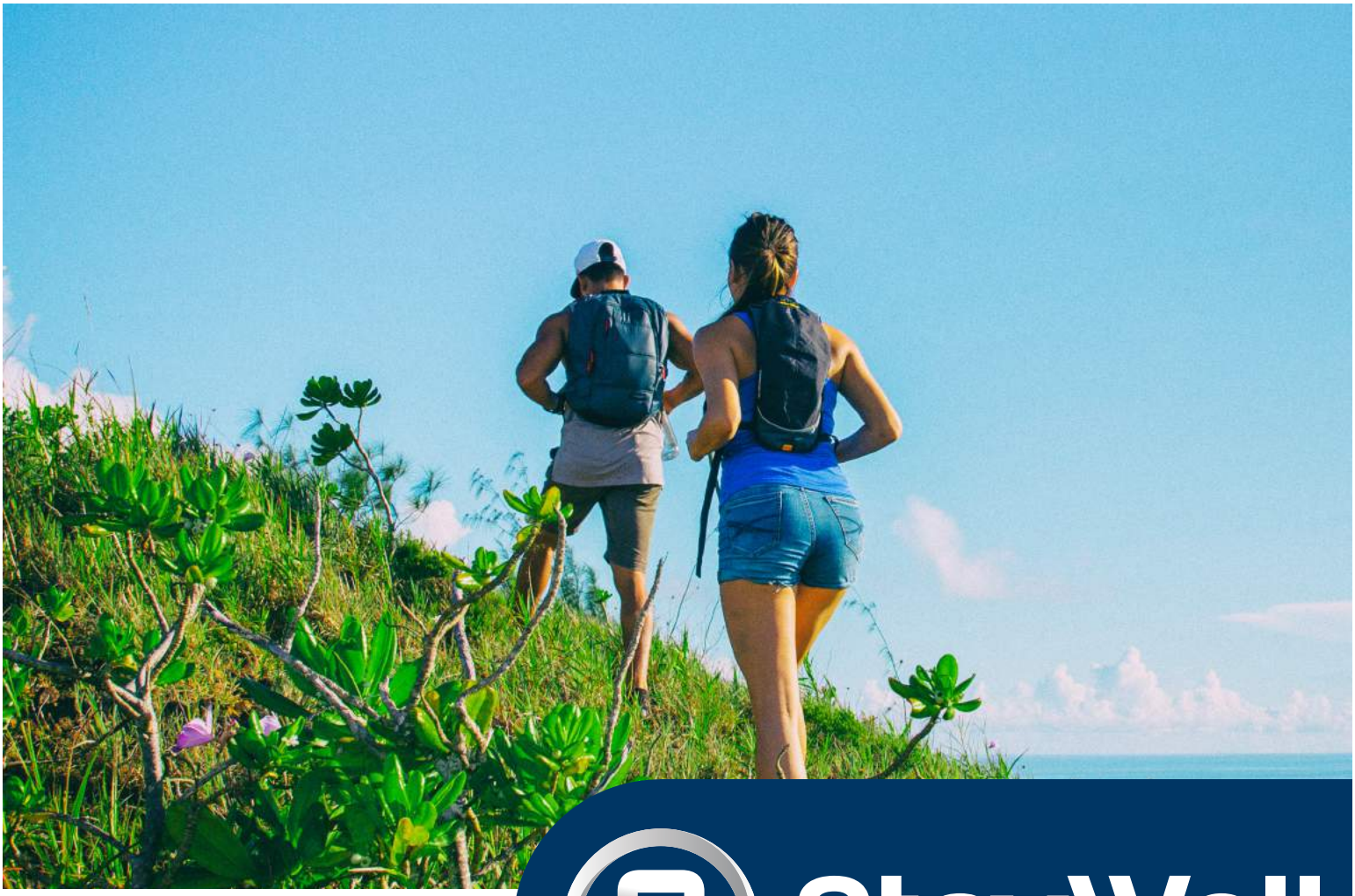


See how far we'll go.

StayWell INSURANCE

Member HANDBOOK

staywellguam.com


WELCOME
to StayWell

STRENGTH and **STABILITY**

StayWell currently serves private business employees and families in Guam and the Commonwealth of the Northern Mariana Islands (CNMI). We are pleased to welcome you to our family of members.

Our company is a long-running business backed by Island Home Insurance Company (IHIC), a locally owned insurance company. IHIC is reinsured by Sirius America Insurance Company (Sirius America), a U.S.-based insurer and reinsurer focused primarily on Property and Accident & Health coverages.

This handbook explains all the benefits of being a member. It can also be your quick reference guide to frequently asked questions. We encourage you to contact our Customer Care Department for further advice on your specific health plan, changes or addendums. You may visit our website at www.staywellguam.com for soft copies of our Member Handbook, Notice of Privacy Policy (NPP), Claim forms, Enrollment forms, and Health Management information. You may also register on the StayWell Access web portal to view your current coverage and benefits, member ID, and processed claims.

As a StayWell subscriber, you will also have access to the following benefits at no additional cost:

- Group Fitness Classes at facilities on Guam
- Health Risk Assessment
- Nutrition Education
- Online Health Activity Tracker
- Healthy Living Guidelines Streaming Videos

Once again, welcome and thank you for taking this journey towards better health care and customer satisfaction with StayWell Insurance.

See how far we'll go.

CONTENTS

MEMBER **RIGHTS and RESPONSIBILITIES**

Member's Rights

As a valued StayWell Member, you have the right to:

- Be treated with respect, consideration, and dignity regardless of race, religion, national origin, gender, cultural background, educational or economic status, age, sexual orientation, type of illness, or mental or physical disability.
- Privacy and confidentiality of health information. Member disclosures and records are treated confidentially. Members are given the opportunity to approve or refuse the release of records except when required by law.
- Receive information about the out-of-pocket share and fees you must pay.
- Receive information about your plan benefits, coverage, limitations, and exclusions.
- Be advised by a health care professional on how to schedule appointments and get health care during and after office hours, and for emergent care. This includes continuity of care.
- Obtain medically necessary emergency and urgent care.
- Know your access to out of area care and covered services, as applicable.
- Access the network for primary and specialty care, including behavioral/mental health care.
- Select and change providers within your plan's network. Refer to the provider directory for a list of all participating providers.
- Know the names, credentials, and qualifications of healthcare professionals providing your health treatment.
- Talk about appropriate or medically necessary care options, regardless of cost or coverage.
- Be informed if a healthcare professional plans to use an experimental treatment or procedure. You have the right to refuse to participate in research projects.
- Complete an advance directive, living will, or other directive, and to place that directive in your medical record.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Receive complete information concerning your evaluation, diagnosis, treatment, and prognosis.
- Receive interpretive services, as necessary.
- File complaints or grievances about the plan, your provider, or care you receive.
- File an Appeal for reconsideration of an Adverse Determination of a health service request or benefit.
- Have any questions or concerns about your rights and protections answered by us.

Member's Responsibilities

As a valued StayWell Member, you are responsible to:

- Treat all healthcare providers, staff, and others with respect.
- Provide an accurate health history, including information about medications and over-the-counter products, dietary supplements, and allergies or sensitivities.
- Follow the treatment plan prescribed by your provider and to participate in your care.
- Inform your provider about any living will, medical power of attorney, or other directive that could affect your care.
- Accept personal financial responsibility for any charges not covered by insurance, if applicable.
- Be familiar with your coverage. Pay your premiums and any copayments, coinsurance, and deductibles you may owe.

BENEFITS
of the STAYWELL PLAN

- **COMPREHENSIVE** medical and dental Benefits, including preventive care
- **FREEDOM** to choose any medical and dental care provider
- **HEALTH MANAGEMENT PROGRAM** that includes wellness, fitness and disease management
- **DEDICATED** Customer Care
- **EXCELLENT** StayWell service
- **UNLIMITED** Lifetime Coverage
- **100% COVERAGE** after Annual Out of Pocket Maximum is met
- **100% COVERAGE** for inpatient care at the Centers of Excellence
- **100% COVERAGE** for formulary prescription by mail for maintenance medications
- **100% COVERAGE** for preventive health services
- **AIRFARE BENEFITS** available when qualifications are met

ACCESSING STAYWELL CARE

PREFERRED PROVIDER ORGANIZATION

As a Preferred Provider Organization (PPO), the StayWell Plan allows you to choose any hospital, physician, or other healthcare provider you wish. However, when you use a hospital/facility or provider who is part of the StayWell PPO network, your claims will be processed based on specifically negotiated reduced rates. These rates mean out-of-pocket savings to you because your cost is based on lower fees. Your Coinsurance and Copayment for services rendered at a Participating Provider is based on Eligible Charges and is accumulated towards the Annual Out of Pocket Maximum. You don't have to choose a particular primary care physician, nor are you required to obtain approval before seeing a specialty care physician. You're also not required to seek a prior authorization if you decide to transfer your primary care services within the StayWell network of providers. Network providers are under contract to provide certain services at reduced rates. Payment for all treatments you receive from network providers are subject to those contracted rates.

ON ISLAND CARE

StayWell has a large local provider network. StayWell contracts with over 95% of Guam and CNMI's physicians, including the staff of Evergreen Health Center, American Medical Center, The Seventh Day Adventist Clinic, IHP, and the Guam Radiology Consultants.

BEHAVIORAL/MENTAL HEALTH ACCESS TO CARE

As a StayWell member, you have access to behavioral/mental health and substance abuse treatment and services. You may access behavioral/mental health care through direct access to the behavioral/mental health provider or through a recommendation from your primary care physician or other treatment providers. StayWell does not require pre-certification for consultations. If therapy is recommended for you, StayWell may require prior authorization. Please refer to the pre-certification process section of this handbook for further detail.

URGENT CARE – AFTER HOURS

For information on where to seek after-hours care, you may view StayWell's Provider Directory. You can also call your provider for information on receiving after-hours care. Urgent Care (After Hours) is needed when you have a health problem that requires attention right away, but your life is not in danger. Urgent Care is not

Emergency Care. It is usually not life-threatening, yet you cannot wait for a visit to your Primary Care Physician (PCP). Some examples of Urgent Care include:

- A child with an earache who wakes up in the middle of the night,
- A sore throat,
- A sprained ankle, or,
- A bad splinter you cannot remove.

EMERGENCY CARE

An emergency is when you have a medical condition with symptoms severe enough that the lack of immediate medical attention could result in serious danger to your health, or, in the case of a pregnant woman, the health of her unborn child. If you think you have an emergency, call 911 or go to the nearest hospital. You do not need a doctor's approval. Services will be covered. Some examples of Emergency Care include:

- A broken bone,
- Bleeding that will not stop,
- Severe chest pain,
- Drug overdose,
- Trouble breathing,
- A gun wound,
- Poisoning, or,
- You are pregnant, in labor, and/or bleeding

BEHAVIORAL/MENTAL HEALTH EMERGENCY

You should call 911 if you or your dependent is having a life-threatening behavioral/mental health emergency or go to the nearest hospital. As a StayWell member, you have access to behavioral/mental health services and do not have to wait for an emergency to get help. Call StayWell's Utilization Management department for someone to help you or your dependent obtain services for depression, behavioral/mental illness, substance abuse, or emotional questions. Some examples of behavioral/mental health emergencies include:

- Acting on a suicide threat,
- Homicidal or threatening behavior,
- Self-injury needing immediate medical attention,
- Severe impairment by drugs or alcohol, or
- Highly erratic or unusual behavior that indicates very unpredictable behavior

PROVIDER APPOINTMENT AVAILABILITY STANDARDS

StayWell Insurance has appointment availability standards for primary care providers (PCPs) and specialists. The requirements apply to routine, urgent, and after-hours care. These standards will help ensure you receive timely access to care.

Medical Care Appointment Type	Standard
Emergencies	Immediate
Urgent Care	24 hours
Routine Symptomatic Cases	Within 1 week or 5 business days
Routine Non-Symptomatic Cases	As soon as possible but no longer than 30 days
After-Hours	24 hours/7 days a week
Behavioral Health Appointment Type	**Standard**
Life-Threatening Emergency Care	24 hours/7 days a week
Non-Life-Threatening Emergency Care	Within 6 hours
Urgent Care	Within 48 hours
Routine Care	Within 10 business days

PHARMACY/MEDICATION

To help manage the increasing costs of prescription drugs, StayWell has secured the services of Medimpact Healthcare Systems, Inc., a pharmacy benefit manager (PBM) based in San Diego, California. Together, we aim to provide you with high quality of care. Medimpact's pharmacy network provides flexibility in receiving prescriptions within the following channels:

Retail Pharmacy

Medimpact's participating pharmacy network includes more than 64,000 participating pharmacies, including regional and national chains as well as independent community pharmacies. The Choice 30 benefit allows you to obtain a 30-day supply of covered medication. The Choice 90 pharmacy benefit will allow you to obtain a 90-day supply of formulary maintenance medications through local and nationwide retail stores at a reduced out-of-pocket expense.

Specialty Pharmacy

Your Specialty Pharmacy is Medimpact Direct Specialty. Our specialty pharmacies were carefully chosen to provide you with convenient delivery and personalized service. The Specialty program supports members with complex health conditions who need injectable medications,

MEDIMPACT'S online tools allow you to:

- Order new prescriptions or transfer from retail pharmacy
- Refill mail-order drugs or renew expired mail prescriptions
- Review estimated copay amount, last order status, and date for next refill
- Get reminders and alerts via phonecall, email or two-way text
- View and sort your list of mail-order drugs
- Manage account information
- Make payments

medications with strict compliance requirements, or who have special storage needs.

Mail Order Pharmacy

You can obtain a 90-day supply for ongoing formulary maintenance medication(s)– prescriptions you take on a regular basis to manage conditions like arthritis, high blood pressure, asthma, diabetes, or high cholesterol– through the mail order program with Medimpact Direct. With mail-order, you can have your prescriptions delivered right to your home and coinsurance/copayment is waived.

Set up new maintenance mail order prescriptions:

1. From your doctor

Your doctor directly submits your prescription electronically or faxes your prescription to: 1-888-783-1773. Medimpact can only accept faxes from doctors, not patients. Once your prescription is received, you will be contacted to confirm details. Medimpact will not ship until you confirm that you want the medication(s).

2. Mail your prescriptions

Mail your prescription(s) to Medimpact with a completed Medimpact Direct Mail Order Form. Please enclose payment details with your order.

- Download a mail order form in PDF format which is available at www.medimpact.com.
- Send your order form to Medimpact Direct at PO Box 51580 Phoenix, AZ 85076-1580.

3. Sign in to website

Sign in to www.medimpact.com or their mobile app and choose "Request a Prescription" on the "My Prescriptions" page and follow the instructions.

Once your new prescription is processed, track orders at www.medimpact.com or on their mobile app.

For prescription refills:

1. Order by phone

Call the Toll-Free number (855) 873-8739 for Medimpact's refill phone service or to speak to a representative.

- For refills please be ready to provide your prescription refill number(s), cardholder ID, year of birth, and your Visa, Discover, or MasterCard for payment.

2. Order online

Register for online account access with your member identification number from your member ID card, first name, last name and date of birth. Once logged in, select the prescription you need to have refilled, your payment method and your preferred shipping address.

OFF ISLAND CARE - CENTERS OF EXCELLENCE

StayWell's extensive off island network of providers includes outstanding medical facilities located in California and the Philippines.

The Centers of Excellence (COE) are chosen for their outstanding facilities, services and regional location. These Centers offer significantly discounted rates to StayWell members. In cases of inpatient care, members are covered at 100% of Eligible Charges, subject to Benefit maximums.

When you require off island treatment you may be eligible for round-trip airfare if the following criteria are met:

- StayWell is your primary insurance carrier
- You have been a StayWell member for at least six consecutive months
- You obtain a written pre-certification from StayWell
- You have a catastrophic illness that requires any of these medical procedures: open heart surgery, angioplasty, cardiac catheterization, endarterectomy, oncology

surgery, aneurysmectomy, pneumonectomy, intracranial surgery, treatment for acute leukemia, gamma knife, or NICU Level III care

- Service is scheduled to be provided at a Center of Excellence

Round-trip commercial tickets to the Center of Excellence are purchased at the lowest economy fare available inclusive of medical discounts. Coverage of airfare is subject to review by StayWell and will depend on the submission of required documents (e.g. operative report, boarding pass, proof of purchase). Proactive airfare coverage may be granted only if there is a written request from a COE physician that a qualifying procedure will be performed. An off island referral does not guarantee airfare coverage.

In the event you purchase the seat(s), StayWell may reimburse no more than what it would have paid had it purchased the seat(s) in advance. In no event will StayWell reimburse for any seat(s) purchased with frequent flyer miles.

UTILIZATION MANAGEMENT– INFORMED CHOICE PROGRAM

StayWell's Utilization Management-Informed Choice (UM-IC) Program helps you secure excellent medical care, both on island and offisland, for the least out-of-pocket expense. The program's staff are medical service specialists knowledgeable about StayWell's pre-certification procedures and off island coverage.

Without compromising the confidentiality of your medical condition, the Customer Care staff can assist you in making appropriate choices about health care such as:

- Allowable Benefits – the tests, supplies & treatment options covered by StayWell
- Participating Providers – the doctors, laboratories, pharmacies, and other health care providers in the StayWell network
- Centers of Excellence – the off island hospitals and ambulatory surgicenters affiliated with StayWell
- Ways to Save Money – advice on how the health care choices you make can reduce your out-of-pocket expenses

Whether it is on island or offisland, StayWell requires that you obtain a written pre-certification from the UM-IC Program specialists before receiving care.

In an emergency, pre-certification is not required before receiving care.

When accessing care, please note StayWell's policy regarding medical necessity for treatment and care. To keep medical costs at an affordable level, StayWell only pays for Services that are Medically Necessary, as defined in the Plan Contract. Cases that are Medically Necessary require the most appropriate and economical use of services and facilities. The overuse or unnecessary use of costly or ineffective medical services is discouraged and will not be paid.

The fact that a doctor may prescribe, order, recommend or approve a service or supply does not in itself make it Medically Necessary or make the charge an allowable expense. Should medical necessity be unclear, StayWell's medical coordinators will evaluate the case, based on available information, before particular services are performed.

Referral Process

The Primary Care Physician (PCP) initiates referrals to specialty or sub-specialty services as they deem necessary. Depending on the specialty clinic's protocol, a referral may or may not be required from the PCP prior to a consultation. StayWell does not require pre-certification or prior approval for consultation with on-island participating specialists and emergency room services as well as consultation for a second opinion.

Out of Network Referrals

If a PCP refers a member to an out-of-network specialist, he/she must secure a pre-certification of eligibility and a prior authorization for the contemplated services. Coverage will be based on the non-participating benefit, which means higher out of pocket expense for the member. Your coinsurance at a Non-Participating Provider does not accumulate towards your annual out-of-pocket maximum.

Pre-certification Process

Pre-certification is a formal process where a provider obtains eligibility information and prior authorization or approval from StayWell's UM-IC Department before performing a certain treatment or providing covered services such as:

- Hospital Admissions
- Ambulatory procedures
- Surgery center procedures
- Certain outpatient office procedures
- Diagnostic Imaging procedures
- Home Health Care
- Hospice Care
- Durable Medical Equipment
- Certain Medications

The UM-IC Department reviews and prior authorizes physician's orders based on eligibility, plan benefit coverage, and medical necessity. The UM-IC Department follows nationally recognized standard guidelines in making

In accordance with ERISA, StayWell follows the following timeframes for UM determinations:

Review Type	Standard Timeframe of Notification
Urgent pre-service	72 hours
Non-urgent/routine pre-services	15 days
Concurrent review	24 hours
Post-service review	30 days

clinical determinations. Any adverse determination for medical necessity is reviewed by a health professional with training relevant to the request. These guidelines are available to the member and to the providers upon request.

A complete Pre-certification request can be faxed to the UM-IC Department at (671) 477-2464. For immediate processing, the requesting provider must complete the following:

- Accomplished StayWell's Pre-certification form
- ICD10 and CPT codes with description
- Complete pertinent medical records to support the request

Emergent cases do not require prior authorization. Payment of claims for services rendered as Emergent is subject to review according to StayWell's health plan benefits, member eligibility, exclusions, and medical necessity at the time the services are rendered.

The absence of a prior authorization may result in denial of claims.

TIPS FOR OFF ISLAND CARE

- Before your departure, you or your authorized representative may call or visit the Customer Care Department at the StayWell office to coordinate your off island care and pick up your pre-certification.
- Hand carry your StayWell pre-certification.
- Hand carry all imaging films, pathology slides/ specimens, medical records and referral papers to doctors appointments.
- If you are unable to make it to a scheduled appointment, notify the doctor's office for cancellation and re-scheduling. Otherwise, you may be charged a no-show fee.
- If you will be out of the Service Area for more than 60 accumulative days, submit a request for extension of benefits outside the Service Area, together with the treatment plan of your doctor, to StayWell's Customer Care Department prior to the 60th day.
- When you return to Guam, bring back all materials that will help facilitate continuity of care.
- Call the StayWell toll free number at **1-866-782-9955** or email **offislandreferral@staywellguam.com**, if you have questions regarding your coverage.

THE STAYWELL NETWORK

SAVES YOU MONEY!

It's good to discover ways you can cut the cost of your health care without reducing the quality of care. Here's an easy way you can do just that.

You will save money simply by using StayWell's Network of Participating Providers. StayWell's network includes doctors, dentists, chiropractors, mental health professionals, hospitals, pharmacies, laboratories, optical firms, private home health care agencies and other medical facilities, in the Service Area and outside the Service Area, which have agreed to provide services to StayWell members at substantially reduced rates.

The overall cost of your health care is much less when you go to a provider INSIDE the network than when you go OUTSIDE the network. As a result, your out-of-pocket expenses are greatly reduced. In some cases, your Coinsurance/ Copayment is waived altogether, and you pay nothing! However, if you choose to go OUTSIDE the network for care, you pay much more for Coinsurance/Copayment for service.

TRAVEL ALLOWANCE

StayWell members enrolled in certain plans are eligible for a one-time reimbursement of up to **$500** when traveling roundtrip from member's place of residence (Guam or Saipan) to Centers of Excellence in the Philippines for specific procedures. Below are the terms and conditions of StayWell's Travel Allowance benefit for members:

a. StayWell members may utilize their annual Travel Allowance benefit for the following qualified procedures after pre-certification has been issued:
   - Arthroscopy
   - Cataract Extraction
   - Cholecystectomy (Open/ Endoscopic)
   - Colonoscopy
   - Cystoscopy/Cystoure-throscopy
   - Esoagogastroduodenos-copy (EGD)
   - Extracorporeal Shock Wave Lithotripsy (ESWL)
   - Transurethral Resection of Prostate (TURP)

b. Members are eligible for one (1) roundtrip Travel Allowance benefit per year.

c. The Travel Allowance benefit is paid via reimbursement to the member for eligible charges upon submission of original, official receipts and documentation as listed below:
   - Airfare Receipt (lowest economy-class, direct roundtrip to Centers of Excellence in the Philippines from your place of residence)
   - Airline Boarding Passes (to and from COE in the Philippines)
   - Official Hotel Receipt

   i. All official receipts and documents must have claimant's name and must be submitted within 30 days of date of return to place of residence.

   ii. Reimbursement up to $500 for airfare/lodging

   iii. No reimbursement will be made for use of airline mileage and/or for complimentary lodging

   iv. Reimbursement for lodging up to 5 days maximum.

   v. Reimbursement for travel allowance will follow existing Paid to Claimant reimbursement process.

d. Eligibility for the Travel Allowance benefit will be based on current airfare benefit criteria (with the exception of qualifying conditions) and are as follows:
   - StayWell must be the Primary Insurance Carrier
   - Patient must be a StayWell member for 6 consecutive months
   - Procedure must be done at a StayWell Philippine Centers of Excellence
   - Precertification must be issued prior to travel.
   - Member must be going to a StayWell Philippine Center of Excellence for specific conditions as noted in section a.

e. Members may avail of either their Travel Allowance or existing airfare benefit within the same year provided all qualifying conditions are met.

f. In the event that member will be traveling to Philippine COE for two (2) different qualifying conditions (i.e. heart surgery and colonoscopy), only one (1) benefit (either airfare or travel allowance) will be paid.

STAYWELL ACCESS WEB PORTAL

StayWell Access is an online web portal that gives members the ability to access coverage, benefits and claims information online 24-hours a day, 7-days a week.

Members can view the following:

- ID card
- Current coverage and benefits
- Processed health claims
- Deductible and coinsurance/ copayment
- Prior authorization requests
- Forms

Follow these instructions to connect to StayWell Access:

1. Visit www.staywellguam.com
2. Click on ACCESS at the top of the page
3. Select Member
4. Click on Register Account
5. Read the License Agreement
6. Select Accept and click Next
7. Enter required information and follow instructions to create login

HEALTH **MANAGEMENT PROGRAM**

StayWell Insurance is proud to offer our EnjoyLife Program, an exclusive Health Management Program. EnjoyLife delivers a comprehensive, proactive and integrated approach to help StayWell members to manage their well-being and improve health outcomes. Our exclusive program is categorized into three key components of wellness, fitness, and chronic disease management. Each component is designed to help members get healthy, stay healthy and ultimately enjoy life! Services offered in each program component are provided by our staff and partners who have acquired the appropriate credentials, education, training, skills, and continuing education necessary to oversee program administration and specific responsibilities within their role of the program. Each component takes into consideration the medical, psychological, social, cultural and occupational needs of StayWell's member population. To ensure and improve program efficacy outcomes are measured and assessed through a collaboration of program staff and partners. Below are the detailed descriptions of each program component and how each is administered.

WELLNESS

Health Risk Assessment

A Health Risk Assessment (or HRA) is a yearly screening tool for identifying an individual's lifestyle behavior risk through a personal health survey with questions based on demographics, biometric and physical health information, exercise and nutrition patterns, conditions of personal risk, stress and mental status, tobacco and alcohol use, productivity, and readiness to change. Any personal health data collected is protected under federal law (Health Insurance Portability and Accountability Act). An individual report is generated at the completion of the assessment, which summarizes the member's overall health and risk levels for specific risk factors to help the member identify areas for possible improvement, specific interventions, and programs that will help meet their individual needs. Group reporting features are also available to help employers address the needs of their workforce. Members 18 years old and older are eligible to complete the online HRA.

Secured login information is distributed upon request through the subscriber's respective Human Resources Department, or they may call our Health Management Department at (671) 477-5091 ext. 1185 to obtain login information. Members who do not have access to the internet, computer, smart phone or device can make an appointment to complete the

online HRA at our office during business hours. Our staff can assist them with registering online for the EnjoyLife web portal.

Worksite Health Screening

Worksite health screening may be arranged upon request by the employer/group and may be scheduled in advance for the policy year. During worksite health screenings, members may receive a number of screening tests, such as Body Mass Index (BMI), blood pressure, and blood glucose tests, which are proven to be effective in the early detection of certain illnesses allowing for early intervention to make a real and measurable impact. Members will also have the opportunity to consult with a health coach and/or nurse to discuss their screening test results, address any questions or concerns the member might have, and help the member plan the next steps to address the risks or illnesses identified in their results. A "Health Screening Record" is issued to members which logs the tests measured during the screening. A follow-up letter is sent to inform members of their screening results and any recommendation or suggestions for areas that need improvement or are considered high risk. With the approval of the member, a copy of member screening results and the follow-up letter are sent to the member's primary care physician or provider. An aggregated report of the member's screening results is provided to their Human Resources Department for the purpose of offering specific recommendations to address the group's health needs and concerns.

Worksite Flu Vaccination Clinic

Worksite flu vaccination clinics may be arranged upon request by the employer group and may be scheduled in advance for the policy year. Together with their Wellness Partners, StayWell will coordinate each group to administer annual flu vaccines at no cost to eligible members, all within the convenience of their worksite. Influenza is a serious disease that can have fatal consequences with the "flu season" beginning as early as October and lasting as late as May, in the U.S.

Nutrition Education

StayWell Members have access to nutrition education and this is provided to our members through the following methods:

a. At a worksite, this is usually done as a 'Lunch-and-Learn' activity. StayWell invites a Clinical Nutritionist, Dietitian or medical professional to provide a 15- to 20-minute lecture focused on healthy eating habits, nutritional guidance, or specific talks on nutrition programming on certain conditions such as diabetes, hypertension, gout, etc. StayWell provides free healthy lunch to participants of this activity, subject to approval by the governing agency.

b. Counseling, whether individual or as a group, through appointment with one of our preferred providers and wellness centers.

c. Informational materials through the EnjoyLife web portal (online) or by request to our office. To request a lunch-and-learn or for more information on counseling, or our EnjoyLife web portal you may contact our office at (671) 477-5091 ext. 1185.

Wellness Programs

StayWell members have access to several health and wellness programs through our Wellness Partners at Guam Seventh-day Adventist Clinic (SDA) and Dr. Horinouchi Wellness Clinic.

SDA 7 Day Wellness Programs

The 7 Day Shape Up program is an introductory program designed to help members implement healthy dietary intake and lifestyle habits. The program addresses chronic conditions including, but not limited to diabetes, hyperlipidemia,

hypertension, obesity, etc. With the Shape Up Program, members will learn the importance of eating a whole food diet and mindful eating. The program also emphasizes healthy eating habits, exercise regimens, sleep hygiene, hydration level, management of blood sugar level for those with diabetes, as well as techniques to improve determination/motivation to practice healthy lifestyle habits. The program consists of a pre- and post-screening, including BMI, weight, height, body fat percentage, body water percentage, muscle mass and waist-to-hip ratio. At the conclusion of the program, participants can expect significant improvements in their weight, fat percentage, BMI, waist circumference, cholesterol levels and blood pressure levels.

The 7 Day Detox program is designed to cleanse the body by focusing on whole, unprocessed foods that help nurture and heal the body, while reducing toxins in the body. By emphasizing the importance of exercise regimens, sleep hygiene, and hydration levels, the program can help with weight loss, lowering, cholesterol levels, and even reverse pre-diabetes. The 7 Day Detox program includes a fresh fruit smoothies, whole food meals, and whole food powder mixes. Recipes and ingredients are provided for the weekend meals, which will be prepared by participants.

The 7 Day Advanced Detox program is a continuation of the 7 Day Detox program, and helps to address chronic conditions including, but not limited to diabetes, hyperlipidemia, hypertension, obesity, etc. The program includes high nutrient density whole food powder mix with powder phytonutrients that will help one to gain their health back, feel great, and look astounding. The powders provided for this program are compact with nutrients from fresh fruits and vegetables to help the body's health on a cellular level. The 7 Day Advanced Detox program is not an all-liquid diet and participants will be able to have unlimited fruits and vegetables during the program.

The 7 Day Advanced Detox has helped participants improve their energy levels, lower the use of or eliminate maintenance medications, and improve their sleeping patterns. The program also emphasizes healthy exercise regimens, sleep hygiene, and hydration levels.

The NEWSTART Program is a 2-week comprehensive course that has been meticulously designed, critically evaluated, and is continuously improved to help reverse chronic diseases, such as diabetes, high blood pressure, gout, obesity, chronic fatigue, hormonal imbalance, osteoporosis, food allergies, thyroid problems, arthritis, or inflammation. During the program, participants will learn about healthy lifestyle habits. The two-week long course emphasizes healthy exercise regimens, sleep hygiene, and hydration levels. The NEWSTART program includes meals, cooking demonstrations, group workout sessions, discussions, and so much more.

The Stress Management program focuses on education and provides members with tools necessary to manage symptoms of stress and daily stressors. Participants will be focused on developing permanent coping skills to reduce stress, health related problems, and improve their overall lifestyle.

The Stop-Smoking program is available to all StayWell members who are current smokers and wish to quit. The program is conducted over five, two-hour sessions and lead by a medical physician with support staff certified in smoking and tobacco smoking cessation strategy, and guiding participants to strengthen their motivation to change. The program focuses on physical effects and psychological issues of smoking and utilizes natural solutions to help participants understand the effects of tobacco use. Participants learn skills and techniques to help them on their path to a smoke free lifestyle. The Stop-Smoking program is covered at 100% of eligible charges. Members can enroll in the program by calling the Wellness Partners at SDA ((671)-648-2533) and Dr. Horinouchi Wellness Clinic ((671)-646-9333).

Dr. Horinouchi Wellness Clinic

2-Week Genesis Detox Program is health oriented, not disease oriented. Members enrolled in the program will have the opportunity to consult with the clinical nutritionist for an individualized approach to identify and address the member's deficiencies and imbalances. The program includes a 2-week meal plan, 2-week supplementation to improve liver function, detoxification and digestion health, weekly follow-up assessments (blood sugar, blood pressure, weight and body composition), and an Ionic Detox Footbath. For more information or to register for the program members can call the Wellness Partners at Dr. Horinouchi Wellness Clinic ((671)-646-9333).

Smoking Cessation counseling is available to all StayWell members who are current smokers with a desire to make better lifestyle choices by quitting smoking. Smoking cessation counseling sessions are patient-centered with an individualized approach. Members will work with Dr. Horinouchi to identify their deficiencies and imbalances, to address their individual needs, and

overcome their smoking habit. Members can schedule their individual smoking cessation counseling sessions by calling the Wellness Partners at Dr. Horinouchi Wellness Clinic ((671)-646-9333).

Wellness Classes and Workshops

Members are able to join Dr. Horinouchi Wellness Clinic for free wellness and nutrition sessions. Topics will vary within each workshop and may include digestive health, detoxification and heavy metals, hormone balance, childhood development, healthy sleep, men's and women's health, and much more. For more information or to register for the classes members can call the Wellness Partners at Dr. Horinouchi Wellness Clinic ((671)-646-9333).

Cholesterol and Hormone Deficiency Management Class
Today, cholesterol-lowering drugs are the most commonly prescribed medications in the United States. Cholesterol is the precursor or the building block for the basic hormones: pregnenolone, DHEA, progesterone, estrogen, testosterone. Join Dr. Horinouchi and discover the latest research on nutrition and cholesterol management with supplemental support.

Metabolic Syndrome and Insulin Resistance Management Class
Insulin, not cholesterol, is the true culprit in heart disease. Metabolic syndrome is the medical term for a combination of diabetes, high blood pressure and obesity. It is also linked to a condition called insulin resistance. Insulin is a hormone that helps the body control the level of sugar, or glucose in the blood. Metabolic syndrome increases the risk of cardiovascular disease, diabetes, stroke and coronary artery disease. Join Dr. Horinouchi to learn more about how to control your insulin level.

Stress & Emotional Health Management Class
Stress, whether physical, emotional, environmental or mental, can impact the quality of our lives. Join Dr. Horinouchi and discover the latest research on nutrition and stress management with supplemental support.

Addiction & Brain Health Management Class
Addictions come in many different forms, such as food cravings, chemical dependency and even some types of compulsive behaviors. Sugar and junk food, nicotine and alcohol abuse can cause nutrition deficiencies and trigger imbalance in hormones, pain, anxiety and depression. High potency supplements and a healthy diet can support overall wellness without side effects. Join Dr. Horinouchi and discover the latest research on nutrition and addictions and brain health management with supplemental support.

Online Wellness

StayWell members have access to several online tools to help them reach their health goals. Currently, StayWell offers the following:

Online Health Activity Tracker, available through the EnjoyLife web portal, is an online tool that allows members to stay on track with their health activity. Each health practice or activity has a corresponding point value that corresponds to their importance in leading a healthier lifestyle, allowing members to properly appraise their health activities and reach their health goals. The activities are categorized into: key health practices, health events, health challenges, self-study projects, and other wellness goals.

The Healthy Living Guidelines™
Streaming Video, is a 90-minute online video divided into 12 brief and educational chapters that provides vital information to guide members in understanding their major health risks, and presents useful advice on how to improve their health and set achievable goals. The videos can be viewed at the member's pace in the convenience of their home, or it can also be a topic for discussion in a Lunch-and-Learn activity. All videos require an Adobe Flash Player to view.

Wellness News and Health Educations Materials

StayWell provides to our members monthly wellness and health education materials including:

WellNotes™ is a monthly newsletter that features current health topics and recommendations for living a healthy lifestyle. It is available online through our website, or in print through our office. Other health education materials such as Monthly Health Challenge™ and Ask the Wellness Doctor™ are also available to our members online, in paper format, via electronic mail, and at StayWell Health Management events and activities.

Health Observances are a month-to-month health awareness campaign to educate members about health risks and to provide information on different health topics. Communications are sent out to members via electronic mail and advertisement of our participation in local and national events like Guam Cancer Care, Strides for the Cure, or Relay for Life.

Patient-Centered Education allows StayWell's health management team to empower our members with the right information in becoming the most informed health consumer. StayWell believes that patients who are informed, engaged, and equipped with the tools to take care of their health utilize the healthcare system more

appropriately. Members may request for an electronic or printed copy of available health education sheets, by contacting the Health Management Department by phone at (671) 477-5091 ext. 1185 or by e-mailing enjoylife@staywellguam.com.

EnjoyLife Rewards Program

The EnjoyLife Rewards Program is offered to certain group health plans as an added benefit. This wellness incentive program aims to inspire members to adopt healthy behaviors and take proactive steps in maintaining and improving their health. Eligible members must be at least 18 years or older at the start of their policy year with the EnjoyLife Reward Program under their health plan, enrolled in the health plan for 12-months of continuous coverage within the reward period of the policy year. Members must complete one or more of the following:

- Annual completion of the online HRA
- Preventive health services for age and gender, as recommended by the United States Preventive Services Task Force (USPSTF) guidelines:
  - Annual physical exam
  - Screening mammogram and clinical breast exam for breast cancer
  - Cervical cancer screening with Pap Smear
  - Colorectal cancer screening
  - Osteoporosis screening
  - Screening for lipid profile disorders
- Diabetes care (i.e., hemoglobin A1c, urine microalbumin test, retinal eye exam, foot exam, fasting lipid profile)
- Completion of dental prophylaxis/cleaning services
- Completion of two StayWell-approved health education classes
- Participation in monthly gym/fitness activities

Community Resources

StayWell members are provided information on resources, treatment options and local community–based programs that are focused on alcohol and substance abuse and violence prevention.

24 Hour Hotline	
Guam Alternative Lifestyles Association (GALA) 24-hour Crisis Helpline	Phone: (671) 969-5483
Guam Crisis Helpline	Phone: (671) 647-8833
National Suicide Prevention Lifeline	Phone: 1 (800)–273-TALK (8255)

Community Organizations	
American Cancer Society	250 Route 4 Suite 204 Nanbo Guahan Bldg. Hagåtña, GU 96913 Phone: (671) 477-9451
Catholic Social Services	234A US Army Juan G. Fejer-an Street Barrigada, GU 96913 Phone: (671) 635-1442 www.catholicsocialserviceguam.org
Guam Cancer Care	341 S. Marine Corps Drive RK Plaza Suite 102 Tamuning, GU 96913 Phone: (671) 969-3222
Guam Diabetes Association	220 T. Stanaka Bldg. Suite 100, 4 Hagåtña, GU 96913 Phone: (671) 671-477-7776
Guam Diabetes Control Coalition	194 Hernan Cortez Avenue Hagåtña, GU 96910 Phone: (671) 735-7265 Fax: (671) 735-7500 c/o: Guam Diabetes Prevention and Control Program (DPHSS) https://m.facebook.com/guamdiabetescoalition/
The Salvation Army Guam Corps	Corten Torres Street Mangilao, GU 96913 Phone: (671) 472-7671 https://hawaii.salvationarmy.org/hawaii/guam

Counseling Services	
Inafa'maolek Inc. Peer Mediation and Conflict Resolution	Phone: (671) 475-1977 Email: inafamaolek@teleguam.net
Isa Psychological Services Center	Office Hours: Monday-Friday 9:00AM-8:00PM Phone: (671) 735-2883 Email: isa@triton.uog.edu www.uog.edu

Emergency Contact Numbers	
In case of an emergency please call 911	
Guam Police Department	Dededo Precinct Phone: (671) 632-9809 / (671) 632-9811 Tumon/Tamuning Precinct Phone: (671) 649-6330 / (671) 647-9660 Agat Precinct Phone: (671) 472-8915 / (671) 472-8916 Central Precinct Phone: (671) 475-8537 / (671) 475-8541

Emergency Departments	
Guam Memorial Hospital Authority (GMHA)	Ward Clerk: (671) 648-7909 / 7910 GMHA Operator: (671) 647-2555
Guam Regional Medical City (GRMC)	Phone: (671) 645-5500

Family Care Giver Support Services	
Get Care	https://www.guamgetcare.org/consumer/explore/caregiver_resources/
Health Services of the Pacific – National Family Caregiver Support Program	809 Chalan Pasaheru Unit 2, Tamuning, GU 96913 Phone: (671) 735-3277 Fax: (671) 734-6477 https://www.hspguam.com/national-family-caregiver-support-program

Guam Behavioral Health and Wellness Center	
790 Governor Carlos G. Camacho Rd. Tamuning, GU 96913 *https://gbhwc.guam.gov*	
Child/Adolescent Services Department (I' Famugu-on' Ta)	J&G Commercial Bldg. Chalan Santo Papa St. Suite 107F Hagåtña, Guam
Clinical Services Department	Phone: (671) 647-5440
Drug and Alcohol Treatment Branch (New Beginnings)	J&G Commercial Bldg. Chalan Santo Papa St. Suite 105F Hagåtña, Guam Phone: (671) 475-5438/40 Fax: (671) 477-7782
Prevention and Training Branch (PEACE)	Phone: (671) 477-9079 thru 9083 Fax: (671) 477-9076
Rape Crisis Center - Healing Hearts	Phone: (671) 647-5351

Guam Department of Public Health and Social Services (DPHSS)		
http://dphss.guam.gov/		
	Bureau of Communicable Disease Control Immunization Program, STD/HIV Prevention Program, Ryan White HIV/AIDS Program, Tuberculosis/Hansen's Disease Control Program	http://dphss.guam.gov/bureau-of-communicable-disease-control/
	Community Health Services Section (CHSS) Guam Diabetes Prevention and Control Program, Tobacco Prevention and Control Program and the Tobacco Quitline, Sexual Violence and Prevention Program, Breast and Cervical Cancer Early Detection Program, Comprehensive Cancer Control Program, Behavioral Risk Factor Surveillance System (BRFSS), and The Non-Communicable Disease Control Program	http://dphss.guam.gov/dph/communityhealthservices/
	Division of Senior Citizens Adult Protective Services, Congregate Meals, Home-Delivered Meals, In-Home Services, Transportation Services for Medical and Hemodialysis, Guam Medicare Assistance Program (MAP) and State Health Insurance Assistance Program (SHIP)	https://dphss.guam.gov/division-of-senior-citizens-2/

Sexual Assault Services 24-Hour Access	
Alee Shelter Crisis Support for family violence and sexual assault	Phone: (671) 648-4673
Victim Advocates Reaching Out (VARO)	Phone: (671) 477-5552
Substance Abuse Services	
Family Services Center	Phone: (671) 477-3528/9
Oasis Empowerment Center	Phone: (671) 646-4601
Salvation Army LIFEHOUSE Recovery Center for Men	Phone: (671) 477-7671 Fax: (671) 477-4649
Tobacco Use Services	
Tobacco Prevention and Control Program - Guam Department of Public Health and Social Services (DPHSS)	Phone: (671) 735-7303 Quit Line: 1-800-QUIT-NOW (1-800-784-8669) www.quitnow.net/guam
Youth-Serving Programs	
Island Girl Power Positive activities for young girls and their families	Phone: (671) 989-1602/3/4 (671) 688-4752
Sanctuary, Inc. Outreach Crisis Intervention for Youth	Phone: (671) 475-7100
Youth for Your Live! Guam Youth helping youth through empowerment and leadership	Phone: (671) 487-0523 Email: yfyliveguam@gmail.com www.yfyliveguam.org

FITNESS

The Physical Activity Guidelines for Americans recommends two types of health-enhancing physical activity: aerobic (cardiovascular) and muscle-strengthening. For significant health benefits, adults (age 18–64) should do any equivalent mix of moderate and vigorous intensity aerobic activity AND muscle-strengthening activities on 2 or more days a week that work all major muscle groups. To meet the recommended physical activity guidelines, StayWell has partnered with the following fitness centers to offer fitness classes to all StayWell members (both subscribers and dependents) at no charge:

- International Sports Center, located in Hagåtña next to KFC
- The Pound Academy, located in Dededo and offering classes at Hyatt Regency Guam
- Urban Dance Studio, located in Maite

To register for these classes, members are required to fill out a one-time registration form and provide a copy of their health insurance card with a valid picture ID on their first visit to the fitness facility of their choosing.

Members are able to enjoy a wide variety of exercise classes that provide different levels of health-enhancing physical activity, with an equivalent mix of light, moderate, or vigorous intensity moves. Whether you opt for cardiovascular (aerobic) training, muscle-strengthening, or flexibility and resistance training, these classes are facilitated by certified instructors that will surely help you improve your health. Certified fitness trainers are also available to provide assistance to individuals with physical and mental impairments.

StayWell's Fitness Class Calendar is updated monthly and can be found online on our website, or in print at our office. Please call our Health Management Department at (671) 477-5091 ext. 1185 or email at enjoylife@staywellguam.com to obtain a copy of this month's fitness schedule.

CHRONIC DISEASE MANAGEMENT

StayWell's Medical Care Management Department, through its Utilization Management–Informed Choice (UM–IC) department, provides a variety of programs that oversees the different populations with specific conditions, whether acute or chronic.

StayWell's Disease Management Program for Coronary Artery Disease (CAD) is designed to identify members with CAD. Following the American College of Cardiology and the American Heart Association Practice Guidelines, the program will assist in educating members about CAD by emphasizing the importance of proper self-management of their chronic condition and regular care. The components of the program include: condition monitoring and reporting, patient adherence, consideration of other health conditions and lifestyle issues, and intervention strategies. The components of the program include: condition monitoring and reporting, and intervention strategies. To ensure and improve program efficacy, outcomes are measured and assessed through a collaboration of program staff and partners.

StayWell's Disease Management Program for Diabetes is designed to identify members with type 1, type 2, and gestational diabetes. The program will assist in education of these members and emphasize the importance of proper self-management of their disease and regular care. It also aims to provide support tools and resources to reduce diabetes-related complications and morbidities. The components of the program include: condition monitoring and reporting, patient adherence, consideration of other health conditions and lifestyle issues, intervention strategies and access to Diabetes Self-Management Training (DSMT). To ensure and improve program efficacy, outcomes are measured and assessed through a collaboration of program staff and partners.

The DiaBEAT-It! Living Well with Diabetes Program is the only program accredited by the Diabetes Education Accreditation Program, AADE on Guam. It is a 2-week program that consists of tools to live well with diabetes, such as diabetes reversal/remission, health eating/health coping with follow ups up to 12 months, and much more via the 7 Day Program. A booklet and program information will be given to each participant. The program consists of a pre- and post-screenings including lab work.

The American Medical Center Diabetes Education Program provides Diabetes Self-Management Education in a one-on-one setting with schedules based on the individual's preferences, meeting 12 sessions a year. The Diabetes Education Program provides an introduction to the American Association for the Diabetes Educators 7 self-care behaviors and works with clients to develop SMART goals. Regular education sessions include disease process, nutrition, exercise, blood glucose monitoring, medication, preventing/delaying complications, complication management,

reducing risks, behavioral and lifestyle change and healthy coping. People with diabetes have specific and individual needs and no two clients are alike. Individual education sessions will allow for client's specific concerns and needs to be addressed while maintaining confidentiality and privacy of the client and their information. The client's family and any support members are encouraged to attend all education visits and to be involved in the client's care. Clients will be called by staff members at American Medical Center 2 to 3 days prior to the client's appointment to remind them of their scheduled visits.

The Diabetes Self-Management Education Program at Hardt Eye Clinic & Diabetes Education Center in the CNMI is the only diabetes program to be certified by the American Diabetes Association in any of the United States Pacific Territories. The 12-month program covers seven modules which discuss topics on healthy eating, being active, blood glucose monitoring, taking medications, acute complications, healthy coping, and long-term complications. The program does not end after the seven modules are introduced. Doctors and educators will work with the patient to discuss and develop their Diabetes Self-Management Support strategies during the 10 hours of DSME service to ensure certain sustainability of lifestyle modifications made during the program. There will be three-hour post program follow-up each calendar year afterwards.

Our case managers use a team approach to ensure an effective discharge planning and care coordination for all our members, particularly those with chronic conditions (i.e., CAD, diabetes with complications) and catastrophic illness identified by self-referrals or by referral from their primary care provider. By a team approach, we involve the attending physician, primary care provider if different from admitting physician, hospital staff, social worker, home health care agency, and pharmacy in addressing potential gaps in the systems of care. StayWell UM-IC staff facilitate appropriate and efficient delivery of health care services to these members to better manage their overall health.

COSTS and CLAIMS

ELIGIBLE CHARGES

Services at a Participating Provider are based on Eligible Charges.

When you receive service from a Participating Provider for treatment, that provider will submit your claim to StayWell Insurance. Payment will be made directly less any amounts that you are responsible for (e.g., applicable coinsurance/copayments, expenses above StayWell Insurance Eligible Charges, etc.). Covered services will be paid provided the Provider of services bills StayWell within ninety (90) days after the date in which the service was rendered.

If you receive services from a Non-Participating Provider, StayWell will pay only a percentage of Eligible Charges (see Summary of Coverage for details). The Company has no agreement with Non-Participating Providers and they may charge you more than the Eligible Charge for any Service.

The Eligible Charge for Services by a Non-Participating Provider will be less than for a Participating Provider. You are responsible for paying the specified Coinsurance/ Copayment plus any amount by which the Provider's charge exceeds the Eligible Charge.

HOW TO MAKE A MEDICAL CLAIM

When a Participating Provider treats you, that Provider will submit your claim to our office, unless the Provider agrees to file the claim on your behalf. However, if you should receive treatment from a non-Participating Provider you must pay for the services and then seek reimbursement from StayWell, unless the provider agrees to file claim on your behalf. Request your reimbursement by sending to StayWell Insurance your itemized bill and original receipt within ninety (90) days after the date in which the service was rendered.

When an off island dental provider, outside of the United States treats you, you must request the provider to complete an Off Island Dental Claim form and submit the completed form with an original receipt for reimbursement. You may obtain the form at the StayWell office or at staywellguam.com.

For reimbursement of eligible expenses that you've paid in full, please submit the following documents:

DOCTOR'S SERVICES

- Name of Doctor
- Date of Service
- Diagnosis code (ICD10)
- Procedure code (CPT)
- CMS 1500 claim form
- Itemized billed charges
- Proof of payment

LABORATORY

- Name of Laboratory
- Name of referring physician
- Date of Service
- Diagnosis code (ICD10)
- Procedure code (CPT)
- Name of procedure
- Itemized billed charges
- Proof of payment

HOSPITAL SERVICES

- Proof of payment in full
- UB-04 claim form
- Itemized breakdown of total charges
- Complete medical report
- Patient account number
- Proof of payment

PRESCRIPTION DRUGS

- Name of Pharmacy
- Name of prescribing physician
- Date of Service
- Name and strength of medication
- National Drug Code (NDC)
- Quantity
- Itemized billed charges
- Proof of payment

If you submit a bill in a foreign language for services rendered off island, all required information must be translated into English for you to receive reimbursement.

COORDINATION of BENEFITS

DUAL COVERAGE

If you're covered under any other health plan this is called "dual coverage". As a StayWell member you are responsible for informing StayWell of your dual coverage as soon as, or prior to, the start date of each "Other Plan". The benefits and health plan for Members with dual coverage will be appropriately coordinated and adjusted so that benefits will not exceed 100% of allowable charges between your StayWell plan and each Other Plan.

Should StayWell be determined to be your primary health plan, then the benefits described in your StayWell health plan will apply to all eligible charges. When StayWell is the secondary health plan, then StayWell will determine its benefits contributions based on the allowed amount not paid by your primary health plan. In addition, note that additional provisions apply for those who are eligible for Medicare.

For more information regarding dual coverage under your StayWell health plan please contact our customer care department at 671-477-5091.

MEDICARE

Medicare is a U.S. health insurance program for:

- People 65 years of age or older.
- Some people with disabilities under age 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance): If you or your spouse have worked for at least 10 years in U.S. Medicare covered employment, you may qualify for premium-free Part A insurance. Otherwise, you may become eligible upon reaching age 65 or older.
- Part B (Medical Insurance): Generally, Medicare Part B acts like most other health plans, and premiums are withheld from your monthly Social Security check or your monthly retirement check.
- Part C ("Medicare+Choice" now known as "Medicare Advantage"): Through the 1997 Balanced Budget Act Medicare Part C offers Medicare benefits to include medical savings accounts, managed care plans, and private fee-for-service plans. The new Medicare Part C programs are in addition to the fee-for-service options available under Medicare Parts A and B.
- Part D (Prescription Drug Coverage): Medicare offers a prescription drug benefit within which you may enroll only if you are enrolled in Part A or Part B. Those who wish to enroll in a Medicare Part D program must choose from a large list of approved drug plans.

Should you become eligible, you must enroll in Medicare to ensure no interruption in your coverage as your StayWell plan benefits will be reduced by the amount that is covered by Medicare, even if you are not currently enrolled.

For more information on Medicare you may contact the Guam Medicare Assistance Program under the Department of Public Health and Social Services at 671-735-7388 or Medicare directly at 1-800-633-4227.

DENTAL **CARE**

You have the option of enrolling in our dental plan. Once you join you must continue receiving dental coverage to the end of the policy year. Cancellation of dental coverage can only be done during the annual open enrollment period. Most dentists send the bill for your care directly to StayWell for payment of Eligible Charges on covered Services, less the part you pay as your Coinsurance. Some dentists, however, prefer to have their patients pay them directly. If this is your dentist's procedure, you pay 100% of the bill and then submit a claim to StayWell for reimbursement. We require a copy of your dentist's bill, listing all the Services performed and the price for each Service.

Pre-authorization by StayWell is required for treatment estimated to cost $600 or more.

Staying within the StayWell network of participating dentists will ultimately save you money! Your coinsurance will substantially increase when Services are rendered by a non-participating dentist.

GENERAL INFORMATION

CUSTOMER CARE

Customer Care Representatives are trained in your plan's coverage, benefits and procedures. They can provide you with up-to-date lists of StayWell's Participating Providers and Centers of Excellence – the doctors, hospitals, clinics, laboratories, pharmacies and other health care providers, which offer services at reduced rates to StayWell members. They can also help you file claims and receive reimbursements, which include cases where you paid 100% for a covered Benefit on Guam or off island.

The StayWell Customer Care Department is there to provide quick answers to your questions regarding:

- Claims
- Providers
- Eligibility
- New Cards
- Memberships
- Reimbursements

Call Guam Customer Care at (671) 477-5091 extension 1120, or CNMI Customer Care at (670) 323-4260, or stop by the StayWell Guam/CNMI Office. We're open Monday–Friday from 8:00 a.m. to 5:00 p.m.

ELIGIBILITY INFORMATION

Who is Eligible?

Subscriber:

- Resident of Guam or CNMI
- Regular full-time employee who works 30 hours or more per week

Dependent:

- Resident of Guam or CNMI
- Legal spouse or domestic partner. Domestic partner must be at least 18 years old and has lived with you for at least two (2) consecutive years. Domestic partner may only be enrolled during open enrollment or initial enrollment.

- Natural children, stepchildren, legally adopted children, children placed for adoption under the age of 26. Children of domestic partners are not eligible for coverage as a stepchild.
- A child of a domestic partner can enroll as a dependent if the domestic partner is enrolled as a dependent of the same subscriber. If the domestic partner is not enrolled, then the subscriber must have legal guardianship of the domestic partner's child to enroll said child as a dependent. A child of a domestic partner may only be enrolled during open enrollment or initial enrollment.
- Legal guardianship. Children under legal guardianship may only be enrolled during open enrollment or initial enrollment. A child under legal guardianship will remain eligible until guardianship terminates, or until the child reaches the age of 18 years, whichever occurs earlier. An unborn child cannot be enrolled under legal guardianship. Legal Guardianship is not a HIPAA qualifying event.
- Children age 19 through 25. If the child resides outside of Guam and the CNMI and is attending an accredited school, college, or university as a full-time student, a full time school verification must be submitted.
- Disabled child incapable of self-sustaining employment by reason of mental retardation or physical handicap. A medical certification from your doctor must be submitted.
- To add eligible dependents, including newborn babies, you must complete a "change of status" form signed by you as the subscriber and submit to StayWell within 30 days of the eligibility.

When to Enroll

- Within 30 days of the time you are first hired;
- Within 30 days of the time you first become eligible for the plan.
- During the annual enrollment period; or
- Within 30 days after a HIPAA event. Please refer to "HIPAA Provisions" section below for further explanation.
- Within 30 days of birth, adoption, marriage, or placement for adoption.

Once you join you must continue receiving medical coverage to the end of the policy year. Cancellation of medical coverage can only be done during the annual open enrollment period.

HIPAA Provisions

As required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, if you decline to enroll yourself or your dependents (including your spouse) in StayWell because of other health insurance coverage, you have the option to enroll later, if there is a qualifying event and provided you submit all enrollment application forms within 30 days of losing the other coverage. You also have the option to enroll again in StayWell when you have a new dependent as a result of marriage, birth, adoption or placement for adoption, provided you enroll within 30 days of acquiring the new dependent. Only under these events will you be allowed enrollment.

What else is required?

- Marriage certificate copy if the spouse has a different last name or enrollling due to marriage.
- Birth certificate copy if a child has a different last name.
- Domestic partner. StayWell shall require a notarized affidavit and other proof of domestic partner status at the time of application for enrollment. The Subscriber's domestic partner is eligible if (i) both the Subscriber and the domestic partner are eligible for marriage without emancipation under the laws of Guam/CNMI (ii) the domestic partner has cohabited with the Subscriber for at least the last two (2) consecutive years immediately preceding the proposed date of enrollment of such spouse.
- Legal guardianship. The subscriber shall provide such evidence as to the qualifications of the dependent for legal guardianship as StayWell may require, including but not limited to annual tax filings and affidavit stating that the dependent will be included in the tax filing and court document copy signed by a judge ordering guardianship.
- Stepchildren. A copy of the child's birth certificate and the parents' marriage certificate.
- Adoption. Court document copy signed by a judge ordering adoption or placement for adoption.
- Students (age 19-25) that reside outside of Guam and CNMI. Letter from school's registrar's office verifying full-time status. Verification must be submitted no later than 30 days after the commencement of each term.

- Disabled child. Proof of total disability and dependence must be submitted within 30 days of the child's attainment of the limiting age and every year after that.
- Newborn. Copy of birth certificate showing subscriber as parent.

StayWell reserves the right to require a Covered Person or Employer to provide documentary evidence of eligibility of Covered Person to supplement an application for enrollment or to confirm eligibility. Other documents may be required to determine whether they are acceptable substitutes, however, final determination will be made by StayWell's Enrollment Department.

Residency Requirement

StayWell members must maintain their principal residence in Guam or the CNMI. Employees/members cannot remain outside the Service Area for more than 60 accumulative days per policy year. A written request for extension may be submitted to StayWell's Informed Choice Department prior to the 60th day. The granting of any extension shall be at the sole discretion of StayWell, is not automatic and is subject to review after submission of all documents as determined necessary by StayWell.

Dependents age 19-25, who are full-time students as described in your group contract, will not be excluded from coverage while attending school outside the Service Area provided proof of full-time student status must be submitted each semester.

Exceptions

1. Exception for difference: You must pay for any difference between StayWell's payment on Eligible Charge and actual costs.

   You are responsible for paying all health care Services not covered by StayWell.
2. Double coverage: If you are covered by a group medical plan, Medicare, or automobile insurance in addition to StayWell, one plan will pay reduced Benefits. This is to prevent any payment of Benefits exceeding the charge for a particular service. Benefits will be adjusted so you do not receive more than 100% of the Eligible Charges. Medical coverage under Medicare will be considered primary for payment unless otherwise provided for by federal law. Motor vehicle insurance will be considered primary for all medical care resulting from a motor vehicle accident. Those Benefits will be applied first before StayWell pays any Benefits.

   In the case of a dependent child, the carrier of the parent whose birthday occurs first in the calendar year is the primary carrier.

   If you receive care at military medical facilities, the Third Party Collection Program established by federal law PL99-2782 (10 USC1095) directs the military to bill private insurance companies for the cost of care provided by the military facility.
3. Third party liability: If another person causes your injury and you have a right to recover damages from that person, StayWell is not liable for benefits in connection with services rendered. Should StayWell elect to make payments for your injury, it has the right to be reimbursed from any recovery you obtain from the third party.
4. Auto accidents: If yours is the only car involved and you are injured, the primary coverage will be your auto policy if it provides for medical payments. StayWell will cover whatever is not paid by your auto policy subject to policy conditions and limits.

   If there was more than one car involved and the accident was your fault, then StayWell will pay per policy conditions and limits whatever is not the responsibility of your auto policy.

   If there was more than one car involved and the other party is at fault, then the driver of the other car and that other car's auto insurance policy must pay all of your medical expenses. StayWell will not pay anything when the other person is responsible. However, StayWell may make payments on your medical expenses in the form of a no interest loan pending the outcome of your action against the other party. In order to have StayWell make such payments, you must apply for this special benefit.

Non-Member Status

Members are at risk of losing their coverage with StayWell if any of the following circumstances occur:

a) If premiums are not paid.

b) If you allow someone else to use your membership card to obtain Services.

c) If you remain outside the Service Area for more than 60 accumulative days, off island benefits will be terminated.

d) A spouse's coverage will end on the first day of the month following the termination of your marriage. A domestic spouse's coverage will end on the first day of the month following the date the couple is no longer living together. You must complete and submit all necessary forms in these events.

e) When eligible for Medicare coverage and you fail to enroll in

all portions of the Medicare Program open to you and refuse to sign or maintain in effect the necessary releases. This includes members eligible for Medicare due to end stage renal disease.

f) If a medical claim for reimbursement is found to be fraudulent after all required grievance actions have been completed.

REVIEW AND APPEALS PROCESS

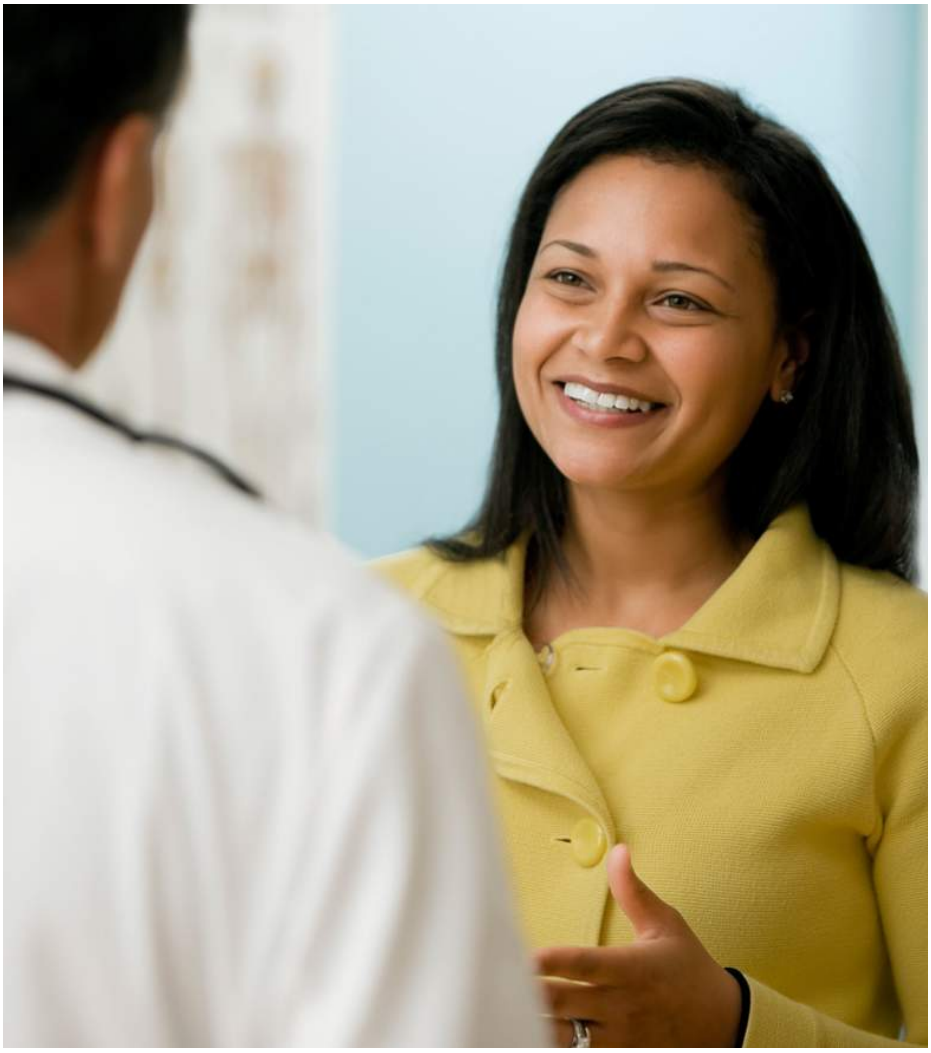
If you have questions about the benefit coverage or payments made by StayWell, you are entitled to request a review of the claim. If you are not satisfied with any preliminary determination made, you or your authorized representative are entitled to appeal in writing to StayWell's Appeals Committee.

If an authorized representative is filing the appeal on your behalf, you will need to complete the StayWell Authorized Representative form to name the representative. Your doctor can only obtain the right to act on your behalf in pursuing appeals if your doctor has become your authorized representative. In the case of an appeal involving urgent care, the provider treating you can automatically act as your authorized representative without your having to complete the StayWell Authorized Representative form.

How do I file an appeal?

A. Appeal to StayWell in writing to reconsider initial decision. You should:

- Write to StayWell's Appeals Committee within six (6) months from the date of StayWell's decision or Accomplish StayWell's Appeal Form; and
- Send your appeal to StayWell at: 520 Route 8 Maite, Guam 96910; and



- Explain why you believe the initial determination should be reconsidered, based on the benefit provisions in your health plan; and
- Attach documents supporting your explanation including medical records, physician letters, bills, receipts and any other form that would serve the same purpose.
- File for an expedited internal appeal in urgent care situations by contacting our Customer Care Department at (671) 477-5091 ext. 1120. Urgent internal appeals will be processed within 24 to 72 hours. You may request for an expedited internal appeal orally or in writing.

B. The Appeals Committee has thirty (30) days from the date it received your Pre-Service Appeal and sixty (60) days from the date it received your Post-Service Appeal to:

- Authorize coverage for the requested service, or supply;
- Request for more information from you or your provider – Proceed to Step C; or
- Write to inform you that the denial is maintained – Proceed to Step D

C. You or your provider should send the information so that the Appeals Committee will receive it within forty-five (45) days of our request. The Appeals Committee will then decide within thirty (30) more days.

If information is not received within

forty-five (45) days, the Appeals Committee will decide within thirty (30) days from the date the information was due. The decision will be based on available information. The Appeals Committee will write to you about the decision.

D. If you do not agree with the Appeals Committee's decision, you can file an External Review.

Proceed to Step E;

E. Almost always, issues find resolution within the first level of appeal. Otherwise, you may seek arbitration or request for standard or expedited external review.

For more information regarding this, you may contact StayWell's Customer Care Department at (671) 477-5091 ext. 1120.

F. Standard external review.

If we continue to deny the payment, coverage, or service requested or we do not comply with Federal Standards, or in the case of medical urgency, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Per the interim external review guidelines issued by Health and Human Services (HHS), this process will be administered by MAXIMUS Federal Services. Within four (4) months after receipt of a denial of coverage or service, request for an external review in writing by submitting an online request at externalappeal.cms.gov, under the "Request a Review Online" heading, or in writing by faxing the request to 1-888-866-6190, or by sending it by mail to: MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534

You may submit additional written comments to the external reviewer, though any submitted information will be shared with us to give StayWell an opportunity to reconsider the denial. If you have any questions or concerns during the external review process, you can call MAXIMUS at the toll-free number 1-888-866-6205 or contact the Guam Department of Revenue and Taxation, Regulatory Division at (671) 635-1844/5 or (671) 635-7664.

When the examiner, designated by MAXIMUS, receives an external review request, the examiner will contact StayWell. Within five (5) business days of receipt of request by the examiner, StayWell will provide to the examiner all of the documents and any information considered in making the Adverse Benefit Determination or final internal appeal decision

Within forty-five (45) days after receipt of the request for external review, the examiner will provide you and StayWell a written decision. If the decision of the examiner includes reversal of the denial of coverage or service, StayWell will immediately comply.

G. Expedited external review.

In urgent care situations, e.g. when the expedited/urgent internal appeals process timeframe would seriously jeopardize your life and health or would jeopardize your ability to regain maximum function, you may request for an expedited external review by selecting "expedited" if submitting the review request online, or by emailing FERP@MAXIMUS.com, or calling Federal External Review Process at 1-888-866-6205 ext. 3326. If you have an urgent health situation, you can file for an external appeal, orally or in writing, at the same time as your request for an internal appeal.

The examiner, designated by MAXIMUS, must provide notice of the expedited external review decision as promptly as your medical conditions or circumstances require, but no more than 72 hours after receipt of the request for an expedited external review.

The examiner will provide you and StayWell with an oral or written decision. Any decision provided orally by the examiner will be followed by a written notice within 48 hours.

If you do not agree with the final determination on your internal or external appeal, you have a right to bring a civil action under Section 502(a) of ERISA, if applicable.

COMPLAINTS AND GRIEVANCES

We have steps for handling any problems you may have. As a StayWell member, you have a right to voice your complaint if you are not happy with our providers or with us. To make a complaint, please call Customer Care or come into our office to speak with one of our Customer Care staff. Some complaints can be resolved through first call resolution if they can be fully addressed and you are satisfied with the outcome.

If your complaint cannot be resolved or it meets the definition of a grievance, you can complete the Grievance Form and submit it to StayWell. We will send you a Grievance Acknowledgment letter after receipt of your written grievance. All grievances will go under review by the appropriate department and the Quality Assurance Manager. We will inform you in writing within 30 days as to how your grievance was addressed. If additional time is needed for resolution, we will keep you informed, in writing, on the status of your grievance until it is resolved. If you require assistance

in filing a grievance or if you are unable to submit the grievance in writing, you can call Customer Care at 671-477-5091 to ask for help through the process.

QUALITY IMPROVEMENT PROGRAM

StayWell has a comprehensive Quality Improvement (QI) Program to ensure members receive quality care and services. The QI Program is an important part of the member's health plan. The StayWell Board of Directors (BOD) oversees the QI Program and has established various committees to monitor and support the QI Program. The BOD has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The QI Program monitors the quality of care and services provided in some of the areas below:

- Making sure members get the care they need, when and where they need it
- Making sure members are receiving quality care
- Cultural and linguistic needs of our members
- Member satisfaction
- Member safety and privacy
- Network access and adequacy

The goal of the QI Program is to improve member health. This is achieved through many different activities. Some of our goals include the following:

- Provide timely access to high-quality healthcare for all members, through a safe health care delivery system;
- Systematically monitor and evaluate the quality and appropriateness of health care and services; and
- Pursue opportunities to improve health care, services, and safety.

The Quality Improvement Committee (QIC) is a StayWell committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to prove oversight and direction in assessing the appropriateness of services and continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers, and staff.

Another aspect of our quality program and the services we provide to our members is the member satisfaction survey. The survey is conducted by an external vendor on an annual basis. The survey provides information on the experiences of members with StayWell's services and the provider services. The survey gives us a general indication of how well we are meeting the needs of our members. We also evaluate member complaints, grievances, appeals, and denials annually. We encourage all members to participate in the survey so we can enhance our quality improvement initiatives.

If you would like more information about our QI Program, contact the Quality Assurance Manager at 671-477-5091 ext. 1231

GLOSSARY

ADVERSE DETERMINATION means:

1. A determination by StayWell that is based upon the information provided, a request for a benefit under StayWell's health benefit plan upon application of any utilization review technique that does not meet StayWell's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated, or payment is not provided or made, in whole or in part, for the benefit; The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by IHIC of a member's eligibility to participate in the health plan; or Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.
2. Adverse Determination also includes a rescission of coverage determination.

APPEAL An appeal is a request by the Member or the Member's Authorized Representative for reconsideration of an Adverse Determination of a health service request or benefit that the Member believes he or she is entitled to receive.

1. Urgent Care Appeal – Also known as an Expedited Appeal, are a special kind of pre-service appeal that requires a quicker decision when there is an immediate need for health services because a standard appeal could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. If a physician with knowledge of the members medical condition tells StayWell that a pre-service appeal is urgent, StayWell must treat it as an urgent care appeal
2. Pre-Service Appeal (Prior Authorizations) – Are requests for reconsideration of an Adverse Determination for approval required before medical care, such as preauthorization or a decision on whether a treatment or procedure is medically necessary.
3. Post Service Appeal – Are all other Appeals for benefits under IHIC's health plan that are not pre-service appeals, including appeals after medical services have been provided, such as requests for reimbursement or payment for the provided services. Most appeals for group health benefits are post-service appeals.

CENTERS OF EXCELLENCE The selected off island hospitals and ambulatory surgi-centers that have agreed to provide health care services at reduced rates to StayWell members.

COVERED SERVICES The medical and dental services for which you are insured under this plan.

COINSURANCE The portion of charges for Covered Services for which an enrollee is responsible for payment after satisfaction of the Deductible.

COMPLAINT Any verbal expression of dissatisfaction by a Member or a Member's Authorized Representative regarding an issue that may be resolved at the point at which it occurs by the staff present. Most complaints will have simple solutions that can be promptly addressed and are considered resolved when the member/authorized representative is satisfied with the action taken on their behalf.

COPAYMENT The predetermined (flat) dollar amount that an enrollee must pay for certain Covered Services after satisfaction of the Deductible.

DEDUCTIBLE A deductible is the amount required to be paid by you for Covered Services rendered before the plan participates in paying your Covered Services rendered.

DOCTOR A properly licensed doctor of medicine (M.D.), psychiatrist, licensed clinical psychologist, dentist(D.M.D. or D.D.S.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.)

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. For Covered Services rendered by a Participating Provider, the Eligible Charges shall be limited to the lesser of the actual billed charges or the reimbursement amounts agreed to between the Company and the Participating Provider. For covered medical Services rendered by a Non-Participating Provider, the Eligible Charges shall be limited to the lesser of the actual billed charges made by the provider; or in the United States, the Medicare Participating Provider fees in the geographic area where the Service was rendered; or in Asia, the fees most recently contracted by the Company at St. Luke's Medical Center in Manila, Philippines; or elsewhere, the Medicare National Standard Fee. When Services are provided to a Covered Person by a Non-Participating Provider, the Covered Person shall inform the Provider

of Services that the Covered Person is a Covered Person of the Company and that in order for payments to be made by the Company for eligible Services, such Provider of Services is required to file a Treatment Plan with the Company as prescribed hereunder and, within 90 days after the last day on which such Services were rendered, is required to submit to the Company a report of Services rendered upon such claim form or forms as the Company shall prescribe. The responsibility for having the proper Treatment Plan and claim timely submitted to the Company shall be with Subscriber, and the Company shall not be obligated to make any payment until such Treatment Plan and claim are received and approved by the Company.

EMERGENCY The sudden and unexpected onset of a severe medical condition which, if not treated immediately, could result in irreparable harm, a life-threatening situation, or permanent disability.

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan at the completion of the internal appeals process.

FORMULARY The list of preferred prescription drugs, devices and supplies that are Covered Services under the Plan and selected for their safety, effectiveness and affordability. The Formulary is subject to change during the Plan Year.

GRIEVANCE Any formal verbal or written expression of dissatisfaction by a Member or a Member's Authorized Representative that requires follow up and/or investigation. A standard grievance must be addressed within 30 days. All verbal or written complaints of abuse, neglect, patient harm, or the risk of patient harm, a violation of the Patient Rights and Responsibilities, are examples of grievances. Any verbal complaint requested by a member/authorized representative to treat a complaint like a grievance will be considered a grievance.

MEDICALLY NECESSARY OR MEDICAL NECESSITY Shall be defined as services or supplies, which under the provisions of this Agreement, are determined to be: appropriate and necessary for the symptoms, diagnosis or treatment of the Injury or Illness or dental condition; provided for the diagnosis or direct care and treatment of the Injury or Illness or dental condition; within standards of good medical or dental practice within the organized medical or dental community; not primarily for the convenience of the Covered Person or of any Provider providing Covered Services to the Covered Person; an appropriate supply or level of service needed to provide safe and adequate care; within the scope of the medical or dental specialty, education and training of the Provider; provided in a setting consistent with the required level of care; or preventive Services as provided in the Plan.

MEMBER, ENROLLEE, OR COVERED PERSON Any employee or eligible dependent of an employee, who is properly enrolled in the StayWell Health Plan.

PARTICIPATING PROVIDERS "Participating Providers" shall be defined as doctors, medical groups, hospitals, skilled nursing facilities, pharmacies, dentists, laboratories, and other health care facilities that: (i) have directly, or indirectly through StayWell's agreements with other networks, entered into an agreement with StayWell to provide Covered Services; and (ii) are assigned from time to time by StayWell to participate in the StayWell provider network.

PRE-CERTIFICATION The authorization from StayWell for all hospital admissions, outpatient surgical procedures, and certain diagnostic tests.

RECISSION OF COVERAGE The retroactive cancellation of a health insurance policy. StayWell will retroactively cancel your entire policy if you intentionally misrepresent on your initial application for your insurance policy.

SCHEDULE OF BENEFITS Sets forth the benefits which will be provided to each Subscriber and to each of his or her eligible enrolled Dependents, if any, and the extent of each benefit, including the requirements, limitations and maximums under which the benefits will be provided when enrolled in this Plan for the Plan Year. The Schedule of Benefits is shown in Exhibit C of the Certificate.

SERVICE AREA The Territory of Guam and the Commonwealth of the Northern Mariana Islands (CNMI).

SERVICE Health care services, supplies and equipment, or any combination thereof.

YOUR **RIGHTS**

PRIVACY POLICY STATEMENT

We are required by law to:

- maintain the privacy of your Protected Health Information (PHI);
- provide you this notice of our legal duties and privacy practices with respect to your PHI; and
- follow the terms of this notice.

We protect your PHI from inappropriate use or disclosure. Our employees, and those of companies that help us service your StayWell insurance, are required to comply with our requirements that protect the confidentiality of PHI. They may view your PHI only when there is an appropriate reason to do so, such as to administer our products or services.

We will **not disclose** your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your health insurance coverage.

The main reasons for which we may use and may disclose your PHI are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you.

The following describe these and other uses and disclosures, together with some examples.

- **For Treatment** We may use and disclose your PHI to coordinate or manage your health care and any related services. In addition, we may share your PHI with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.
- **For Payment** We may use and disclose PHI to pay for benefits under your health insurance coverage. For example, we may review PHI contained on claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment related functions, such as eligibility determination, audit and review or to assist you with your inquiries or disputes.
- **For Health Care Operations** We may also use and disclose PHI for our insurance operations. These purposes include evaluating a request for health insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose PHI to affiliates, and to business associates outside StayWell Insurance, if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are: billing companies, data processing companies, or companies that provide general administrative services. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order to make an informed business decision regarding any such prospective transaction.
- **Where Required by Law or for Public Health Activities** We disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities. We may also release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.
- **To Avert a Serious Threat to Health or Safety** We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.
- **For Health-Related Benefits or Services** We may use PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of interest to you.
- **For Law Enforcement or Specific Government Functions** We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as Part of a Regulatory or Legal Proceeding** If you or your estates are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.
- **Other Uses of PHI** Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your health insurance coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Personal Health Information We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about a specific right, please write to the administrator of your health insurance coverage.

Right to Inspect and Copy Your PHI In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. To inspect and obtain a copy of your PHI, you must submit your request in writing. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes; and also includes PHI collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding.

In very limited circumstances we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Right to Amend Your PHI If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must provide your request in writing. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that:

- is accurate and complete;
- was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
- is not part of the PHI kept by or for us; or
- is not part of the PHI, which you would be permitted to inspect and copy.

Right to a List of Disclosures You have the right to request a list of disclosures we have made of PHI about you. This list will not include disclosures made for treatment, payment, and health care operations, for purposes of national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclose or both; (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

Right to Request Confidential Communications You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to File a Complaint If you believe your privacy rights have been violated, you may file a complaint with us. Please contact StayWell Insurance HIPAA Privacy Officer, P.O. Box CZ Hagåtña, Guam 96932. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA option is available to groups with more than 20 employees (part time and full-time). StayWell is not a COBRA administrator. COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health plan coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the group health plan is lost because of the qualifying event. Under the group health plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the group health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the group health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the group health plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

If your employer offers Retiree coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the group health plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the group health plan.

When is COBRA Coverage Available?

The group health plan will offer COBRA continuation coverage to qualified beneficiaries only after the health insurance issuer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the

employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the health insurance issuer of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the health insurance issuer within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the health insurance issuer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates,

COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the group health plan is determined by the Social Security Administration to be disabled and you notify the health insurance issuer in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to qualify for this extension you must provide a copy of your Disability Award letter that is received from the Social Security Administration prior to the end of your COBRA continuation period to the health insurance issuer.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the health insurance issuer. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the group health plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred.

THE HEALTH CARE PROMPT PAYMENT ACT OF 2000

§ 9902. Prompt Payment for Health Care and Health Insurance Benefits.

(a) This Section applies to Health Plan Administrators, as defined by this Chapter, organized and operating under the laws of Guam.

(b) Health Plan Administrators shall reimburse a Clean Claim, or any portion thereof, submitted by a patient or Health Care Provider, that is eligible for payment and not contested or denied not more than 45 calendar days after receiving the Clean Claim filed in writing.

(c) If a claim is contested or denied, or requires more time for review by the Health Plan Administrator, the Health Plan Administrator shall notify the Health Care Provider in writing not more than 30 calendar days after receiving a claim filed for payment. The notice shall identify the contested or denied portion of the

claim and the specific reason for contesting or denying the claim, and may request additional information. Requests for information on a contested or denied claim, or portion thereof, shall be reasonable and relevant to the determination of why the claim is being contested or denied. In no event may a claim be contested or denied for the lack of information that has no factual impact upon the Health Plan Administrator's ability to adjudicate the claim.

(d) If information received pursuant to a request for additional information is satisfactory to warrant paying the Clean Claim, the Clean Claim shall be paid not more than 45 calendar days after receiving the additional information in writing.

(e) The payment of a Clean Claim under this Section shall be effective upon the date of postmark of the mailing.

(f) Health Care Providers shall be responsible for obtaining proof in writing that a specific claim was delivered to a Health Plan Administrator on a specific date for determining the time periods for the purposes of prompt payment.

(g) Notwithstanding any provisions to the contrary, interest shall be allowed to accrue at a rate of 12% per annum as damages for money owed by a Health Plan Administrator for payment of a Clean Claim, or portion thereof, that exceeds the applicable reimbursement time limitations under this Section, including applicable costs for collecting past due payments as provided in § 9905 of this Article, as follows:

(1) for an uncontested Clean Claim:

(i) filed in writing, interest from the first calendar day after the 45-day period in § 9902(b); or

(2) for a contested claim, or portion thereof, filed in writing:

(i) for which notice was provided under § 9902(c), interest from the first calendar day 45 days after the date the additional information is received; or

(ii) for which notice was not provided, but not within the time specified under § 9902(c), interest from the first calendar day after the claim is received.

(h) Each Health Care Provider shall notify the Health Plan Administrator and patient in writing of all claims for which they intend to charge interest. Any interest that accrues as a result of the delayed payment of a Clean Claim, or any portion thereof, in accordance with the provisions of this Act shall be automatically added by the Health Plan Administrator to the amount of the unpaid Clean Claims due the Health Care provider.

(i) Interest shall only apply to the principal portion of the claim.

(j) The provisions of this Section shall not apply to the payment or reimbursement of any claim, or portion thereof, involving a Coordination of Benefits between multiple payers of a claim.

§ 9903. Timely Filing of Accurate Claims.

(a) This Section applies to Health Care Providers, as defined by this Act, duly certified, licensed, or organized and operating under the laws of Guam.

(b) All claims submitted for reimbursement must be submitted on a UB-04, HCFA 1500, ADA claim, or other billing document generally accepted by Health Plan Administrators. Claims may be submitted electronically if such a transmittal arrangement has been agreed to by the Health Plan Administrator.

(c) Health Care Providers shall be responsible for the accuracy of all claims filed. Duplicate claims, unbundled claims, or fee-for-service claims billed in a capitated arrangement, may not be submitted and cannot be considered for prompt payment in accordance with the provisions of this Act.

(d) Should a Health Care Provider fail to submit a response to a reasonable request for additional information on a contested or disputed claim, within 45 days from the date of request for such additional information, no interest shall accrue to the claim or portion thereof eligible for payment. For purposes of this Subsection, should a Health Care Provider be a hospital, then such a hospital provider shall be allowed to submit a response to a reasonable request for additional information on a contested or disputed claim within 90 days from the date of request for such additional information.

(e) In order for a Health Care Provider to receive interest for the late payment of a claim as provided in § 9902, a claim for health services rendered must be submitted within 45 days from the date the health service was provided.

(f) With the exception of those claims that involve the coordination of benefits, all claims for payment must be submitted by the Health Care Provider within 90 days from the date that health services were rendered. Any claim not submitted by the Health Care Provider within 90 days from the date that health services were rendered shall not be the financial responsibility of either the Health Plan Administrator or the patient.

§ 9904. Billing of Patients Allowed.

(a) No patient receiving care from a Health Care Provider, may be billed for the same Clean Claim, or portion thereof, submitted for payment to a Health Plan Administrator, unless the provider has elected to terminate that person's efforts to collect interest penalties as provided for in § 9902(g) of this Act, or a period of 90 days has lapsed from the date of submission of a Clean Claim for payment. This provision shall not apply to any Clean Claim or portion of a Clean Claim that is due and payable by the patient as a benefit limitation, deductible, co-payment, non-covered benefit, patient share, or personal comfort or convenience item.

(b) A Health Care Provider may not charge more than 12% interest per annum to any patient as a penalty for their failure to make prompt payment of a Clean Claim, or portion thereof, for which the patient is responsible for paying.

(c) A Healthcare Provider may not charge both the Health Plan Administrator and the patient interest penalties for the same Clean Claim, or portion thereof, submitted for payment to either party.

PUBLIC LAW NO. 20-88

To mandate prompt payment for health care services performed in the CNMI and to authorize CNMI health care service providers to impose penalties on late payments received for clean claims; to set uniform standards for the processing of electronic claims; and for other purposes

§ 103. Prompt Payment

(a) Within 180 calendar days of the effective date of this Act, for covered services rendered to its members, a health insurance issuer shall reimburse any person entitled to reimbursement under the health plan within forty (40) calendar days after the date of receipt on a clean claim.

(b) If a health insurance issuer fails to comply with subsection (a) of this section, the health insurance issuer shall pay interest beginning on the forty-first (41st) calendar day after the receipt of the claim if the date of payment is not within forty (40) calendar days. A formal claim by the person filing the original claim shall not be required.

(c) For electronic claims, the interest payable shall be at a monthly rate from the receipt of claim of:

(1) One and one-half (1.5) percent from the 41st day through the 60th calendar day;

(2) Two (2) percent from the 61st day through the 120th calendar day; and

(3) Two and one-half (2.5) percent after the 120th calendar day.

(d) For paper claims, the interest payable shall be at a monthly rate of:

(1) Two and one-half (2.5) percent from the 41st day through the 60th calendar day;

(2) Three (3) percent from the 61st day through the 120th calendar day; and

(3) Three and one-half (3.5) percent after the 120th calendar day.

(e) This section shall not apply to claims if the health insurance issuer:

(1) Notifies the person submitting the claim within 30 calendar days after the receipt of the claim that the legitimacy of the claim or the appropriate amount of reimbursement is in dispute;

(2) States, in writing, to the person the specific reasons why the legitimacy of the claim, a portion of the claim, or the appropriate amount of reimbursement is in dispute; and

(3) Pays any undisputed portion of the claim within 40 calendar days of the receipt of the claim.

(f) The health insurance issuer shall process the disputed portion of the claim within 40 calendar days after receipt of all reasonable and necessary documentation.

(g) If a health insurance issuer fails to comply with the requirements of subsection (f) of this section, it shall pay interest at the rates set forth in subsections (c) and (d) of this section beginning on the 41st calendar day after the filing of the receipt of the documentation as provided in subsection (f) of this section.

(h) A health insurance issuer shall allow a provider a minimum of 180 calendar 28 days from the date a covered service is rendered or the date of inpatient discharge to submit a claim for reimbursement for the service.

(i) There shall be a rebuttable presumption that a claim has been received by a health insurance issuer:

(1) Within 15 business days from the date the provider or person entitled to reimbursement placed the claim in the United States mail;

(2) Within 8 working hours if the claim was submitted by the provider or provider's agent electronically and was not returned to the provider by a health care clearinghouse or returned to the provider by the insurer if submitted directly to the health insurer; or

(3) On the date recorded by the courier if the claim was delivered by courier.

(j) Each health insurance issuer shall provide a manual or other document that sets forth the claims submission procedures to all contracting providers at the time of contracting and 30 calendar days prior to any changes in the procedure.

(k) A health insurance issuer shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect the record on request and to rely that record or on any other admissible evidence as proof of the fact of receipt of the claim, including electronic facsimile confirmation of receipt of a claim.

(l) A health insurance issuer shall not be in violation of this chapter if its failure to pay a claim in accordance with the time periods provided in this chapter is caused:

(1) In material part by the person submitting the claim; or

(2) By impossibility due to matters beyond the health insurer's reasonable control, such as an act of God, insurrection, strike, fire, or power outages.

(m) This section shall not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the health insurer's obligation on such claims

(n) Nothing in this chapter shall prevent a health care provider and health insurance issuer from entering into a services agreement with a stricter time frame for payment and/or penalty schedule

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under the group health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- reconstruction of the breast on which a mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of all stages of mastectomy, including lymphedemas.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Staywell Insurance Plan recognizes State court and administrative orders directing a participant to provide health benefit coverage for dependent children even if the participant does not have custody of these children, if a court order is a Qualified Medical Child Support Order (QMCSO). This shall include enrolling the employee, if eligible, and the relevant Child if eligible, outside a regularly scheduled open enrollment period. If the order is not a QMCSO, then the Employee must wait until the next open enrollment period to enroll. Participants and beneficiaries can obtain a copy of the procedures governing QMCSO, without charge, from the Group Health Benefit Plan Administrator.

INTERPRETIVE SERVICES

As a StayWell member you have the right to interpretive services that are prescribed by law. StayWell Insurance assures that members with limited English proficiency (LEP), hearing or speech impairments are provided interpretive services, such as foreign language, American Sign Language, or use of TDD/TTY lines, when appropriate. Every attempt is made to provide services in any language needed by the member.

Standards for Culturally and Linguistically Appropriate Notices

In compliance with Paragraph O of ERISA § 2560.503-1, **(1) Requirements.** (i) The Plan must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language; (ii) The Plan must provide, upon request, a notice in any applicable non-English language; and (iii) The Plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan.

(2) Applicable non-English language. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of Health and Human Services.

ADVANCE DIRECTIVES

Planning Your Advance Directive

An advance directive (also known as a living will) is a legal document that provides written instructions to your doctor, family, or health care representative about the type of medical care you want–and do not want–if you cannot make decisions for yourself. You should think about having an advance directive no matter what age or health condition.

An advance directive becomes effective only when your doctor has evaluated you and has determined that you are unable to understand your diagnosis or treatment options. Your doctors, family, or your health care representative should have copies of your advance directive(s), so your medical wishes are honored.

You can also name someone, known as a Medical Power of Attorney, to make medical decisions on your behalf if you are unable to.

Creating Your Advance Directive

StayWell recommends all of our plan members take the time to create an advance directive, assign a Medical Power of Attorney, and provide their advance directive to their primary care physician.

There are two types of advance directives. You can choose to have one or both:

1. A proxy directive is also known as a durable power of attorney for health care. With this, you name a person to make health care decisions for you if you are unable to make them yourself. A proxy directive does not allow anyone to make legal or financial decisions for you.
2. An advance directive is also known as a living will. In this, you explain the situations in which you would want or not want, life-sustaining treatment, and the types of such treatment you would want or not want. You can also explain your beliefs, values, and the general care and treatment you prefer.

You decide what goes in an advance directive and can make it as personalized or as general as you like. You can change your advance directive at any time. You should make sure others know you have an advance directive. If you choose to designate a Medical Power of Attorney, that person should be made aware of your advance directive or living will as well.

You can obtain an Advance Directive Form in a doctor's office, hospital, law office, nursing home, or online. The Guam legislature provided statutes governing the content and use of a living will declaration. Refer to Guam Health and Safety Code, Title 10, Div. 4, Chapter §9110 to §9117 for specific information. If you have questions about Advance Directives, you may call StayWell at (671) 477-5091 or speak to your doctor.

Once you have completed your advance directive, ask your doctor to put the form in your file. You can also talk to your doctor about the decision-making process of creating your advance directive or living will. Together, you can make decisions that will put your mind at ease.

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a grievance with StayWell. Refer to the grievance section of this handbook or contact Customer Care at (671) 477-5091 for more information.

NOTES

NOTES

OFFICE DIRECTORY

GUAM

Location:	520 Route 8 Maite, Guam 96910
Hours:	8:00 a.m. - 5:00 p.m. Monday – Friday
Phone Line:	(671) 477-5091
Fax Line:	(671) 477-5096
Toll Free Line:	1-866-782-9955
Extension Departments:	1100 Administration 1120 Customer Care (Health) 1140 Informed Choice (Pre-certification and referrals) 1150 Enrollment 1180 Provider Relations 1185 Health Management 1190 Sales & Marketing
After Hours Access:	available 5:00 p.m. - 8:00 p.m
Informed Choice (Pre-Certification):	(671) 971-1190

SAIPAN

Location:	1st Floor, RJ Commercial Building, Suite 2 Chalan Monsignor Guerrero Road Dandan, Saipan 96950
Hours:	8:00 a.m. - 5:00 p.m. Monday – Friday
Phone Line:	(670) 323-4260
Fax Line:	(670) 323-4263

PHILIPPINES

Location 1:	St. Luke's Medical Center - Quezon City Rm. 1104 - 1105 North Tower, Cathedral Heights Bldg. Complex St. Luke's Medical Center, 279 E. Rodriguez Sr. Ave. Quezon City, Philippines 1112
Phone Line:	(+632) 8723-0101 local 5145
Fax Line:	(+632) 8723-3349
Mobile Line:	(+63) 8919-394-6690 (during office hours only)
Location 2:	St. Luke's Medical Center - Global City Unit 1135 Medical Arts Bldg., St. Luke's Medical Center Bonifacio Global City, Taguig Philippines 1630
Phone Line:	(+632) 8789-7700 local 7135
Fax Line:	(+632) 8403-7061
Mobile Line:	(+63) 8917-628-1760 (Dr. Edwin Denis Magno)
Hours:	7:00 a.m. - 4:00 p.m Monday – Friday