGENCY CARE Plan must be contacted and advised within 48 hours for off-island emergencies 1. On/Off Island emergency facility, physician services, laboratory, x-rays 2. Ambulance Services (Ground Transportation Only)	Plan pays 80%; Member pays 20%		Plan pays 80%, Member pays 20%
END STAGE RENAL DISEASE / HEMODIALYSIS	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
HEARING AIDS Maximum $500 per member per plan year	Plan pays 80%; Member pays 20%		Not Covered
HOSPITALIZATION & INPATIENT BENEFITS 1. Room & Board for semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication. 3. Physician's Hospital Services	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
IMPLANTS Limitations apply, please refer to contract. Limited to the following: • Cardiac Pacemakers • Intraocular Lens • Heart Valves • Orthopedic Internal Prosthetic Devices • Stents	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
INHALATION THERAPY	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
MATERNITY CARE Labor and Delivery	Plan pays 80%; Member pays 20%		Plan pays 70%*, Member pays 30%
MENTAL HEALTH CARE	$20 Member Co-payment		Plan pays 50%*, Member pays 50%
NUCLEAR MEDICINE (Pre-Certification Required)	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
OCCUPATIONAL THERAPY (Pre-Certification Required)	Plan pays 80%; Member pays 20%		Not Covered
ORTHOPEDIC CONDITIONS • Internal and External Prosthesis	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
OUTPATIENT PHYSICIAN CARE & SERVICES			
1. Primary Care Visit	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 50%*, Member pays 50%
2. Specialist Care Visit	$40 Member Co-Payment		Plan pays 50%*, Member pays 50%
3. Voluntary Second Surgical Opinion	$40 Member Co-Payment		Plan pays 50%*, Member pays 50%
4. Home Health Care Visit	$15 Member Co-Payment at SDA Clinic	$40 Member Co-Payment at other Clinics	Plan pays 50%*, Member pays 50%
5. Hospice (Pre-Certification Required) • Guam Only • Maximum 180 Days • Maximum $100 Per Day	$40 Member Co-Payment		Not Covered
6. Outpatient Laboratory (Diagnostic/Non-Preventive)	$0 Member Co-Payment		Plan pays 50%*, Member pays 50%
7. X-ray Services	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 50%*, Member pays 50%
8. Injections (Does not include those on the Specialty Drug List and Orthopedic Injections)	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 50%*, Member pays 50%

EXHIBIT Q (continued)
FY2015 Schedule of Benefits

HSA2000

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)		Judiciary HSA2000 NON-PARTICIPATING PROVIDERS (After Deductible is Met)
PHYSICAL THERAPY (Pre-Certification Required)	Plan pays 80% for the first 20 visits and 50% thereafter		Plan pays 50%*, Member pays 50%
PRESCRIPTION DRUGS	Retail	Mail	
1. Formulary Generic Drugs	Member pays 10%	Member pays 10%	Plan pays 50% of AWP**
2. Formulary Brand Name Drugs	Member pays 20%	Member pays 20%	Plan pays 50% of AWP**
3. Non-Formulary Drugs (Medically Necessary Only and Pre-Certification Required)	Member pays 30%	Member pays 30%	Plan pays 50% of AWP**
4. Specialty Drugs (Medically Necessary Only and Pre-Certification Required)	Member pays 40%	Not Covered	Plan pays 50% of AWP**
RADIATION THERAPY (Pre-Certification Required)	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
SKILLED NURSING FACILITY (Pre-Certification Required) • Maximum 60 Days per Member per Plan Year	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
SLEEP MEDICINE • Sleep Apnea Study Coverage	Plan pays 80%; Member pays 20%		Plan pays 70%*, Member pays 30%
URGENT CARE			
1. In the Service Area	$20 Member Co-payment		Plan pays 80%; Member pays 20%
2. Outside the Service Area	Plan pays 80%; Member pays 20%		Plan pays 80%; Member pays 20%

ADDITIONAL BENEFITS: What the Plan Covers		
YOUR DEDUCTIBLE DOES NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
WELLNESS AND FITNESS BENEFIT 1. Wellness Benefit at a Wellness Center (Pre-Certification Required) • Member co-insurance may be reimbursed upon program completion	Plan pays 80%; Member pays 20%	Not Covered
2. Fitness Benefit • Limited to participating Fitness Centers • Attendance participation of 7 times per month	Plan pays up to $150 Cash Reward	Not Covered
VISION RIDER 1. Eye Glasses • Frames • Eyeglass Fitting 2. Eye Glass Lenses • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses • Lenticular/Aphakik Lenses 3. Contact Lenses	Plan pays 100% up to $100 per member per Plan Year.	

* ELIGIBLE CHARGES - Shall be defined as the portion of charges made to a covered person for covered services rendered which are payable to the Provider under this contract. Non-Participating Providers are limited to the lesser of actual charges of Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges.

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

DEDUCTIBLE - a fixed dollar amount the Covered Person or family must pay for covered benefits during the plan year before first dollar benefits apply. The deductible does not apply to annual Preventive Care defined in this Schedule of Benefits and non-covered benefits.

PHILIPPINE CARE - Pre-certification is required for services rendered at Philippine Participating Providers. No deductible and co-payment will apply for an annual outpatient Executive Check-up, limited to Eligible Charges in accordance to USPSTF, Grades A & B, at NetCare's Philippine Preferred Providers. The deductible will apply for non-routine or non-preventive services before first dollar benefits are paid. All charges in excess of NetCare's eligible expense is the responsibility of the member.

PRE-CERTIFICATION - covered benefits requiring a pre-certification of services from a physician must be approved by NetCare prior to services rendered.

EXHIBIT Q (continued)

FY2015 Schedule of Benefits

PPO1000

NetCare
Life & Health Insurance

JUDICIARY OF GUAM PPO1000

YOUR BENEFITS: WHAT NETCARE COVERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
DEDUCTIBLE PER INDIVIDUAL MEMBER	$1,000	$2,000
DEDUCTIBLE PER FAMILY If a member meets their $1,000 individual deductible, NetCare begins to pay for covered services for that individual member.	$2,000	$6,000
COVERAGE MAXIMUMS Individual member annual maximum	Unlimited	
OUT-OF-POCKET MAXIMUMS (Includes accumulated deductible and copays) Per Individual member per plan year Per Family per plan year	$3,000 $9,000	No Maximum No Maximum
OUT OF AREA SERVICES Any service in the Philippines, Hawaii & the U.S. Mainland	Pre-certification and approval from NetCare is required prior to services rendered at out of area services	

YOUR DEDUCTIBLE AND CO-PAY DO NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
PREVENTIVE SERVICES (Outpatient Only) In accordance with guidelines established by USPSTF, Grades A & B, and CDC. • Annual Physical Exam • Immunizations/Vaccinations • Counseling and Health Screenings	Plan Pays 100%	Not Covered
OUTPATIENT LABORATORY (Preventive & Diagnostic)	Plan Pays 100%	Not Covered
PRE-NATAL CARE Including routine labs and 1st ultrasound	Plan Pays 100%	Not Covered
WELL-BABY / WELL-CHILD CARE • For children ages 0 to 17 years • Maximum of 7 visits per year for ages 0 to 4 years • Maximum of 1 visit per year for ages 5 to 17 years	Plan Pays 100%	Not Covered
WELL-WOMAN CARE In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA) and the Women's Health and Cancer Act	Plan Pays 100%	Not Covered
STERILIZATION PROCEDURES (Pre-Certification Required) 1. Tubal Ligation 2. Vasectomy (Outpatient Only)	Plan Pays 100%	Not Covered

YOUR DEDUCTIBLE DOES NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS		NON-PARTICIPATING PROVIDERS (After Deductible is Met)
ANNUAL EYE REFRACTION/EXAM (Refer to the Vision Rider benefit for eye hardware coverage)	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Not Covered
OUTPATIENT PHYSICIAN CARE & SERVICES			
1. Primary Care Visit	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%
2. Specialist Care Visit	$40 Member Co-Payment		Plan pays 70%*, Member pays 30%
9. Urgent Care	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%
3. Voluntary Second Surgical Opinion	$40 Member Co-Payment		Plan pays 70%*, Member pays 30%
4. Home Health Care Visit	$15 Member Co-Payment at SDA Clinic	$40 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%
5. Hospice (Pre-Certification Required) • Guam Only • Maximum 180 Days • Maximum $100 Per Day	$40 Member Co-Payment		Not Covered
6. X-ray Services	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%
7. Injections (Does not include those on the Specialty Drug List and Orthopedic Injections)	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%

EXHIBIT Q (continued)
FY2015 Schedule of Benefits

PPO1000

YOUR DEDUCTIBLE DOES NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS		Judiciary PPO1000 NON-PARTICIPATING PROVIDERS (After Deductible is Met)
PRESCRIPTION DRUGS Annual Out-of-Pocket Maximum is $2,000 Individual/$3,500 Family	Retail	Mail	
1. Formulary Generic Drugs	Member pays 10%	Member pays 10%	Plan pays 50% of AWP**
2. Formulary Brand Name Drugs	Member pays 20%	Member pays 20%	Plan pays 50% of AWP**
3. Non-Formulary Drugs (Medically Necessary Only and Pre-Certification Required)	Member pays 30%	Member pays 30%	Plan pays 50% of AWP**
4. Specialty Drugs (Medically Necessary Only and Pre-Certification Required)	Member pays 40%	Not Covered	Plan pays 50% of AWP**

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)	NON-PARTICIPATING PROVIDERS (After Deductible is Met)
ACUPUNCTURE	Plan pays 80%; Member pays 20%	Not Covered
AIDS TREATMENT Exclusive of Experimental drugs	Plan pays 80%; Member pays 20%	Not Covered
AIRFARE BENEFIT TO CENTERS OF CARE Members must meet qualifying conditions. Plan provides roundtrip airfare upon required Plan approval.	Plan pays 100%	Not Covered
ALLERGY TESTING $500 per member per plan year	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
AMBULATORY SURGI-CENTER CARE (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
BLOOD & BLOOD DERIVATIVES	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
BREAST RECONSTRUCTIVE SURGERY In accordance with 1998 W.H.C.R.A.	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CARDIAC SURGERY	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CATARACT SURGERY (OUTPATIENT) Includes Lens Implants	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CHEMICAL DEPENDENCY	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
CHEMOTHERAPY BENEFIT	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CHIROPRACTIC CARE	Plan pays 80%; Member pays 20%	Not Covered
CLINICAL TRIALS In relation to treatment of cancer or other life-threatening disease or condition as approved by the National Institute of Health or in case of cancer, the National Cancer Institute.		
1. Outpatient Clinical Trial	$40 Member Co-payment	Plan pays 70%*, Member pays 30%
2. Inpatient Clinical Trial	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CONGENITAL ANOMALY DISEASES COVERAGE	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
DIAGNOSTIC TESTING (Pre-Certification Required) • MRI, CT Scan, and other diagnostic procedures	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
DURABLE MEDICAL EQUIPMENT (DME) The lesser amount between the purchase or rental when prescribed by a Physician. (Pre-Certification Required) • Accessories • Hospital Beds • Walkers • CPAP Machine • Suction Machine • Wheelchairs • Crutches • Oxygen	Plan pays 80%; Member pays 20% of the total rental cost or purchase	Not Covered
ELECTIVE SURGERY (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
EMERGENCY CARE Plan must be contacted and advised within 48 hours for off-island emergencies 1. On/Off Island emergency facility, physician services, laboratory, x-rays 2. Ambulance Services (Ground Transportation Only)	Plan pays 80%; Member pays 20%	Plan pays 80%, Member pays 20%
END STAGE RENAL DISEASE / HEMODIALYSIS	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
HEARING AIDS Maximum $500 per member per plan year	Plan pays 80%; Member pays 20%	Not Covered
HOSPITALIZATION & INPATIENT BENEFITS 1. Room & Board for semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication. 3. Physician's Hospital Services	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%

EXHIBIT Q (continued)
FY2015 Schedule of Benefits

PPO1000

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)	Judiciary PPO1000 NON-PARTICIPATING PROVIDERS (After Deductible is Met)
IMPLANTS Limitations apply, please refer to contract. Limited to the following: • Cardiac Pacemakers • Intraocular Lens • Heart Valves • Orthopedic Internal Prosthetic Devices • Stents	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
INHALATION THERAPY	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
MATERNITY CARE Labor and Delivery	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
MENTAL HEALTH CARE	$20 Member Co-payment	Plan pays 70%*, Member pays 30%
NUCLEAR MEDICINE (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
OCCUPATIONAL THERAPY (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Not Covered
ORTHOPEDIC CONDITIONS • Internal and External Prosthesis	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
PHYSICAL THERAPY (Pre-Certification Required)	Plan pays 80% for the first 20 visits and 50% thereafter	Plan pays 70%*, Member pays 30%
RADIATION THERAPY (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
SKILLED NURSING FACILITY (Pre-Certification Required) • Maximum 60 Days per Member per Plan Year	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
SLEEP MEDICINE • Sleep Apnea Study Coverage	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%

ADDITIONAL BENEFITS: What the Plan Covers		
YOUR DEDUCTIBLE DOES NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
WELLNESS AND FITNESS BENEFIT 1. Wellness Benefit at a Wellness Center (Pre-Certification Required) • Member co-insurance may be reimbursed upon program completion	Plan pays 80%; Member pays 20%	Not Covered
2. Fitness Benefit • Limited to participating Fitness Centers • Attendance participation of 7 times per month	Plan pays up to $150 Cash Reward	Not Covered
VISION RIDER 1. Eye Glasses • Frames • Eyeglass Fitting 2. Eye Glass Lenses • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses • Lenticular/Aphakik Lenses 3. Contact Lenses	Plan pays 100% up to $100 per member per plan year	

* ELIGIBLE CHARGES - Shall be defined as the portion of charges made to a covered person for covered services rendered which are payable to the Provider under this contract. Non-Participating Providers are limited to the lesser of actual charges of Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges.

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

DEDUCTIBLE - a fixed dollar amount the Covered Person or family must pay for covered benefits during the plan year before first dollar benefits apply. The deductible does not apply to annual Preventive Care defined in this Schedule of Benefits and non-covered benefits.

PHILIPPINE CARE - Pre-certification is required for services rendered at Philippine Participating Providers. No deductible and co-payment will apply for an annual outpatient Executive Check-up, limited to Eligible Charges in accordance to USPSTF, Grades A & B, at NetCare's Philippine Preferred Providers. The deductible or co-payment defined in this Schedule will apply for non-routine or non-preventive services before first dollar benefits are paid. All charges in excess of NetCare's eligible expense is the responsibility of the member.

PRE-CERTIFICATION - covered benefits requiring a pre-certification of services from a physician must be approved by NetCare prior to services rendered.

EXHIBIT Q (continued)

FY2015 Schedule of Benefits

Dental

NetCare
Life & Health Insurance

JUDICIARY OF GUAM DENTAL 2000

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

TERMS:

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

EXHIBIT R

List of Judiciary's Most Utilized Providers

PROVIDER NAME
OPTUM RX INC
GUAM SEVENTH-DAY ADVENTIST CLINIC
PARADISE FITNESS INC.
AMERICAN MEDICAL CENTER, LLC
DIAGNOSTIC LABORATORY SERVICES, INC.
EXPRESS CARE HEALTH & SKIN CENTER, INC
ST LUKES MEDICAL CENTER GLOBAL CITY
INTERNATIONAL SPORTS CENTER
ISA DENTAL
THE DOCTORS' CLINIC
TUMON PEDIATRIC CORP.
ORDOT DENTAL CLINIC, LLP.
GUAM XRAY dba GUAM RADIOLOGY CONSULTANTS
PEDIATRIC & ASTHMA CLINIC
PREMIER KEN GUAM DBA HILTON GUAM RESORT
FRANCISCO SAN NICOLAS DBA PEDS DENTL CTR
GUAM MEMORIAL HOSPITAL
INTERNATIONAL HEALTH PROVIDERS, LLC
HAFA ADAI FAMILY DENTAL, PC
LABTECH DIAGNOSTICS
DAVINA M. LUJAN
ISLA PEDIATRICS, PC
PACIFIC RADIOLOGY
REIMBURSEMENTS
PACIFIC MEDICAL GROUP
PHAM, LLC-DBA REFLECTION CTR DENTAL CARE
GUAM SEVENTH-DAY ADVENTIST CLN
PITO Q. CRUZ DBA THE GYM GUAHAN
ANNIE U. BORDALLO, M.D.
GREGORY JOHN MILLER, D.C.
C.V. ALEGRIA D.D.S., INC.
GUAM SPECIALIST GROUP, PLLC
HAWAII PATHOLOGISTS' LABORATORY
ISLAND FOOT SPECIALISTS
MARIANAS FOOTCARE CLINIC
MDX IMAGING
MPG PEDIATRICS, P.C.
RONALD T. KOBAYASHI & ASSOCIATES, P.C.
GCIC DENTAL CLINIC
GUAM E.N.T., LLC
KIRK BELLIS, D.O.
MICHAEL A. FERNANDEZ, D.D.S.
PACIFIC UROLOGY CONSULTANTS, LLC
PARADISE SMILES
Sheila Keenan, MSW
STANLEY Y YASUHIRO
TIMOTHY P. BRADY, D.D.S.
DR. RONALD ANTONIO REODICA
DR. SHIEH'S CLINIC & ASSOCIATES, INC.

PROVIDER NAME
FRANCIS JOHN PILE
GBHC, INC.
HEALTH SERVICE MANAGEMENT DBA PMC ISLA
KEITH MASAO HORINOUCHI
MYRA ABUYABOR CANLAS
ROBERT J YANG DMD
TUMON MEDICAL OFFICE

EXHIBIT S

Judiciary of Guam Mandatory Contract Requirements

PPACA Requirements

Offerors must comply with the PPACA requirements for summary of benefits and uniform glossary of terms.

It is the intent of this contract to provide all of the benefits, rights and responsibilities afforded as a result of the Patient Protection and Affordable Care Act (Public Law 111-148), and the regulations promulgated under the authority of this Act, notwithstanding the outcome of any federal court case that is now pending before a court of the United States, or may be brought before a court of the United States concerning this Act.

Participating Contract

A fully participating contract will be implemented effective 10/1/14 that allows for an annual accounting settlement – no later than 4/1/16 – which will produce either a positive or negative balance after accounting for Incurred claims and guaranteed retention. This surplus will be returned to Judiciary of Guam either toward reducing any needed rate increase or in cash. If the result is a deficit, the amount of the deficit maybe added to any needed rate increase for FY 2017 provided the incumbent vendor continues to be the insurance provider.

Guaranteed Renewability of Health Insurance Coverage

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

Important Requirement of any Certificate of Insurance or Group Health Insurance Contract:

The process to resolve disputes between the insurance provider and the covered person (the subscriber and eligible dependents) related to denial of coverage by the insurance provider, to include rescissions, eligibility, pre-exclusion, medical necessity denial, and post-service reimbursement, must be consistent with the Patient Protection and Affordable Care Act and applicable regulations to include 45 CFR 147.136 and 29 CFR 2560.503. Requirements or provisions for an arbitration process to resolve disputes are not acceptable and will not be agreed to.

EXHIBIT T

Statement that Plan Designs are Consistent in All Material Respects with the Request for Health Proposal

On behalf of _____[Company Name], by submitting this proposal for a contract, I state that the plan designs being submitted are consistent in all material respects with the plan designs solicited in the FY2016 Judiciary of Guam Request For Health Proposal, and that the Judiciary of Guam may rely upon this statement in its evaluation of these proposals, to include evaluation of rates. It is understood that any discrepancies between the plan designs in these proposals and the plan designs solicited by FY2016 Judiciary of Guam Request For Health Proposal are to be resolved during future negotiations, if any negotiations are to take place, without any concession on the part of the Judiciary of Guam that proffered plan designs inconsistent with the FY2015 Schedule of Benefits in **Exhibit Q** or the Request For Health Proposals are acceptable.

Plan Name: _____

Authorized Signature: _____

Print Name: _____

Title: _____

Contact Number: _____

Email Address: _____

EXHIBIT U

Wellness and Fitness Benefit (FY2015)

Wellnes and Fitness Benefit at a minimum shall include the following:

A) Cardiovascular Training;

B) Resistance and Strength Training;

C) Flexibility Training;

D) Regular Group Exercise Classes with options to provide additional classes to organized groups of subscribers upon request to be determined in coordination with the Dept. of Administration;

E) Nutrition Classes, Counseling and Access to Nutritional Information Material

F) Health Risk Assessments;

G) Fitness Assessments including Body Mass Index (BMI) s;

H) Assistance to individuals with physical or mental impairments to meet the laws on equal access and comply with Americans with Disabilities Act (ADA) regulations;

I) Utilization of the above should be accessible to subscribers and dependents

EXHIBIT V

Group Health Insurance Contract (FY2015)

FOR THE PERIOD OF:

OCTOBER 1, 2014 – SEPTEMBER 30, 2015

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GROUP HEALTH INSURANCE CONTRACT

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JUDICIARY OF GUAM

and

NETCARE LIFE AND HEALTH INSURANCE COMPANY

GROUP HEALTH INSURANCE CONTRACT

PPO1000 / HSA2000 / DENTAL2000

To Be Used for the Contract Period of:

October 1, 2014 - September 30, 2015

ARTICLE 1

PREAMBLE AND RECITALS

PREAMBLE

This Contract is made effective by and between the JUDICIARY OF GUAM ("Judiciary") and NETCARE LIFE AND HEALTH INSURANCE COMPANY ("Company" or "NetCare"). The effective date of this Contract is October 1, 2014.

RECITALS

WHEREAS, NetCare is an Insurance Company duly licensed to do business in Guam; and

WHEREAS, NetCare is qualified to provide group health insurance program to Judiciary; and

WHEREAS, Judiciary selected NetCare to provide group health insurance benefits to Judiciary active and retired employees, their dependents, and

WHEREAS, NetCare offers group health insurance program benefits, as hereinafter set forth, under a group health insurance plan known as the "Plan," and

WHEREAS, the parties wish to enter into a contract defining their mutual rights and obligations.

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

Preamble and Recitals

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

ARTICLE 2

GENERAL PROVISIONS

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

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

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

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

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

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

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

2.1.4 Birthing Center: Shall be defined as any facility, other than the mother's usual place of residence, that is staffed, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum and newborn care rendered within 24 hours after delivery for low risk women and their newborns.

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

2.1.5.1 The total cost of said alternative benefits does not exceed the total benefits payable for covered services;

2.1.5.2 The covered person's Physician recommends that the covered Person receives said alternative benefits;

2.1.5.3 The covered person's Physician agrees that the recommended alternative benefits are expected to be beneficial for the treatment of the illness or injury; and

2.1.5.4 The covered person, or the covered person's guardian, if the covered person is a minor or incapacitated, agrees to receive the alternative benefits.

2.1.5.5 The services prior authorized by NetCare's Medical Management Department.

2.1.6 Certificate: Shall be defined as the Group Health Insurance Certificate – PPO1000 and HSA2000 and Dental Plan 2000 attached hereto, including the related exhibits.

2.1.7 Chemotherapy: Shall be defined as remedial services of a euplastic illness or tumor by means of systemic hormonal agents.

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

2.1.9 Co-Insurance: Shall be defined as the percentage of eligible charges that a covered person must pay for certain covered services as stated in this contract, and after the deductible has been met and before the Out-of-Pocket Maximum has been met. The Out-of-Pocket provision does not apply to Non-Participating Providers. Subject to the terms of this contract, a covered person shall be required to pay, as Co-Insurance, twenty percent (20%) of eligible charges for covered services rendered by a Participating Provider and thirty percent (30%) of eligible charges for covered services rendered by a Non-Participating Provider.

2.1.10 Co-Payment: Shall be defined as the predetermined (flat) dollar amount that a covered person must pay for certain covered services as stated in this contract and the certificate and after the deductible, when applicable, has been met.

2.1.11 Cohabiting Partner: Shall be an individual eighteen (18) years of age or older who; is not related to Subscriber by blood to a degree that would bar marriage; is not legally married to any other person; has cohabited for two (2) consecutive years immediately preceding enrollment; and provides a notarized affidavit attesting to such, in a form acceptable to the company.

2.1.12 Contract: Shall be defined as this group health insurance contract including the Group Health Insurance Certificate and Exhibits A through G entered between Judiciary and NetCare pursuant to 4 GCA §4301.

2.1.13 Cosmetic Procedure or Surgery: Shall be defined as services performed solely for the improvement of a covered person's appearance rather than for the improvement, restoration or correction of normal body functions.

2.1.14 Covered Dependent: Shall be defined as a dependent eligible to receive benefits under the terms of this plan.

2.1.15 Covered Person: Shall be defined as a person entitled to receive covered services pursuant to the plan. A covered person shall reside in the service area, as provided in this contract and in the accompanying certificate, and shall be:

2.1.15.1 a bona fide employee of Judiciary who is classified as a full time employee by Judiciary; or

2.1.15.2 except as otherwise provided in this contract, a covered dependent as defined in Article 5 of the attached certificate.

2.1.16 Covered Services: Shall be defined as medically necessary services that are not specifically excluded from coverage by this contract and other services which are specifically included.

2.1.17 Currency: Shall be defined as money accepted as a medium of exchange for payment of debts such as the United States Dollar in the United States and the Peso in the Philippines.

2.1.18 Custodial Care: Shall be defined services, whenever furnished and by whatever name called, designed primarily to assist an individual, whether or not totally disabled, in the activities of daily living. These activities include, but are not limited to, services that constitute personal services such as help in walking, getting in and out of bed, assistance in bathing, dressing, feeding and services which do not entail or require the continuing attention of trained medical or paramedical personnel.

2.1.19 Deductible: Shall be defined as the amount paid by a covered person or family for covered services during a plan year before covered services shall be paid by NetCare under this contract. No deductible shall apply to preventive services as defined by PPACA, as provided in the attached certificate.

2.1.20 Dental Service: Shall be defined as the act of:

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

2.1.20.2 providing services for teeth, gums and related parts of the oral cavity; or

2.1.20.3 performing any other service normally rendered by a Dentist.

2.1.21 Dentist: Dentist means any person, dental organization, facility, or institution licensed by a Country, State or Territory to deliver or furnish dental or health care services and satisfying NetCare's accreditation and credentialing requirements.

2.1.22 Dependent: Shall be defined as specified in Article 5 of the attached certificate.

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

2.1.24 Durable Medical Equipment: Shall be defined as equipment which is:

2.1.24.1 Able to withstand repeated use; and

2.1.24.2 Primarily and customarily used to serve an illness or injury; and

2.1.24.3 Not generally useful for a person in the absence of illness or injury.

2.1.25 Eligible Charge(s): Shall be defined as the portion of charges made to a covered person for covered services rendered which are payable to the Provider under this contract. For a Participating Provider, the eligible charges shall be the reimbursement amounts agreed to between NetCare and the Participating Provider.

For a Non-Participating Provider, the eligible charges for covered medical services rendered by a Provider who is not a Participating Provider, shall be limited to the lesser of (a) the actual charge made by the Provider, or (b) whichever of the following is applicable: (I) in the United States, the Medicare participating provider fee schedule in the geographical area where the service was rendered; or (II) in Asia, the fees most recently contracted by NetCare at Participating Providers in the Philippines or (III) in other Asian countries the fees most recently contracted between NetCare and its Participating Providers or (IV) elsewhere, the Medicare national standard fee schedule.

For a Non-Participating Provider, the eligible charges for covered dental services shall be the lesser of (a) the actual charges made by the Provider or (b) the Usual Customary and Reasonable charge, as determined by NetCare, for the dental service in the geographic region in which that service was rendered.

2.1.26 Emergency:

2.1.26.1 Emergency shall mean an injury or medical condition by acute symptoms of sufficient severity (including severe pain) so that a

prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of an individual (including, in the case of the health of a pregnant woman, or her unborn child) in serious jeopardy, or to result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

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

2.1.26.3 Co-Insurance percentages and co-payment amounts for any PPACA emergency services provided by Non-Participating Providers shall not be greater than such percentages or amounts that would be applied to Participating Providers. NetCare's payments for any PPACA emergency service shall not be less than the greater of:

2.1.26.3.1 The amount negotiated with Participating Providers for the PPACA emergency service (excluding any co-insurance or co-payment normally charged the covered person for such service when provided by Participating Providers); or

2.1.26.3.2 The amount calculated using the same method NetCare generally uses under this contract to determine payments for such services when provided by Participating Providers; or

2.1.26.3.3 The amount that would be paid under Medicare (Part A or Part B) for the PPACA emergency service, excluding any co-insurance or co-payment normally charged the covered persons for such service when provided by Participating Providers

2.1.27 Enrollment: Shall be defined as the acceptance, as a specified date, of a written application for coverage under the plan on forms provided by NetCare.

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

2.1.29 Family: Shall be defined as a subscriber and his or her covered dependents.

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

2.1.31 Home Health Care: Shall be defined as the services set forth below, subject to all other exclusions and limitations set forth in this contract.

2.1.31.1 Part-time or intermittent home nursing services from or supervised by a registered Nurse or a licensed practical Nurse.

2.1.31.2 Part-time or intermittent home health aid services;

2.1.31.3 Physical Therapy; and

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

2.1.31.5 To be a covered service, Home Health services shall:

2.1.31.5.1 replace a needed Hospital or Skilled Nursing Facility stay.

2.1.31.5.2 be for the care or treatment of a covered person's illness or injury

2.1.31.5.3 be ordered in writing by the covered person's Physician; and

2.1.31.5.4 be provided in the covered person's home (permanent or temporary) by a properly licensed Home Health Care Agency

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

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

2.1.32.2 Keeps clinical records on all patients;

2.1.32.3 Services are supervised by a Physician or Nurse; and

2.1.32.4 Services provided by the Home Health Care Agency are certified by Medicare/Medicaid which include at least one Physician and one Nurse

2.1.33 Home Health Care Plan: Shall be defined as a program of Home Health Care established and approved in writing by the covered person's Physician for the provision of Home Health Care services. The physician shall state that confinement to a Hospital or Skilled Nursing Facility would be medically necessary for the treatment of the covered person's injury or illness if the Home Health Care Plan is not provided.

2.1.34 Hospice: Shall be defined as a coordinated plan of home and/or inpatient services, which treats a terminally ill patient and his or her family. The plan provides services to meet the special needs of the family during the final stages of a terminal illness and during bereavement. Services are provided by a team made up of trained medical personnel, homemakers and counselors. The team acts under an independent hospice administration and helps the family cope with physical, psychological, spiritual, social and economic stresses. The hospice must be approved as meeting established standards, including but not limited to compliance with any licensing requirements of Guam, and the benefit period begins on the date the attending Physician certifies that a covered member is terminally ill.

2.1.35 Hospital: Shall be defined as a medical institution which is operated in accordance with the laws of the jurisdiction which the hospital is located. The hospital must be primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis for inpatients, and treatment of injured and sick persons. These services must be provided by or under the supervision of Physicians and the institution must continuously provide twenty-four (24) hours a day Nursing Service by Nurses.

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

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

2.1.36 Injury: Shall be defined as a condition caused by accidental means that results in damage to the covered person's body independently of illness and is a result of an unexpected slip, fall, blow or other violent external force. Injury shall also include a scenario that is not unexpected or not accidental if it constitutes a PPACA emergency.

2.1.37 Illness: Shall be defined as a bodily disorder, disease, physical sickness, pregnancy, mental or nervous condition or congenital abnormality.

2.1.38 Inhalation Therapy: Shall be defined as remedial services for an illness or injury by means of intermittent positive pressure breathing equipment.

2.1.39 Inpatient: Shall be defined as a covered person admitted to a Hospital, Skilled Nursing Facility or Hospice for a condition requiring confinement.

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

2.1.41 Maximum Annual Benefit: Shall be defined as those benefits payable under this contract that have annual maximum limits for each covered person as shown in Schedule of Benefits.

2.1.42 Medically Necessary or Medical Necessary: Shall mean services or supplies which, under the provisions of this contract, are determined to be:

2.1.42.1 appropriate and necessary for the symptoms, diagnosis or treatment of the injury or illness or dental condition; and/or

2.1.42.2 provided for the diagnosis or direct care and treatment of the injury or illness or illness or dental condition; and/or

2.1.42.3 within standards of good medical or dental practice within the organized medical or dental community; and/or

2.1.42.4 not primarily for the convenience of the covered person or of any provider providing covered services to the covered person; and/or

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

2.1.42.6 within the scope of the medical or dental specialty, education and training of the provider; and/or

2.1.42.7 provided in a setting consistent with the required level of care; and/or

2.1.42.8 preventative services as provided in the plan.

2.1.43 Medicare: Shall be defined as Title XVIII (Health Insurance for the Aged) of the Social Security Act of 1965, which includes Part A, Hospital Insurance Benefits for the Aged; Part B, Supplemental Medical Insurance Benefits for the Aged; and Part C, miscellaneous provisions regarding both programs, and also including any subsequent changes or additions to those programs.

2.1.44 Mental Conditions: Shall be defined as a condition which includes neurosis, psychoneurosis, psychopathy, or psychosis or disease of any kind, in a degree which subsequently impairs the covered person's economic social functioning; and shall, as required by the Parity in Health Insurance for Mental Illness and Chemical Dependency Act, Title 22, Guam Code Annotated, Chapter 28 and as required by the Mental Health Parity Act, 29 U.S.C. § 1185a, and shall include the definition of Mental Illness contained in said Acts.

2.1.45 Military Service: Shall be defined as service for any length of time in any branch of the Armed Forces or Merchant Marine of any Country, combination of Countries, or International Organizations, except temporary training service for two months or less.

2.1.46 Newborn: Shall be defined as an infant during the period beginning on the date of birth until the initial hospital discharge or until the infant is thirty (30) days old, whichever occurs first.

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

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

2.1.49 Out-of-Pocket Maximum: Shall be defined as the total maximum of any eligible charges paid, or payable as defined by a payment schedule or arrangement by a covered person to a participating provider to satisfy any applicable deductible, co-payment, and/or co-insurance specified in this contract before the plan will begin to pay covered services at one hundred percent (100%) for the remainder of the plan year, subject to the maximum amounts provided in the plan as indicated in the Schedule of Benefits.

2.1.50 Participating Providers, Non-Participating Providers, Providers and Network:

2.1.50.1 "Providers" shall be defined as health care providers who are duly in their jurisdiction and acting with the scope of their license such term shall include, without limitation, physicians, hospitals, ancillary health services facilities and ancillary health care providers.

2.1.50.2 "Participating Providers" shall be defined as providers who: (I) have directly, or indirectly through NetCare's agreements with other networks, entered into an agreement with NetCare to provide the covered services; and (II) are assigned from time to time by NetCare to

participate in the network of NetCare pursuant to this contract.

2.1.50.3 "Network" shall be defined as the network of participating providers. Network may also be referred to as "Plan Network."

2.1.50.4 "Non-Participating Provider" shall be defined as providers who have NOT been contracted by NetCare to provide medical or dental services to covered persons.

2.1.50.5 Payment of claims to providers: Claims shall be paid based on the agreement that NetCare has with its providers whenever the services are rendered by participating provider; and based on the Usual Customary and Reasonable charge whenever the services are rendered by a non-participating provider, except as otherwise provided in 2.1.26.3.3.

2.1.51 PHSA: Shall mean the Public Health Service Act provisions that are part of HIPAA (as defined above), some of which have been added to the PHSA by PPACA.

2.1.52 Physicians' Services: Shall be defined as medically necessary professional services provided by duly licensed health care providers including diagnosis, consultation, medical treatment, surgery, anesthesia, physical therapy, x-ray and laboratory services, diagnostic procedures such as electrocardiograms, electroencephalograms and other services customarily provided by physicians for patients. Experimental services shall not be included within the scope of physician's services.

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

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

2.1.53 Physical Therapy: Shall be defined as remedial services for the treatment of an injury or illness by means of therapeutic massage and exercise; heat, light and sound waves; electrical stimulation; hydrotherapy; and traction.

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

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

2.1.56 PPACA: Shall mean the Patient Protection and Affordable Care of 2010 (P.L. 111-148), as amended.

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

2.1.57.1 Care considered PPACA Preventive Care shall be:

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

2.1.57.1.2 Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the advisory Committee on immunization practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

2.1.57.1.3 With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and

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

2.1.57.2 No co-payments, co-insurance or deductibles shall be imposed on covered persons for PPACA Preventive

Care Services. If participating provider billing data for office visits bill or track PPACA Preventive Care Services separately from other services or items provided at an office visit, co-payments, co-insurance and deductibles shall apply (unless otherwise provided under this contract) to all services that are not PPACA Preventive Care Services. If PPACA Preventive Care Services are not billed or tracked separately, the entire office visit shall be treated as a PPACA Preventive Care Services visit if PPACA Preventive Care was the primary purpose of such visit, but otherwise the entire office visit shall (unless otherwise provided under his contract)be treated as not being a PPACA Preventive Care Service,

2.1.57.3 Except as specifically provided in this contract, PPACA Preventive Care Services shall only be provided without deductibles, co-insurance or co-payments if provided by participating providers.

2.1.58 Preferred Drug Formulary: Shall be defined as those medications chosen by NetCare for their safety, effectiveness and affordability. The preferred drug formulary is subject to change during plan year.

2.1.59 Preferred Provider: Preferred provider shall be defined as a participating provider that is a Hospital or Ambulatory Surgical Center located outside of the service area. The Hospital or Ambulatory Surgical Center shall be a participating provider at the time of services are rendered to the covered person and shall be specifically designated by name as a participating provider in the more recent of NetCare's most current member brochure or NetCare's most current updated listing of participating providers.

2.1.60 Pregnancy: Shall be defined as the physical state which results in childbirth, abortion or miscarriage and any medical complications arising out of or resulting from such state.

2.1.61 Premium: Shall be defined as the dollar amount paid to NetCare for the provision of this plan to covered persons, including any contributions required from the covered persons.

2.1.62 Psychiatric Services or Psychoanalytical Care: Shall be defined as services provided for the treatment of a mental condition.

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

2.1.64 Registered Bed Patient: Shall be defined as a covered person who has been admitted to a hospital or a skilled nursing facility or a hospice upon the recommendation of a Physician for any injury or illness covered by this contract and who is confined by the hospital, skilled nursing facility or hospice as an inpatient.

2.1.65 Room and Board: Shall be defined as all charges, by whatever name called, which are made by a hospital, hospice or skilled nursing facility as a condition of providing inpatient services. Such charges do not include the professional services of Physicians nor intensive, private duty nursing services by whatever name called.

2.1.66 Semi-Private: Shall be defined as a class of accommodations in a hospital or a skilled nursing facility in which at least two (2) patient beds are available per room.

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

2.1.68 Service Area: Shall be defined as Guam, the Commonwealth of the Northern Mariana Islands and Palau.

2.1.69 Skilled Nursing Facility: Shall be defined as a specifically qualified and licensed facility that:

2.1.69.1 For a free and on an inpatient basis, provides 24 hour per day skilled nursing services under the full-time supervision of a Physician or nurse and provides physical restoration services for persons convalescing from an injury or illness; and

2.1.69.2 maintains daily clinical records; and

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

2.1.69.4 has transfer arrangements with one or more hospitals; and

2.1.69.5 has an effective utilization review plan; and

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

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

2.1.71 Spouse: Shall be defined as the Subscriber's legal spouse.

2.1.72 Subscriber: Shall be defined as covered person employed by the Judiciary of Guam.

2.1.73 Surgery and Surgical Services: Shall be defined as medically necessary services directly performed by a Physician in the treatment of an injury or illness which requires one or more of the performed by a Physician in the treatment of an injury or illness which requires one or more of the following: cutting; suturing; procedures; debridement of wounds, including burns; surgical management or reduction of fractures or dislocation; orthopedic casting; manipulation of joints under general anesthesia; or destruction of localized lesions, cryotherapy or electrosurgery. The term "Surgery" does not include dental services, routine venipuncture or examinations.

2.1.74 Terminally Ill: Shall be defined as a medical prognosis of limited expected survival of six (6) months or less at a time of referral to a hospice of a covered person with a chronic, progressive illness which has been designated by the covered person's attending Physician as incurable.

2.1.75 Non-Participating Provider Eligible Charges: Eligible charges for covered medical services rendered by a provider who is not a participating provider, shall be limited to the lesser of (a) the actual charge made by the provider, or (b) whichever of the following is applicable: (I) in the United States, the Medicare participating provider fee schedule in the geographical area where the service was rendered, or (II) in Asia, the fees most recently contracted by NetCare at its Participating Providers in the Philippines or (III) in other Asian Countries, the fees most recently contracted between NetCare and its Participating Providers or (IV) elsewhere, the Medicare national standard fee schedule.

2.1.76 Well Baby Care: Shall be defined as services rendered to a dependent child under the age of two (2) solely for the purpose of health maintenance and not for the treatment of an illness or injury.

2.1.77 Well Child Care: Shall be defined as services rendered to a dependent child, age two (2) to attainment of eighteen (18) years of age, solely for the purpose of health maintenance and not for the treatment or an illness or injury.

2.2 PPACA Requirements: It is the intent of this contract to provide, at a minimum, all of the benefits, rights and responsibilities afforded as a result of the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended and the regulations promulgated under the authority of this Act.

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

ARTICLE 3

SERVICES

3.1 NetCare shall provide covered persons with the group health insurance benefits, subject to the applicable limitations and conditions, set forth under Exhibit A, the "Schedule of Benefits" attached to the Group Health Insurance Certificate, PPACA-required Summary of Benefits and Coverage, the Group Health Insurance Certificate and all exhibits and appendices thereto, incorporated herein by reference. The contract between Judiciary and the NetCare provides that Judiciary may purchase a rider for benefits to be known as the "Gym Benefit Rider" to be available to all subscribers, and in addition employees and their covered dependents are entitled to participate in NetCare's Wellness and Disease Management benefits under Exhibit B of the certificate offered to all NetCare members as a part of the PPO1000 Plan and the HSA2000 Plan.

ARTICLE 4

RATES, PREMIUMS, AND EXPERIENCE PARTICIPATION

4.1 Rates: NetCare shall provide the group health insurance benefits set forth in the Premium Provisions set forth below:

MONTHLY

HSA2000 PLAN

	MEDICAL	DENTAL
CLASS I	$105.85	$30.96
CLASS II	$232.87	$68.11
CLASS III	$190.53	$55.73
CLASS IV	$317.55	$92.88

MONTHLY

PPO1000 PLAN

	MEDICAL	DENTAL
CLASS I	$209.86	$30.96
CLASS II	$461.69	$68.11
CLASS III	$377.75	$55.73
CLASS IV	$629.58	$92.88

BI-WEEKLY

HSA2000 PLAN

	MEDICAL	DENTAL
CLASS I	$48.85	$14.29
CLASS II	$107.48	$31.44
CLASS III	$87.94	$25.72
CLASS IV	$146.56	$42.87

BI-WEEKLY

PPO1000 PLAN

	MEDICAL	DENTAL
CLASS I	$96.86	$14.29
CLASS II	$213.09	$31.44
CLASS III	$174.35	$25.72
CLASS IV	$209.58	$42.87

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

4.3 Experience Participation. No later than April 1, 2016, NetCare shall present to the client an annual experience participation accounting, which will produce either a positive or negative balance after accounting for all incurred claims and the 14% of premium guaranteed retention for NetCare, such experience participation to be determined as follows:

4.3.1 The term "Target Experience" shall mean the amount calculated by multiplying (a) the total premiums earned by NetCare for the full 12-month plan year ending September 30, 2015 under the HSA $2,000 deductible policy and the PPO $1,000 deductible policy issued to Judiciary with respect to such plan year (such two separate policies being referred to, collectively, as the "Participating Policies"), by a (b) eighty-six percent (86%).

The "Actual Experience" shall be an amount calculated by subtracting from the Target Experience all claims incurred during such plan year under both participating policies (i.e., Actual Experience = Target Experience (Total Premiums x 86%) minus incurred claims).

4.3.2 To the extent the actual experience is positive (i.e., an amount greater than zero), such amount will be called an "Experience Refund", and NetCare shall place such amount into such trust fund as may established by Judiciary for its self-funded health benefits plan negotiated by Judiciary pursuant to 4 GCA § 4301.

4.3.3 To the extent the actual is negative (i.e., an amount less than zero), NetCare may add this amount to the premium needed for the plan year beginning on October 1, 2016, but only if NetCare is the health insurance provider during such year.

4.3.4 This experience participation provision determines the combined actual experience of both the participating policies. Identical provisions, describing the combined calculation, are included in each of the participating policies for convenience, but the result of the combined calculation shall be applied only once. If necessary to determine the distribution of any positive or negative amount of actual experience between the two participating policies, such amount may be allocated between the two policies in any share, at the discretion of Judiciary, as long as that the total of the total of the shares is equal to the combined amount of the actual experience.

4.3.5 If PPACA's Minimum Loss Ratio ("MLR") requirements result in payment from NetCare to Judiciary, of a refund for 2015 calendar year MLR calculations any experience refund calculated above in §4.3.2 will be reduced by the portion of the MLR refund payable to Judiciary and applicable to the participating policies. The portion applicable to the participating policies is determined by multiplying the MLR refund by the ratio of the participating policies' earned premium in the calendar year to the total of Judiciary earned premium in that calendar year.

ARTICLE 5

CONTRACT TERM AND TERMINATION

5.1 Term. The contract is for a one year term beginning October 1, 2014 ending September 30, 2015 unless terminated for major default in services.

5.2 Termination.

5.2.1 By NetCare. If Judiciary fails to make any premium payment within fifteen (15) business days after receipt of a written notice of non-payment from NetCare, NetCare may terminate this contract providing at least fifteen (15) business days prior written notice of termination to Judiciary and all subscribers under this contract.

5.3 Individual Termination.

5.3.1 Non-payment of Premium. NetCare may, in accordance with the notice provisions contained in 5.2.1, terminate coverage of one or more individual covered person's for non-payment of premium without terminating this contract as to other covered persons for whom premiums have been received by NetCare.

5.3.2 Other Reasons. Except for non-payment of premiums, NetCare may only terminate a covered person as provided in Article 5 of the attached certificate.

5.3.3 Review of Termination. Any covered person whose coverage is terminated pursuant to this §5.3 shall be entitled to a review through the Grievance Procedure set forth in this contract, if so requested.

5.4 Effect of Termination. In the event of termination of this contract for a covered person, NetCare shall be responsible for providing the benefits contained in this contract up to the effective date of termination and Judiciary shall be responsible for payment of the premiums up to said effective date.

5.4.1 Termination of Subscriber's Coverage. If a subscriber's coverage terminates the coverage of all of that subscriber's covered dependents also terminates as of the same date.

ARTICLE 6

ENROLLMENT

6.1 Regular Open Enrollment. The parties to this contract shall establish one (1) open enrollment period. During such period Judiciary shall provide NetCare with the assistance and cooperation detailed in Article 8. Except as provided in §6.1.1, §6.2, and §6.3 below, the open enrollment period is the only time during which current and potential covered persons shall be allowed to enroll in this plan or to disenrollment from this plan. The effective date of such enrollment or disenrollment shall be effective date of this contract, unless otherwise specified by Judiciary in accordance with this contract, or unless otherwise required by HIPAA.

6.1.1 Special Open Enrollment. If Judiciary holds a special open enrollment during the plan year, NetCare shall practice in such special open enrollment, unless otherwise agreed by the parties, or unless the plan is no longer to be offered as the entry date of the special open enrollment period. If the special open enrollment shall impact on rates, the parties shall negotiate an appropriate change prior to the participation of NetCare in such special open enrollment.

6.2 Newly Eligible Persons. Subject to §6.3, any individual who becomes a Judiciary employee, or for any other reason first becomes eligible to be a covered person outside the open enrollment period, shall have thirty (30) days after the date on which he/she became eligible to become a covered person. The effective date of such enrollment shall be as specified in §5.7.2 of the certificate.

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

6.4 Disenrollment Permitted. Covered persons for whom this group health insurance is secondary to Medicare coverage, shall be permitted to disenroll with 30 days' notice to NetCare, in the event that Judiciary initiates Medicare Supplemental insurance for retirees.

ARTICLE 7

NETCARE'S RESPONSIBILITIES

7.1 Marketing. NetCare shall print and provide necessary brochures, announcements, instructions, enrollment forms, and benefit plans for enrollment purposes and for distribution to potential covered persons regarding the plan. NetCare shall provide agreed upon quarterly communication to members clearly defining the benefits of the current plans in place. NetCare will work directly with the Judiciary of Guam to determine their needs in distribution, and type of communication desired.

7.2 Benefits to be Provided. NetCare shall, in consideration of receipt of applicable premiums, provide the benefits contained in this contract through the earlier of the effective date of a covered person's termination or the termination of this contract.

7.3 Financial and Medical Cost Information. In accordance with Title 4 GCA § 4302 (a), (b), and (g), NetCare shall provide Judiciary detailed claims and utilization and cost information, and shall provide upon reasonable request, the most recent audited financial statements, experience data, and any other information pertaining to this contract. Judiciary may, upon reasonable notice, audit NetCare to confirm the accuracy of the information provided specifically to the Judiciary of Guam book of business.

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

7.5 Errors and Omission Insurance. NetCare shall use all reasonable efforts to secure and maintain current errors and omission liability insurance of One Million Dollars ($1,000,000) per occurrence and Five Million Dollars ($5,000,000) aggregate, during the term of this contract.

7.6 Payment of Claims. NetCare shall pay claims in accordance with Title 10 GCA Chapter 9, Article 9, the Healthcare Prompt Payment Act of 2000, and the applicable claims payment requirements of PPACA claim and external review requirements.

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

7.8 Termination Notification. If NetCare terminates this contract, NetCare shall provide Judiciary with an adequate number of payroll stuffers announcing its termination at least fifteen (15) days prior to the date of termination. Further, NetCare shall fully cooperate with Judiciary in transitioning covered persons to other plans.

7.9 Sole Source Provider. If there is a covered service which is provided in Guam by only one provider who is not a participating provider, the eligible charges for such services shall be as if the sole source provider were a participating provider.

7.10 Dialysis Reimbursement. For dialysis services provided in Guam by an entity which is not a participating provider, the eligible charges for such services shall be lesser of (a) the actual charge made by the provider, or (b) seventy percent (70%) of the eligible charge which would have been made by the Guam Memorial Hospital.

For the purposes of calculating the deductible, co-payments and out-of-pocket maximums, these eligible charges will be considered as having been charged by a participating provider. However, the covered person will be responsible for paying an amount charged by the non-participating provider in excess of the eligible charges applicable to Guam Memorial Hospital, and such excess amount will not accrue toward any deductible or out-of-pocket maximum.

7.11 Performance Guarantees. Performance guarantees have the appropriate annual penalties listed by each guarantee as stated in Exhibit F (attached to the certificate) with a maximum amount of $115,000 annually. The penalties, if any, are to be paid annually upon an annual review meeting with thirty (30) days after the end of the plan year, and they are combined for the PPO1000 and HSA2000 contracts.

7.12 Online Access Capabilities. NetCare shall provide for the benefit of the covered person and Judiciary, the following online access capabilities:

7.12.1 Online access as provided here twenty-four (24) hours a day, seven (7) days a week in accord with Section 508 standards of the Rehabilitation Act of 1973 as amended.

7.12.2 For the covered person, access to Patient Health Record ("PHR") to include historical health conditions, prescription medications, office visit summary and procedures where a medical claim has been filed.

7.12.3 For the covered person, access to record of medical and drug claims.

7.12.4 For the covered person, ability to verify eligibility.

7.12.5 Ability of Providers to submit claims electronically for payment.

7.12.6 For the covered person, Judiciary, and Providers access to Schedule of Benefits, Certificates and Provider Network information.

7.12.7 For the covered person, ability to export PHR to federal compliance standard file formats or plain text file.

7.12.8 For the covered person, ability to print online a membership card.

7.12.9 For the covered person, access to interactive tools for researching health issues, treatments and risk assessment tools for health conditions.

ARTICLE 8

JUDICIARY'S RESPONSIBILITIES

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

8.2 Responsible Persons. Judiciary shall designate persons within Judiciary who shall be responsible for handling of health insurance problems, enrollment and cancellations. These designated persons shall be available to attend meetings on Government time for the purpose of reviewing administrative procedures, and to assist in problem solving relating to this contract.

8.3 Personnel changes. Judiciary shall provide written notice to NetCare of terminations, resignations, department transfers and other enrollment changes in enrollment, so that coverage can be terminated at the appropriate time. Judiciary shall make available to NetCare a computer listing of each employee receiving an applicable payroll deduction for premiums no later than fifteen (15) business days following each pay period.

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

8.4 No restrictions on Enrollment. Judiciary shall place no restriction or limitation on the percentage or number of enrollments in the plan.

ARTICLE 9

COVERED PERSON'S RESPONSIBILITIES

9.1 Acceptance. By enrolling in the plan, all covered persons agree to the terms, provisions and conditions of this contract.

9.2 Continued Residency. Except as specifically stated in this contract, enrollment in the plan shall be limited to employees domiciled in the service area, and who do not reside outside the service area for more than ninety (90) consecutive days per plan year, NetCare shall be entitled to require substantiation from a covered person to determine the covered person's domicile and may deny benefits under this contract for lack thereof. For a covered person domiciled in the service area, time spent receiving continuous medical services out of the service area shall not count toward the (90) day maximum, provided the receipt of such services precludes returning to the service area. Further, time spent by a parent or spouse of such covered person shall not count toward the (90) day maximum, provided the parent or spouse is providing necessary assistance to the covered person and further provided that under no circumstance can there be more than one such caregiver hereunder for any incident of care out of the service area. The requirement to reside in the service area shall not apply to employees' children under age 26 who are covered under the plan.

ARTICLE 10

NOTICES

10.1 Address of Record. For the purpose of communication and service of notice under this contract, the parties' addresses are as follows:

To: NetCare Life & Health Insurance Co.
Attn: Plan Administrator
424 West O'Brien Dr., Ste 200
Hagatna, Guam 96910

To: Judiciary of Guam
Administrator of the Courts
Attn: Human Resources Administrator
120 West O'Brien Drive
Hagatna, Guam 96910

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

ARTICLE 11

CONTRACT DISPUTE RESOLUTION

11.1 Disputes shall be resolved as set forth in the Dispute Resolution Provisions of the certificate.

ARTICLE 12

GOVERNING LAW

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

ARTICLE 13

MISCELLANEOUS

13.1 Government Laws and Regulation. NetCare guarantees the negotiated rates shall remain in effect for the plan year. However, if during such year the Government of the United States or the Government of Guam enacts statutes or promulgates regulations which: (I) require that NetCare offer different coverage to covered persons than that specifically provided in this contract; or (II) causes an increase or decrease in provider rates or other costs, the parties reserve the right on thirty (30) days' written notice to the other to adjust the premiums if the parties mutually determine that such mandate or law shall change NetCare's costs under this contract by more than five percent (5%). Where the contract indicates that a PPACA requirement might override a specific limitation, this §13.1 shall apply if it is determined that a PPACA override is in fact required.

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

13.3 Gratuity Warranty. NetCare warrants that it has not violated, is not violating, and promises it shall not violate the prohibition against gratuities and kickbacks set forth in Judiciary of Guam Procurement Regulations or applicable law.

13.4 Personal Interest Disclaimer. NetCare warrants that no member of any governing body of any agency of Judiciary and no officer, employee, or agent of Judiciary who exercises any functions or responsibilities in connection with the work to which this contract pertains has or shall have any personal interest, direct or indirect, in this contract, except that such members officers or employees may be covered persons under the plan. NetCare further warrants that no

other official of Judiciary who exercises functions and responsibilities in connection with the work to which this contract pertains has or shall have any personal interest, direct or indirect, in this contract except as possible covered persons under the plan.

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

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

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

13.8 Entire Contract. This contract, including the "Schedule of Benefits," the Certificate of Insurance, and all exhibits and appendices thereto, incorporated herein by reference Exhibits A through G, is the entire contract between the parties. There are no terms or obligations other than those contained herein applicable to this contract. The instrument shall supersede all previous communications or representations, whether verbal or written between the parties.

13.9 Amendment. The contract may only be amended upon the written consent of both parties.

13.10 Time of Essence. Time is expressly made of the essence in this contract and for performance hereunder,

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

13.12 Third Party Rights. Nothing in this contract, whether expressed or implied, is intended to confer any rights or remedies under or by reason of this contract on any persons other than the parties to this contract and their respective successors and assigns other than the rights conferred upon covered persons in the Certificate of Insurance.

13.13 Successors in Interest. Each and all of the covenants, conditions and restrictions in this contract shall insure to the benefit of and shall be binding upon the assignees and successors in interest of NetCare. However, NetCare shall not be entitled to assign its interest in this contract, or any prior or future contract with Judiciary, without the express written consent of Judiciary.

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

13.15 Counterparts. This contract may be execute by the parties in several counterparts, each of which shall be deemed to be an original copy.

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

13.17 Determination of Currency Exchange Payments. When a service is rendered by a participating provider outside of the United States, the claims shall be paid in accordance with its participating providers. Claims incurred outside of the United States by non-participating providers will be based on the date of service and will be converted according to the conversion rate, for cash transaction against the U.S. Dollar as found in the Wall Street Journal published in the date of service.

13.18 Availability of Funds. This contract is subject to the availability of funds.

1319 Restriction Against Contractor Employing Sex Offenders to work at Government of Guam venues. NetCare warrant that no person convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated, or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated, in Guam, or an offense in any jurisdiction which included, at a minimum, all of the elements of said offenses, or who is listed on the Sex Offender Registry, shall work for NetCare on property of the Government of Guam other than a public highway. Further, NetCare warrants that if any person providing services on behalf of NetCare is convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated or an offense in another jurisdiction with a minimum, the same element such as offenses, or who is listed on the Sex Offender Registry, that such person will be immediately removed from working at such agency and that the administrator of said agency be informed of such within twenty-four (24) hours of such conviction.

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

13.21 Minimum Wages as Determined by U.S. Government. NetCare agrees to comply with Title 5 Guam Code Annotated §§ 5801 and 5802. In the event that NetCare employs persons whose purpose, in whole or in part, is the direct delivery of service contracted by the Government, then NetCare shall pay such employees, at a minimum, in accordance with the U.S. Department of Labor Wage Determination for Guam and the Northern Marianas Islands in effect on the date of this contract. In the event that this contract is renewed by the Government and the Contractor, at the time of the renewal, NetCare shall pay such employees in accordance with the Wage Determination for Guam and the Northern Marianas Islands promulgated on a date most recent to the renewal date. NetCare agrees to provide employees whose purpose, in whole or in

part, is the direct delivery of service contracted by the Government those mandated health and similar benefits having a minimal value as detailed in the U.S. Department of Labor Wage Determination for Guam and the Northern Marianas Islands, and guarantee such employees a minimum of ten (10) paid holidays per annum per employee.

IN WITNESS WHEREOF, Judiciary and NetCare have signed this contract on the aforementioned date.

NetCare Life & Health Insurance Co

By:

Ricardo D. Bordallo
Legal Counsel
Date: 8/14/14

Judiciary of Guam

By:

FOR Christopher M. Budasi
Controller
Date:

Approved as to Legality and Form:
By:

Geraldine A. Cepeda, Acting Staff Attorney

Troy K. Moylan
Vice-President/Director
Date:

Joshua F. Tenorio
Administrator of the Courts, Acting
Date: 8/14/14

Kurt S. Moylan
President
Date:

Robert J. Torres
Chief Justice of Guam
Date:

Exhibit W
Group Health Insurance Certificate (FY2015)

JUDICIARY OF GUAM

and

NETCARE LIFE & HEALTH INSURANCE CO.

GROUP HEALTH INSURANCE CERTIFICATE

JUDICIARY OF GUAM PPO 1000 / HSA 2000 / DENTAL 2000

FOR THE PERIOD OF:

OCTOBER 1, 2014 - SEPTEMBER 30, 2015

JUDICIARY OF GUAM

and

NETCARE LIFE & HEALTH INSURANCE CO.

GROUP HEALTH INSURANCE CERTIFICATE

JUDICIARY OF GUAM PPO 1000 / HSA 2000 / DENTAL 2000

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

ARTICLE 1

Conditions

§1.1 Agreement Definitions. The definitions contained in Article 2 of the Group Health Insurance Agreement by and between Judiciary of Guam and Company ("Agreement" or "Contract"), to which this Certificate is attached, apply to this Certificate unless a term is otherwise defined herein.

§1.2 Scope of Benefits: Company shall provide only the benefits described in this Certificate. Covered Person shall be responsible for payment of:

§1.2.1 Deductibles;

§1.2.2 Co-Payments and Co-Insurance;

§1.2.3 Any difference between a Non-Participating Provider's charges and Company's reimbursement to such Provider;

§1.2.4 Services that are not covered under this Certificate;

§1.2.5 Otherwise Covered Services that exceed the maximums provided under this Certificate; and

§1.2.6 Services received while the individual is not covered under this Certificate.

§1.2.7 All benefits are subject to the terms and conditions contained in this Agreement, including all applicable conditions, limitations and exclusions.

§1.3 Deductible: Under this Plan, there is no Deductible for Dental Benefits (as defined in Article 7 of this Certificate), and there is no Deductible when Participating Providers are utilized for PPACA Preventive Care Services, but there is a Deductible for other Medical Benefits (as defined in Article 2 of this Certificate). Payments by a Covered Person for Dental Benefits shall not be applied to the Deductible for Medical Benefits. Any costs paid towards the Deductible applicable to Participating Providers do not accumulate towards the Deductible applicable to Non-Participating Providers.

a. **For PPO 1000**: The Deductible shall be accumulated by each Covered Person during the Plan Year. The Deductible for this Plan is $1,000 for Covered Services received through Participating Providers per

Covered Person, with a Family maximum of $2,000 for Covered Services received through Participating Providers. There is a separate Deductible of $2,000 per Covered Person, with a Family maximum of $6,000 for Covered Services received through Non-Participating Providers.

b. **For HSA 2000**: The Deductible shall be accumulated by each Covered Person during the Plan Year. The Deductible for this Plan is $2,000 for Covered Services received through Participating Providers per Covered Person, with a Family maximum of $4,000 for Covered Services received through Participating Providers. There is a separate Deductible of $4,000 per Covered Person, with a Family maximum of $12,000 for Covered Services received through Non-Participating Providers.

§1.4 Co-Insurance. Co-Insurance shall be in addition to the Deductibles. The Co-Insurance shall be paid by each Covered Person, if applicable, during each Plan Year, subject to the maximum amounts provided in the Plan as indicated in the charts in Exhibits A and B. No Co-insurance shall be imposed when Participating Providers are utilized for preventive care as required by PPACA.

§1.5 Out of Pocket Maximums

§1.5.1 Out of Pocket: is the most the Covered Person could pay during a covered period, usually one year, for the cost of covered services.

a. **For PPO 1000**: Out of Pocket Maximums for Covered Services, including Deductibles, Co-Insurances and Co-Payments for Participating Providers, regardless of whether the costs were incurred in Guam or outside Guam, shall be $3,000 per Covered Person and $9,000 per Family. Only payments for Covered Services rendered by Participating Providers will accumulate towards the Out of Pocket Maximums. No Deductibles, Co-Payments or Co-Insurance shall be imposed when Participating Providers are utilized for PPACA Preventive Care Services only.

b. **For HSA 2000**: Out of Pocket Maximums for Covered Services, including Deductibles, Co-Insurances and Co-Payments for Participating Providers, regardless of whether the costs were incurred in Guam or outside Guam, shall be $4,000 per Covered Person and $11,900 per Family. Only payments for Covered Services rendered by Participating Providers will accumulate towards the Out of Pocket Maximums. No Deductibles, Co-Payments or Co-Insurance shall be imposed when Participating Providers are utilized for PPACA Preventive Care Services only.

§1.5.2 There are no Out of Pocket Maximums for Non-Participating Providers.

§1.5.3 Exceptions to Out of Pocket Maximums. The following payments do not accumulate towards the Out of Pocket Maximums: (a) payments for Services which are not covered; (b) payments for otherwise Covered Services that exceed the Plan's maximums; (c) payments for Services of Non-Participating Providers; and (d) payments for Dental Benefits under the optional dental plan. All other out of pocket expenses for covered benefits shall count towards the deductible and out of pocket maximum.

§1.6 Deductibles, Co-Payments and Co-Insurance for Participating and Non-Participating Provider Charges. The Deductibles, Co-Payments and Co-Insurance for Covered Persons shall, in most cases, be separate for Participating Providers and for Nonparticipating Providers. Subject to the limitations set forth in this Certificate, including Exhibits A and B, the Covered Person shall pay Deductibles, Co-Payments and Co-Insurance for Covered Services for Medical Benefits and Dental Benefits indicated in Exhibits A and B. Deductibles, Co-Payments and Co-Insurance shall be based on the Eligible Charges for Covered Services.

§1.7 LIMITATIONS ON BENEFITS. A COVERED PERSON UTILIZING A NONPARTICIPATING PROVIDER SHALL BE RESPONSIBLE FOR ANY AMOUNT BY WHICH SUCH PROVIDER'S CHARGES EXCEED ELIGIBLE CHARGES.

However, and not withstanding any other provision of this Agreement, in no event will a Covered Person's Co-Payment or total Out of Pocket Expense, due to Out of Service Area Emergency Services rendered by a Non-Participating Provider, exceed what they would have been if the Service had been rendered by a Participating Provider, provided the Covered Person's medical condition precluded receiving care from a Participating Provider. Covered Person shall not be responsible for any amount by which the Non-Participating Provider exceeds eligible charges for Emergency cases only. In the case of a PPACA Emergency, the Covered Person's Co-Payments or Co-Insurance for PPACA Emergency Services rendered by a Non-Participating Provider shall not exceed what they would have been if the PPACA Emergency Service had been rendered by a Participating Provider, whether or not the Emergency Care could have been received from a Participating Provider, but normal Nonparticipating deductibles and out of pocket maximums may be charged to the Covered Person, and the Covered Person may be responsible for amounts by which the Nonparticipating Provider's charges exceed those that would have been paid for a Participating Provider.

ARTICLE 2

Medical Benefits

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

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

§2.1.1 Primary Care Services. As required by Section 2719A of the PHSA, as added by PPACA, each Covered Person shall be entitled to designate any Participating Provider who is a Primary Care Physician and who is available to accept the Covered Person as the Primary Care Physician for that Covered Person. If the Covered Person is a child, the child's parents shall be entitled to select for the child a Primary Care Physician who specializes in pediatric care.

Generally, a Primary Care Physician is a family practitioner, internist, pediatrician, or obstetrician-gynecologist. A Primary Care Physician may also be a medical group or clinic providing medical care.

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

Some examples of covered Specialist Care Services are:

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by the Company.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.

- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Hearing Aids - Coverage will be provided for medically necessary expenses incurred in the purchase of a hearing aid for covered members. Coverage is provided for the purchase of a hearing aid for each hearing impaired ear once in a 24-month period when it is medically necessary and prescribed by a licensed physician or audiologist, and limited to the amounts in Exhibits A and B.

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

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

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

§2.2 Preventive Physical Exam. A routine preventive physical examination (including limited hearing testing and mammograms in accordance with the U.S. Preventive Services Task Force Recommendations with a Grade A or B only as found at www.uspreventiveservicestaskforce.org/uspstf/uspsrecsdate.htm and www.hrsa.gov/womensguidelines.com. Physical examinations required for obtaining or continuing any employment, insurance, schooling or licensing are excluded from this benefit. Coverage for routine preventive physical exam is limited to one exam per plan year and at least 9 months have passed following the last covered preventive physical exam.

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

§2.3 Immunizations. Charges incurred in connection with immunizations in accordance with the guidelines provided by the Center of Disease Control. See Exhibit D, "Schedule of Covered Immunizations."

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

§2.5 Allergy testing and treatment. A maximum benefit of Five Hundred Dollars ($500) per Plan Year per Covered Person for charges for allergy testing and treatment.

§2.6 Maternity. Hospital and Physician charges for maternity services, including prenatal, postnatal, delivery and newborn care, in accordance with all applicable restrictions thereon, and to include coverage for epidural injections when medically indicated. Provided, however, that newborn care shall not be provided to a child born to a non-Spouse Dependent even if the non-Spouse Dependent's own prenatal, postnatal and delivery care are covered.

§2.7 Well Baby/Child Care. Charges incurred by a Covered Person from ages 1 to 4 years of age for services rendered solely for the purpose of health maintenance and not for the Treatment of an Illness or Injury, Payment, for such Services shall be limited to no more than seven (7) visits per Plan Year, commencing at birth; and 1 visit per year for ages 5 to 17 years of age. Benefits for such services may include immunization and lab tests. Services must be performed by or under the supervision of a Physician. Well Baby Care will not be subject to the deductible, and shall be covered at 100% by the Company. Any such care that is PPACA Preventive Care Services shall be covered without Deductibles, Co-Payments or Co-Insurance if received from a Participating

Provider. Charges for treatment of illness or injury shall be covered as regular benefits. If the care is PPACA Preventive Care Services, requirements of this agreement and PPACA regulations shall be followed in determining the portion of any combined visit or service that is to be provided without Deductibles, Co-Payments or Co-Insurance.

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

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

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

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

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

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

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

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

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

§2.8.6.3 Pre-admission tests and/or examinations.

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

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

§2.8.7 Ambulatory Surgical Center benefits. Charges for Outpatient Surgery.

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

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

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

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

§2.9.3.1 Company covers bariatric surgery using a covered procedure outlined below as medically necessary when ALL of the following criteria are met:

§2.9.3.1.1 The individual is >_ 18 years of age or has reached full expected skeletal growth AND has evidence of EITHER of the following:

- a BMI (Body Mass Index) >_ 40
- a BMI (Body Mass Index) 35-39.9 with at least one clinically significant comorbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease, or pulmonary hypertension.

Failure of medical management including evidence of active participation within the last two years in a weight-management program that is supervised either by a physician or a registered dietician for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of ALL of the following components:

- weight
- current dietary program
- physical activity (e.g., exercise program)

§2.9.3.1.2 For individuals with long-standing, morbid obesity, participation in a program within the last five years is sufficient if reasonable attendance in the weight-management program over an extended period of time of at least six months can be demonstrated. However, physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

§2.9.3.1.3 A thorough multidisciplinary evaluation within the previous twelve (12) months which includes the following:

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

§2.10 Basic diagnostic and therapy benefits.

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

§2.10.1.1 Laboratory Services. Charges for laboratory Services.

§2.10.1.2 X-ray Services. Charges for diagnostic X-ray procedures.

§2.10.1.3 Electrocardiograms. Charges for EKG procedures.

§2.10.1.4 Radiotherapy. Charges for radiotherapy.

§2.10.1.5 Inhalation Therapy. Charges for Inhalation Therapy provided as an Outpatient Service.

§2.10.1.6 Polysomnograph. Charges for diagnostic polysomnograph procedures.

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

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

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

§2.12 Home Health Care. Home Health Care, provided by allied health care professionals, is covered.

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

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

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

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

§2.13.4 Unless otherwise specifically approved in advance by Company, the Covered Person must have been first confined in a Hospital and then transferred to the Skilled Nursing Facility.

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

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

§2.14 Hospice Care. Charges for a maximum of one hundred eighty (180) days per lifetime. The attending Physician must determine limited life expectancy of six (6) months or less. The Covered Person shall

not be entitled to benefits for any Services for the Terminal Illness except for palliative care. Services must be provided through a bona fide Hospice. Coverage for Hospice Services shall be limited to a maximum of One Hundred Dollars ($100) per day.

§2.15 Prescription Drugs. The following provisions and definitions apply to coverage for Prescription Drugs:

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

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

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

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

§2.15.5 For other medications, a Unit represents a single container, inhaler unit, package or course of therapy. For DEA controlled subscriptions, a unit may be set at a smaller quantity for the covered person's protection and safety.

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

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

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

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

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

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

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

limited to one rental or purchase every three (3) years and is limited to standard equipment only, unless subject to a treatment plan.

§2.19 Mental health benefits. The charges for the diagnosis and treatment of mental Illness, as that term is defined in Chapter 28, Division 2 of Title 22 of the Guam Code Annotated, and the federal Mental Health Parity Act, 29 U.S.C. § 1185, are subject to the same conditions and restrictions applicable to physical illness.

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

§2.21 Tubal ligation. The charges for tubal ligations.

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

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

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

§2.25 Hearing Screening. Charges for infant hearing screening as required by P.L. 27-150.

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

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

§2.27.1 The Covered Person has obtained written Pre-certification from Company or Company's agent to receive Services from Preferred Providers and has agreed to receive Services from such Preferred Providers chosen by Company or Company's agent. No Pre-certification shall be required for Emergency or PPACA Emergency cases.

§2.27.2 Company is the primary payor based on the coordination of benefits provisions of this Certificate, unless the primary payor is Medicare.

§2.27.3 For Inpatient Services which are unavailable in Guam and rendered by Preferred Providers.

§2.27.3.1 Company shall pay 100% of these services.

§2.27.3.2 Company shall waive any co-insurance for such services.

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

Regardless of the location of the Covered Person, or if it is Medically Necessary to provide for a break in the trip,

Company shall provide the lesser of the lowest applicable economy airfare or the lowest economy, round-trip airfare on a commercial direct flight between Guam and the Preferred Providers. In no event shall Company provide an air ambulance.

§2.27.3.4 If the Service is one of the following specific procedures or conditions: open heart surgery, oncology surgery, aneurysmectomy, pneumonectomy, intra cranial surgery, acute leukemia, gamma knife or if the level of care required is NICU Level III, or if the expected cost to the Company for off-island Covered Services exceeds $25,000.00, Company shall pay the air fare of one companion of the Covered Person to the Preferred Providers under the terms set forth in §2.27.4.2.

§2.27.3.5 If it is Medically Necessary that a licensed medical attendant be with the Covered Person, Company shall provide for one airline seat for such attendant under the same terms set forth in §2.27.4.2.

§2.27.3.6 If the Covered Person is unable to self-care, Company shall provide for one airline seat for a qualified assistant under the same terms as §2.27.4.2.

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

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

§2.27.3.9 For Company to be liable to pay any airfare, the proposed Service to be performed at the Preferred Providers must be a specific procedure and not merely a diagnostic work-up or to confirm or rule out the diagnosis of another Physician.

§2.27.4 For Ambulatory Surgical Center Services which are unavailable in Guam and rendered by Preferred Providers in the Philippines:

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

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

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

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

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

§2.27.6 Only those facilities identified as Centers of Care or Preferred Providers in the Company's most recently updated Participating Provider Directory will qualify for the airfare benefit.

§2.28 If no Participating Provider available. If there is no Participating Provider available, within the United States, to provide necessary Covered Services to a Covered Person, Company will cover those services at a Non-Participating Provider, within the United States, unless otherwise agreed by the Covered Person, such that the Covered Person will have no greater out of pocket cost than he or she would have had had the Services been rendered by a Participating Provider.

§2.29 If not able to travel. In case Emergency medical care is needed off-island, and it is medically imprudent for the Covered Person to be transported to a Participating Provider, Company will cover Services

rendered to the Covered Person at a Non-Participating Provider such that the Covered Person will have no greater out of pocket cost than he or she would have had had the Services been rendered by a Participating Provider.

§2.30 Continuation of Existing Care in Limited Circumstances.

§2.30.1 Judiciary employees who, at the time of the signing of this contract, have existing medical records for themselves or their enrolled dependents at the FHP Health Center during any part of the Judiciary's Fiscal Year 2014 contract for health insurance with TakeCare Insurance, may continue to utilize primary care providers employed by FHP Health Center, despite the fact that the primary care providers are not otherwise participating providers in the NetCare Contract with the Judiciary for FY 2015. Visits to such primary care providers shall be reimbursable at the in-network percentage of NetCare's eligible and UCR charges.

§2.30.2. Judiciary employees or their enrolled dependents who wish to patronize the Urgent Care Facility in late night hours at the FHP Health Center, during the FY2015 Plan year, may utilize the FHP Health Center Urgent Care Facility between the hours of 9 p.m. to 11 p.m. Monday through Sunday despite the fact that the primary care providers are not otherwise participating providers in the NetCare Contract with the Judiciary for FY 2015. Visits to the FHP Urgent Care Center between 9 p.m. and 11 p.m. shall be reimbursable at the in-network percentage of actual charges.

ARTICLE 3

Specific Limitations on Benefits

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

§3.1.1 Maximum Annual Benefit. The total benefits payable to or on behalf of a Covered Person per Plan Year shall be as stated in Exhibits A and B.

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

§3.1.3 Non-Spouse Dependent. Maternity benefits for a non-Spouse Dependent are covered. Except that newborn care shall not be covered for a child born to a non-Spouse Dependent. A child born to a non-Spouse Dependent shall not be covered unless such child specifically meets the requirements for coverage as a Dependent of an employee (such as the employee becoming the guardian of such child).

§3.1.4 Nuclear medicine. Coverage for nuclear medicine and all Covered Services related thereto are included.

§3.1.5 Orthopedic conditions. Coverage for orthopedic conditions and related internal and external prosthetic devices are included.

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

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

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

§3.1.6 Radiation therapy. Coverage for radiation therapy and all Services related thereto shall be included.

§3.1.7 Allergy testing and treatment. A maximum benefit of Five Hundred Dollars ($500) per Plan Year for charges for allergy testing and treatment that are not considered essential benefits under PPACA. Benefits for Allergy testing and treatment that constitute essential benefits under PPACA are subject only to the PPACA Annual Limit.

§3.1.8 Annual refraction eye examination. Coverage is limited to one visit per member per Plan Year. There is no dollar limit for an annual eye examination.

§3.1.9 Blood and blood products and derivatives. Coverage for blood and blood products/derivatives and services related thereto shall be included.

§3.1.10 Hearing aids. Coverage for hearing aids is limited to Five Hundred Dollars ($500) per Plan Year. Replacements for hearing aids are allowed once every three years as covered by the Medicare guidelines.

§3.1.11 Acupuncture. Coverage for acupuncture Services are up to the Annual Maximum Benefit per Plan Year as stated in Exhibit A.

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

§3.1.13 Chiropractic. Coverage for chiropractic Services are up to the Annual Maximum Benefit per Plan Year as stated in Exhibit A.

§3.1.14 Occupational Therapy. Coverage for Occupational Therapy shall not be subject to a dollar or visit limit up to the Annual Maximum Benefit per Plan Year.

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

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

§3.2.2 Hospital and Surgical authorization. Pre-certification must be obtained from the Company before a Covered Person is admitted to a Hospital or has one of the Surgeries or Medical Procedures listed in §3.2.2.3. Pre-certification will be handled in accordance to the Milliman Healthcare Guidelines.

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

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

Pre-certification denials shall be handled pursuant to the PPACA Claims Procedure Requirements provided in §6.7 and as reflected in the Company's Appeal Procedures attached as Exhibit G, to the extent required by PPACA.

§3.2.2.2 No benefit without Pre-certification. If a required Pre-certification is not obtained in accordance with §3.2.2, Company shall not pay any of the Eligible Charges incurred in connection with. the confinement or Surgery. If the Participating Provider is the person required to obtain the Pre-certification, the cost of the services or treatment shall not be charged to the Covered Person. No penalty for failure to obtain Pre-certification shall be imposed for a PPACA Emergency, whether Participating or Non-Participating Providers are utilized

§3.2.2.3 List of outpatient and inpatient procedures requiring pre-certification (unless a PPACA Emergency):

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

§3.2.3 Excess Non-Participating Provider charges. The Covered Person shall be responsible for charges by a Non-Participating Provider in excess of Eligible Charges, except (a) Out-Of-Service Area emergency, or (b) when the Non-Participating Provider is a Sole Source Provider as defined in §7.9 of

the Agreement. A Covered Person using a Non-Participating Provider for a PPACA Emergency shall not be liable for CoPayments or Co-Insurance in excess of Co-Payments and Co-Insurance that would have been charged if Participating Providers had been used. The Company shall pay an amount for PPACA Emergency Services computed as provided in this Agreement.

§3.2.4 Excessive Participating Provider charges. Neither the Covered Person nor the Company shall be liable for charges by a Participating Provider in excess of the Eligible Charges. These charges shall be the responsibility of the Participating Provider.

§3.2.5 Physical therapy. Charges to a licensed physical therapist for physical therapy, including neuromuscular rehabilitation are covered.

§3.2.6 Pregnancy termination. Charges for the termination of Pregnancy are covered only when Medically Necessary.

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

§3.2.8 Well Baby Care. Well Baby Care is covered only as set forth in §2.35 and as required by PPACA (as a PPACA Preventive Care Services or otherwise).

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

ARTICLE 4

Specific Exclusions from Benefits

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

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

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

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

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

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

§4.6 No benefits will be paid for Services and supplies not specifically described as covered in the Agreement.

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

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

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

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

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

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

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

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

§4.15 No benefits will be paid for Services and supplies provided to a dependent of a non-Spouse Dependent. Dependents of non-Spouse Dependents are not eligible for coverage. For example, when a

Dependent, other than a Spouse of the Subscriber, has a child, that child is a dependent of a non-Spouse Dependent and is not eligible to become covered under the Plan, unless such child otherwise becomes eligible for enrollment.

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

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

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

§4.19 No benefits will be paid for treatment and services provided by Chiropractors, except as otherwise covered as shown in the Schedule of Benefits.

§4.20 No benefits will be paid for Services and supplies provided for occupational and/or speech therapy except as otherwise covered as shown in the Schedule of Benefits.

§4.21 No benefits will be paid for:

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

§4.21.2 Drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury, or

§4.21.3 Drugs or substances labeled "Caution: limited by federal law to investigational use."

§4.21.4 Any drug or substance which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug).

§4.22 No benefits will be paid for experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by Company, unless Pre-certification is obtained from the Company.

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

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

§4.23 No benefits will be paid for services or supplies related to Genetic Testing, with the exception of BRAC1 Testing.

§4.24 No benefits will be paid for services or supplies related to Paternity Testing.

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

§4.26 No benefits will be paid in relation to the Robotic Suite or for Robotic Surgery

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

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

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

§4.30 No benefits will be paid for audiograms, regardless of the reason for such tests.

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

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

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

§4.31.3 Surgical treatment of TMJ or "Temporomandibular Joint Syndrome."

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

§4.32 To the extent permitted by PPACA, no benefits will be paid for Services and supplies provided for the purpose of organ transplantation. Unless PPACA requires otherwise, all organ transplants are excluded from coverage, including but not limited to: heart, lung, liver, kidney, pancreas, bone marrow and cornea. Autologous bone marrow transplant (where the donor is also the recipient) is also excluded. Services and supplies directly related to the transplant, such as tissue typing and other pre-operative procedures are excluded as are Services and supplies provided post-operatively which are a consequence of the transplant surgery or the

presence of the transplanted organ. This exclusion for post-operative supplies, to include anti-rejection or immunosuppressant medications, and Services continues for the life of the patient. Benefits directly related to the transplant will cease as of the time when it is determine that a transplant will be performed.

§4.33 No benefits will be paid for Services and supplies provided in the course of organ donation whether for a Covered Person who is donating an organ or for someone who is donating an organ for transplantation into a Covered Person.

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

§4.35 No benefits will be paid for vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision), Lasik, keratoplasty, and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the Covered Benefits section of the Group Health Insurance Certificate.

§4.36 No benefits will be paid for eyeglasses or contact lenses or for Services and supplies in connection with surgery for the purpose of diagnosing or correcting errors in refraction.

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

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

§4.39 No benefits will be paid in connection with dialysis treatments which would not have been charged in the absence of the Plan.

§4.40 No benefits will be paid for hypnotherapy.

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

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

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

§4.41.2 surgery to correct the results of injuries causing an impairment;

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

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

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

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

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

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

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

§4.48 No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction even if it is prescribed by a Physician.

§4.49 If for the purpose of weight reduction or aesthetic purposes, no benefits will be paid in connection with gastric bypass, stapling or reversal.

§4.50 No benefits will be paid for surgical operations, procedures or treatment of

obesity, except when pre-authorized by Company.

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

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

§4.51.2 The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or

gestational carriers;

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

§4.51.4 Home ovulation prediction kits;

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

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

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

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

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

§4.51.10 Reversal of sterilization surgery; and

§4.51.11 Any charges associated with obtaining sperm for ART procedures.

§4.52 No benefits will be paid for the purchase or rental of durable or disposable medical equipment and supplies, other than for equipment and supplies used in a Hospital or Skilled Nursing Facility or in conjunction with an approved Hospital or Skilled Nursing Facility confinement or as otherwise noted in the Agreement.

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

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

§4.5 5 No benefits will be paid for Services and supplies provided for penile implants of any type.

§4.56 Except for intraocular lens implants, pace makers, heart valves, cardiac stents and as provided in Exhibit E attached hereto, no benefits will be paid in connection with any implants or transplants.

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

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

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

§4.60 Except as specifically provided in this Agreement, no benefits will be provided for the treatment of orthopedic conditions, prosthetic devices or any Services related thereto, including:

§4.60.1 External devices: Non-orthopedic external prosthetic devices, disposable prosthetic devices, non-orthopedic corrective appliances and prosthetic and orthotic devices and supplies available over-the-counter.

§4.60.2 Internal devices: Non-orthopedic internal prosthetic devices, except pacemakers, heart valves, intra ocular lenses and stents.

§4.60.3 Orthopedic footwear: Orthopedic footwear unless attached to an artificial foot or unless attached as a permanent part of a leg brace.

§4.60.4 Motorized limbs: Motorized artificial limbs.

§4.60.5 Durable medical equipment: Durable medical equipment, unless specifically covered in this Agreement.

§4.61 No benefits will be paid for temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth.

§4.62 Except as specifically provided in this Agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment, including inhalation therapy related equipment.

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

§4.64 No benefits will be paid for treatment for all relative services, procedures, supplies and medications related to sleeping disorders.

§4.65 No benefits will be paid for recreational or educational therapy.

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

§4.67 Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a Physician.

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

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

§4.70 No benefits will be paid for educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders including developmental and learning disorders associated with mental retardation, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

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

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

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

§4.73.1 Which are not Medically Necessary, as determined by Company, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

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

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

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

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

§4.74 As required by HIPAA, no source-of-injury exclusion, such as exclusion 4.37 for off-road sporting events, will apply if the accident resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

ARTICLE 5

General Terms and Conditions

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

§5.2 Dependent. A Dependent is either a Spouse, Cohabiting Partner or Child as defined herein.

§5.3 Spouse, Cohabiting Partner, and Children. A Subscriber's legally married Spouse or Cohabiting Partner continuously residing within the Service Area, a Subscriber's Children under twenty-six (26) years of age or Children of a Subscriber's legally married Spouse under twenty-six (26) years of age may enroll as Eligible Dependents of the Subscriber if they meet each of the applicable eligibility requirements set forth in this Policy. For purposes of eligibility, "Children" means persons from birth up to but not including their twenty-sixth (26th) birthday, who are a Subscriber's or a Subscriber's legally married Spouse's natural or adopted Children, Children placed for adoption by an adoption agency with the Subscriber, Children under the legal guardianship and custody of the Subscriber by a court order, or Children for whom the Subscriber is required to provide health coverage pursuant to a Qualified Medical Child Support Order. Children of Cohabiting Partners are eligible for coverage so long as the Cohabiting Partner is a Covered Person. The Spouses and children of Children are not eligible for coverage. For purposes of this paragraph, if a Subscriber's Spouse is absent from the Service Area for ninety (90) consecutive days within the Benefit Period, then the Spouse does not continuously reside in the Service Area.

§5.3.1 Cohabiting Partner Eligibility. This Contract includes coverage for a Cohabiting Partner provided that the Subscriber and Cohabiting Partner have complied with the following provisions:

§5.3.1.1 A Cohabiting Partner becomes eligible for coverage only during the Group's Open Enrollment Period.

§5.3.1.2 The Subscriber and a Cohabiting Partner are eighteen (18) years of age or older; are not related to each other by blood to a degree that would bar marriage; are not legally married or the Cohabiting Partner of any other person; have cohabited for two (2) consecutive years immediately preceding enrollment; and a notarized affidavit in a form acceptable to the Company attesting to these facts is submitted to the Company during the Judiciary's Open Enrollment Period for each year that the Cohabiting Partner is to be enrolled.

§5.3.1.3 For purposes of this paragraph, if a Cohabiting Partner is absent from the Company's Service Area for ninety (90) consecutive days within the Benefit Period, then the Cohabiting Partner does not continuously reside in the Service Area.

§5.3.2 Coverage for Children Outside the Service Area. Eligible Dependent Children residing outside the Service Area are eligible for coverage up to but not including their twenty-sixth (26th) birthday, provided proof of eligibility such as but not limited to a legal birth certificate being submitted to the Company. The Eligible Dependent Children must select a Participating Provider as provided in Section 2.1.1 of this Certificate. To obtain coverage, all care must be provided or coordinated with the Participating Primary Care Provider and Pre-certification must be obtained from the Company for Specialty and Hospital Services excluding Emergency and covered Primary Care Services.

§5.3.3 Commencement of Coverage for Eligible Dependents.

§5.3.3.1 To add Eligible Dependents, unless enrollment is pursuant to a Qualified Medical Child Support Order or other Special Enrollment Period as specified herein, a Subscriber shall complete

an application for enrollment to add an Eligible Dependent within thirty (30) days of the date the Eligible Dependent becomes eligible or during open enrollment. After the thirty (30) days limit has passed, the Subscriber will not be allowed to add an Eligible Dependent until the next Open Enrollment Period.

§5.3.3.2 Coverage for newborn Children of a Subscriber begins at birth, provided an application for enrollment form for the newborn is received by the Company within thirty (30) days of their birth. An Application for enrollment received after this period will result in no coverage for the newborn until the next Open Enrollment Period at which time the Subscriber has another opportunity to enroll Eligible Dependents.

§5.3.3.3 Coverage for Children for whom a Subscriber or the Subscriber's legally married Spouse has been appointed legal guardian by a court can only be applied for during the Group's Open Enrollment Period. Coverage begins on the effective date immediately following the Open Enrollment Period. Eligibility for a Child for whom a Subscriber or the Subscriber's legally married Spouse has been appointed legal guardian ends when the guardianship ends or the Child reaches the age of majority.

§5.3.3.4 Coverage for adopted Children of a Subscriber can be applied for on the date of placement for adoption, which is the date the Subscriber assumes and retains a legal obligation for full or partial support of the Child in anticipation of the adoption of the Child, provided an enrollment form for the Child is received by the Company within thirty (30) days of the date of placement for adoption. The Company may require the Subscriber to present evidence that placement has been obtained, including adoption agency documentation. Eligibility for coverage for an adopted Child ends if the placement is interrupted before legal adoption or the Child is removed from the Subscriber's custody.

§5.3.4 Commencement of Coverage for New Spouse. Eligibility for coverage of a new legally married Spouse of Subscriber begins on the date of marriage as indicated on the marriage certificate, provided an enrollment form is submitted to the Company within thirty (30) days of the date of marriage. Official documentation of proof of marriage will be required.

§5.3.5 Commencement of Coverage for Cohabiting Partner. Coverage for a Cohabiting Partner can only be applied for during the Group's Open Enrollment Period. Coverage begins on the Group's effective date following the Open Enrollment Period, provided an enrollment form, affidavit, and other documentation as requested by the Company, is submitted to the Company during the Group's Open Enrollment Period.

§5.4 Documentary Evidence. NetCare reserves the right to require a Subscriber to provide documentary evidence of eligibility of an Eligible Dependent, including but not limited to, copies of tax returns, birth certificates, marriage certificates and court orders, to supplement an application for enrollment.

§5.5 Other Eligibility Requirements. Additionally, the following requirements must be met to ensure eligibility:

§5.5.1 Subscriber through whom the Eligible Dependent is eligible must be enrolled in the Plan;

§5.5.2 The Eligible Dependent must continuously reside in the Service Area, except as provided herein for Children in Section 5.3.2 above. For purposes of this Certificate, if an Eligible Dependent is absent from the Service Area for more than ninety (90) consecutive days in any one hundred eighty (180) day period, that Eligible Dependent does not continuously reside in the Service Area; and the Eligible Dependent Children must select a Participating Provider as provided in Section 2.1.1 of this Certificate.

§5.6 Subscriber's biological or adopted children or children placed for adoption.

Eligible children include the Subscriber's biological or adopted children or children placed with the Subscriber for adoption by the Subscriber, and children under legal guardianship of the Subscriber; and children of the Subscriber's lawfully married Spouse. Except for children under legal guardianship, the Plan may not deny enrollment of a child on the grounds that the child is not claimed as a Dependent on the Subscriber's Guam tax return or on the grounds that the child does not reside with the Subscriber or in the Plan's Service Area. If a Subscriber is required, by a court or administrative order, to provide health care for a child, as defined above, the Plan shall permit the Subscriber to enroll, under family coverage, the child and himself/herself, provided the child is otherwise eligible, without regard to any open enrollment season or open enrollment restriction. Notwithstanding the aforesaid, a child under legal guardianship is not eligible for enrollment solely because the Subscriber is required, by a court or administrative order, to provide health coverage for that child; or

§5.7 Incapacitated Child. An unmarried, dependent biological child, adopted child, or child placed for adoption with the Subscriber or the Subscriber's lawfully wedded spouse, which child is over the age of twenty-six (26) years, and incapable of self-sustaining employment by reason of mental retardation or physical handicap, and is therefore primarily dependent on the Subscriber for support and maintenance and has been continuously dependent since reaching age twenty-six (26).

§5.8 Child Not Denied Coverage. In accordance with Public Law 22-101, 10 GCA § 95101, and notwithstanding any other provision of this Agreement, no child whose parent is a Subscriber or Spouse shall be denied coverage solely for any of the following reasons:

§5.8.1 The child was born out of wedlock.

§5.8.2 The child is not claimed as a dependent on the parent's Guam tax return.

§5.8.3 The child does not reside with the parent or in the Service Area.

§5.8.4 The child has a pre-existing or excluded medical condition.

§5.8.5 The child is adopted or the subject of adoption proceedings.

§5.9 Residency Requirement. Except as otherwise specifically stated in this Agreement, Enrollment in the Plan shall be limited to only those Covered Persons who are Domiciled in the Service Area and do not reside out of the Service Area for more than ninety (90) consecutive days per Plan Year. Company shall be entitled to require substantiation from a Covered Person to determine the Covered Person's Domicile and may deny benefits under this Agreement for lack thereof. For a Covered Person who is Domiciled in the Service Area, time spent receiving continuous medical services out of the Service Area shall not count toward the ninety (90) day maximum provided the receipt of such services precludes returning to the Service Area. Further, time spent by a parent or spouse of such Covered Person shall not count toward the ninety (90) day maximum, provided the parent or spouse is providing necessary assistance to the Covered Person and further provided that under no circumstance can there be more than one such caregiver hereunder for any incident out of the Service Area.

§5.10 Enrollment Documentation. The following documents are required prior to enrolling the following Dependents:

§5.10.1 Incapacitated child. For a child with a continuing dependency resulting from incapacity, as described in §5.7, satisfactory proof of such continuing incapacity and dependency, within thirty-one (31) days of such child attaining the limiting age and annually thereafter.

§5.10.2 Child under court order. For a Dependent child under court order requiring the Subscriber to provide health coverage for such child, a certified copy of the court order requiring such coverage.

§5.10.3 Child under guardianship. For a Dependent child of an eligible common law spouse and a Dependent child otherwise under guardianship, a certified copy of the court order granting the

guardianship of such child to the Subscriber. The Subscriber shall also be required to provide such evidence as to the qualification of the Dependent for legal guardianship as Company may require.

§5.10.4 Cohabiting Partner. For a Cohabiting Partner of the Subscriber.

§5.10.4.1 Affidavit. A notarized affidavit executed by both the Subscriber and the Cohabiting Partner verifying the parties' cohabitation for the two (2) consecutive years immediately preceding the proposed Enrollment of such Cohabiting Partner.

§5.10.4.2 Proof of eligibility. Satisfactory proof that the Cohabiting Partner is over age 18 years.

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

§5.12 Enrollment.

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

§5.12.2 Enrollment after Open Enrollment period. Persons becoming eligible for Enrollment after completion of the open Enrollment period under this Agreement may elect to enroll within thirty (30) days of the date of first becoming eligible.

§5.12.3 After Thirty (30) Day Enrollment.

§5.12.3.1 Subscriber. Subject to §5.12.3.3, an individual eligible to enroll as a Subscriber who does not make written election for Enrollment within thirty (30) days after first becoming eligible shall not be permitted to enroll hereunder until the next open Enrollment period unless entitled to special enrollment rights under HIPAA or PPACA.

§5.12.3.2 Dependents. Subject to 5.12.3.3, a Subscriber with Dependents eligible for Enrollment who does not make written election for Enrollment of such Dependents within thirty (30) days after their first becoming eligible shall not be permitted to enroll such Dependents hereunder until the next open Enrollment period unless entitled to special enrollment rights under HIPAA or PPACA.

§5.12.3.3 HIPAA and PPACA Enrollment requirements. If an individual eligible to Enroll as a Subscriber loses other employer coverage or acquires a Dependent through marriage, birth, adoption of a child under nineteen (19) years of age, or placement for adoption of a child under nineteen 19) years of age, then the special Enrollment requirements of HIPAA may be applicable. If a Subscriber becomes eligible for a HIPAA special enrollment, such Subscriber and Spouse and children, if applicable, shall be entitled to change from Class I or Class 11 to Class III during such special Enrollment. A child previously excluded, or whose coverage ceased, because of age, shall have special enrollment rights to enter or reenter the Plan upon receipt of notice of the right to do so, to the extent required by Section 2714 of the PHSA, as added by PPACA, and the regulations thereunder.

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

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

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

§5.13.3 Afterborn children. Except as provided in §5.14, coverage of a Dependent of a Subscriber who becomes eligible after such Subscriber has been Enrolled hereunder shall commence as of the first day of the pay period following the timely filing of an application for Enrollment and liability for the appropriate Premium accrues, except that coverage for a child born, adopted (if under nineteen (19) years), placed for adoption (if under nineteen (19) years), or for whom legal guardianship has taken place after the Subscriber has been enrolled hereunder, shall commence from the date of birth, date of adoption, date of placement for adoption or from the date at which custody commences, whichever is applicable; provided that the Subscriber applies to Enroll the child within the first thirty (30) days of that date and the applicable Premium is paid.

§5.13.4 Open Enrollment period. For any eligible individual and his or her eligible Dependents who apply for Enrollment or re-Enrollment during Judiciary's open Enrollment period, coverage shall commence as of the Plan effective date first following the open Enrollment.

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

§5.15 Medical term. Covered Persons must continue medical coverage under this Agreement for a minimum of twelve (12) months or for the balance of the Plan Year, except when terminating Judiciary employment, or when termination of Enrollment is approved by Judiciary and by Company. A rate increase during the Plan Year is not grounds for disenrollment.

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

§5.17 Leave without pay, reduction in force, sabbatical and related status. A Subscriber, who enters the status with Judiciary of leave without pay, sabbatical leave, educational leave of absence or a faculty exchange program as approved by Judiciary, or is laid off due to a reduction in the workplace by Judiciary, and all enrolled Dependents of such Subscriber, can remain covered under this Agreement if such Subscriber self-pays both the Subscriber's and Judiciary's share of the premium for such coverage directly to the Company. Within 10 business days following commencement of the leave without pay, reduction in force, sabbatical and related status, the Subscriber must provide Company: (i) proof, in a form satisfactory to Company, that he or she has been approved by Judiciary for such status and (ii) written notice of his or her intention to continue coverage during the leave. Such notice must be accompanied by the first month's Premium. Subsequent Premium payments must be made by the 15th day of the month preceding the month for which coverage is being paid. Subscribers who do not make their Premium payments when due shall have their coverage terminated as of the last day for which payment was made and shall not be allowed to reenroll in the Plan until the next Enrollment period following the return to work. In no case, however, can such continued membership in the Plan extend for a period in excess of 12 months. If Company does not receive the full amount of Premium due at least 15 days in advance, it shall make a good faith effort to notify the Subscriber that Coverage shall terminate on the last day of the month for which Premium was paid. Notwithstanding the aforesaid, laid off Subscribers may not remain in the Plan beyond the end of the current Plan Year.

§5.17.1 Notwithstanding the aforesaid, if the leave is taken pursuant to the Family and Medical Leave Act of 1993, Company shall fully cooperate in assisting Judiciary in complying with this Act.

§5.17.2 Active employees required to live out of the Service Area pursuant to their employment by Judiciary or Judiciary sponsored training status and their eligible Dependents shall be eligible for coverage under the Plan.

§5.18 Military leave. Company shall be given prior written notice if a Subscriber shall take a military leave of absence ("Military Leave"). Coverage for such Subscriber shall continue for the shorter of eighteen (18) months or the duration of the Military Leave up to a cumulative length of no longer than five (5) years unless otherwise agreed upon with Company, provided Premiums are paid. Even if the Subscriber elects not to continue coverage for himself or herself or any Dependent during the Subscriber's Military Service, the Subscriber and all Dependents shall be eligible to re-enroll immediately after such Military Leave terminates, without a waiting period or health statement, upon the Subscriber's return to employment by Judiciary if the Subscriber satisfies applicable requirements that were in the Plan prior to such Military Leave and no discharge from Military Service is less than fully honorable. Company shall not provide coverage for any Injury or Illness determined by the Secretary of Veterans' Affairs to have been incurred or aggravated during Military Service. The provisions of this paragraph are notwithstanding any other section of this Agreement.

§5.19 Reduction in hours. If a Subscriber's work hours are reduced below 30 per week due to a Judiciary cost-saving program, such Subscriber and his/her enrolled Dependents shall be eligible to remain in the Plan in accordance with all other terms of the Plan. Alternatively, such Subscriber shall have the option to disenroll within 30 days of the effective date on which the reduction in hours occurs provided that, within 10 business days following such effective date, the Subscriber shall have provided notice to Company of his/her intent to disenroll. Further, he/she shall not be eligible to reenroll until a future open Enrollment or until his/her work hours are increased to at least 30 hours per week.

§5.20 Coordination of Benefits. If a Covered Person receives any medical, Surgical, Hospital or other Services entitling that Covered Person to the payment of benefits under this Agreement and such Services are also covered or payable under any other plan, which, for purposes of this section, shall include Medicare Parts A and B and any motor vehicle insurance policy or contract, then the benefits of this Plan and each other plan shall be appropriately coordinated and adjusted so that such benefits shall not exceed one hundred percent (100%) of Eligible Charges. Integration or coordination of benefits with Medicare shall be done on a "Carve Out" or "Benefit Offset" basis. When any other plan provides benefits in the form of Services rather than cash payments, the reasonable cash value of such Services rendered shall be deemed to be both an allowable expense and a benefit paid. The coordination and adjustment of benefits shall be determined as follows:

§5.20.1 The plan under which the Covered Person is a Subscriber is primary.

§5.20.2 In the case of a Dependent child, the plan of the parent whose birthday occurs earlier in the calendar year is the primary carrier. If both parents have the same birthday, then the plan in which the Covered Person has been enrolled for the longest continuous time pays first. However, other rules apply if a claim is made for an insured dependent child whose parents are separated or divorced. If the parent with custody of the child has not remarried, the plans shall pay in this order: first, any plan in which the child is insured as a Dependent of the parent who has custody; and second, any plan in which the child is insured as a Dependent of the parent who does not have custody.

If the parent with custody of the child has remarried, the plans shall pay in this order: first, any plan in which the child is insured as a dependent of the parent who has custody; second, any plan in which the child is insured as the dependent of the stepparent; and third, any plan in which the child is insured as the dependent of the parent who does not have custody.

These rules do not apply when a court decree fixes the responsibility for the health Services costs of a child whose parents have separated or divorced. Any plan in which the child is insured as the dependent of a parent with this legal responsibility shall always pay first.

If the order of payment is unclear, the National Association of Insurance Commissioners' (NAIC) Coordination of Benefits model shall apply.

§5.20.3 In no event shall coordination of benefits require Company to: (i) make any payment which would exceed the amount for which it would be liable under this Plan if a Covered Person were not eligible to receive benefits from any other plan; or (ii) pay the excessive, unnecessary or unreasonable portion of any charge or expense. A Covered Person who is also enrolled in one or more of Company's other plans shall be entitled to receive benefits from all of such plans not to exceed one hundred percent (100%) of Eligible Charges.

§5.21 Subrogation, Right of Reimbursement and Right of Recovery. The Company reserves the "right of subrogation," the "right of reimbursement," and the "right of recovery," in the event of an illness, injury or condition caused by a third party or with respect to which a "first party payor" has liability, for which the Company has paid or is being requested to pay benefits under this Plan or for which the Company chooses to advance benefits as provided in this Section.

§5.21.1 Definitions.

§5.21.1.1 As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to or for the benefit of a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes (without limitation) the liability insurer of such party or any insurance coverage.

§5.21.1.2 For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured or underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

§5.21.1.3 For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Company pays or provides any benefit including, but not limited to, the participating employee or former employee and any minor child or other dependent of any such employee, and any person who acts or holds funds on behalf of such an employee, former employee or dependent. For example, if an injured Covered Person is a minor child, and the child's parents receive a recovery for the child, "Covered Person" for purposes of the Company's right to repayment shall include a right for the Company to recover from the parents or other party receiving or holding such recovery on behalf of the child.

§5.21.1.4 For the purposes of this section, a first party payor is a person or company with whom a Covered Person has either a contractual relationship, is in privity with a non-responsible party through whom benefits are available that are related to the Illness or Injury, or for whom benefits are otherwise available, regarding the Illness or Injury but regardless of fault, such as workers' compensation coverage, uninsured motorist coverage and no-fault motorist coverage.

§5.21.2 Subrogation. Immediately upon paying or providing any benefit under

the Judiciary of Guam Health Insurance Plan, and as permitted by Guam's laws, the Company shall be subrogated to all rights of recovery that a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the Company.

§5.21.3 Reimbursement. In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the Company has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Company has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

§5.21.4 Right of Recovery. The Company also has a "right of recovery," in that it may choose to take action to recover the amount of all claims paid to or on behalf of a Covered Person from the third party, or from any insurer or other party that is or may be liable for damages related to the third party's actions.

§5.21.5 Constructive Trust. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Company, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Company and the Plan, and will give the Company rights to recover equitable and money damages from the Covered Person.

§5.21.6 Lien Rights. The Company shall automatically have a lien to the extent of benefits paid by the Company for treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the Company paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Company including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Company. The Company may file this lien with the third party, third party's agent, any insurance company, first party payor or the court in which any action is filed, to assure that the lien is satisfied from any such recovery. Further, the Plan reserves the right to notify the Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

§5.21.7 First-Priority Claim. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Company, the Covered Person acknowledges that the Company's recovery rights are the first priority claim against all Responsible Parties and are to be paid to the Company before any other claim for the Covered Person's damages. The Company shall be entitled to full reimbursement on a first-dollar basis from any and all payments from each and every Responsible Party, even if such payment to the Company will result in a recovery to the Covered Person that is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Company is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

§5.21.8 Applicability to All Settlements and Judgments. The terms of this entire subrogation, reimbursement and right of recovery provision shall apply to each and every settlement or judgment related to the injury, illness or condition of the Covered Person, and the Company is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies any medical benefit the Company provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Company is entitled to recover from any and all settlements or judgments, including (without limitation) those designated as pain and suffering, non-economic damages, and/or general damages only.

§5.21.9 Cooperation. The Covered Person shall fully cooperate with the Company's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Company within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Company or the Plan, or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Company may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person. The Covered Person shall do nothing to prejudice the Company's subrogation or recovery interest or to prejudice the Company's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

§5.21.10 Right of Investigation. The Company has the right to conduct an investigation regarding the injury, illness, or condition of any Covered Person to or for the benefit of whom the Company pays benefits under the Plan to identify any Responsible Party. Each Covered Person receiving benefits under the Plan acknowledges or is deemed to acknowledge that the Company has such right of investigation.

§5.21.11 Interpretation. In the event that any claim is made that any part of this subrogation, reimbursement and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Company shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

§5.21.12 Jurisdiction. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Company, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Company may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

§5.21.13 After expenses incurred by the Company in obtaining any recovery from, on behalf of or related to such third party, the net amount recovered must be divided proportionately with the Covered Person to allow the Covered Person to recover a proportionate share of any deductible for which the insured was responsible.

§5.21.14 Benefit Exclusion or Delay. In cases where third party or first party payor liability is being pursued, and upon the execution and delivery to Company of all documents required by it, to secure its rights of subrogation, reimbursement and right of recovery entitlements, as provided in this Section 5.16, the Company may pay benefits in connection with such Injury or Illness if it is satisfied that its subrogation, reimbursement and recovery rights are being upheld and shall be repaid only from the proceeds (beginning with the first proceeds) of any and all recoveries, if any, from or on behalf of such third party or from any first party payor. As security for such repayment, the Company shall have a lien, as provided in this as described in §5.21, against any and all such recoveries to the extent of the amount advanced to the Covered Person by Company.

§5.21.15 PPACA Compliance. In the event that any applicable provision of PPACA prohibits the application of any provision of this §5.16, the section shall be deemed modified to the extent necessary to comply with PPACA.

§5.22 Covered Person eligible for Medicare. The Plan shall pay its benefits pursuant to this Agreement before Medicare if (i) the Subscriber is an active, full-time employee of Judiciary or his or her Spouse is a

Covered Person and the Subscriber or Spouse who is a Covered Person is sixty-five (65) or older; or (ii) the Subscriber or Spouse who is a Covered Person is under age sixty-five (65) and is in the Medicare waiting period during which he or she or his or her Spouse is receiving treatment for end-stage renal disease (ESRD).

If any Covered Person, including disabled active individuals as defined in the Omnibus Budget Reconciliation Act of 1993, incurs expense for benefits covered under the Plan and for which the Covered Person is eligible for and entitled to benefits under Medicare, then the Plan, where primary carrier, shall pay to the full limit of its coverage before Medicare assumes coverage. The Covered Person shall have covered benefits equal to the greater of the two plans' benefits (shall reduce benefits by the amount Medicare would pay, and the Plan shall not provide any benefit if the amount Medicare would pay equals or exceeds its benefit.)

If any Covered Person, for whom Medicare is or would be primary, is eligible for but not enrolled in the entire Medicare program but is receiving income benefits from Social Security, the Plan shall provide no benefits on behalf of that person. However, under no circumstances shall anyone be required to enroll in Medicare in order to receive benefits under the Plan, unless the Medicare programs are available at no cost. Eligible Persons receiving Social Security may be required to enroll in Medicare Part A in order to receive benefits under the Plan, unless Medicare Part A is available to her or him at no cost but shall be required to enroll in Part B, subject to the Judiciary of Guam or some other entity paying the Part B premium.

For a Covered Person enrolled in Medicare Parts A and B and where Medicare is primary, Company shall pay the co-payments, deductibles, and co-insurance required by Medicare and treat Covered Person as having met the Out of Pocket maximum under the plan for purpose of receiving benefits under this Agreement.

§5.23 Incarcerated Benefits. The Plan is secondary payor for services furnished to individuals in the custody of penal authorities. The state (or other government component which operates the prison) in which the beneficiary resides is responsible for all medical costs incurred.

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

§5.25 No warranty of Service.

§5.25.1 Company is not an insurer against, nor liable for, the negligence or other wrongful act or omission of any Physician, Hospital, Hospital employee or other Provider, or for any act or omission of any Covered Person.

§5.25.2 Company does not guarantee the availability of or undertake to provide any Services of any third party.

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

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

§5.26.2 Non-payment. A Covered Person's failure to pay or arrange to pay applicable Deductibles, Co-Payments, or Co-Insurance as soon as practicable, and in no case later than the next Enrollment period.

§5.26.3 To the extent required by PPACA, terminations for cause (other than for non-payment of premiums) shall be handled as required by the applicable PPACA Claims Procedure Requirements provided in §6.7 and as reflected in the Company's Appeal Procedures attached as Exhibit G.

§5.27 Termination other than for cause. Other terminations of benefits, not for cause, are as follows:

§5.27.1 Termination by a Covered Person. Except as otherwise provided in this Agreement or applicable law, if the Covered Person terminates his or her rights under this Agreement then all rights to benefits shall cease as of the effective date of such termination. If a Subscriber's coverage so terminates, his or her Covered Dependents' coverage shall terminate on the same date. However, Company shall pay Eligible Charges for all Covered Services incurred prior to the date of termination.

§5.27.2 Marriage terminated or no longer eligible spouse. If the spouse of a Subscriber ceases to be a Spouse as defined herein, coverage for such person under this Agreement shall terminate on the first (1st) day of the pay period following termination of eligibility.

§5.27.3 Children no longer eligible as Dependents. Coverage shall terminate as to a Dependent child who attains age twenty-six (26), or who enters the Military Service, on the date of such occurrence. However, a Dependent child who has attained the limiting age (26), and who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, and who is primarily dependent upon the Subscriber for support and maintenance, may continue to be covered under this Plan as an enrolled Dependent during the continued disability or handicap provided proof of such incapacity and dependency is furnished to Company within thirty (30) days of the child's attainment of the limiting age and annually thereafter.

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

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

§5.27.6 To the extent required by PPACA, disputed terminations (other than for non-payment of premiums) shall be handled as required by the applicable PPACA claims procedure rules.

§5.27.7 HIPAA compliance. Company shall provide the certifications required by HIPAA for terminated Subscribers and their Covered Dependents, upon notification by Judiciary of the Subscriber's termination. Company shall also provide certifications for all other terminated Covered Persons, such as Dependent children reaching the limiting age, divorce of a Spouse, or no longer cohabiting, without notification by Judiciary, but after receipt of actual notice of the triggering event.

§5.28 Grievance Procedures. The Grievance Procedure is not applicable to adverse benefit determinations, including rescission of coverage, and their appeals which are subject to PPACA Claims Procedure Requirements provided in §6.7 and reflected in the Company's Appeal Procedures attached as Exhibit G. A grievance is a formal complaint or dissatisfaction with the service received by a Covered Person. Grievance includes complaints about the quality of care or non-quality of care services at any of the Company's contracted network facilities, providers or with any administration provider/behavioral services and access to care. Non-quality of care services includes complaints about administrative services, sales processes or other marketing issues. A Covered Person and/or his or her representative may file a written grievance claim, including all relevant documentation, with the Company. The Covered Person and Company shall provide additional information or documentation, as applicable, if requested in writing.

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

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

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

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

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

§5.28.2.4 If, after receipt of the written decision on disposition of the grievance appeal the Covered Person is not satisfied, then the Covered Person may proceed with arbitration.

§5.28.3 For issues that are not subject to the Company's Appeals Procedures (Exhibit G), and for matters that are not required by law to be submitted to arbitration, the parties agree that disputes will first be submitted to some form of Alternative Dispute Resolution (ADR) before a lawsuit may be filed. The form of ADR used shall be in the discretion of the appellant, and shall be governed by the Rules and Procedures promulgated by JAMS found at www.jamsadr.com, including: (i) Mediation; or (ii) Arbitration including those conducted pursuant to JAMS' Streamlined Arbitration Rules and Procedures. Judgment on either the Mediation or Arbitration award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of Mediation or Arbitration from a court of appropriate jurisdiction.

§5.29 Notice. For purposes of service of any notice or other document under this Agreement, a Covered Person's address shall be that stated in the Enrollment materials, unless the Covered Person designates a new address by providing written notice to the Company. The address of the Company is: 424 West O'Brien Drive, Suite 200, Julale Center, Hagatna, Guam 96910, unless the Company designates a new address in writing served on the Covered Person.

§5.30 Cooperation Regarding Federal Law. Company and the Judiciary of Guam shall fully cooperate in implementing any Qualified Medical Child Support Order as defined and required by federal law. This shall include enrolling the employee, if eligible, and the relevant child, if eligible, outside a regularly scheduled open Enrollment period.

ARTICLE 6

Claims and Payment for Service

§6.1 Submission of claims. When Services are provided to a Covered Person, the Covered Person shall inform the Provider that he or she is a Covered Person of Company. In the case of a Participating Provider, the Covered Person is not responsible for filing the claim. In the case of a Non-Participating Provider, the Covered Person must file a claim for reimbursement unless the Provider agrees to file a claim on the Covered Person's behalf. Company shall not be obligated to make any payment until it receives, reviews and approves a claim for payment.

§6.2 Payment for Covered Services. Company shall make payment of claims for Covered Services directly to Participating Providers. In the case of Non-Participating Providers, the Covered Person is responsible for payment to the Provider, and payment of claims shall be made by Company directly to the Covered Person.

§6.3 Reimbursement for Services. If the Covered Person has paid for Covered Services, Company, upon submission of a complete claim by the Covered Person shall reimburse the Covered Person to the same extent that it would have directly paid the Provider of the Covered Services.

§6.4 Payment of late claims. In no event shall any payment be owed or made on any claim submitted to Company more than ninety (90) days after which the Covered Services were rendered, unless:

§6.4.1 The claim is subject to coordination of benefits, Company is not the primary carrier, and the claim was submitted to the primary carrier during the twelve (12) month period; or

§6.4.2 Required by law, including applicable PPACA Claims Procedure requirements.

§6.5 Proof of Payment of Deductible. Company shall require participating providers to report all payments made by members for covered services within 120 days of the date when the covered services were rendered. Company shall not credit any eligible amounts paid towards any Deductible unless proof of such payment is submitted within one hundred twenty (120) days of the date on which the Covered Services were rendered.

§6.6 Utilization review.

§6.6.1 Company shall not be required to pay any claim until it determines that Services provided to a Covered Person are Covered Services.

§6.6.2 Company has the right to conduct utilization review on a prospective concurrent and/or retrospective basis, subject to compliance with PPACA applicable Claims Procedure Requirements.

§6.7 PPACA Claims Procedure Requirements. Adverse benefit determinations, including rescissions of coverage, and their appeals are subject to the requirements of Section 2719 of the PHSA, as added by PPACA, and applicable regulations to include 45 CFR 147.136 and 29 CFR 2560.503-1. The Company's PPACA Claims Procedure is reflected in Exhibit G.

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

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

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

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

§6.7.3 Other aspects of the PPACA Claims Procedure regulations must be followed.

ARTICLE 7

Optional Dental Plan 2000

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

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

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

§7.3 Maximum Allowances. The maximum dental benefit payable by the Company for each Covered Person shall be Two Thousand Dollars ($2,000) per Plan Year.

§7.4 Co-Payments for Diagnostic and Preventive Services.

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

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

§7.5 Payments for Basic and Restorative Services.

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

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

§7.6 Payments for Major and Replacement Services.

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

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

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

§7.7.1 Diagnostic and Preventive Services.

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

§7.7.1.2 Radiographs (X-rays).

§7.7.1.2.1 Full mouth series (once per 36 months).

§7.7.1.2.2 Bite-wings. Maximum of four per Plan Year.

§7.7.1.3 Prophylaxis (cleaning and polishing) limited to twice per Plan Year.

§7.7.1.4 Topical application of fluoride (once every Plan Year for Covered Persons under the age of 19);

§7.7.1.5 Study models.

§7.7.1.6 Space maintainers (for Covered Persons age 15 and under). This includes adjustments within 6 months of installation.

§7.7.1.7 Caries susceptibility test.

§7.7.1.8 Sealants (for permanent molars of Covered Persons age 15 and under).

§7.7.2 Basic and Restorative Services.

§7.7.2.1 Emergency Services (during office hours).

§7.7.2.2 Pulp treatment.

§7.7.2.3 Routine fillings (amalgam and composite resin).

§7.7.2.4 Simple extractions.

§7.7.2.5 Complicated extractions.

§7.7.2.6 Extraction of impacted teeth.

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

§7.7.2.8 Periodontal treatment.

§7.7.2.9 Pulpotomy and root canals (endodontic surgery and care).

§7.7.2.10 Conscious sedation and nitrous oxide for Covered Persons under the age of 13.

§7.7.3 Major Dental Services and Replacement Services.

§7.7.3.1 Fixed prosthetics.

§7.7.3.1.1 Crowns and bridges.

§7.7.3.1.2 Gold inlays and onlays.

§7.7.3.1.3 Repairs of crowns and bridges.

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

§7.7.3.2 Removable prosthetics.

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

§7.7.3.2.2 Denture repair and relines.

§7.7.3.3 General anesthesia, but only if medically or dentally necessary.

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

§7.9 Reasonableness and necessity of Services and charges.

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

§7.9.2 Preliminary determination that any Dental Service or charge is unnecessary or unreasonable or otherwise not payable shall, at the Dentist's or Covered Person's request, be reviewed through Company's grievance procedure The determination made through the grievance procedure shall be conclusive upon all parties in interest, subject, however to the parties' right to mediation in §5.24.1 of this Certificate.

§7.10 General Provisions.

§7.10.1 Dental Exclusions. No benefits will be paid for:

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

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

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

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

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

§7.10.1.3 Any Service unless required and rendered in accordance with accepted standards of dental practice.

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

§7.10.1.5 Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable

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

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

§7.10.1.8 Any Service for which the Covered Person received benefits under any other coverage offered by the Company.

§7.10.1.9 Spare or duplicate prosthetic devices.

§7.10.1.10 Services included, related to, or required for:

§7.10.1.10.1 Implants;

§7.10.1.10.2 Cosmetic purposes;

§7.10.1.10.3 Services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to, equilibrium, full mouth rehabilitation and restoration for malalignment of teeth;

§7.10.1.10.4 Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction of harmful habits;

§7.10.1.10.5 Experimental procedures; and

§7.10.1.10.6 Intentionally self -inflicted injury unless resulting from a medical condition including physical or mental conditions) or from domestic violence.

§7.10.1.11 Any over the counter drugs or medicine.

§7.10.1.12 Fluoride varnish.

§7.10.1.13 Charges for finance charges, broken appointments, completion of insurance forms or reports, providing records, oral hygiene instruction, pit and fissure sealants and dietary instruction, or lack of cooperation on the part of the patient.

§7.10.1.14 Charges in excess of the amount allowed by the Plan for a Covered Service.

§7.10.1.15 Any treatment, material, or supplies which are for orthodontic treatment, including extractions for orthodontics.

§7.10.1.16 Services for which no charge would have been made had the Agreement not been in effect.

§7.10.1.17 All treatments not specifically stated as being covered.

§7.10.1.18 Surgical grafting procedures.

§7.10.1.19 General anesthetic, conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein.

§7.10.1.20 Services paid for by Worker's Compensation.

§7.10.1.21 Charges incurred while confined as an inpatient in a Hospital unless such charges would have been covered had treatment been rendered in a dental office.

§7.10.1.22 Treatment and/or removal of oral tumors. All surgical procedures except for surgical extractions of teeth and periodontal surgeries Performed by a Dentist. Surgical procedure is defined as the surgical and adjunctive treatment of diseases, injuries, and deformities of the oral and maxillofacial region.

§7.10.1.23 Panoramic x-ray if provided less than three (3) years from the Covered Person's last full mouth x-rays; and full mouth x-rays if provided less than three (3) years from the Covered Person's last panoramic x-ray.

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

§7.10.3 DENTAL COVERAGE SPECIAL CONDITIONS OF ENROLLMENT.

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

ARTICLE 8

Fitness and Gym Benefit

§8.1 Fitness and Gym Benefit are available. The Contract between the Judiciary and the Company provides that the Judiciary of Guam is entitled to participate in the fitness and gym benefits offered by NetCare. This benefit is available to all Subscribers of the Plan and their covered dependents. The benefits offered under this program are in addition to all Wellness and Disease Management benefits offered to all NetCare members as a part of the PPO 1000 Plan and the HSA 2000 Plan.

§8.1.1 The benefit provides that Covered Persons aged 18 years of age and older, enrolled under one of the Company's group medical plans offered by the Judiciary, are eligible to participate in this program by selecting a gym of their choice and notifying the Judiciary's human resource department and The Company of that choice. By participating, members will qualify for the Judiciary's $40/month gym subsidy and NetCare's fitness reward of up to $150.00 per year either through direct membership payment to the chosen gym by the Company or reimbursement to the member. Actual gym membership expenses in excess of the $40/month subsidy and the $150.00 fitness reward are the member's responsibility.

§8.2 Prices. The Fitness and Gym Benefit Program prices are attached hereto as Exhibit H. Under the Fitness and Gym Benefit, enrollees may select any gym of their choosing and are responsible for expenses in excess of the subsidy chosen by the Judiciary of Guam. The Judiciary will pay Company the selected subsidy amount times the individuals participating on a monthly basis. Company will administer the payment of the subsidy to the gyms selected. The benefit shall be charged to the Judiciary at the rates set forth in Exhibit H not to exceed $40.00, and the Judiciary's payments to the Company for the Fitness and Gym Benefit are governed under the same provisions governing premium payments.

§8.3 Usage. The Fitness and Gym Benefit is available only to those enrollees who can demonstrate consistent use of the gym facility that is being subsidized by the gym rider by utilizing the facility at a minimum of seven (7) times on a monthly basis. If enrollee fails to use the subsidized gym facility at the minimum number of times, the enrollee will not be qualified for the subsidy and/or the fitness reward. The enrollee must be able to prove in writing through an attendance sheet or to the satisfaction of the Judiciary and the Company that the gym facility is being used based on the requisite number of times to maintain the subsidy and fitness reward.

ARTICLE 9

Rates

JUDICIARY OF GUAM

Rates for active Covered Persons shall be effective from October 1, 2014 through September 30, 2015 as follows:

§9.1 HSA2000 PLAN Monthly rates:

	Medical	Dental
Actives		
Class I	$105.85	$30.96
Class II	$232.87	$68.11
Class III	$190.53	$55.73
Class IV	$317.55	$92.88

§9.2 PPO1000 PLAN Monthly rates:

	Medical	Dental
Actives		
Class I	$209.86	$30.96
Class II	$461.69	$68.11
Class III	$377.75	$55.73
Class IV	$629.58	$92.88

§9.3 HSA2000 PLAN Bi-weekly rates:

	Medical	Dental
Class I	$ 48.85	$ 14.29
Class II	$107.48	$ 31.44
Class III	$ 87.94	$ 25.72
Class IV	$146.56	$ 42.87

§9.4 PPO1000 PLAN Bi-weekly rates:

	Medical	Dental
Class I	$ 96.86	$ 14.29
Class II	$213.09	$ 31.44
Class 111	$174.35	$ 25.72
Class IV	$209.58	$ 42.87

EXHIBIT A - MEDICAL SCHEDULE OF BENEFITS

NetCare
Life & Health Insurance

JUDICIARY OF GUAM PPO1000

YOUR BENEFITS: WHAT NETCARE COVERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
DEDUCTIBLE PER INDIVIDUAL MEMBER	$1,000	$2,000
DEDUCTIBLE PER FAMILY If a member meets their $1,000 individual deductible, NetCare begins to pay for covered services for that individual member.	$2,000	$6,000
COVERAGE MAXIMUMS Individual member annual maximum	Unlimited	
OUT-OF-POCKET MAXIMUMS (Includes accumulated deductible and copays) Per Individual member per plan year Per Family per plan year	$3,000 $9,000	No Maximum No Maximum
OUT OF AREA SERVICES Any service in the Philippines, Hawaii & the U.S. Mainland	Pre-certification and approval from NetCare is required prior to services rendered at out of area services	

YOUR DEDUCTIBLE AND CO-PAY DO NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
PREVENTIVE SERVICES (Outpatient Only) In accordance with guidelines established by USPSTF, Grades A & B, and CDC. • Annual Physical Exam • Immunizations/Vaccinations • Counseling and Health Screenings	Plan Pays 100%	Not Covered
OUTPATIENT LABORATORY (Preventive & Diagnostic)	Plan Pays 100%	Not Covered
PRE-NATAL CARE Including routine labs and 1st ultrasound	Plan Pays 100%	Not Covered
WELL-BABY / WELL-CHILD CARE • For children ages 0 to 17 years • Maximum of 7 visits per year for ages 0 to 4 years • Maximum of 1 visit per year for ages 5 to 17 years	Plan Pays 100%	Not Covered
WELL-WOMAN CARE In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA) and the Women's Health and Cancer Act	Plan Pays 100%	Not Covered
STERILIZATION PROCEDURES (Pre-Certification Required) 1. Tubal Ligation 2. Vasectomy (Outpatient Only)	Plan Pays 100%	Not Covered

YOUR DEDUCTIBLE DOES NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS		NON-PARTICIPATING PROVIDERS (After Deductible is Met)
ANNUAL EYE REFRACTION/EXAM (Refer to the Vision Rider benefit for eye hardware coverage)	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Not Covered
OUTPATIENT PHYSICIAN CARE & SERVICES			
1. Primary Care Visit	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%
2. Specialist Care Visit	$40 Member Co-Payment		Plan pays 70%*, Member pays 30%
9. Urgent Care	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%
3. Voluntary Second Surgical Opinion	$40 Member Co-Payment		Plan pays 70%*, Member pays 30%
4. Home Health Care Visit	$15 Member Co-Payment at SDA Clinic	$40 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%
5. Hospice (Pre-Certification Required) • Guam Only • Maximum 180 Days • Maximum $100 Per Day	$40 Member Co-Payment		Not Covered
6. X-ray Services	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%
7. Injections (Does not include those on the Specialty Drug List and Orthopedic Injections)	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Plan pays 70%*, Member pays 30%

YOUR DEDUCTIBLE DOES NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS		Judiciary PPO1000 NON-PARTICIPATING PROVIDERS (After Deductible is Met)
PRESCRIPTION DRUGS Annual Out-of-Pocket Maximum is $2,000 Individual/$3,500 Family	Retail	Mail	
1. Formulary Generic Drugs	Member pays 10%	Member pays 10%	Plan pays 50% of AWP**
2. Formulary Brand Name Drugs	Member pays 20%	Member pays 20%	Plan pays 50% of AWP**
3. Non-Formulary Drugs (Medically Necessary Only and Pre-Certification Required)	Member pays 30%	Member pays 30%	Plan pays 50% of AWP**
4. Specialty Drugs (Medically Necessary Only and Pre-Certification Required)	Member pays 40%	Not Covered	Plan pays 50% of AWP**

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)	NON-PARTICIPATING PROVIDERS (After Deductible is Met)
ACUPUNCTURE	Plan pays 80%; Member pays 20%	Not Covered
AIDS TREATMENT Exclusive of Experimental drugs	Plan pays 80%; Member pays 20%	Not Covered
AIRFARE BENEFIT TO CENTERS OF CARE Members must meet qualifying conditions. Plan provides roundtrip airfare upon required Plan approval.	Plan pays 100%	Not Covered
ALLERGY TESTING $500 per member per plan year	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
AMBULATORY SURGI-CENTER CARE (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
BLOOD & BLOOD DERIVATIVES	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
BREAST RECONSTRUCTIVE SURGERY In accordance with 1998 W.H.C.R.A.	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CARDIAC SURGERY	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CATARACT SURGERY (OUTPATIENT) Includes Lens Implants	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CHEMICAL DEPENDENCY	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
CHEMOTHERAPY BENEFIT	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CHIROPRACTIC CARE	Plan pays 80%; Member pays 20%	Not Covered
CLINICAL TRIALS In relation to treatment of cancer or other life-threatening disease or condition as approved by the National Institute of Health or in case of cancer, the National Cancer Institute.		
1. Outpatient Clinical Trial	$40 Member Co-payment	Plan pays 70%*, Member pays 30%
2. Inpatient Clinical Trial	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
CONGENITAL ANOMALY DISEASES COVERAGE	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
DIAGNOSTIC TESTING (Pre-Certification Required) • MRI, CT Scan, and other diagnostic procedures	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
DURABLE MEDICAL EQUIPMENT (DME) The lesser amount between the purchase or rental when prescribed by a Physician. (Pre-Certification Required) • Accessories • Hospital Beds • Walkers • CPAP Machine • Suction Machine • Wheelchairs • Crutches • Oxygen	Plan pays 80%; Member pays 20% of the total rental cost or purchase	Not Covered
ELECTIVE SURGERY (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
EMERGENCY CARE Plan must be contacted and advised within 48 hours for off-island emergencies 1. On/Off Island emergency facility, physician services, laboratory, x-rays 2. Ambulance Services (Ground Transportation Only)	Plan pays 80%; Member pays 20%	Plan pays 80%, Member pays 20%
END STAGE RENAL DISEASE / HEMODIALYSIS	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
HEARING AIDS Maximum $500 per member per plan year	Plan pays 80%; Member pays 20%	Not Covered
HOSPITALIZATION & INPATIENT BENEFITS 1. Room & Board for semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication. 3. Physician's Hospital Services	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)	Judiciary PPO1000 NON-PARTICIPATING PROVIDERS (After Deductible is Met)
IMPLANTS Limitations apply, please refer to contract. Limited to the following: • Cardiac Pacemakers • Intraocular Lens • Heart Valves • Orthopedic Internal Prosthetic Devices • Stents	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
INHALATION THERAPY	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
MATERNITY CARE Labor and Delivery	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
MENTAL HEALTH CARE	$20 Member Co-payment	Plan pays 70%*, Member pays 30%
NUCLEAR MEDICINE (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
OCCUPATIONAL THERAPY (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Not Covered
ORTHOPEDIC CONDITIONS • Internal and External Prosthesis	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
PHYSICAL THERAPY (Pre-Certification Required)	Plan pays 80% for the first 20 visits and 50% thereafter	Plan pays 70%*, Member pays 30%
RADIATION THERAPY (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
SKILLED NURSING FACILITY (Pre-Certification Required) • Maximum 60 Days per Member per Plan Year	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
SLEEP MEDICINE • Sleep Apnea Study Coverage	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%

ADDITIONAL BENEFITS: What the Plan Covers		
YOUR DEDUCTIBLE DOES NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
WELLNESS AND FITNESS BENEFIT 1. Wellness Benefit at a Wellness Center (Pre-Certification Required) • Member co-insurance may be reimbursed upon program completion	Plan pays 80%; Member pays 20%	Not Covered
2. Fitness Benefit • Limited to participating Fitness Centers • Attendance participation of 7 times per month	Plan pays up to $150 Cash Reward	Not Covered
VISION RIDER 1. Eye Glasses • Frames • Eyeglass Fitting 2. Eye Glass Lenses • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses • Lenticular/Aphakik Lenses 3. Contact Lenses	Plan pays 100% up to $100 per member per plan year	

* ELIGIBLE CHARGES - Shall be defined as the portion of charges made to a covered person for covered services rendered which are payable to the Provider under this contract. Non-Participating Providers are limited to the lesser of actual charges of Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges.

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

DEDUCTIBLE - a fixed dollar amount the Covered Person or family must pay for covered benefits during the plan year before first dollar benefits apply. The deductible does not apply to annual Preventive Care defined in this Schedule of Benefits and non-covered benefits.

PHILIPPINE CARE - Pre-certification is required for services rendered at Philippine Participating Providers. No deductible and co-payment will apply for an annual outpatient Executive Check-up, limited to Eligible Charges in accordance to USPSTF, Grades A & B, at NetCare's Philippine Preferred Providers. The deductible or co-payment defined in this Schedule will apply for non-routine or non-preventive services before first dollar benefits are paid. All charges in excess of NetCare's eligible expense is the responsibility of the member.

PRE-CERTIFICATION - covered benefits requiring a pre-certification of services from a physician must be approved by NetCare prior to services rendered.

EXHIBIT A - MEDICAL SCHEDULE OF BENEFITS

NetCare
Life & Health Insurance

JUDICIARY OF GUAM HSA2000

YOUR BENEFITS: WHAT NETCARE COVERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
DEDUCTIBLE PER INDIVIDUAL MEMBER	$2,000	$4,000
DEDUCTIBLE PER FAMILY If a member meets their $2,500 individual deductible, NetCare begins to pay for covered services for that individual member.	$4,000	$12,000
COVERAGE MAXIMUMS Individual member annual maximum	Unlimited	
OUT-OF-POCKET MAXIMUMS (Includes accumulated deductible and copays) Per Individual member per plan year Per Family per plan year	$4,000 $11,900	No Maximum No Maximum
OUT OF AREA SERVICES Any service in the Philippines, Hawaii & the U.S. Mainland	Pre-certification and approval from NetCare is required prior to services rendered at out of area services	

YOUR DEDUCTIBLE AND CO-PAY DO NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
PREVENTIVE SERVICES (Outpatient Only) In accordance with guidelines established by USPSTF, Grades A & B, and CDC. • Annual Physical Exam • Immunizations/Vaccinations • Laboratory • Counseling and Health Screenings	Plan Pays 100%	Not Covered
PRE-NATAL CARE Including routine labs and 1st ultrasound	Plan Pays 100%	Not Covered
WELL-BABY / WELL-CHILD CARE • For children 0 to 17 years • Maximum of 7 visits per year for ages 0 to 4 years • Maximum of 1 visit per year for ages 5 to 17 years	Plan Pays 100%	Not Covered
WELL-WOMAN CARE In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA) and the Women's Health and Cancer Act	Plan Pays 100%	Not Covered
STERILIZATION PROCEDURES (Prior authorization required) 1. Tubal Ligation 2. Vasectomy (Outpatient Only)	Plan Pays 100%	Not Covered

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)		NON-PARTICIPATING PROVIDERS (After Deductible is Met)
ACUPUNCTURE	Plan pays 80%; Member pays 20%		Not Covered
AIDS TREATMENT Exclusive of Experimental drugs	Plan pays 80%; Member pays 20%		Not Covered
AIRFARE BENEFIT TO CENTERS OF CARE Members must meet qualifying conditions. Plan provides roundtrip airfare upon required Plan approval.	Plan pays 100%		Not Covered
ALLERGY TESTING $500 per member per plan year	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
AMBULATORY SURGI-CENTER CARE (Pre-Certification Required)	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
ANNUAL EYE REFRACTION/EXAM (Refer to the Vision Rider benefit for eye hardware coverage)	$15 Member Co-Payment at SDA Clinic	$20 Member Co-Payment at other Clinics	Not Covered
BLOOD & BLOOD DERIVATIVES	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
BREAST RECONSTRUCTIVE SURGERY In accordance with 1998 W.H.C.R.A.	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CARDIAC SURGERY	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CATARACT SURGERY (OUTPATIENT) Includes Lens Implants	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CHEMICAL DEPENDENCY	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CHEMOTHERAPY BENEFIT	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
CHIROPRACTIC CARE	Plan pays 80%; Member pays 20%		Not Covered

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)	NON-PARTICIPATING PROVIDERS (After Deductible is Met)
		Judiciary HSA2000
CLINICAL TRIALS In relation to treatment of cancer or other life-threatening disease or condition as approved by the National Institute of Health or in case of cancer, the National Cancer Institute. 1. Outpatient Clinical Trial 2. Inpatient Clinical Trial	$40 Member Co-payment Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50% Plan pays 50%*, Member pays 50%
CONGENITAL ANOMALY DISEASES COVERAGE	Plan pays 80%; Member pays 20%	Not Covered
DIAGNOSTIC TESTING (Pre-Certification Required) • MRI, CT Scan, and other diagnostic procedures	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
DURABLE MEDICAL EQUIPMENT (DME) The lesser amount between the purchase or rental when prescribed by a Physician. (Pre-Certification Required) • Accessories • Hospital Beds • Walkers • CPAP Machine • Suction Machine • Wheelchairs • Crutches • Oxygen	Plan pays 80%; Member pays 20% of the total rental cost or purchase	Not Covered
ELECTIVE SURGERY (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
EMERGENCY CARE Plan must be contacted and advised within 48 hours for off-island emergencies 1. On/Off Island emergency facility, physician services, laboratory, x-rays 2. Ambulance Services (Ground Transportation Only)	Plan pays 80%; Member pays 20%	Plan pays 80%, Member pays 20%
END STAGE RENAL DISEASE / HEMODIALYSIS	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
HEARING AIDS Maximum $500 per member per plan year	Plan pays 80%; Member pays 20%	Not Covered
HOSPITALIZATION & INPATIENT BENEFITS 1. Room & Board for semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication. 3. Physician's Hospital Services	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
IMPLANTS Limitations apply, please refer to contract. Limited to the following: • Cardiac Pacemakers • Intraocular Lens • Heart Valves • Orthopedic Internal Prosthetic Devices • Stents	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
INHALATION THERAPY	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
MATERNITY CARE Labor and Delivery	Plan pays 80%; Member pays 20%	Plan pays 70%*, Member pays 30%
MENTAL HEALTH CARE	$20 Member Co-payment	Plan pays 50%*, Member pays 50%
NUCLEAR MEDICINE (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
OCCUPATIONAL THERAPY (Pre-Certification Required)	Plan pays 80%; Member pays 20%	Not Covered
ORTHOPEDIC CONDITIONS • Internal and External Prosthesis	Plan pays 80%; Member pays 20%	Plan pays 50%*, Member pays 50%
OUTPATIENT PHYSICIAN CARE & SERVICES		
1. Primary Care Visit	$15 Member Co-Payment at SDA Clinic / $20 Member Co-Payment at other Clinics	Plan pays 50%*, Member pays 50%
2. Specialist Care Visit	$40 Member Co-Payment	Plan pays 50%*, Member pays 50%
3. Voluntary Second Surgical Opinion	$40 Member Co-Payment	Plan pays 50%*, Member pays 50%
4. Home Health Care Visit	$15 Member Co-Payment at SDA Clinic / $40 Member Co-Payment at other Clinics	Plan pays 50%*, Member pays 50%
5. Hospice (Pre-Certification Required) • Guam Only • Maximum 180 Days • Maximum $100 Per Day	$40 Member Co-Payment	Not Covered
6. Outpatient Laboratory (Diagnostic/Non-Preventive)	$0 Member Co-Payment	Plan pays 50%*, Member pays 50%
7. X-ray Services	$15 Member Co-Payment at SDA Clinic / $20 Member Co-Payment at other Clinics	Plan pays 50%*, Member pays 50%
8. Injections (Does not include those on the Specialty Drug List and Orthopedic Injections)	$15 Member Co-Payment at SDA Clinic / $20 Member Co-Payment at other Clinics	Plan pays 50%*, Member pays 50%

YOUR DEDUCTIBLE MUST BE MET FOR THE FOLLOWING SERVICES:	PARTICIPATING PROVIDERS (After Deductible is Met)		Judiciary HSA2000 NON-PARTICIPATING PROVIDERS (After Deductible is Met)
PHYSICAL THERAPY (Pre-Certification Required)	Plan pays 80% for the first 20 visits and 50% thereafter		Plan pays 50%*, Member pays 50%
PRESCRIPTION DRUGS	Retail	Mail	
1. Formulary Generic Drugs	Member pays 10%	Member pays 10%	Plan pays 50% of AWP**
2. Formulary Brand Name Drugs	Member pays 20%	Member pays 20%	Plan pays 50% of AWP**
3. Non-Formulary Drugs (Medically Necessary Only and Pre-Certification Required)	Member pays 30%	Member pays 30%	Plan pays 50% of AWP**
4. Specialty Drugs (Medically Necessary Only and Pre-Certification Required)	Member pays 40%	Not Covered	Plan pays 50% of AWP**
RADIATION THERAPY (Pre-Certification Required)	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
SKILLED NURSING FACILITY (Pre-Certification Required) • Maximum 60 Days per Member per Plan Year	Plan pays 80%; Member pays 20%		Plan pays 50%*, Member pays 50%
SLEEP MEDICINE • Sleep Apnea Study Coverage	Plan pays 80%; Member pays 20%		Plan pays 70%*, Member pays 30%
URGENT CARE			
1. In the Service Area	$20 Member Co-payment		Plan pays 80%; Member pays 20%
2. Outside the Service Area	Plan pays 80%; Member pays 20%		Plan pays 80%; Member pays 20%

ADDITIONAL BENEFITS: What the Plan Covers		
YOUR DEDUCTIBLE DOES NOT APPLY TO THESE BENEFITS WHEN YOU GO TO A PARTICIPATING PROVIDER	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
WELLNESS AND FITNESS BENEFIT 1. Wellness Benefit at a Wellness Center (Pre-Certification Required) • Member co-insurance may be reimbursed upon program completion	Plan pays 80%; Member pays 20%	Not Covered
2. Fitness Benefit • Limited to participating Fitness Centers • Attendance participation of 7 times per month	Plan pays up to $150 Cash Reward	Not Covered
VISION RIDER 1. Eye Glasses • Frames • Eyeglass Fitting 2. Eye Glass Lenses • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses • Lenticular/Aphakik Lenses 3. Contact Lenses	Plan pays 100% up to $100 per member per Plan Year.	

* ELIGIBLE CHARGES - Shall be defined as the portion of charges made to a covered person for covered services rendered which are payable to the Provider under this contract. Non-Participating Providers are limited to the lesser of actual charges of Medicare's participating provider fee schedule in the geographic location where the service was rendered, unless otherwise provided in the Agreement. The Covered Person pays any excess above Eligible Charges.

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

DEDUCTIBLE - a fixed dollar amount the Covered Person or family must pay for covered benefits during the plan year before first dollar benefits apply. The deductible does not apply to annual Preventive Care defined in this Schedule of Benefits and non-covered benefits.

PHILIPPINE CARE - Pre-certification is required for services rendered at Philippine Participating Providers. No deductible and co-payment will apply for an annual outpatient Executive Check-up, limited to Eligible Charges in accordance to USPSTF, Grades A & B, at NetCare's Philippine Preferred Providers. The deductible will apply for non-routine or non-preventive services before first dollar benefits are paid. All charges in excess of NetCare's eligible expense is the responsibility of the member.

PRE-CERTIFICATION - covered benefits requiring a pre-certification of services from a physician must be approved by NetCare prior to services rendered.

NetCare
Life & Health Insurance

EXHIBIT A - DENTAL SCHEDULE OF BENEFITS

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

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

EXHIBIT B – DISEASE MANAGEMENT

Disease Management

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

The following is the current Disease and Case Management criteria:

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

Other Disease Management Programs include the following programs:

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

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

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

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

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

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

- ***Pre-Natal Care Management-*** *NetCare utilizes and contracts with the ROSEBUD Program to handle and manage pre-natal and perinatal case management issues. The ROSEBUD Program which is facilitated and coordinated by a registered nurse provides educational resources to promote healthy lifestyles in low risk pregnancies. This is accomplished through a comprehensive risk screening assessment. For perinatal cases, the goal is to bring high risk pregnancies closer to term and decrease neonatal intensive care unit days.*

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

Wellness

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

SDA Wellness Center
Horinouchi Wellness Clinic
Dr. Lombard's Supervised Weight Management Therapy

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

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

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

Fitness

NetCare offers and provides up to $150 cash reward or reimbursement if the member participates or attends a minimum of eight visits per month for a fitness or gym membership at the following fitness partners:

-Hilton Wellness Center
-The Gym Guahan
-Urban Studios
-Unified Gym
-Kontenda's Gym
-Paradise Fitness Center
-International Sports Center
-Synergy

All of the above fitness facilities offer cardiovascular training, resistance and strength training, flexibility training, group exercise classes.

EXHIBIT C – HEALTH EDUCATION AND WELLNESS

NetCare offers the following health education and wellness programs available to NetCare members

Special Direct Access Programs

We have developed several benefit programs that allow NetCare members to receive care directly without ever needing a referral or pre-certification for treatment.

- *Well Woman Advantage*

  With NetCare's *Well Woman Advantage* Program, female members are able to visit a participating obstetrician and/or gynecologist once a year for a breast exam, pelvic exam and pap smear without ever needing a referral or pre-certification.

- *Vision Direct*

  Once a year, you may see a NetCare participating vision provider for a routine eye exam including refractions without ever needing a referral or pre-certification.

- *Chiropractic Direct*

  If you require non-surgical spine and back treatment for an acute condition, you may visit a NetCare participating chiropractic provider without ever needing a referral or pre-certification. The number of visits is limited based on your plan benefits.

- *Podiatry Direct*

  In the event you require care for your feet, you may visit a NetCare participating podiatrist without ever needing a referral or pre-certification. Keep in mind that visits are subject to an approved treatment plan.

Passport To Wellness

NetCare's Passport To Wellness is a collection of wellness programs and activities designed specifically for NetCare members to encourage and support a healthy lifestyle

- *Great Expectations*

  Great Expectations is NetCare's pre-natal and maternity care program provided as a free service to NetCare members through the ROSEBUD Program with RGA Reinsurance Company. This important benefit is designed to help expectant mothers throughout their pregnancy and delivery. Great Expectations members can call

NetCare's Medical Management Department who will be available to answer questions and listen to concerns. At planned intervals throughout pregnancy, NetCare's Registered Nurse will call expectant NetCare mothers to provide support, encourage a healthy lifestyle, and provide information about resources available. These resources can include childbirth, breast feeding and pre-natal exercise classes as well as social services and general maternity/baby care services.

- ***Smoking Cessation***

  For those members who have been unable to kick the tobacco habit, NetCare offers a program that produces results! Our ***smoking cessation*** program focuses on helping members to stop smoking through the use of scientific, behavorial management techniques that will result in permanently neutralizing the desire for tobacco.

- ***Fitness Clubs***

  By establishing partnerships with respected local health and fitness clubs, NetCare members have a complete range of exercise activities and fitness equipment to choose from. In addition, fitness professionals are available to help with training, instruction or the development of a personalized fitness program. NetCare pays up to $150.00 of a member's fitness club membership as long as the member maintains a minimum of seven (7) visits per month. ***Participating Fitness Clubs include Paradise Fitness Centers, Hilton Fitness & Wellness Center, Kotenda's Gym, The Gym Guahan, Unified Gym, Synergy, Urban Studios, International Sports Center.***

- ***Work Site Health Fairs***

  NetCare in coordination with its wellness partners is able to schedule and conduct a full or half day of work site ***Healthylife Fairs*** for your employees. NetCare will issue a "Health Report Card" to each employee that participates. This is a great opportunity to get your employees involved in taking charge of their health care by getting their blood pressure and blood sugar levels checked.

Disease Management Programs

Education plays a critical role for "at-risk" members, such as those who suffer from cardiac disease, hypertension, diabetes and asthma. By identifying these members and providing the necessary education and resources to help them better cope with their medical condition, NetCare is able to improve their quality of life.

In Control

In Control is NetCare's Diabetes Education Program designed to provide members with the knowledge and resources about the importance of keeping their blood sugar levels in control. NetCare provides and offers a free Accu-Chek Advantage Diabetes

Care Kits for eligible members. NetCare also covers diabetic supplies includes the monitoring meter, test strips, lancets etc..required for blood glucose monitoring. In addition, NetCare contracts with ***Health Services Pacific (HSP)*** as an outsourced provider to provide on-going wellness treatment and services to diabetic members.

- ***Great Inspirations***

  Great Inspirations is a Disease and Wellness Program designed to aid those who suffer from chronic illnesses such as hypertension, cardiac, asthma, diabetes and to better understand and control their condition. NetCare identifies members who suffer from chronic medical conditions and refers them to the SDA Wellness Center, Dr. Horinuchi Wellness Clinic or Health Services of the Pacific (HSP) for evaluation and treatment plan.

- ***Self-Care Health Resources***

  NetCare's HealthySteps To Wellness is an interactive web page that allows members to go directly on line at www.netcarelifeandhealth.com from their computer terminal to seek information and guidelines on medical resources on any specific diseases or medical condition at the onset.

- ***Health Education Classes***

  NetCare sponsors and coordinates monthly health education classes with its wellness partners including the SDA Wellness Center and Horinuchi Wellness Clinic for members that want to take a more active role in improving their lifestyle and health outcomes. Classes offered include smoking cessation, diabetes, hypertension, proper eating habits and more.

- ***Informed Nurseline***

  NetCare's 24/7 Nurseline is there for members to talk to a registered nurse any time, toll free. While only a medical doctor can diagnose, prescribe or give medical advise, the Informed Nurseline nurses can provide information on more than 5,000 health topics. This program is in coordination with AmericanHealth Holdings, LLC.

- ***Health Risk Assessment***

  NetCare's free Health Risk Assessment (HRA) provides a health assessment and personalized results to help members understand where they're at risk and what they can do. The program includes personalized online health programs with topics to include:

  -Relieving Stress
  -Eating Healthy and Getting Physical Activity
  -Sleeping Better
  -Managing Depression
  -Increased physical activity

-Quitting Tobacco

Recommended Immunization Schedule for persons aged 0 through 18 years – United States, 2014

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are in bold.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13–15 yrs	16–18 yrs
Hepatitis B[1] (HepB)	1st dose	2nd dose			3rd dose											
Rotavirus[2] (RV) RV1 (2-dose series); RV5 (3-dose series)			1st dose	2nd dose	See footnote 2											
Diphtheria, tetanus, & acellular pertussis[3] (DTaP: <7 yrs)			1st dose	2nd dose	3rd dose			4th dose				5th dose				
Tetanus, diphtheria, & acellular pertussis[4] (Tdap: ≥7 yrs)														(Tdap)		
Haemophilus influenzae type b[5] (Hib)			1st dose	2nd dose	See footnote 5		3rd or 4th dose, See footnote 5									
Pneumococcal conjugate[6] (PCV13)			1st dose	2nd dose	3rd dose		4th dose									
Pneumococcal polysaccharide[6] (PPSV23)																
Inactivated poliovirus[7] (IPV) (<18 yrs)			1st dose	2nd dose	3rd dose							4th dose				
Influenza[8] (IIV; LAIV) 2 doses for some: See footnote 8					Annual vaccination (IIV only)						Annual vaccination (IIV or LAIV)					
Measles, mumps, rubella[9] (MMR)							1st dose					2nd dose				
Varicella[10] (VAR)							1st dose					2nd dose				
Hepatitis A[11] (HepA)							2-dose series, See footnote 11									
Human papillomavirus[12] (HPV2: females only; HPV4: males and females)														(3-dose series)		
Meningococcal[13] (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)			See footnote 13											1st dose		Booster

Range of recommended ages for all children

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

Range of recommended ages during which catch-up is encouraged and for certain high-risk groups

Not routinely recommended

This schedule includes recommendations in effect as of January 1, 2014. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm) or by telephone (800-CDC-INFO [800-232-4636]).

This schedule is approved by the Advisory Committee on Immunization Practices (http//www.cdc.gov/vaccines/acip), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2014

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the adult immunization schedule.

Additional information

- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
- Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see *MMWR, General Recommendations on Immunization and Reports* / Vol. 60 / No. 2; Table 1. *Recommended and minimum ages and intervals between vaccine doses* available online at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
- Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destinations/list.
- For vaccination of persons with primary and secondary immunodeficiencies, see Table 13, "*Vaccination of persons with primary and secondary immunodeficiencies*," in General Recommendations on Immunization (ACIP), available at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.; and American Academy of Pediatrics. Immunization in Special Clinical Circumstances, in Pickering LK, Baker CJ, Kimberlin DW, Long SS eds. *Red Book: 2012 report of the Committee on Infectious Diseases. 29th ed.* Elk Grove Village, IL: American Academy of Pediatrics.

1. **Hepatitis B (HepB) vaccine. (Minimum age: birth)**

Routine vaccination:

At birth:

- Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of the HepB series, at age 9 through 18 months (preferably at the next well-child visit).
- If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight. For infants weighing less than 2,000 grams, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HBIG for infants weighing 2,000 grams or more as soon as possible, but no later than age 7 days.

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose at least 8 weeks after the second dose AND at least 16 weeks after the **first** dose. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks.
- Administration of a total of 4 doses of HepB vaccine is permitted when a combination vaccine containing HepB is administered after the birth dose.

Catch-up vaccination:

- Unvaccinated persons should complete a 3-dose series.
- A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- For other catch-up guidance, see Figure 2.

2. **Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix] and RV5 [RotaTeq])**

Routine vaccination:

Administer a series of RV vaccine to all infants as follows:

1. If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
2. If RotaTeq is used, administer a 3-dose series at ages 2, 4, and 6 months.
3. If any dose in the series was RotaTeq or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

Catch-up vaccination:

- The maximum age for the first dose in the series is 14 weeks, 6 days; vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- The maximum age for the final dose in the series is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

3. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks. Exception: DTaP-IPV [Kinrix]: 4 years)**

Routine vaccination:

- Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

Catch-up vaccination:

- The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.
- For other catch-up guidance, see Figure 2.

4. **Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for Boostrix, 11 years for Adacel)**

Routine vaccination:

- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of time since prior Td or Tdap vaccination.

Catch-up vaccination:

- Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as 1 (preferably the first) dose in the catch-up series; if additional doses are needed, use Td vaccine. For children 7 through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose at age 11 through 12 years should NOT be administered. Td should be administered instead 10 years after the Tdap dose.
- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- Inadvertent doses of DTaP vaccine:
  - If administered inadvertently to a child aged 7 through 10 years may count as part of the catch-up series. This dose may count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11 through 12 years.
  - If administered inadvertently to an adolescent aged 11 through 18 years, the dose should be counted as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

5. ***Haemophilus influenzae* type b (Hib) conjugate vaccine. (Minimum age: 6 weeks for PRP-T [ACTHIB, DTaP-IPV/Hib (Pentacel) and Hib-MenCY (MenHibrix)], PRP-OMP [PedvaxHIB or COMVAX], 12 months for PRP-T [Hiberix])**

Routine vaccination:

- Administer a 2- or 3-dose Hib vaccine primary series and a booster dose (dose 3 or 4 depending on vaccine used in primary series) at age 12 through 15 months to complete a full Hib vaccine series.
- The primary series with ActHIB, MenHibrix, or Pentacel consists of 3 doses and should be administered at 2, 4, and 6 months of age. The primary series with PedvaxHib or COMVAX consists of 2 doses and should be administered at 2 and 4 months of age; a dose at age 6 months is not indicated.
- One booster dose (dose 3 or 4 depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months. An exception is Hiberix vaccine. Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years who have received at least 1 prior dose of Hib-containing vaccine.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

5. ***Haemophilus influenzae* type b (Hib) conjugate vaccine (cont'd)**
   - For recommendations on the use of MenHibrix in patients at increased risk for meningococcal disease, please refer to the meningococcal vaccine footnotes and also to *MMWR* March 22, 2013; 62(RR02);1-22, available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf.

   Catch-up vaccination:
   - If dose 1 was administered at ages 12 through 14 months, administer a second (final) dose at least 8 weeks after dose 1, regardless of Hib vaccine used in the primary series.
   - If the first 2 doses were PRP-OMP (PedvaxHIB or COMVAX), and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
   - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a third (and final) dose at age 12 through 15 months or 8 weeks after second dose, whichever is later, regardless of Hib vaccine used for first dose.
   - If first dose is administered at younger than 12 months of age and second dose is given between 12 through 14 months of age, a third (and final) dose should be given 8 weeks later.
   - For unvaccinated children aged 15 months or older, administer only 1 dose.
   - For other catch-up guidance, see Figure 2. For catch-up guidance related to MenHibrix, please see the meningococcal vaccine footnotes and also *MMWR* March 22, 2013; 62(RR02);1-22, available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf.

   Vaccination of persons with high-risk conditions:
   - Children aged 12 through 59 months who are at increased risk for Hib disease, including chemotherapy recipients and those with anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, immunoglobulin deficiency, or early component complement deficiency, who have received either no doses or only 1 dose of Hib vaccine before 12 months of age, should receive 2 additional doses of Hib vaccine 8 weeks apart; children who received 2 or more doses of Hib vaccine before 12 months of age should receive 1 additional dose.
   - For patients younger than 5 years of age undergoing chemotherapy or radiation treatment who received a Hib vaccine dose(s) within 14 days of starting therapy or during therapy, repeat the dose(s) at least 3 months following therapy completion.
   - Recipients of hematopoietic stem cell transplant (HSCT) should be revaccinated with a 3-dose regimen of Hib vaccine starting 6 to 12 months after successful transplant, regardless of vaccination history; doses should be administered at least 4 weeks apart.
   - A single dose of any Hib-containing vaccine should be administered to unimmunized* children and adolescents 15 months of age and older undergoing an elective splenectomy; if possible, vaccine should be administered at least 14 days before procedure.
   - Hib vaccine is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized* persons aged 5 years or older who have anatomic or functional asplenia (including sickle cell disease) and unvaccinated persons 5 through 18 years of age with human immunodeficiency virus (HIV) infection.

     ** Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine after 14 months of age are considered unimmunized.*

6. **Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13, 2 years for PPSV23)**

   Routine vaccination with PCV13:
   - Administer a 4-dose series of PCV13 vaccine at ages 2, 4, and 6 months and at age 12 through 15 months.
   - For children aged 14 through 59 months who have received an age-appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).

   Catch-up vaccination with PCV13:
   - Administer 1 dose of PCV13 to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - For other catch-up guidance, see Figure 2.

   Vaccination of persons with high-risk conditions with PCV13 and PPSV23:
   - All recommended PCV13 doses should be administered prior to PPSV23 vaccination if possible.
   - For children 2 through 5 years of age with any of the following conditions: chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy); diabetes mellitus; cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency:
     1. Administer 1 dose of PCV13 if 3 doses of PCV (PCV7 and/or PCV13) were received previously.
     2. Administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV (PCV7 and/or PCV13) were received previously.

6. **Pneumococcal vaccines (cont'd)**
     3. Administer 1 supplemental dose of PCV13 if 4 doses of PCV7 or other age-appropriate complete PCV7 series was received previously.
     4. The minimum interval between doses of PCV (PCV7 or PCV13) is 8 weeks.
     5. For children with no history of PPSV23 vaccination, administer PPSV23 at least 8 weeks after the most recent dose of PCV13.
   - For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma:
     1. If neither PCV13 nor PPSV23 has been received previously, administer 1 dose of PCV13 now and 1 dose of PPSV23 at least 8 weeks later.
     2. If PCV13 has been received previously but PPSV23 has not, administer 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13.
     3. If PPSV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.
   - For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPSV23, administer 1 dose of PPSV23. If PCV13 has been received previously, then PPSV23 should be administered at least 8 weeks after any prior PCV13 dose.
   - A single revaccination with PPSV23 should be administered 5 years after the first dose to children with sickle cell disease or other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma.

7. **Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)**

   Routine vaccination:
   - Administer a 4-dose series of IPV at ages 2, 4, 6 through 18 months, and 4 through 6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

   Catch-up vaccination:
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
   - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years and at least 6 months after the previous dose.
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age. IPV is not routinely recommended for U.S. residents aged 18 years or older.
   - For other catch-up guidance, see Figure 2.

8. **Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV], 2 years for live, attenuated influenza vaccine [LAIV])**

   Routine vaccination:
   - Administer influenza vaccine annually to all children beginning at age 6 months. For most healthy, nonpregnant persons aged 2 through 49 years, either LAIV or IIV may be used. However, LAIV should NOT be administered to some persons, including 1) those with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) those who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2013; 62 (No. RR-7):1-43, available at http://www.cdc.gov/mmwr/pdf/rr/rr6207.pdf.

   For children aged 6 months through 8 years:
   - For the 2013–14 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses. For additional guidance, follow dosing guidelines in the 2013-14 ACIP influenza vaccine recommendations, *MMWR* 2013; 62 (No. RR-7):1-43, available at http://www.cdc.gov/mmwr/pdf/rr/rr6207.pdf.
   - For the 2014–15 season, follow dosing guidelines in the 2014 ACIP influenza vaccine recommendations.

   For persons aged 9 years and older:
   - Administer 1 dose.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

9. **Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)**
Routine vaccination:
- Administer a 2-dose series of MMR vaccine at ages12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
- Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.
- Administer 2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.

Catch-up vaccination:
- Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

10. **Varicella (VAR) vaccine. (Minimum age: 12 months)**
Routine vaccination:
- Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

Catch-up vaccination:
- Ensure that all persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007; 56 [No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine. For children aged 7 through 12 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

11. **Hepatitis A (HepA) vaccine. (Minimum age: 12 months)**
Routine vaccination:
- Initiate the 2-dose HepA vaccine series at 12 through 23 months; separate the 2 doses by 6 to 18 months.
- Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
- For any person aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.

Catch-up vaccination:
- The minimum interval between the two doses is 6 months.

Special populations:
- Administer 2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; men having sex with men; users of injection and non-injection illicit drugs; persons who work with HAV-infected primates or with HAV in a research laboratory; persons with clotting-factor disorders; persons with chronic liver disease; and persons who anticipate close, personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. The first dose should be administered as soon as the adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

12. **Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for HPV2 [Cervarix] and HPV4 [Gardisil])**
Routine vaccination:
- Administer a 3-dose series of HPV vaccine on a schedule of 0, 1-2, and 6 months to all adolescents aged 11 through 12 years. Either HPV4 or HPV2 may be used for females, and only HPV4 may be used for males.
- The vaccine series may be started at age 9 years.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose 24 weeks after the first dose and 16 weeks after the second dose (minimum interval of 12 weeks).

Catch-up vaccination:
- Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals (see above) for vaccine series catch-up.

13. **Meningococcal conjugate vaccines. (Minimum age: 6 weeks for Hib-MenCY [MenHibrix], 9 months for MenACWY-D [Menactra], 2 months for MenACWY-CRM [Menveo])**
Routine vaccination:
- Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of Menactra or Menveo with at least 8 weeks between doses.
- For children aged 2 months through 18 years with high-risk conditions, see below.

Catch-up vaccination:
- Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up guidance, see Figure 2.

Vaccination of persons with high-risk conditions and other persons at increased risk of disease:
- Children with anatomic or functional asplenia (including sickle cell disease):
  1. For children younger than 19 months of age, administer a 4-dose infant series of MenHibrix or Menveo at 2, 4, 6, and 12 through 15 months of age.
  2. For children aged 19 through 23 months who have not completed a series of MenHibrix or Menveo, administer 2 primary doses of Menveo at least 3 months apart.
  3. For children aged 24 months and older who have not received a complete series of MenHibrix or Menveo or Menactra, administer 2 primary doses of either Menactra or Menveo at least 2 months apart. If Menactra is administered to a child with asplenia (including sickle cell disease), do not administer Menactra until 2 years of age and at least 4 weeks after the completion of all PCV13 doses.
- Children with persistent complement component deficiency:
  1. For children younger than 19 months of age, administer a 4-dose infant series of either MenHibrix or Menveo at 2, 4, 6, and 12 through 15 months of age.
  2. For children 7 through 23 months who have not initiated vaccination, two options exist depending on age and vaccine brand:
     a. For children who initiate vaccination with Menveo at 7 months through 23 months of age, a 2-dose series should be administered with the second dose after 12 months of age and at least 3 months after the first dose.
     b. For children who initiate vaccination with Menactra at 9 months through 23 months of age, a 2-dose series of Menactra should be administered at least 3 months apart.
     c. For children aged 24 months and older who have not received a complete series of MenHibrix, Menveo, or Menactra, administer 2 primary doses of either Menactra or Menveo at least 2 months apart.
- For children who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or the Hajj, administer an age-appropriate formulation and series of Menactra or Menveo for protection against serogroups A and W meningococcal disease. Prior receipt of MenHibrix is not sufficient for children traveling to the meningitis belt or the Hajj because it does not contain serogroups A or W.
- For children at risk during a community outbreak attributable to a vaccine serogroup, administer or complete an age- and formulation-appropriate series of MenHibrix, Menactra, or Menveo.
- For booster doses among persons with high-risk conditions, refer to *MMWR* 2013; 62(RR02);1-22, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm.

Catch-up recommendations for persons with high-risk conditions:
1. If MenHibrix is administered to achieve protection against meningococcal disease, a complete age-appropriate series of MenHibrix should be administered.
2. If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.
3. For children who initiate vaccination with Menveo at 7 months through 9 months of age, a 2-dose series should be administered with the second dose after 12 months of age and at least 3 months after the first dose.
4. For other catch-up recommendations for these persons, refer to *MMWR* 2013; 62(RR02);1-22, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm.

For complete information on use of meningococcal vaccines, including guidance related to vaccination of persons at increased risk of infection, see *MMWR* March 22, 2013; 62(RR02);1-22, available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf.

Recommended Adult Immunization Schedule—United States - 2014

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended adult immunization schedule, by vaccine and age group[1]

VACCINE ▼ / AGE GROUP ▶	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza [2,*]	1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap) [3,*]	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs					
Varicella [4,*]	2 doses					
Human papillomavirus (HPV) Female [5,*]	3 doses					
Human papillomavirus (HPV) Male [5,*]	3 doses					
Zoster [6]					1 dose	
Measles, mumps, rubella (MMR) [7,*]	1 or 2 doses					
Pneumococcal 13-valent conjugate (PCV13) [8,*]	1 dose					
Pneumococcal polysaccharide (PPSV23) [9,10]	1 or 2 doses					1 dose
Meningococcal [11,*]	1 or more doses					
Hepatitis A [12,*]	2 doses					
Hepatitis B [13,*]	3 doses					
Haemophilus influenzae type b (Hib) [14,*]	1 or 3 doses					

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indication)

No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse-Midwives (ACNM).

Figure 2. Vaccines that might be indicated for adults based on medical and other indications[1]

VACCINE ▼ / INDICATION ▶	Pregnancy	Immuno-compromising conditions (excluding human immunodeficiency virus [HIV])[4,6,7,8,15]	HIV infection CD4+ T lymphocyte count[4,6,7,8,15]: < 200 cells/μL	HIV infection CD4+ T lymphocyte count[4,6,7,8,15]: ≥ 200 cells/μL	Men who have sex with men (MSM)	Kidney failure, end-stage renal disease, receipt of hemodialysis	Heart disease, chronic lung disease, chronic alcoholism	Asplenia (including elective splenectomy and persistent complement component deficiencies)[8,14]	Chronic liver disease	Diabetes	Healthcare personnel
Influenza [2,*]	1 dose IIV annually				1 dose IIV or LAIV annually	1 dose IIV annually					1 dose IIV or LAIV annually
Tetanus, diphtheria, pertussis (Td/Tdap) [3,*]	1 dose Tdap each pregnancy	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs									
Varicella [4,*]	Contraindicated			2 doses							
Human papillomavirus (HPV) Female [5,*]		3 doses through age 26 yrs				3 doses through age 26 yrs					
Human papillomavirus (HPV) Male [5,*]		3 doses through age 26 yrs				3 doses through age 21 yrs					
Zoster [6]	Contraindicated				1 dose						
Measles, mumps, rubella (MMR) [7,*]	Contraindicated			1 or 2 doses							
Pneumococcal 13-valent conjugate (PCV13) [8,*]		1 dose									
Pneumococcal polysaccharide (PPSV23) [9,10]		1 or 2 doses									
Meningococcal [11,*]	1 or more doses										
Hepatitis A [12,*]	2 doses										
Hepatitis B [13,*]	3 doses										
Haemophilus influenzae type b (Hib) [14,*]		post-HSCT recipients only	1 or 3 doses								

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

No recommendation

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of February 1, 2014. For all vaccines being recommended on the Adult Immunization Schedule: a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/hcp/acip-recs/index.html). Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

Footnotes
Recommended Immunization Schedule for Adults Aged 19 Years or Older: United States, 2014

1. **Additional information**
   - Additional guidance for the use of the vaccines described in this supplement is available at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
   - Information on vaccination recommendations when vaccination status is unknown and other general immunization information can be found in the General Recommendations on Immunization at www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm.
   - Information on travel vaccine requirements and recommendations (e.g., for hepatitis A and B, meningococcal, and other vaccines) is available at http://wwwnc.cdc.gov/travel/destinations/list.
   - Additional information and resources regarding vaccination of pregnant women can be found at http://www.cdc.gov/vaccines/adults/rec-vac/pregnant.html.
2. **Influenza vaccination**
   - Annual vaccination against influenza is recommended for all persons aged 6 months or older.
   - Persons aged 6 months or older, including pregnant women and persons with hives-only allergy to eggs, can receive the inactivated influenza vaccine (IIV). An age-appropriate IIV formulation should be used.
   - Adults aged 18 to 49 years can receive the recombinant influenza vaccine (RIV) (FluBlok). RIV does not contain any egg protein.
   - Healthy, nonpregnant persons aged 2 to 49 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (LAIV) (FluMist), or IIV. Health care personnel who care for severely immunocompromised persons (i.e., those who require care in a protected environment) should receive IIV or RIV rather than LAIV.
   - The intramuscularly or intradermally administered IIV are options for adults aged 18 to 64 years.
   - Adults aged 65 years or older can receive the standard-dose IIV or the high-dose IIV (Fluzone High-Dose).
3. **Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination**
   - Administer 1 dose of Tdap vaccine to pregnant women during each pregnancy (preferred during 27 to 36 weeks' gestation) regardless of interval since prior Td or Tdap vaccination.
   - Persons aged 11 years or older who have not received Tdap vaccine or for whom vaccine status is unknown should receive a dose of Tdap followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-toxoid containing vaccine.
   - Adults with an unknown or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series including a Tdap dose.
   - For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6 to 12 months after the second.
   - For incompletely vaccinated (i.e., less than 3 doses) adults, administer remaining doses.
   - Refer to the ACIP statement for recommendations for administering Td/Tdap as prophylaxis in wound management (see footnote 1).
4. **Varicella vaccination**
   - All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose.
   - Vaccination should be emphasized for those who have close contact with persons at high risk for severe disease (e.g., health care personnel and family contacts of persons with immunocompromising conditions) or are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).
   - Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health care facility. The second dose should be administered 4 to 8 weeks after the first dose.
   - Evidence of immunity to varicella in adults includes any of the following:
     - — documentation of 2 doses of varicella vaccine at least 4 weeks apart;
     - —U.S.-born before 1980, except health care personnel and pregnant women;
     - — history of varicella based on diagnosis or verification of varicella disease by a health care provider;
     - — history of herpes zoster based on diagnosis or verification of herpes zoster disease by a health care provider; or
     - — laboratory evidence of immunity or laboratory confirmation of disease.
5. **Human papillomavirus (HPV) vaccination**
   - Two vaccines are licensed for use in females, bivalent HPV vaccine (HPV2) and quadrivalent HPV vaccine (HPV4), and one HPV vaccine for use in males (HPV4).
   - For females, either HPV4 or HPV2 is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 26 years, if not previously vaccinated.
   - For males, HPV4 is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 21 years, if not previously vaccinated. Males aged 22 through 26 years may be vaccinated.

5. **Human papillomavirus (HPV) vaccination (cont'd)**
   - HPV4 is recommended for men who have sex with men through age 26 years for those who did not get any or all doses when they were younger.
   - Vaccination is recommended for immunocompromised persons (including those with HIV infection) through age 26 years for those who did not get any or all doses when they were younger.
   - A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 4 to 8 weeks (minimum interval of 4 weeks) after the first dose; the third dose should be administered 24 weeks after the first dose and 16 weeks after the second dose (minimum interval of at least 12 weeks).
   - HPV vaccines are not recommended for use in pregnant women. However, pregnancy testing is not needed before vaccination. If a woman is found to be pregnant after initiating the vaccination series, no intervention is needed; the remainder of the 3-dose series should be delayed until completion of pregnancy.
6. **Zoster vaccination**
   - A single dose of zoster vaccine is recommended for adults aged 60 years or older regardless of whether they report a prior episode of herpes zoster. Although the vaccine is licensed by the U.S. Food and Drug Administration for use among and can be administered to persons aged 50 years or older, ACIP recommends that vaccination begin at age 60 years.
   - Persons aged 60 years or older with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication, such as pregnancy or severe immunodeficiency.
7. **Measles, mumps, rubella (MMR) vaccination**
   - Adults born before 1957 are generally considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine or laboratory evidence of immunity to each of the three diseases. Documentation of provider-diagnosed disease is not considered acceptable evidence of immunity for measles, mumps, or rubella.

   Measles component:
   - A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who:
     - — are students in postsecondary educational institutions;
     - — work in a health care facility; or
     - — plan to travel internationally.
   - Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type during 1963–1967 should be revaccinated with 2 doses of MMR vaccine.

   Mumps component:
   - A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who:
     - — are students in a postsecondary educational institution;
     - — work in a health care facility; or
     - — plan to travel internationally.
   - Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g., persons who are working in a health care facility) should be considered for revaccination with 2 doses of MMR vaccine.

   Rubella component:
   - For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health care facility.

   Health care personnel born before 1957:
   - For unvaccinated health care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.
8. **Pneumococcal conjugate (PCV13) vaccination**
   - Adults aged 19 years or older with immunocompromising conditions (including chronic renal failure and nephrotic syndrome), functional or anatomic asplenia, cerebrospinal fluid leaks, or cochlear implants who have not previously received PCV13 or PPSV23 should receive a single dose of PCV13 followed by a dose of PPSV23 at least 8 weeks later.
   - Adults aged 19 years or older with the aforementioned conditions who have previously received 1 or more doses of PPSV23 should receive a dose of PCV13 one or more years after the last PPSV23 dose was received. For adults who require additional doses of PPSV23, the first such dose should be given no sooner than 8 weeks after PCV13 and at least 5 years after the most recent dose of PPSV23.
   - When indicated, PCV13 should be administered to patients who are uncertain of their vaccination status history and have no record of previous vaccination.
   - Although PCV13 is licensed by the U.S. Food and Drug Administration for use among and can be administered to persons aged 50 years or older, ACIP recommends PCV13 for adults aged 19 years or older with the specific medical conditions noted above.

9. **Pneumococcal polysaccharide (PPSV23) vaccination**
   - When PCV13 is also indicated, PCV13 should be given first (see footnote 8).
   - Vaccinate all persons with the following indications:
     - all adults aged 65 years or older;
     - adults younger than 65 years with chronic lung disease (including chronic obstructive pulmonary disease, emphysema, and asthma), chronic cardiovascular diseases, diabetes mellitus, chronic renal failure, nephrotic syndrome, chronic liver disease (including cirrhosis), alcoholism, cochlear implants, cerebrospinal fluid leaks, immunocompromising conditions, and functional or anatomic asplenia (e.g., sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, splenic dysfunction, or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]);
     - residents of nursing homes or long-term care facilities; and
     - adults who smoke cigarettes.
   - Persons with immunocompromising conditions and other selected conditions are recommended to receive PCV13 and PPSV23 vaccines. See footnote 8 for information on timing of PCV13 and PPSV23 vaccinations.
   - Persons with asymptomatic or symptomatic HIV infection should be vaccinated as soon as possible after their diagnosis.
   - When cancer chemotherapy or other immunosuppressive therapy is being considered, the interval between vaccination and initiation of immunosuppressive therapy should be at least 2 weeks. Vaccination during chemotherapy or radiation therapy should be avoided.
   - Routine use of PPSV23 vaccine is not recommended for American Indians/Alaska Natives or other persons younger than 65 years unless they have underlying medical conditions that are PPSV23 indications. However, public health authorities may consider recommending PPSV23 for American Indians/Alaska Natives who are living in areas where the risk for invasive pneumococcal disease is increased.
   - When indicated, PPSV23 vaccine should be administered to patients who are uncertain of their vaccination status and have no record of vaccination.
10. **Revaccination with PPSV23**
   - One-time revaccination 5 years after the first dose of PPSV23 is recommended for persons aged 19 through 64 years with chronic renal failure or nephrotic syndrome, functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), or immunocompromising conditions.
   - Persons who received 1 or 2 doses of PPSV23 before age 65 years for any indication should receive another dose of the vaccine at age 65 years or later if at least 5 years have passed since their previous dose.
   - No further doses of PPSV23 are needed for persons vaccinated with PPSV23 at or after age 65 years.
11. **Meningococcal vaccination**
   - Administer 2 doses of quadrivalent meningococcal conjugate vaccine (MenACWY [Menactra, Menveo]) at least 2 months apart to adults of all ages with functional asplenia or persistent complement component deficiencies. HIV infection is not an indication for routine vaccination with MenACWY. If an HIV-infected person of any age is vaccinated, 2 doses of MenACWY should be administered at least 2 months apart.
   - Administer a single dose of meningococcal vaccine to microbiologists routinely exposed to isolates of *Neisseria meningitidis*, military recruits, persons at risk during an outbreak attributable to a vaccine serogroup, and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic.
   - First-year college students up through age 21 years who are living in residence halls should be vaccinated if they have not received a dose on or after their 16th birthday.
   - MenACWY is preferred for adults with any of the preceding indications who are aged 55 years or younger as well as for adults aged 56 years or older who a) were vaccinated previously with MenACWY and are recommended for revaccination, or b) for whom multiple doses are anticipated. Meningococcal polysaccharide vaccine (MPSV4 [Menomune]) is preferred for adults aged 56 years or older who have not received MenACWY previously and who require a single dose only (e.g., travelers).
   - Revaccination with MenACWY every 5 years is recommended for adults previously vaccinated with MenACWY or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia, persistent complement component deficiencies, or microbiologists).
12. **Hepatitis A vaccination**
   - Vaccinate any person seeking protection from hepatitis A virus (HAV) infection and persons with any of the following indications:
     - men who have sex with men and persons who use injection or non-injection illicit drugs;
     - persons working with HAV-infected primates or with HAV in a research laboratory setting;
     - persons with chronic liver disease and persons who receive clotting factor concentrates;
     - persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A; and

12. **Hepatitis A vaccination (cont'd)**
     - unvaccinated persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. (See footnote 1 for more information on travel recommendations.) The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.
   - Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6 to 12 months (Havrix), or 0 and 6 to 18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21 to 30 followed by a booster dose at month 12.
13. **Hepatitis B vaccination**
   - Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:
     - sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than 1 sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection drug users; and men who have sex with men;
     - health care personnel and public safety workers who are potentially exposed to blood or other infectious body fluids;
     - persons with diabetes who are younger than age 60 years as soon as feasible after diagnosis; persons with diabetes who are age 60 years or older at the discretion of the treating clinician based on the likelihood of acquiring HBV infection, including the risk posed by an increased need for assisted blood glucose monitoring in long-term care facilities, the likelihood of experiencing chronic sequelae if infected with HBV, and the likelihood of immune response to vaccination;
     - persons with end-stage renal disease, including patients receiving hemodialysis, persons with HIV infection, and persons with chronic liver disease;
     - household contacts and sex partners of hepatitis B surface antigen–positive persons, clients and staff members of institutions for persons with developmental disabilities, and international travelers to countries with high or intermediate prevalence of chronic HBV infection; and
     - all adults in the following settings: STD treatment facilities, HIV testing and treatment facilities, facilities providing drug abuse treatment and prevention services, health care settings targeting services to injection drug users or men who have sex with men, correctional facilities, end-stage renal disease programs and facilities for chronic hemodialysis patients, and institutions and nonresidential day care facilities for persons with developmental disabilities.
   - Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, give 3 doses at 0, 1, and 6 months; alternatively, a 4-dose Twinrix schedule, administered on days 0, 7, and 21 to 30 followed by a booster dose at month 12 may be used.
   - Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 mcg/mL (Recombivax HB) administered on a 3-dose schedule at 0, 1, and 6 months or 2 doses of 20 mcg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.
14. ***Haemophilus influenzae type b*** **(Hib) vaccination**
   - One dose of Hib vaccine should be administered to persons who have functional or anatomic asplenia or sickle cell disease or are undergoing elective splenectomy if they have not previously received Hib vaccine. Hib vaccination 14 or more days before splenectomy is suggested.
   - Recipients of a hematopoietic stem cell transplant should be vaccinated with a 3-dose regimen 6 to 12 months after a successful transplant, regardless of vaccination history; at least 4 weeks should separate doses.
   - Hib vaccine is not recommended for adults with HIV infection since their risk for Hib infection is low.
15. **Immunocompromising conditions**
   - Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, and inactivated influenza vaccine) and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

EXHIBIT E – IMPLANTS AND PROSTHETICS

An Implant is defined as any surgically inserted or embedded graft or device. A Prosthetics is defined as an artificial device, which is attached to the body and is used to replace a missing functional body part.

The following is a listing of Covered Implants and Prosthetics:

1. Covered Implants:

    a. Breast Implants after a mastectomy due to cancer in accordance with the Women's Health and Cancer Rights Act of 1998
    b. Joint and Hip Replacement if specified as covered
    c. Treatment of acute traumatic orthopedic injury with the use of orthopedic fixating appliances (such as pins, rods, plates etc..)
    d. Indwelling appliances (such as for colostomy, ileostomy, gastrostomy, urostomy, urethral catheterization, etc…) are not considered as implants.
    e. Intrauterine device for birth control is covered
    f. PE Tube Placement if persistent Serous Otitis Media or Recurrent Otitis Media occurs and has not responded positively to treatment.
    g. Carotid Stent for Carotid Stenosis
    h. Kidney/Urethral Stents used after a stone removal or ESWL
    i. Cochlear Implant
    j. Intraocular Lens
    k. Radioactive Implants or seeds that are placed directly into a tumor or body cavity and may be referred to as brachytherapy, interstitial, irradiation or intracavitary irradication.
    l. Heart Valve
    m. Cardiac Pacemakers
    n. Stents
    o. Orthopedic Internal Prosthetic Devices

EXHIBIT F – PERFORMANCE GUARANTEES

Performance Category	Minimum Standards	Proposed Penalty
Claims Administration		
• Turnaround Time	90% of clean claims processed within 30 days of receipt	$10,000 annual penalty
• Financial Accuracy	Claims will be processed with a 99.30% accuracy rate	$5,000 annual penalty
• Payment Accuracy	Claims will be processed with a 95.00% accuracy rate	$5,000 annual penalty
• Total Claims Accuracy	Overall Claims Accuracy will be at 95.00%	$10,000 annual penalty
Account Management		
• Overall Account Management	Average evaluation score of 3.0 or higher out of a total of 5.0	$10,000 annual penalty
Customer Service		
• Call Response Time	Average Speed to Answer will be within 30 seconds	$5,000 annual penalty
• Call Abandonment Rate	Call Abandonment Rate will be no less than 3%	$5,000 annual penalty
• First Call Resolution	85% of all First Call Resolutions will be resolved	$5,000 annual penalty
Web Enabled Portal		
• Judiciary Web Page	NetCare will have a dedicated web page strictly for Judicary of Guam members by 10/1/2014	$5,000 annual penalty
• On-Line Tools	Members will have access to MyNetCare Portal to access claims, eligibility, wellness etc	$5,000 annual penalty
Account Administration		
• Member ID Card	Member ID Cards will be mailed to new members within 10 days of the effective date	$10,000 annual penalty
• Provider Network Disruption	Network Disruption will be no more than 5%	$10,000 annual penalty
• Eligibility Posting	Electronic Eligibility posting will posted and on-line with 24 hours of receipt/Manual eligibility will be posted within 48 hours of receipt	$5,000 annual penalty
• Member Fulfillment Packets	Member Fulfillment Packets will be mailed out within 10 days of the effective date of coverage	$5,000 annual penalty

Reporting Guarantees		
• Required Monthly Reports	NetCare will guarantee all monthly and annual required reports including claims, wellness, utilization review and enrollment data within 10 days after the close of the reporting month	$10,000 annual penalty
Medical Management		
• Pre-certification/Prior Authorization	Properly and fully completed pre-certification or prior authorization request shall be processed within 48 hours of receipt or submission	$5,000 annual penalty
• Wellness/Fitness Programs	NetCare will implement an integrated wellness and fitness program including a health risk assessment and on-line tools and resources	$5,000 annual penalty

EXHIBIT G
NETCARE APPEALS & GRIEVANCE PROCEDURES

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

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

NOTICE OF APPEAL RIGHTS

You have the right to appeal any decision we make that denies payment on you claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact our office at 671-472-3610 when you:

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

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

Appeals

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

you do not receive our decision within **60 days** of receiving your appeal, you may be entitled to file a request for an external review.

When you appeal, NetCare must give you its decision within:

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

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

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

External Review

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

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

EXHIBIT H – FITNESS AND GYM BENEFIT PARTNERS

NetCare Life & Health Insurance Company
Fitness & Gym Partners

Gym Facility	Services Offered	Hours	Monthly Cost	Registration Fee	Contact	Location
Gym Guahan	Fitness Classes Gym Workout	Mon-Sun 4:00am to 11pm	$25.00	Waived	472-4496	Maite
Kotenda's Gym	Gym Equipment Fitness Classes	Mon-Fri 5:00am – 9pm Sat: 5:00am to 5:00pm	$35.00	Waived	647-9280	Tamuning
Hilton Fitness	Gym Equipment Fitness Classes Water Park	Mon-Sun 5:00am-10:00pm	$50.00	Waived	646-1835 ext5886	Tumon
Urban Studios	Fitness Classes Gym Workout	Mon-Fri 5:30am-9:00pm Sat: 5:30am -2:00pm	$40.00	Waived	969-7308	Tamuning
Unified Gym	Crossfit Activities Gym Workout	Mon-Thurs 5:00am-8:00pm Fri: 5:00am to 7:00pm	$60.00	Waived	969-8641	Tamuning
Paradise Fitness	Gym Workout Fitness Classes	Mon-Sun 4:00am to 11:00pm	$45.00	Waived	472-2100	Hagatna Dededo
International Sports Center	Fitness Classes Gym Workout	Mon-Fri 5:00am-10:00pm Sat-Sun 8:00am – 6:00pm	$75.00	$59.00	477-9885	Hagatna
Synergy Studios	Fitness Classes	Mon-Fri 5:00pm -8:00pm Sat: 8:00am-12:00n	$40.00	Waived	472-9642	Maite East Hagatna