# COMMONWEALTH REGISTER

**VOLUME 24 NUMBER 10**

**OCTOBER 30, 2002**

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PUBLIC NOTICE

PROPOSED (CNMI) LOBBYING RULES AND REGULATIONS

The Public Auditor hereby provides public notice of the Proposed (CNMI) Lobbying Rules and Regulations.

The Proposed (CNMI) Lobbying Rules and Regulations govern the policy and procedures to implement and provide enforcement of the Lobbying Disclosure Act, 1 CMC, Division 9, Chapter 4. The rules and regulations are established pursuant to 1 CMC § 9417, which authorizes the Public Auditor to promulgate such rules and regulations pursuant to 1 CMC, Division 9, Chapter 4, as he may determine are necessary to effectuate the chapter.

The Proposed (CNMI) Lobbying Rules and Regulations are published in the Commonwealth Register. Copies of the proposed rules and regulations may be obtained from the Office of the Public Auditor, Gualo Rai, P.O. Box 1399, Saipan, MP 96950.

Anyone interested in commenting on these proposed revised regulations may do so in writing, addressed to the Public Auditor, at the address given above not later than thirty (30) days from the date of its publication in the Commonwealth Register.

Issued by:  

[Signature]  
Michael S. Sablan, Public Auditor  
10/4/02  
Date

Pursuant to 1 CMC § 2153, the rules and regulations attached hereto have been reviewed and approved by the CNMI Attorney General’s Office.

Dated this 28th day of October, 2002.

[Signature]  
Ramona Manglona  
Deputy Attorney General

[Signature]  
Thomas A. Tebuteb  
SAA  
10/28/02  
Date

[Signature]  
Soledad B. Sasamoto  
Registrar of Corporations  
10/29/02  
Date
NUTISIAN PUPBLIKU

PRINIPONEN AREKLAMENTO YAN REGULASION MAÑOHYO’ GIYA (CNMI)

I Aoditun Pupbliku ginen este ha prubiniyi nutisian publiku put i Priniponen Areklamento yan Regulasion Mañohyo’ giya (CNMI).

I Priniponen Areklamento yan Regulasion Mañohyo’ giya (CNMI) para u gobietna i areklamento yan kondison siha para maiimplementa yan prubiniyi maenfuetsan i Lobbying Disclosure Act, 1 CMC, Dibision 9, Kapitulu 4. I areklamento yan regulasion manmaestablesi sigun gi sinangan 1 CMC § 9417, komu ha aturisa i Aoditun Pupbliku para u famatinas este siha na klasen areklamento yan regulasion sigun gi 1 CMC, Dibision 9, Kapitulu 4, yanggen ha ditetmina na nisisisariu yan na annok i kapitulu.

I Priniponen Arekiamento yan Regulasion Mafiohyo’ giya (CNMI) mapublika gi Rehistran Commonwealth. Guaha kopian i priniponen areklamento yan regulasion para hayi inetersao gumai kopia gi Ofisian Aoditun Pupbliku, Gualo Rai, P.O. Box 1399, Saipan, MP 96950.

Hayi malago mamatinas komentu put este i priniponen maribisa na regulasion siña ha’ ha chogue’ gi tinige’, ya u adres guatu para i Aoditun Pupbliku, gi ayu na adres i gaige gi sanhilo ti mas di trenta (30) dias desde i fecha ni malaknos gi Rehistran Commonwealth.

Linaknos as:  

Michael S. Sablan, Aoditun Pupbliku  

Fecha  

10/4/02

Sigun gi sinangan 1 CMC § 2153, i areklamento yan regulasion siha ni chechetton guine esta manmaribisa yan apreba ni Ofisinan Attorney General giya CNMI.

Ma fecha gi mina’ 28th na dia, gi mes October, 2002.

Ramona Mangona  
Deputy Attorney General

Rinisip as:  

Thomas A. Tebuteb  
SAA

Fecha  

10/28/02

Rinekod as:  

Soledad B. Sasamoto  
Rehistradoran Kotporasion

Fecha  

10/29/02
ARONGORONGOL TOULAP

POMWOL (CNMI) LOBBYING MEALLÉGHÚL

Public Auditor iyeey e aghal ayoora arongorong ngaliir toulap bwelle reel Pomwol (CNMI) Lobbying me Alléghúl.

Reel Pomwol (CNMI) Lobbying me Alléghúl iye e lemeli alléghúl bwal afalafalal reel ebwe isáliiwow me ayoora mille Lobbying Disclosure Act, 1 CMC, Division 9, Chapter 4. Allégh kkaal nge e ffééreta sångi 1 CMC § 9417, iye e ngalleey bwángil Public Auditor reel ebwe atéeweló allégh kkaal sångi 1 CMC, Division 9, Chapter 4, reel ngare e tipeli bwe efil ebwe aléghelégh ló chapter.

Reel Pomwol (CNMI) Lobbying me Alléghúl iya a tooolong Commonwealth Register. Kopiyal pomwol allégh kkaal nge emmwel ebwe bweibwogh mereel Bwulasiyol Public Auditor, Gualo Rai, P.O. Box 1399, Saipan, MP 96950.

Iyo e tipeli ebwe isisilong yaal mângemâng bwelle reel pomwol allégh kkaal nge ebwe féérú schagh reel ebwe isch ngâli yaal address Public Auditor, iye e lo weiláng nge essóbw aluuw ló eliigh (30) rál sångi rál e tooolong arong yee llól Commonwealth Register.

Mereel:  
Michael S. Sablan, Public Auditor  10/4/02  
Rál

Sângi 1 CMC § 2153, allégh kkaal ikka e appasch nge atakkal amweri me alúghúlúgh sångi Bwulasiyol CNMI Attorney General.

Rál ye 28 llól maramal October, 2002.

Ramona Mangloa  
Deputy Attorney General

Bwughyial:  
Thomas A. Tebuteb  
SAA  
Rál

Soledad B. Sasamoto  
Registrar of Corporations  
Rál

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OFFICE OF THE PUBLIC AUDITOR

PROPOSED (CNMI) LOBBYING RULES AND REGULATIONS

Citation of Statutory Authority: The Lobbying Rules and Regulations are established pursuant to 1 CMC § 9417, which authorizes the Public Auditor to promulgate such rules and regulations pursuant to 1 CMC, Division 9, Chapter 4, as he may determine are necessary to effectuate the Chapter.

Short Statement of Goals and Objectives: To provide regulations that govern the policy and procedures for implementation and enforcement of the Lobbying Disclosure Act, 1 CMC, Division 9, Chapter 4.

Brief Summary of the Rules: These Lobbying Rules and Regulations set forth the procedures for lobbyist reporting, and for initiating and processing complaints and conducting investigations. Civil sanctions are defined.

For Further Information Contact: Michael S. Sablan, CNMI Public Auditor, telephone no. 234-6481/82, fax no. 234-7812, or e-mail at mail@opacnmi.com.

Citation of Related and/or Affected Statutes, Regulations and Orders: None

Submitted by: Michael S. Sablan
Public Auditor

Date 10/4/02
# COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

## LOBBYING RULES AND REGULATIONS

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LOBBYING RULES AND REGULATIONS

Section 100 Authority

The authority for the promulgation and issuance of the Lobbying Rules and Regulations is by virtue of the authority and directions set forth in the Commonwealth Code, including, but not limited to, 1 CMC § 9417.

Section 101 Purpose and Scope

The purpose of these Regulations is to establish policy and procedures to implement and provide enforcement of the Lobbying Disclosure Act. Unless specifically provided otherwise, these Regulations apply to 1 CMC, Division 9, Chapter 4.

Section 102 Statement of Policy

It is the policy of the Commonwealth of the Northern Mariana Islands that the public is entitled to know what private persons or interest groups influence enactment of laws and formulation of public policy in the Commonwealth.

Section 103 Definitions

The definitions in this section apply throughout these Regulations.

(a) "Anything of value" includes the following:

1. A pecuniary item, including money or a bank bill or note;
2. A promissory note, bill of exchange, order, draft, warrant, check, or bond given for the payment of money;
3. A contract, agreement, promise, or other obligation for an advance, conveyance, forgiveness of indebtedness, deposit, distribution, loan, payment, gift, pledge or transfer of money;
4. A stock, bond, note or other investment interest in an entity;
5. A receipt given for the payment of money or other property;
6. A right in action;
(7) A gift, tangible good, chattel, or an interest in a gift, tangible good, or chattel;
(8) A loan or forgiveness of indebtedness;
(9) A work of art, antique, or collectible;
(10) An automobile or other means of personal transportation;
(11) Real property or an interest in real property, including title to realty, a fee simple or partial interest, present or future, contingent or vested within realty, a leasehold interest, or any other beneficial interest in realty.
(12) An honorarium or compensation for services;
(13) A rebate or discount in the price of anything of value unless the rebate or discount is made in the ordinary course of business to a member of the public without regard to that person's status as a public official or public employee, or the sale or trade of something for reasonable compensation that would ordinarily not be available to a member of the public.
(14) A promise or offer of employment; or
(15) Any other thing of value that is pecuniary or compensatory in value.

"Anything of value" does not mean a campaign contribution properly received and reported as required by law.

(b) "Business associate" includes the following:

(1) An employer.
(2) A general or limited partnership, or a general or limited partner within the partnership.
(3) A corporation:
   (A) that is family owned; or
   (B) in which all shares of stock are closely held;

or the shareholders, owners, or officers of the corporation.

(4) A corporation in which the public official or public employee, or other person subject to these Regulations:
   (A) has an investment interest in;
   (B) owns; or
   (C) has a beneficial interest in;

   shares of stock having a value of $500 or more.

(5) A corporation, business association, or other business entity in which the public official or public employee, or other person subject to these
Regulations, serves as an agent or a compensated representative.

(6) An association not otherwise covered by this definition between the public official or public employee, or other person subject to these Regulations, and another person, which involves the conduct of a common enterprise.

(c) “Candidate” means that definition set forth in 1 CMC §6003(e).

(d) “Compensation” includes:

money, anything of value or other pecuniary benefit received or to be received in return for, services rendered or to be rendered.

The term does not include reimbursement of expenses if:

(1) the reimbursement does not exceed the amount actually expended for the expenses; and

(2) it is substantiated by an itemization of expenses.

(e) “Contribution” means:

(1) a gift, subscription, loan or forgiveness of a loan, conveyance, advance, payment, distribution, or deposit of money or anything of value made to a political party or to influence the results of an election, or to reduce the debt of a candidate for nomination or election to public office;

(2) a written contract, promise, or agreement to make a contribution for any purpose described in subdivision (1);

(3) an expenditure made by a person or committee other than a candidate’s committee, with the cooperation of, or in consultation with, a candidate, candidate committee, or candidate’s agent or that is made in concert with, or at the request or suggestion of, a candidate, candidate committee, or candidate’s agent;

(4) the payment of compensation to a person other than a candidate or committee for personal services that are rendered to a candidate or committee at a rate less than the reasonable and customary charge to the candidate or committee for those services;

(5) funds or anything of value received by a committee that are transferred from another committee or other source;

(6) the purchase of tickets for an event such as a meal, reception, rally, raffle, or any similar fund-raising event;

(7) the candidate’s own money or property used on behalf of his or her candidacy; or

(8) the granting of a discount or rebate:
(A) not extended to the public generally; or
(B) by a television or radio station not extended equally to all
candidates for the same office.

A contribution does not include the following:

(1) Volunteer personal services not normally offered for sale to the public.
(2) A payment made by an individual for the individual’s own travel expenses
if the payment is made voluntarily without an understanding or agreement
that the payment will be repaid to the individual.
(3) A payment made by an occupant of a residence or office for costs related
to a meeting or fund-raising event held in the occupant’s residence or
office if the costs for the meeting or fund-raising event do not exceed five
hundred dollars ($500). However, if the occupant hosts more than one (1)
event in an election cycle for the same beneficiary, all subsequent
payments that exceed five hundred dollars ($500) in the aggregate are a
contribution.
(4) A loan of money made in the ordinary course of business by a financial
institution authorized to transact business in the Commonwealth at terms
and interest rates generally available to a member of the public without
regard to that person’s status as a public official or public employee by the
institution.
(5) Expenditures for nonpartisan voter registration.
(6) A communication by a corporation, organization, or association aimed at
its members, owners, stockholders, executive administrative personnel, or
their families.
(7) An offer or tender of a contribution if the offer or tender is expressly and
unconditionally rejected and not negotiated, deposited, or used, including
as collateral, and returned to the contributor within two (2) days or to the
Commonwealth, if the contribution is an anonymous contribution
prohibited under these Regulations.

(f) “Executive action” means the proposal, drafting, development, consideration,
amendment, adoption, approval, promulgation, issuance, modification, rejection,
or postponement by a Commonwealth government entity of a rule, regulation,
order, decision, determination, or other quasi-legislative or quasi-judicial action or
proceeding.

(g) “Executive agency” means:

(1) an agency, board, commission, or other body in the executive branch of
the Commonwealth government; or
(2) an independent body of the Commonwealth government that is not a part
of the legislative or judicial branch.

(h) “Executive official” includes:

(1) a member or employee of a CNMI agency, board, commission, or other body in the executive branch of the Commonwealth government; or

(2) a public official or employee of the Commonwealth who takes any executive action.

(i) “Expenditure” means a payment, distribution, loan advance, deposit, or gift of money or anything of value.

(j) “Gift” means anything of value other than a contribution under Section 103(d) to the extent that consideration of equal or greater value is not received. The term includes a rebate or discount in the price of anything of value unless the rebate or discount is made in the ordinary course of business to a member of the public without regard to that person’s status as a candidate.

The term does not include the following:

(1) Printed informational promotional material.

(2) A gift that:

(A) is not used; and

(B) no later than thirty (30) days after receipt, is returned to the donor or delivered to a charitable organization and is not claimed as a charitable contribution for income tax purposes.

(3) A gift, devise, or inheritance from an individual’s spouse, child, parent, grandparent, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, first cousin, or the spouse of any of the foregoing individuals, unless the donor is acting as the agent or intermediary for someone other than a person covered by this paragraph.

(4) A personalized plaque or trophy with a value that does not exceed five hundred dollars ($500).

(k) “Immediate family” means an unemancipated child residing in a public official’s or public employee’s household, a spouse of a public official or public employee, or an individual claimed by that public official or public employee or that public official’s or public employee’s spouse as a dependent for tax purposes.

(l) “Legislative action” includes the following:
(1) Preparation, research, drafting, introduction, consideration, modification, amendment, approval, passage, enactment, tabling, postponement, defeat, or rejection of a bill, resolution, amendment, motion, report, nomination, appointment, or other matter by:

(A) the Legislature; or
(B) a member or employee of the Legislature acting or purporting to act in an official capacity.

(2) Action by the Governor in approving or vetoing a bill, resolution, or other action of the Legislature.

(3) Action by the Legislature in:

(A) overriding or sustaining a veto by the Governor; or
(B) considering, confirming, or rejecting an appointment or nomination by the Governor.

(m) “Legislative official” includes:

(1) a member or member-elect of the Legislature;
(2) a member of a commission or other entity established by and responsible to the Legislature, or either house of the Legislature; or
(3) a staff member to a member or member-elect of the Legislature, or to a member of a commission or other entity established by and responsible to the Legislature, or either house of the Legislature.

(n) “Lobbying” means:

(1) influencing or attempting to influence legislative or executive action through oral or written communication;
(2) soliciting others to influence legislative or executive action; or
(3) attempting to obtain the goodwill of a legislative or executive official.

(o) “Lobbyist” means a person who by himself or herself or through any agent, employee, or other person in any manner whatsoever, directly or indirectly, solicits, collects or receives any money or any other thing of value to be used in any manner to aid in or influence:

(1) passage or defeat of any legislation by the legislature, or approval or veto of any legislation by the Governor; or
(2) adoption or defeat of any regulation, rule, rate, standard or decision of any board or commission of the Commonwealth which has rule-making
authority by law, regulation or the Constitution.

(p) “Lobbyist’s principal” means the entity in whose behalf the lobbyist influences or attempts to influence legislative or executive action.

(q) “Person” means an individual, proprietorship, firm, partnership, joint venture, joint stock company, syndicate, business trust, estate, company, corporation, association, club, committee, organization, or group of persons acting in concert.

(r) “Public employee” means that definition set forth in 1 CMC 8503(k).

(s) “Public official” means that definition set forth in 1 CMC 8503(l).

(t) “Value” means the retail cost or fair market worth of an item or items, whichever is greater.

Section 104 Registration

(a) Registration Requirements

A lobbyist shall file a registration statement with the Commonwealth Election Commission within five (5) days after becoming a lobbyist or lobbyist’s principal. A lobbyist or lobbyist’s principal existing at the time these Rules and Regulations are promulgated shall file a registration statement with the Commonwealth Election Commission within thirty (30) days thereafter.

(b) Contents of Registration Statement

A registration statement must include the following information:

(1) the name, address, and telephone number of the lobbyist;
(2) the name, address, and telephone number of the lobbyist’s principal;
(3) the kind of business of the lobbyist’s principal;
(4) the full name of the individual(s) who control(s) the lobbyist’s principal, the partners, if any, and officers and directors of the lobbyist’s principal;
(5) an identification of the subject matter in which the lobbyist will engage in lobbying, including the name and legislative identification number of the piece of legislation, or name and court or agency identification number of a case or action;
(6) the name and address of any public official who

(A) is employed by; or
(B) is a business associate of the lobbyist; and
(7) certification by the lobbyist that the information contained in the lobbyist registration statement is true and correct.

Section 105 Lobbyist Reporting

(a) A lobbyist shall file with the Commonwealth Election Commission a separate report, for each lobbyist's principal, of contributions, expenditures, and gifts containing all contributions and expenditures that were initiated or paid by the lobbyist on behalf of each lobbyist's principal during the prior calendar year.

(b) Each expenditure for the purpose of lobbying must be reported in the appropriate category of the expenditure as follows:

1. food and beverages;
2. entertainment;
3. travel and lodging;
4. direct payments to person or entity lobbied; and
5. research and education.

(c) The report must include a description of a contribution or expenditure of twenty-five dollars ($25) or more in the aggregate in one (1) calendar year initiated or made by the lobbyist to a public official or employee.

(d) For each public official or employee in whose behalf a payment of twenty-five dollars ($25) or more in the aggregate in one (1) year was initiated or made by the lobbyist under subsection (c), the report must also include the:

1. name of the public official or employee in whose behalf the payment was made;
2. name of the person receiving the payment;
3. name of the person making the payment;
4. amount of the payment; and
5. date of the payment.

(e) A cumulative report of contributions and expenditures for all reportable categories must be filed with the Commonwealth Election Commission no later than January 15 for the preceding calendar year.

Section 106 Exemptions

The registration and reporting provisions of these Regulations do not apply to:

(a) A public official or employee acting in an official capacity.
(b) A person who:

(1) represents only himself/herself/itself;
(2) purports to represent only that individual;
(3) receives no compensation or anything of value for lobbying; and
(4) has no pecuniary interest in the legislative, executive or administrative action, and the individual’s lobbying does not exceed:

(A) forty hours; or
(B) $500 of compensation;

in any calendar year.

(c) An individual who:

(1) limits lobbying solely to formal testimony before a public meeting of a legislative, executive or administrative body; and
(2) registers the appearance in the records of the public body or agency.

(d) A person whose lobbying does not exceed:

(1) twenty (20) hours; or
(2) $100 of compensation;

in any calendar year.

(e) News media and employees of the news media whose activity is limited solely to the publication or broadcast of news, editorial comments, or paid advertisements that attempt to influence legislative, executive or administrative action.

Section 108 Retention of Records by a Lobbyist or Lobbyist Principal

A lobbyist shall preserve for a period of five (5) years all accounts, bills, books, papers, receipts, and other documents and records necessary to substantiate the expenditure reports submitted under these Regulations. For example, documents supporting expenditures for 2002 shall be retained up to the end of 2007.

Section 109 Termination

(a) A lobbyist may seek to terminate a lobbyist registration by filing a report required under Sections 105 and 106, including information through the last day of lobbying activity.
(b) A termination report must indicate that the lobbyist intends to use the report as the final accounting of lobbying activity.

(c) Termination does not become effective until approved by the Commonwealth Election Commission. In determining whether the termination should become effective, the Commonwealth Election Commission shall consider the following:

1. completeness and accuracy of reporting;
2. the likelihood that the lobbying activity will continue; and
3. any circumstances about the lobbyist’s principal that the Commonwealth Election Commission deems appropriate in determining whether the termination should be honored.

Section 110 Authority of the Public Auditor

(a) Conduct of Investigations

1. The Public Auditor may conduct investigations, inquiries, and hearings concerning any matter covered by these Regulations.

2. When the Public Auditor determines that assistance is needed in conducting investigations, or when required by law, the Public Auditor shall request the assistance of other appropriate agencies.

(b) Prescription of Forms and Preservation of Documents

The Public Auditor shall prescribe and provide forms for reports, statements, notices, and other documents required by these Regulations. Documents filed with the Commonwealth Election Commission as public records must be retained for at least five (5) years from the date of their receipt.

(c) Review of Statements

The Commonwealth Election Commission shall:

1. review each statement filed in accordance with these Regulations for compliance with its provisions; and
2. notify the individual on whose behalf the statement is filed of any error, omission or deficiency.

(d) Access to Statements

The Commonwealth Election Commission shall make statements and reports filed
(e) Maintenance of Statements

The Commonwealth Election Commission shall compile and maintain an index of reports and statements filed with the Commonwealth Election Commission to facilitate public access to the reports and statements.

Section 111 Complaints

(a) Complaints Submitted

(1) The Public Auditor may accept complaints in writing that state the name of a person alleged to have committed a violation of these regulations and setting forth the particulars of the violation. The Public Auditor may also initiate an investigation if it receives information that leads it to believe that a violation of the Regulations may have occurred.

(2) The Public Auditor shall forward a copy of the complaint to the person who is the subject of the complaint.

(3) If the Public Auditor determines that the complaint does not allege facts sufficient to constitute a violation of these Regulations, it shall dismiss the complaint and notify the complainant and the respondent. If the Public Auditor determines that the complaint alleges facts sufficient to constitute a violation of these Regulations, the Public Auditor may conduct an investigation with respect to an alleged violation.

(4) If the Public Auditor, during the course of an investigation, or upon the receipt of information, finds that a violation of these Regulations has occurred, it shall forward a copy of the investigative report on the matter to the Attorney General and to the person under investigation.

(b) Right to Offer Information

The Public Auditor shall afford a public official or employee who is the subject of a complaint an opportunity to explain the conduct alleged to be in violation of these Regulations.

(c) Right to Request an Investigation of One’s Own Conduct

A public official or employee may request the Public Auditor to make an investigation of the public official or employee’s own conduct, or of allegations made by another individual as to the public official or public employee’s conduct. This request must be in writing and set forth in detail the reasons for requesting an investigation.
Section 112 Investigations

Public Auditor Investigatory Powers set forth in Public Law 3-91 are available for use in an investigation of a violation of these regulations.

Section 113 Miscellaneous Penalty Provisions

(a) Tax Treatment of Fines and Repayments

(1) A fine, penalty, reimbursement, or other payment ordered by a or court in connection with making the government whole for a transaction improperly entered into by a public official, employee, or consultant, or a member of the immediate household of a public official, employee, or consultant does not qualify for a tax credit or deduction.

(2) The guilt or innocence of a party making a payment under subsection (1) has no effect upon the tax consequences, nor does an admission or failure to admit guilt or complicity in a transaction.
NOTICE OF PROPOSED AMENDMENTS TO THE REGULATIONS FOR REAL ESTATE APPRAISERS

The Board of Professional Licensing hereby notifies the General Public that it proposes to amend its Regulations for Real Estate Appraisers. Interested persons may obtain copies of the proposed amendments from the Board of Professional Licensing office, 2nd Floor of ICC Building, Gualo Rai.

Anyone interested in commenting on the proposed amendments may do so within 30 days from the date of this notice is published in the Commonwealth Register.

Dated this ___ day of September, 2002.

Elizabeth S. Balajadia
Chairwoman

FILED BY: Soledad B. Sasamoto
Registrar of Corporations

RECEIVED BY: Thomas I. Teputeb
Special Assistant for Administration

Pursuant to 1 CMC §2153 as amended by P.L. 10-50 the rules and regulations attached hereto have been reviewed and approved as to form and legal sufficiency by the CMII Attorney General's Office.

Ramona V. Mangiona
Deputy Attorney General

BY: ANGELA BENNETT
Assistant Attorney General

DATE: 10-30-02 9:50AM
NUTISIA PUT I MAPROPOPONE NA AMENDASION 
GI REGULASION REAL ESTATE APPRAISERS

I Board of Professional Licensing ginen este man nana'e nutisia para i publiku henerat na ha propopone para u ma amenda i Regulasion para Real Estate Appraisers. I maninteresao siha na pesona siha manmanaule kopian este siha na amendasion gi Ofisinan Board of Professional Licensing saige gi mina'dos bibenda ICC Building giya Gualo Rai.

Hayi siha maninteresao man na'halom kamento put i manmapropopone siha na amendasion, siha matugi papa ya ma submit gi halom trenta (30) dias despues di mapublika huyong este na nutisia gi Rehistran Commonwealth.

Ma fecha gi dia 30th gi Septembre, 2002.

Elizabeth S. Balaadia
Chairwoman

Ma File As:

Soledad B. Sasamoto
Rehistroran Kotporasion

Kinisibi As:

Thomas I. Tebuteb
Speciat Asst. para i Atministrasion

Sigen gi 1 CMC §2153 ni inamenda ni Lai Pupbliku 10-50 i areklamento yan regulasion ni chechetton esta manmainan moolek yan ma apreba. Sigen i fotma kumo ligat yan sufisiente ni Ofisialis Attorney General guine gi CNMI.

Ma fecha gi dia 30 gi Octobre, 2002.

Ramona V. Manglona
Deputy Attorney General

Ginen: ANGELA BENNETT
Assistant Attorney General
BOARD OF PROFESSIONAL LICENSING
Commonwealth of the Northern Mariana Islands
P.O. Box 503078
Saipan, MP 96950
Tel. No.: (670) 234-5897
Fax No.: (670) 234-6040

Statutory Authority
The Board of Professional Licensing promulgated these proposed amendments pursuant to the powers granted it by Section 3105 of 4 CMC, Div. 3 (P.L. 1-8 and 4-53).

Statement of Goals and Objectives
The intent of the amendments is to update and comply with the applicable federal law, specifically the Financial Institutions Reform, Recovery and Enforcement Act of 1989, federal regulations, as well as to protect the interest of land owners, financial institutions and appraisers in the CNMI.

Brief Summary of the Proposed Amendments
The proposed amendments is to update the regulations to be in compliance with the federal laws as adopted by the Board.

For Further Information Contact:
Florence C. Sablan, Executive Director at 234-5897 or 235-5898 or fax at 234-6040.
PART I. GENERAL PROVISIONS

1.1 Purpose. The purpose of these regulations is to comply with applicable federal law, specifically the Financial Institutions Reform, Recovery and Enforcement Act of 1989, and federal institutions, as well as to protect the interests of land owners, financial institutions, appraisers and other interested persons in the Commonwealth of the Northern Mariana Islands (hereafter "CNMI or NMI").

1.2 Intent and Effect. The receipt of a license or certificate from the CNMI Board of Professional Licensing does not permit a person to engage in business in the CNMI until such person has complied with any and all applicable laws, rules and regulations and secured all necessary licenses and permits for conducting business in the NMI. It is the intent of these regulations to ensure high standards of professional competence for real property appraisers in the CNMI and to comply with applicable federal statutes and regulations.

Due to scarcity of qualified persons in the CNMI, it is the intent of these regulations to establish two classes of approved real property appraisers:

**Non-Federally Related Transactions**
- Licensed Residential Real Property Appraiser
- Licensed General Real Property Appraiser

**Federally Related Transactions**
- Licensed Real Property Appraiser
- Certified Residential Real Property Appraiser
- Certified General Real Property Appraiser

The first class of appraisers will qualify to do appraisals in non-federally related real property transactions and will not qualify under federal law and these regulations to perform federally related real property transactions.

The second class of real property appraisers will qualify to perform appraisals in both federally related and non-federally related real property transactions, the difference between licensed and certified status being further defined.
1.3 **Authority.** The CNMI Board of Professional Licensing (hereafter “Board”) has the authority to regulate real property appraisers pursuant to 4 CMC, Div. 3, Section 3105 and Section 3108.

**PART II. DEFINITIONS**

2.1 **Appraisal Foundation.** The Appraisal Foundation established on November 30, 1987, as a non-for-profit corporation under the laws of Illinois.

2.2 **Appraisal Qualifications Board.** The board appointed by the Appraisal Foundation to establish criteria for appraiser licensing and certification.

2.3 **Appraiser or Real Property Appraiser.** A CNMI Licensed Residential Real Property Appraiser, non-federally related transactions, or a CNMI Licensed General Real Property Appraiser, non-federally related transactions, or a CNMI Licensed Real property Appraiser, federally related transactions, or a Certified Residential Real Property Appraiser, federally related transactions, or a Certified General Real Property Appraiser, federally related transactions, who is expected to perform valuation services competently and in a manner that is independent, impartial and objective.

2.4 **Appraisal.** The act or process of developing an opinion of value.

2.5 **Appraisal Assignment.** One or more real estate appraisals and written appraisal reports which are covered by a single contract to provide an appraisal.

2.6 **Appraisal Consulting.** The act or process of developing an analysis, recommendations, or opinion to solve a problem, where an opinion is a component of the analysis leading to the assignment results.

2.7 **Appraisal Practice.** Valuation services including, but not limited to, appraisal, appraisal review, or appraisal consulting, performed by an individual as an appraiser.

2.8 **Appraisal Review.** The act or process of developing and communicating and communicating an opinion about the quality of another appraiser's work.

2.9 **Appraisal Subcommittee.** The Appraisal subcommittee of the Federal Financial Institutions Examination Council (FFIEC) consisting of representatives from the federal financial institutions regulatory agencies.
2.10 **Appraiser Trainee.** A person who has been issued a registration number as a registered real property appraiser trainee in the Northern Marianas.

2.11 **Certificate.** A document issued by the Board indicating that the person named thereon has satisfied the requirements for certification as CNMI certified real property appraiser, federally related transactions.

2.12 **Certified Appraiser.** A CNMI Certified Residential or General Real Property Appraiser for federally related transactions.

2.13 **Classroom Hour.** Sixty minutes, of which at least fifty minutes are instruction attended by the student. The prescribed number of classroom hours includes time devoted to examinations.

2.14 **Complex One-To Four Family Residential Property Appraisal.** One in which the property to be appraised, market conditions, or form of ownership is a typical and which have a significant value contribution. For example, unusual factors may include but are not limited to:

(a) architectural style;
(b) age of improvements;
(c) size of improvements;
(d) size of lot;
(e) neighborhood land use;
(f) potential environmental hazard liability;
(g) leasehold interests;
(h) limited readily available comparable sales data; or
(i) other unusual factors.

2.15 **Continuing Education.** Education that is creditable toward the education requirements that must be satisfied to renew licensure or certification as a Licensed Real Property Appraiser, Certified Residential Real Property Appraiser, and Certified General Real Property Appraiser.

2.16 **Direct Supervision.** To actively and personally review the appraisal report of an appraiser trainee, to accept responsibility for the appraisal, and to sign the report attesting to the acceptance of the appraisal as being independently and impartially prepared and in compliance with the Uniform Standards of Professional Appraisal Practice (USPAP).
2.17 **Distance Education.** A course instruction in which the pupil received instruction at a location at which the pupil received instruction in CD-ROM, On-line learning, correspondence courses, Video Conference, etc.

2.18 **Federally Related Real Estate Transaction.** The term "federally related transaction" means any real property-related financial transaction which:
(a) a federal financial institutions regulatory agency or the Resolution Trust Corporation engages in, contracts for, or regulates; and
(b) requires the services of an appraiser.

2.19 **License.** The document indicating that the person named thereon has satisfied all requirements for licensure as a CNMI licensed appraiser.

2.20 **Licensed Appraiser.** Licensed Residential Real Property Appraiser, non-federally related transactions, or a Licensed General Real Property Appraiser, non-federally related transactions, or a Licensed Real Property Appraiser, federally related transactions.

2.21 **Market Analysis.** A study of market conditions for a specific type of property.

2.22 **Market Value.** A type of value, stated as an opinion, that presumes the transfer of a property (i.e., a right of ownership or a bundle of such rights), as of a certain date, under specific conditions set forth in the definition of the term identified by the appraiser as applicable in an appraisal.

2.23 **Mass Appraisal.** The process of valuing a universe of properties as of a given date using standard methodology, employing common data, and allowing for statistical testing.

2.24 **Non-Federally Related Real Estate Transaction.** Any transaction which does not meet the definition of a federally related transaction.

2.25 **Qualifying Education.** Education that is creditable toward the education requirements for initial licensure or certification under one or more of the three real property appraiser classifications (Licensed Real property Appraiser, Certified Residential Real Property Appraiser, and Certified General Real Property Appraiser). Qualifying education courses are acceptable as continuing education courses as long as they are not a duplicate.

2.26 **Real Property.** The interests, benefits, and rights inherent in the ownership of real estate.
2.27 **Real Property-Related Financial Transaction.** Any transaction involving:
(a) the sale, lease, purchase, investment in, or exchange of real property, including interests in property, or the financing thereof; or
(b) the refinancing of real property or interests in real property; or
© the use of real property or interests in real property as security for a loan or investment, including mortgage backed securities.

2.28 **Real Estate.** An identified parcel or tract of land, including improvements, if any.

2.29 **Report.** Any communication, written or oral, of an appraisal, appraisal review, or appraisal consulting services that is transmitted to the client upon completion of an assignment.

2.30 **Residential Property.** Any parcel of real property, improved or unimproved, that is utilized for one-to-four family purposes and where the highest and best use is for one-to-four family purposes. A residential unit in a condominium, townhouse or cooperative complex is considered to be residential real property. Residential property does not include subdivisions wherein a development analysis or appraisal is necessary or utilized.

2.31 **Restore or Restoration.** The granting of permission to perform appraiser work by the Board to a person whose license or certificate has been previously suspended or revoked.

2.32 **Temporary Appraiser's License or Certificate.** A license or certificate for one specific appraisal contract, issued to a licensed or certified appraiser not residing in the CNMI, or who has no established business in the CNMI.

2.33 **Tract Development.** A project of five units or more that is constructed or is to be constructed as a single development. A tract development may be units in a subdivision, condominium project, time share project, or any similar project meant to be sold as individual units over a period of time. A project is deemed to be a tract development whether it currently is or is intended to sell as a single development.

2.34 **Uniform Standards of Professional Appraisal Practice or USPAP.** Standards of appraisal practice developed by the Appraisal Standards Board (ASB) of the Appraisal Foundation. These standards deal with procedures to be followed in performing an appraisal, appraisal review, or appraisal consulting service and the manner which an appraisal, appraisal review, or appraisal consulting service is communicated.
2.35 **Value.** The monetary relationship between properties and those who buy, sell, or use those properties.

2.36 **Years of Experience.** A year is defined in terms of hours within a calendar year. One thousand (1,000) hours constitutes a year of appraisal experience.

**PART III. POWERS AND DUTIES OF THE BOARD**

3.1 **Powers and Duties of the Board.** In addition to those powers and duties specifically enumerated by law, the Board shall have the following powers and duties:

(a) to grant, deny, renew, or refuse to renew permission to practice as a licensed or certified real property appraiser in the CNMI;

(b) to adopt, amend, or repeal rules and/or regulations as necessary to effectuate fully the law;

(c) to enforce the law and rules and regulations adopted pursuant thereto;

(d) to discipline a real estate appraiser to any cause prescribed by law or for any violation of the rules and regulations and refuse to grant a person permission to practice as a real property appraiser for any cause that would be grounds for disciplining a real property appraiser;

(e) to act as the designated representative of the CNMI to exempt, waive or implement the requirements of 12 U.S.C.§3301 et seq.;

(f) to revoke or suspend the permission to practice as an appraiser or otherwise condition the scope of the license or certification of the appraiser for any violation of the law or these regulations;

(g) to impose continuing education requirements as a prerequisite to renewal of licensing or certification, as necessary;

(h) to issue an annual statement describing the receipts and expenditures in the administration of these regulations during each fiscal year;

(i) to compel the attendance of witnesses and production of books, documents, records, and other papers; to administer oaths; and to take testimony and receive evidence concerning all matters within their jurisdiction. These powers may be exercised directly by the Board or the Board's authorized representative acting by authority of law;

(j) to contract with qualified persons, including attorneys, hearing officers, accountants, investigators, and other necessary personnel to assist the Board in exercising the Board's powers and duties;

(k) to contract with a professional testing agency to develop and administer examinations;

(l) to do all other things necessary to carry out the provisions of these regulations and to meet the requirements of federal law where necessary regarding licensing and
certification of appraisers that the Board determines are appropriate for licensed and certified appraisers in the CNMI.

PART IV. LICENSE AND CERTIFICATION REQUIREMENTS

4.1 License or Certification Required. It shall be unlawful for an individual who is not licensed or certified in the CNMI to prepare or hold oneself out as being able to prepare an appraisal in connection with a real property related transaction requiring licensure or certification under these regulations. It shall be unlawful for a person with one class of license to perform an appraisal requiring a different class of license.

4.2 General Requirements. All applicants for a license or certificate shall possess a reputation for honesty, trustworthiness, fairness, and financial integrity; meet educational and experience requirements; and shall pass an examination approved by the Appraiser Qualifications Board of the Appraisal Foundation and not have been convicted of a crime related to real property appraisal profession. Applicants for the non-federally related appraiser license must take and pass the local appraisal examination as part of the requirement.

4.3 Requirements for Real Property Appraiser, Federally Related Transactions. All applicants for a Real Property Appraiser license or certificate must meet the following requirements:

A. Education.

1. Classroom Hour.
   a. A classroom hour is 60 minutes, of which at least 50 minutes are instruction attended by the student. The prescribed number of classroom hours includes time devoted to examinations.

   2. Credit for the classroom hour requirement may be obtained only from the following institutions:
      a. Colleges or Universities
      b. Community or Junior Colleges
      c. Real Estate Appraisal or Real Estate Related Organizations
      d. State or Federal Agencies or Commissions
      e. Proprietary Schools
      f. AQB approved course providers

   3. Credit toward the classroom hour requirement may be awarded to instructors of appraisal courses.
4. Experience may not be substituted for education.

5. Qualifying Education (QE).
   a. Classroom hours will be credited only for education offerings with content that covers the real property appraisal core curriculum listed (see Appendix A).
   b. Classroom hours may be obtained only where the minimum length of the education offering is at least 15 hours and the individual successfully completes a closed-book examination pertinent to that education offering.
   c. Courses taken for QE must not be repetitive in nature.
   d. Applicants must take the 15-hour National USPAP Course and pass the 15-hour National USPAP Course Examination. The instructor for this course must be an AQB certified USPAP instructor.

6. A distance education course is acceptable to meet the qualifying education classroom requirements provided the course provides interaction between the learner and the instructor and meets the following conditions:
   a. The course must be presented by an accredited (Commission or Colleges or a regional accreditation association) college or university that offers distance education programs in other disciplines; or
   b. The course has received the American Council on Education through its ACE/Credit Program, or has received approval of the International Distance Education Certification Center's (IDECC) for the course design and delivery mechanism and, the approval of the AQB through the AQB Course Approval Program; and
   c. The course is equivalent to the minimum of 15 classroom hours and the individual successfully completes a written examination proctored by an official approved by the college or university.

B. Examination.
   1. Each applicant for a license or a certificate shall successfully pass the appropriate examinations of the AQB required Uniform Appraiser Examination. The examination must be successfully completed. There is no alternative to successful completion of the examination.
2. Passage of an examination taken in another jurisdiction may be approved as meeting the examination requirement provided the examination is the AQB required Uniform Appraiser Examination.

C. Experience.

1. Education may not be substituted for experience.

2. Acceptable appraisal experience includes, but is not limited to the following:
   a. Fees and staff appraisal
   b. Ad valorem tax appraisal
   c. Condemnation appraisal
   d. Technical review appraisal
   e. Appraisal analysis
   f. Real estate consulting
   g. Highest and best use analysis
   h. Feasibility analysis/study

3. The verification for experience credit claimed by an applicant shall be on forms prescribed by the Board which should include:
   a. Type of property
   b. Date of report
   c. Address of appraised property
   d. Description of work performed
   e. Number of work hours

4. Experience obtained after January 1, 1991 shall comply with the Uniform Standards of Professional Practice (USPAP).

5. There is no time limit during which experience may be obtained. Hours may be treated as cumulative in order to achieve the necessary hours of appraisal experience (i.e. Year 1-200 hours, year 2-800 hours, etc.).

D. Compliance with USPAP
All appraiser classifications shall perform and practice in compliance with the Uniform Standards of Professional Appraisal Practice (USPAP), as amended.
4.4 Real Property Appraiser Classifications

A. Trainee Real Property Appraiser

The scope of practice for this classification is the appraisal of those properties which the supervising appraiser is qualified to appraise. The appraiser trainee shall be entitled to obtain copies of appraisal reports he or she prepared. The supervising appraiser shall keep copies of appraisal reports for a period of five years, or at least two years after final disposition of any judicial proceedings in which testimony was given, whichever period expires last.

1. Qualifying Education

As a prerequisite for application, an applicant must have completed 75 classroom hours, including 30 hours of Basic Appraisal Procedures, and the 15-hour National USPAP Course and examination.

2. Examination

There is no examination requirements for this classification but the trainee shall pass examinations in the prerequisite courses in order to earn credit for the core education courses.

3. Experience

No experience is required as a prerequisite for this classification.

4. Training

a. The appraiser trainee shall be under the direct supervision of a licensed or certified appraiser.

b. The supervising appraiser shall be responsible for the training, guidance, and direct supervision of the appraiser trainee by:

   i) accepting responsibility for the appraisal report by signing and certifying the report complies with generally accepted appraisal procedures and is in compliance with USPAP;

   ii) reviewing and signing the appraiser trainee appraisal report(s); and

   iii) personally inspecting each appraised property with the appraiser trainee until the supervising appraiser determines the appraiser trainee is competent, in accordance with the Competency Rules of the USPAP for the property type.

c. The appraiser trainee is permitted to have more than one supervising appraiser.
d. An appraisal log shall be maintained by the appraiser trainee and the supervising appraiser jointly, that shall, at a minimum, include the following for each appraisal:
   i) Type of property
   ii) Date of Value
   iii) Address of appraised property
   iv) Description of work performed by the trainee and scope of the review and supervision of the supervising appraiser
   v) Number of work hours
   vi) Signature and license/certification number of the supervising appraiser

e. The supervising appraiser shall be in good standing in the CNMI, not subject to any disciplinary action, probation, suspension, or disciplinary proceeding within the last two years.

5. Continuing Education
   a. Fourteen (14) continuing education hours for each year (28 hours); and
   b. Successful completion of the 7-hour National USPAP Update Course, at a minimum of every two years.

B. Licensed Real Property Appraiser

This classification applies to the appraisal of non-complex one to four residential units having a transaction value less than $1,000,000 and complex one to four residential units having a transaction value less than $250,000.

1. Qualifying Education
   The prerequisite for taking the examination is completion of One hundred forty (140) classroom hours, which shall include completion of the 15-Hour National USPAP Course and Examination.

2. Examination
   The AQB approved Uniform State Licensed Real Property Appraiser Examination must be successfully completed.

3. Experience
   Two thousand (2,000) hours of experience are required.
4. Continuing Education
   a. Fourteen (14) continuing education hours for each year (28) hours; and
   b. Successful completion of the 7-hour National USPAP Update Course, at a minimum of every two years.

C. Certified Residential Real Property Appraiser
   This classification qualifies the appraiser to appraise one to four residential units without regard to value.
   a. This classification includes the appraisal of vacant or unimproved land that is utilized for one to four family purposes or for which the highest and best use is for one to four family purposes.
   b. This classification does not include the appraisal of subdivisions for which a development analysis/appraisal is necessary.

1. Qualifying Education
   a. Applicants for this classification shall hold an Associates of Arts or Science degree from an accredited college or university; or
   b. An applicant for this classification shall successfully pass the following collegiate level courses from an accredited college or university with a total of 21 semester credit hours specified below:
      1) English Composition - 3 hrs.
      2) Principles of Economic - 3 hrs.
      3) Finance - 3 hrs.
      4) Algebra and Geometry - 3 hrs.
      5) Statistics - 3 hrs.
      6) Introduction to Computers - 3 hrs.  
         (Word Processing/spreadsheets)
      7) Business or Real Estate Law - 3 hrs.
   c. The prerequisite for taking the examination is completion of two hundred (200) classroom hours, which shall include completion of the 15-hour National USPAP Course and Examination.

2. Examination
   The AQB required Uniform State Certified Residential Real Property Appraiser Examination must be successfully completed. The Certified General Real Property Appraiser Examination is not equivalent to this examination.
3. Experience
   Two thousand five hundred (2,500) hours of experience obtained during no fewer than twenty-four (24) months is required. While the hours may be cumulative, the required number of months must be fewer than (30) months is required, of which one thousand five hundred (1,500) hours must be in non-residential appraisal work. While the hours may be cumulative, the required number of months must accrue before an individual can be certified.

4. Continuing Education
   a. Fourteen (14) continuing education hours for each year (28) hours; and
   b. Successful completion of the 7-hour National USPAP Update Course, at a minimum of every two years.

4.5 Approved Course Providers
   A. Colleges, universities and community and junior colleges accredited by nationally recognized accreditation organizations and State or Federal agencies or commissions are approved course providers; or

   B. Real property appraiser or real estate related organizations, proprietary schools, and others shall be approved provided the course provider or the courses offered has received the American council on Education's Program on Non-Collegiate Sponsored Instruction (ACE/PONSI) approval for college credit; and

   C. Real property appraiser or real estate related organizations, proprietary schools, and others shall be approved provided that the course provider have obtained approval of their course(s) under the Appraisal Qualifications Board (ABQ) Course Approval Program (CAP) and proof of the approval is filed with the Board.

4.6 Continuing Education (CE)
   A. The equivalent of fourteen (14) classroom hours of instruction in courses or seminars for each year during the period preceding the renewal is required. (For example, a two-year certification term would require twenty-eight (28) hours). These hours may be obtained anytime during the two-year term.

   B. Credit towards the continuing education hour requirements for each appraiser classification may be granted only where the length of the educational offering is at least two hours.
C. Credit for the classroom hour requirement may be obtained only from the following institutions:
   a. Colleges or Universities
   b. Community or Junior Colleges
   c. Real Estate Appraisal or Real Estate Related Organizations
   d. State or Federal Agencies or Commissions
   e. Proprietary schools
   f. AQB approved course providers

D. Credit may be granted for education offerings that are consistent with the purpose of continuing education and cover those real estate related appraisal topics, including, but not limited to:
   a. Ad valorem taxation
   b. Arbitration, dispute resolution
   c. Courses related to the practice of real estate appraisal or consulting
   d. Development cost estimating
   e. Ethics and standards of professional practice, USPAP
   f. Land use planning, zoning
   g. Management, leasing, timesharing
   h. Property development, partial interests
   i. Real Estate Appraisal
   j. Real Estate financing and investment
   k. Real Estate law, easements and legal interests
   l. Real estate litigation, damages, condemnation
   m. Real estate appraisal related computer applications
   n. Real estate securities and syndication
   o. Real property exchange

E. Appraisers must successfully complete the 7-Hour National USPAP Update Course, at least once every two years. The 7-Hour USPAP Update Course continuing education credit shall only be awarded when the course is instructed by a AQB certified USPAP instructor.

F. Qualifying education courses are acceptable as continuing education courses as long as they are not a duplicate.

G. An appraiser who has successfully completed an approved course to meet any part of such appraiser's continuing education requirements may be repeat that course unless at least one full year has passed since the completion of that course.
H. The Board, in its discretion, may require the completion of an examination at the end of any continuing education course.

I. Continuing education credit may also be granted by the Board for participation, other than as a student, in appraisal educational processes and programs. Examples of activities for which credit may be granted are teaching, program development, authorship of textbooks, or similar activities that are determined by the Board to be equivalent to obtained continuing education.

J. An appraiser may be granted credit for up to 4 hours of their annual continuing education requirement if they actively supervise and manage a trainee for the entire year, provided the trainee program is compliant with minimum AQB criteria.

K. Educational offerings taken by an individual in order to fulfill the classroom hour requirement for a different classification than his/her current classification may be simultaneously counted towards the continuing education requirement of his/her current classification.

L. A distance education course is acceptable to meet the continuing education requirements provided the course provides interaction between the learner and the instructor and meets the following conditions:
   a. The course must be presented by an accredited (Commission on a Colleges or regional accreditation association) college or university that offers distance education programs in other disciplines: or
   b. The course has received the American Council on Education through its ACE/Credit Program, or has received approval of the International Distance Education Certification Center's (IDECC) for the course design and delivery mechanism and the approval of the AQB through the AQB Course Approval Program; and
   c. The course is equivalent to the minimum of at least two classroom hours.

M. Continuing education credit hours in excess of the twenty-eight (28) continuing education hours for every two year renewal period shall not be credited to satisfy continuing education hours for the next two year renewal period.

N. As a prerequisite to renewal of a license or certificate, a real property appraiser shall present satisfactory evidence of having met the continuing education requirements.
PART V. APPRAISERS-NON-FEDERALLY RELATED TRANSACTIONS

5.1 Education/Experience Requirements for Non-Federally Related Transactions. Applicants must meet the following requirements for licensing as a CNMI Licensed Residential Real Property Appraiser or CNMI Licensed General Real Property Appraiser, non-federally related transactions or for renewal:

A. Licensed Residential Real Property Appraiser - Non-Federally Related Transactions classification - includes the appraisal of vacant or unimproved land of one to four residential units. This classification does not include the appraisal of subdivisions wherein a development appraisal is necessary and utilized. This appraiser is not qualified under the law and these regulations to perform federally related real property transactions. At least 50% of the experience claimed must have been in major residential appraisal work.

B. Licensed General Real Property Appraiser - Non-Federally Related Transactions Classification - This classification requires that at least 50% of the experience claimed must have been in non-residential appraisal work and can do appraisals of all real estate transactions without regard to transaction value or complexity. This appraiser is not qualified under the law and these regulations to perform federally related real property transactions.

C. Education and Experience
1. One Hundred (100) classroom hours in courses related to real property appraisal with six (6) years experience as an appraiser; or

2. An AA in Business Administration with seventy-five (75) classroom hours in courses related to real property appraisal with (4) years experience as an appraiser; or

3. A Bachelor's degree or higher with fifty (50) classroom hours in courses related to real property appraisal and two (2) years experience as an appraiser.

D. All applicants must take and pass the local appraisal examination approved by the Board. The examination shall be based upon recognized appraisal standards, to be selected and administered by the Board pursuant to its rulemaking power.
E. Police clearance from all states where licensed or certified or presently or formerly residing shall be furnished as a condition to apply for a license or certification or renewal.

F. To verify appraisal experience as required in Section (c), the applicant must submit at least one appraisal report he or she has written for each of the required years of experience above mentioned.

**PART VI. APPLICATION**

6.1 **Application for Licensure or Certification.** Application for licensure or certification shall be made under oath or under penalty of perjury as permitted under CNMI law on a form to be furnished by the Board. The form may require the applicant to provide:

A. The applicant's full name;

B. A statement that the applicant has attained the age of majority (18);

C. The applicant's current business or mailing address or publication, and the applicant's current resident address;

D. The applicant's social security number;

E. The applicant's employment history during the five years preceding the date of the filing of the application, with names and addresses of each employer;

F. The date and place of any conviction of felony or any crime in any way related to any appraisal practice;

G. Information regarding any disciplinary proceedings or disciplinary actions taken by any jurisdiction;

H. A designation in writing appointing the Board to act as the applicant's agent upon whom all judicial and other process or legal notices directed to the applicant may be served. The applicant shall agree that service upon the Board shall have the same legal force and validity as if personally served upon the applicant when such judicial or other process or legal notice is related directly or indirectly to a license or certificate issued by the Board. This procedure is for informational purposes only and is not intended to be, and of itself does not constitute, valid, legal service upon the licensee or certificate holder.
who must be served on a basis consistent with applicable CNMI laws, rules, regulations and/or Rules of Court. The Board shall immediately forward such judicial or other process or legal notice to the licensee or certificate holder by the mailing of such document certified mail, return receipt requested, to the last address which the certificate holder or licensee has provided to the Board. The Board's compliance with the notification requirement as provided herein shall conclude the Board's liability and notification responsibility of the licensee or certificate holder.

I. A photograph of the applicant for identification purposes;

J. Any other information the Board may require to investigate the applicant's qualifications for licensure or certification.

6.2 **Supporting Documents Required.** Every applicant shall furnish the following with the applicant:

A. The appropriate fees;

B. Proof that the applicant has met the educational, examination, and experience requirements;

C. Notarized statement of experience or under penalty of perjury as permitted by applicable CNMI law;

D. Three reference from lenders or other individuals who have had dealings relating to the applicant's appraisal assignments attesting to the applicant's experience and reputation for honesty, truthfulness, fairness, and financial integrity;

E. If requested, proof that the applicant is a CNMI or United States citizen or a non-U.S. citizen authorized to work in the CNMI: and

F. If requested, appraisal reports or file memoranda.

G. Other additional information as the Board from time to time deems appropriate or necessary.

6.3 **Reputation for Honesty, Truthfulness, Fairness and Financial Integrity.** Applicant shall demonstrate, as set forth in 6.2 (D) that the applicant possesses a good reputation for honesty, truthfulness, fairness and financial integrity.
6.4 Issuance of License or Certificate. The CNMI appraiser license or CNMI appraiser certificate shall be issued upon the applicant meeting all appropriate requirements and must be renewed as required by the CNMI law and provided herein every two years from the date of issuance or renewal.

6.5 License or Certificate Issued. A CNMI license or CNMI certificate shall only be issued to individuals and the license or certificate shall not be transferable.

6.6 Filing of Current Address. Every licensee or certificate holder shall provide written notice to the Board of any changes of the licensee's or certificate holder's mailing, business, or residence address within ten days of the change. Any requirements that the Board provide notice to licensed or certificate appraisers shall be deemed met if notice is sent to the address on file with the Board.

6.7 Responsibility of Applicant to Furnish Information and Documentation. It shall be each applicant's responsibility to furnish the information and documents requested. In the event of any change of information provided, the applicant shall notify the Board in writing within thirty days of any change.

6.8 Signing and Verification of Application. Every application and all references shall be signed and notarized or signed under penalty of perjury as permitted by applicable CNMI law by the applicant or the person attesting to the experience and reputation of the applicant.

6.9 Application for Temporary Practice. Application for a temporary license or certificate will be processed and issued within five (5) business days after receipt of a complete application for a temporary license or certificate.

6.10 Application for Certified Real Property Appraiser, Federally Related Transactions from Licensed Real Property Appraiser, Federally Related Transaction.

A. An individual holding a current real property appraiser, federally related transaction license may apply for certified real property appraiser, federally related transactions status upon submittal of the following:

1. Certified Residential Real Property Appraiser:
   (a) appropriate fees;
   (b) proof that the applicant has met the education requirement of 200 classroom hours, which may include the 140 classroom hours
requirements for licensed classification, or courses in subjects related to real property appraisal which shall include the 15-hour National USPAP Course and examination and successful completion of the AQB approved Uniform State Certified Residential Appraiser Examination; and
(c) proof that the applicant has performed at least 2,500 hour of major residential appraisal work obtained within 24 months.

2. Certified General Real Property Appraiser:
   (a) appropriate fees;
   (b) proof that the applicant has met the education requirement of 315 classroom hours, which may include the 140 classroom hours requirement for the licensed classification and/or the 200 classroom hours requirement for the certified residential classification of courses in subjects related to real property appraisal which shall include the 15-hour National USPAP Course and examination and successful completion of the AQB approved Uniform State Certified General Appraiser Examination; and
   (c) proof that the applicant has performed at least 3,000 hours of appraisal experience obtained during no fewer than 30 months, of which 1,500 hours must be in non-residential appraisal work.

B. Credit awarded for the continuing education requirement may also be awarded for the classroom hour requirement when an individual seeks a different classification than that held, provided the education offering meets the criteria established for the classroom hour and continuing education requirements.

6.11 Criminal Conviction. When an applicant has been convicted of felony or a crime related to the appraisal profession the Board may request the following documents from the applicant: copies of any court records, orders, or other documents that state the facts and statutes upon which the applicant was convicted, the verdict of the court with regard to that conviction, the sentence imposed, and the actual terms of the sentence.

6.12 Denial or Rejection of Application.
A. An application for issuance of a license or certificate shall be denied when an application is insufficient or incomplete or when an applicant has failed to provide satisfactory proof that the applicant meets the requirements hereunder. In addition, the Board may deny issuance of a license or certificate:
   1. When the applicant is known to have committed any of the acts for which a license or certificate may be suspended or revoked hereunder.
2. If the applicant fails to demonstrate that the applicant possesses a good reputation for honesty, truthfulness, fairness and financial integrity; or

3. If the applicant has had disciplinary action taken by any jurisdiction, including any federal or state regulatory body.

B. An applicant shall be automatically rejected and the applicant shall be denied licensure or certification when the applicant, after having been notified to do so:

1. Fails to pay the appropriate fees within sixty days from notification; or

2. Fails to submit, after notification, any of the information or documentation requested to comply with any of the requirements for licensure or certification within sixty days of notification.

C. Any application which has been denied or rejected shall remain in the possession of the Board and shall not be returned.

D. An applicant, whose application has been denied or rejected, may file for an administrative hearing as provided under applicable law and regulations.

6.13 Term. All licenses and certificate expires two years following its issuance or renewal and becomes invalid after that date unless renewed.

PART VII. TEMPORARY PRACTICE

7.1 Temporary License or Certificate. The Board may grant a temporary license or certificate to a person who desires to practice on a temporary basis, provided that such person is legally qualified and licensed in his or her jurisdiction and that his/her qualifications for obtaining the license or certificate meet those required for licensure/certification by this Board and further provided that:

   a) the person's business is of a temporary nature; and

   b) the appraiser applies for the temporary license or certificate.

A. A temporary license or certificate shall be used to appraise only one assignment.
7.2 Requirements.
A. Application for licensure or certification for temporary practice shall be made under oath or under penalty of perjury as permitted under CNMI law on a form to be furnished by the Board. The form may require the applicant to provide items above mentioned, and in addition, the applicant shall:
(a) submit evidence of current license or certificate from the other jurisdiction;
(b) submit a copy of the contract for appraisal services that requires the applicant to appraise real property in the CNMI and certify that such contract is in full force and effect;
(c) certify that disciplinary proceedings are not pending against the applicant in any jurisdiction;
(d) agree, in writing, to conform with all the provisions of these regulations; and
(e) file a designation in writing appointing the Board to act as the applicant's agent upon whom all judicial and other process or legal notices directed to the applicant may be served. The applicant shall agree that service upon the Board shall have the same legal force and validity as if personally served upon the applicant when such judicial or other process or legal notice is related directly or indirectly to a license or certificate issued by the Board. The Board shall immediately forward such judicial or other process or legal notice to the licensee or certificate holder by the mailing of such document certified mail, return receipt requested, to the last address which the certificate holder or licensee has provided the Board. The Board's compliance with the notification requirement as provided herein shall conclude the Board's liability and notification responsibility of the licensee or certificate holder.

7.3 Additional Temporary Licenses or Certificates. More than one temporary license or certificate per year may be issued to the same individual.

7.4 Renewal of Temporary Licenses or Certificate. The temporary license or certificate is limited to one year, but may be renewed.

PART VIII. RENEWAL

8.1 Date of Filing for Renewal. A renewal notice shall be mailed by the Board a month before the expiration date to appraisers whose license or certificate is expiring. All license and certificate holders shall complete and submit an application together with the required fees, and proof of the required completed continuing education hours on or
before the date of expiration. A completed application with the required documents sent by United States mail shall be considered timely filed if the envelope bears a postmark no later than the date of expiration.

8.2 Automatic Forfeiture for Failure to Renew. The failure to timely renew the license or certificate, pay the applicable fees, submit the required continuing education hours, or paying fees with a check which is dishonored upon first deposit shall cause the license or certificate to be automatically forfeited.

8.3 Restoration of Forfeited License or Certificate.
A. A license or certificate which has been forfeited may be restored within two years after the date of forfeiture provided the applicant pays the appropriate fees including restoration fees, and submits all continuing education hours that would have been required had the licensee or certificate holder maintained licensure or certification.

B. An individual whose license or certificate has been forfeited and who fails to restore the license or certificate within two years must apply as a new applicant and meet new licensing requirements.

8.4 Board May Refuse to Renew or Restore License or Certificate.
A. The Board may refuse to renew or restore a license or certificate for failure or refusal of the licensee or certificate holder:
   1. To properly complete or timely submit the renewal application form and submit all fees and required documentation;
   2. To maintain a good reputation for honesty, truthfulness, fairness and financial integrity;
   3. To meet and maintain the conditions and requirements necessary to qualify for the issuance of the license or certificate; or
   4. To comply with these regulations.

B. An applicant, whose application has been refused by the Board to be renewed or restored for the above reasons may file for an administrative hearing as provided by law.

8.5 Inactive Status.
A. A license or certificate may be placed on an inactive status upon notification to the Board by the licensee or certificate holder in writing of the effective date of inactivation and payment of an inactive file.
B. A licensee or certificate holder on inactive status shall be considered as unlicensed or uncertified.

C. Failure to reactivate a license or certificate on inactive status after two years shall render the license or certificate null and void and appraiser must apply as a new applicant and meet new licensing requirements.

D. Misrepresentation of inactive status on the practice of real property appraisal shall be grounds for disciplinary action.

8.6 Requirements to Reactivate.
A. An inactive licensee or certificate holder may apply for reactivation upon payment of all fees due owing from time of inactivity and proof of completion of all continuing education hours the applicant would have had to submit if the applicant has maintained licensure or certification from the date of inactivation.

B. Failure to meet the requirements for reactivation shall require a person desiring licensure or certification to apply as a new applicant.

PART IX. SCOPE OF APPRAISERS

9.1 Supervision of Appraiser Trainees. Licensed and certified appraisers may directly supervise appraiser trainees provided:

A. The appraiser trainee is a bona fide employee of the licensed or certified appraiser, or an employee of the same entity who employs the licensed or certified appraiser; and

B. The licensed or certified appraiser signs the report attesting the acceptance of the appraisal as being independently and impartially prepared and in compliance with the USPAP.

9.2 Use of Terms "Licensed Appraiser", and "Certified Appraiser". A. The terms "licensed real property appraiser," "certified residential real property appraiser", and "certified general real property appraiser" for federally related transactions and "licensed residential real property appraiser", and "licensed general real property appraiser" for non-federally related transactions, may only be used to refer to an individual who is licensed or certified, federally or non-federally related transactions, as the case may be, under these regulations and may not be used following, or immediately
in connection with, the name or signature of a corporation, partnership, association, or any group practice, or in any manner that might be interpreted as referring to anyone other than the individual who is licensed or certified.

B. This requirement shall not be construed to prevent a licensee or certificate holder from signing an appraisal report on behalf of a corporation, partnership, association, or any other group practice if it is clear that only the individual is licensed or certified and the corporation, partnership, association or group practice is not.

C. No person may assume or use the title "licensed real property appraiser", "certified residential real property appraiser", and "certified general real property appraiser" for federally related transactions, or "licensed residential real property appraiser", and licensed general real property appraiser" for non-federally related transactions, as the case may be, or any title designation or abbreviation likely to create the impression of licensure or certification unless that person holds a current license or certificate hereunder.

9.3 Real Estate-Related Financial Transactions Not Requiring Appraisal by a Licensed or Certified Appraiser. An appraisal performed by a licensed or certified appraiser (federally related transaction) is not required for any real property-related financial transaction in which:

A. The transaction value is at or below the de minimus level established by a federal financial institutions regulatory agency;

B. A lien on real property has been taken as collateral solely through an abundance of caution and where the terms of the transaction as a consequence have not have been more favorable than it would have been in the absence of the lien;

C. Real property is leased unless the lease is the economic equivalent of a purse or sale of the leased real property;

D. There is a renewal of an existing transaction in which the maturity and amortization of the obligation are intentionally mismatched for re-pricing or credit quality consideration, provided that:
   1. The borrower has performed satisfactorily according to the original terms;
   2. No new monies have been advanced;
   3. The credit standing of the borrower has not deteriorated; and
4. There has been no obvious and material deterioration in market conditions or physical aspects of the property which would threaten the institution's collateral protection.

E. A regulated institution purchases a loan or interest in a loan, pooled loan, or interests in real property, including mortgage-backed securities, provided that the appraisal prepared for each pooled loan or real property interest met the requirements of this part, if, applicable, at the time or origination.

9.4 Non-Applicability to Real Estate Brokers or Real Estate Salespersons.
These regulations shall not apply to a real estate broker or salesperson, who, in the ordinary course of the real estate broker's or salesperson's business, gives an opinion as to the recommended listing price of real property or an opinion to a potential purchaser or third party as to the recommended purchase price of real estate, provided:

A. The opinion as to the listing or the purchase price shall not be referred to as an appraisal;
B. No compensation, fee, or other consideration is charged for such opinion other than the normal brokerage fee rendered in connection with the sale of the property; or
C. No misrepresentation is made that the real estate broker or salesperson is a certified or licensed real property appraiser.

PART X. APPRAISAL STANDARDS

10.1 Appraisal Standards for Federally Related Real Property Transactions.
A. For federally related real property transactions valued at or above the de minimus level established by a federal financial institutions regulatory agency, all appraisals shall be performed by a licensed or certified appraiser and shall, at a minimum:
   (a) shall perform and practice in compliance with the Uniform Standards of Professional Appraisal Practice (USPAP), as amended.
   (b) be based upon the definition of market value as defined in these regulations;
   (c) be written and be sufficiently descriptive to enable the reader to ascertain the estimated market value and the rationale for the estimate; and provide detail and depth of analysis that reflect the complexity of the real property appraised which can be readily understood by a third party;
   (d) analyze and report in reasonable detail any prior sales of the property being appraised that occurred within the following minimum time periods:
i) for one-to-four family residential property, one year preceding the date when the appraisal was prepared; or
ii) for all other property, three years preceding the date when the appraisal was prepared.

(e) analyze and report data on current rents and current vacancies for the subject property if it is and will continue to be income-producing;

(f) analyze and report data on current revenues, expenses and vacancies for the subject property if it is and will continue to be income producing;

(g) analyze and report a reasonable marketing period for the subject property and disclose the assumptions used;

(h) analyze and report on current market conditions and trends such as, but not limited to increasing vacancy rates, greater use of rent concessions, or declining sales prices that will affect projected income of the absorption period, to the extent they affect the value of the subject property;

(i) analyze and report appropriate deductions and discounts for any proposed construction, or any completed properties that are partially leased or leased at other than market rents as of the date of the appraisal, or any tract developments with unsold units;

(j) include in the certification required by the USPAP, an additional statement that the appraisal assignment was not conditioned upon the appraisal producing a specific value or a value within a given range or on whether a loan application is approved;

(k) contain sufficient supporting documentation with all pertinent information reported including acceptance or rejection of a third party study and its impact on value so that the appraiser's logic, reasoning, judgment, and analysis in arriving at a final conclusion will enable the reader to understand the reasonableness of the conclusion;

(l) include a legal description in addition to, and not in lieu of, the description required in the USPAP of the real property being appraised;

(m) identify and separately value any personal property, fixtures, or intangible items that are not real property but are included in the appraisal, and discuss the impact of their inclusion, or exclusion, on the estimate of the market value; and

(n) follow a reasonable valuation method that addresses the direct sales comparison, income, and cost approaches to market value, reconciles those approaches, and explains the elimination of each approach not used.
B. If information required or deemed pertinent to the completion of an appraisal is unavailable, that fact shall be disclosed and explained in the appraisal report.

C. An appraiser shall perform all appraisals, reviews, or consultations with impartiality, objectivity, and independence, without any direct or indirect interest in the property.

10.2 Signature on Appraisal Reports.
A. If an appraisal report is prepared and signed by CNMI licensed appraiser, the appraisal report shall state, immediately following the signature on the report, "CNMI Licensed Appraiser" and the appraiser's license number and expiration date.

B. If an appraisal report is prepared and signed by a CNMI certified appraiser, the appraisal report shall state, immediately following the signature on the report, "CNMI Certified Appraiser" and the appraiser's certificate number and expiration date.

C. If an appraisal report is prepared and signed by an appraiser licensed or certified in another jurisdiction whose license or certificate has been temporarily recognized by the Board, the appraisal report shall state, immediately following the signature, "licensed appraiser", "certified residential appraiser", "certified general appraiser", as the case may be, the appraiser's license or certificate number, the expiration date of the license or certificate, and the jurisdiction in which the appraiser is licensed or certified.

D. Appraisal reports prepared by an appraiser trainee shall be approved and signed by a licensed or certified appraiser.

10.3 Records and Appraisal Report Retention Requirement.
A. Every licensed or certified appraiser shall retain originals or true copies of appraisal contracts, appraisals, and all supporting data and documents for a period of five years.

B. The five-year period shall commence upon date of delivery of the appraisal report to the client, provided that; if the appraiser is notified that the appraiser or appraisal report is involved in litigation, the five-year period shall commence upon the date of the final disposition of the litigation.

C. The appraiser shall make all records available, upon request, to the Board or the Board's authorized delegate.
PART XI. ADVERTISING PRACTICES

11.1 Advertising Practices. A license or certificate holder advertising through any media shall be identified as a Licensed Real Property Appraiser - Federally Related Transactions, Certified Residential Real Property Appraiser - Federally Related Transactions, Certified General Real property Appraiser - Federally Related Transactions, Licensed Residential Real Property Appraiser - Non-Federally Related Transactions, or Licensed General Real Property Appraiser - Non-Federally Related Transactions by listing the appropriate designated licensed or certified status and the appraiser's license or certificate number. For purposes of this section, "media" includes, but is not limited to, newspapers, magazines, calling cards, and directories, including all listing in telephone directories.

PART XII. GROUNDS FOR REVOCATION, SUSPENSION, REFUSAL - NEW OR RESTORE - DENIAL OR CONDITIONING OF LICENSES OR CERTIFICATES

12.1 Grounds for Revocation, Suspension, Refusal to Renew or Restore, Denial, or Conditioning of Licenses or Certificates.
In addition to any other acts or conditions provided by law, the Board may revoke, suspend, refuse to renew or restore, deny, or condition in any manner, any license or certificate for any one or more of the following acts or conditions:

A. Procuring a license or certificate through fraud, misrepresentation, or deceit; or

B. Failing to meet or maintain the requirements or conditions necessary to qualify for licensure or certification; or

C. Acting negligently or incompetently or failing without good cause to exercise reasonable diligence in developing an appraisal, preparing an appraisal report or communication an appraisal; or

D. Failing to comply with the Uniform Standards of professional Appraisal Practice; or

E. Performing for any valuable consideration, an appraisal assignment that is contingent upon the appraiser reporting a predetermined estimate, analysis or opinion or
upon the opinion, conclusion, or valuation reached, or upon the consequences resulting from the appraisal assignment; or

F. Conviction of, or pleading nolo contendre to any felony or any crime that is substantially related to the qualification, functions, or duties of an appraiser; or

G. Entrance against the appraiser of a civil or criminal judgment on grounds of fraud, misrepresentation, or deceit in the development or communication of an appraisal; or

H. Committing any act or omission in the practice of real estate appraising which constitutes dishonesty, fraud, or misrepresentation with the intent to substantially benefit the appraiser or another person or with the intent to substantially injure another person; or

I. Accepting an appraisal assignment if the employment or fee is contingent upon:
   1. The appraiser reporting a predetermined estimate, valuation, analysis, or opinion; or
   2. The consequences resulting from the appraisal assignment.

J. Engaging in the business of real estate appraising under an assumed or fictitious name not properly registered; or

K. Paying a finders fee or a referral fee to a person who is not a licensed or certified appraiser in this jurisdiction in connection with appraisal of real property in this jurisdiction; or

L. Making a false or misleading statement in that portion of a written appraisal report that deals with professional qualifications; or

M. Aiding or abetting an unlicensed or uncertified person to directly or indirectly evade these regulations; or

N. Violating any conditions or limitations upon which the license or certificate was issued; or

O. Failing to report to the Board, in writing, any disciplinary decision issued against the licensee or certificate holder in another jurisdiction; or

P. Violating the provisions in these regulations or any order of the Board.
12.2 **Hearings.** Any proceeding before the Board to take disciplinary action or other sanctions against a licensed or certified appraiser shall be conducted pursuant to 1 CMC, Section 9109 Administration Procedures - Conduct of Hearings.

**PART XIII. RESTORATION OF LICENSE OR CERTIFICATE**

13.1 **Restoration of Suspended License or Certificate.** A person whose license or certificate has been suspended may apply for restoration of the license or certificate upon complete compliance with any term or condition imposed by the order of suspension. The application for restoration shall be accompanied by the appropriate fees, application, required continuing education hours, and/or any other additional documents or information the Board deems appropriate.

13.2 **Revoked License or Certificate.** Upon the expiration of at least two years from the effective date of the revocation of the license or certificate, a person may apply for a new license or certificate by filing an application and complying with all current requirements for new applicants. The granting or denying of such application shall be at the discretion of the Board after evaluating such application consistent with the statutory and regulatory requirements relating thereto.

13.3 **Relinquishment No Bar to Jurisdiction.** The forfeiture, non-renewal, surrender, or voluntary relinquishment of a license or certificate by an appraiser shall not bar jurisdiction by the Board to proceed with any investigation, action, or proceeding against the appraiser to revoke, suspend, condition or limit the appraiser's license or certificate.

13.4 **Judicial Review.** Any person aggrieved by a final decision and order of the Board in a contested case is entitled to judicial review thereof according to law.

**PART XIV. UNAUTHORIZED PRACTICE AS AN APPRAISER**

14.1 **No Compensation for Unauthorized Activity; Civil Action.** The failure of any person to maintain a current and valid license or certificate prior to engaging in any activity requiring licensure or certification by the Board shall prevent such person from recovering in a civil action for work or services performed on a contract or on any legal basis to recover the reasonable value thereof.
PART XV. PUBLICATION OF ROSTER

15.1 Publication of Roster. The Board shall prepare annually, a roster showing the name and place of business of each individual holding a license as a CNMI licensed appraiser, or a certificate as a CNMI certified appraiser. The roster shall be sent to the Appraisal Subcommittee by January 15 of each year.

PART XVI. FEES

16.1 Fees. The fees for licensure or certification shall be as follows:

A. Application Fee ........................................ $100.00
B. Licensure or Certificate Fee ........................ $100.00
C. Annual Registry Fee ...................................... $25.00
   To be transmitted to the Appraisal Subcommittee.
D. Temporary Practice Application & License Fee ................ $125.00
E. Renewal Fee ............................................. $100.00
F. Inactive Fee .............................................. $50.00
G. Reactivation Fee ........................................ $100.00
H. Restoration Fee ......................................... $100.00
I. Examination Fee shall be as provided by contract with a professional testing Organization.
J. Local Examination Fee ..................................... $100.00

The application fees shall be nonrefundable. The annual registry fees may be increased if the Appraisal Subcommittee so informs the Board of the increase, and may be imposed on licensees or certificate holders without hearing. Failure to pay an increase of the annual registry fee within sixty days of notification to do so shall result in automatic forfeiture of the license.

16.2 Form of Fee. The fees, if in the form of money order or check, shall be made payable to the CNMI Treasurer.

16.3 Dishonored Checks Considered Failure to Meet Requirements.
The dishonoring of any check upon first deposit shall be considered a failure to meet requirements.

16.4 Fees Deposited; Transmittal Appraisal Subcommittee
A. All fees shall be deposited in the general fund of the CNMI.
B. The annual registry fees shall be transmitted by the Board to the Appraisal Subcommittee annually as required by law.
The Department of Lands and Natural Resources, Commonwealth of the Northern Mariana Islands, hereby notifies the general public of its intention to amend and rescind certain regulations in Part V of the Non-Commercial Fish & Wildlife Regulations pursuant to 1 CMC Section 2654, 2 CMC Section 5104 (b) (7) and the Administrative Procedures Act. The proposed amended and rescinded regulations attached hereto detail the methods of net fishing that are prohibited, the methods of net fishing allowed and the aquarium fish prohibitions. The proposed regulations, if adopted, will replace prior regulations.

All interested parties may examine the proposed regulations and may submit written comments for or against the proposed regulations to the Secretary, Department of Lands and Natural Resources, Lower Base, Caller Box 10007, Saipan, MP 96950 no later than thirty days following the date of publication of this Public Notice in the Commonwealth Register. Copies of said proposed regulations may be obtained or viewed at the Lower Base Offices of the Department of Lands and Natural Resources.

Dated this 26th day of September, 2002 on Saipan.

Submitted by:

Thomas B. Pangelinan
Secretary of Lands and Natural Resources

Date: 10/20/02

Received By:

Thomas A. Tebuteb
Special Assistant for Administration
Office of the Governor

Date: 10/29/02

Filed & Recorded By:

Soledad B. Sasamoto
Registrar of Corporations

Date: 10/22/02

Pursuant to 1 CMC Section 2153, as amended, the proposed regulations on prohibited methods of fishing and use of certain nets for fishing as well as the aquarium fish prohibitions attached hereto, have been reviewed and approved as to form and legality by the Office of the Attorney General.

Peggy Campbell, Asst. Att'y Gen'l
Mona V. Manglona
Acting Attorney General
INFORMATION STATEMENT
FOR THE PROPOSED AMENDMENTS TO PART V
OF THE NON-COMMERICAL FISH & WILDLIFE REGULATIONS
RE: CERTAIN TYPES OF FISHING

Statutory Authority: 1 CMC Sections 2653 and 2654 and 2 CMC Section 5104

Short Statement of Goals And Objectives: To provide further protection to declining reef fish stocks by prohibiting certain types of fishing using nets.

Brief Summary of the Proposed Regulations: The proposed regulations detail the types of net fishing that will no longer be allowed because of the detrimental affect on fish stocks, turtles, coral and marine plants. The regulations also detail the types of net fishing still allowed and the aquarium fish prohibitions as amended.

For further information Contact: Thomas B. Pangelinan, Secretary Department of Lands and Natural Resources Phone 322-2438; Fax 322-2633

Citation of Related or Affected statutes, Regulations or orders: Statutes: 1 CMC Section 2653 and Public Law 2-51, The Fish, Game and Endangered Species Act, codified at 2 CMC 5101 et seq.

Regulations: The Non-Commercial Fish & Wildlife Regulations, Published in the Commonwealth Register on April 20, 2000 at pages 17190-17195.

Orders: Executive Order 94-3.
Section 10. USE OF EXPLOSIVES, CHEMICALS, POISONS, ELECTRIC SHOCKING DEVICES, SCUBA OR HOOKAH, CERTAIN NETS, AND DISTURBANCE OF HABITAT

10.01 PROHIBITIONS: The use of explosives, poisons, electric shocking devices, SCUBA or hookah and use of certain nets as identified in subparagraph (b), is prohibited in the taking of any fish.

a. No person shall use explosives, poisons, electric shocking devices, SCUBA or hookah while fishing.

b. No person shall use drag nets/beach seines (Chenchulun and lagua), trap net (Chenchulun managam), surround net (Chenchulun Umesugon) or gill nets (Tekken) for the taking of fish or other sea life.

c. No person shall possess, sell or purchase any fish, game, marine or other aquatic life taken by means prohibited in this section.

d. Use of any of these nets or devices will result in the net or devices being confiscated and the owners will be subject to penalties (fines and/or imprisonment) as stated in 2 CMC Section 5109 (PL 2-51).

Section 20. USE OF CERTAIN NETS FOR FISHING

20.1 Casting nets (Talaya) are allowed. Scoop nets/landing nets (for landing fish) with a diameter of up to two feet or total square footage of up to four square feet are allowed.

20.1.1 Definitions: Monofilament may not be used on any net except talaya, scoop nets, and hand nets. Fishing nets covered by these regulations include but not limited to the following:

a. Drag net/Beach seine (Chenchulun and lagua)

b. Trap net (Chenchulun managam)

c. Surround net (Chenchulun Umesugon)

d. Gill net (Tekken)

20.2 Drag nets/Beach seines: The use of drag nets or beach seines in the waters of the CNMI is prohibited.

20.3 Gillnets: The use of gillnets in the waters of the CNMI is prohibited.

20.4 Mesh size: The use of nets with a stretch mesh measuring less than two and one-half (2 1/2) inches in linear measure is prohibited unless used for talaya (throw net or cast net), lagua (scoop net or hand net) or when fishing for seasonal runs of atulai (mackerel), Tiao (juvenile goatfish or manahak (juvenile rabbitfish).
20.2 License Required: A license shall be required for fishing with the use of a casting net (Talaya) net. One fee must be paid for each casting net to be used in fishing regardless of whether the nets are of the same size.

20.3 Registration of nets: Upon licensing of nets, the nets shall be marked by the Division with a registration tag, which will reflect the license number. The license holder shall notify the Division immediately if the registration tag becomes detached from the net.

20.4 Identification of nets: For all nets other than talaya, scoop nets, and hand nets, each net must be clearly, indelibly and permanently marked with the name and DFW registration number of the net owner. Identification markers must be placed with a minimum of one marker for each ten feet of net.

20.5 Use Restrictions:
   a. Nets placed in the water shall be tended at all times.
   b. Placed nets found in violation of these provisions, or without a registration tag or identification marker, shall be confiscated by Conservation Officers and are subject to forfeiture pursuant to 2 CMC Section 5109 (f) (3).
   c. All fish, invertebrates, marine plants not intended for consumption shall be returned to their proper natural habitat, if alive, or disposed of lawfully, if dead.
   d. Recreational and/or use of surf nets shall be restricted to 100 meters in length and shall comply with the definitions and mesh requirements pursuant to Section 20.3.
   e. Disturbance of corals shall not be permitted when fishing with nets.
   f. All nets or pieces of nets shall be removed from the water after fishing is competed.

20.6 Abandoned Nets: Abandonment of nets within the waters or coastal zone of the CNMI is prohibited. Nets that are found unattended in the water or within 150 feet of the high water mark on any public beach will be considered abandoned. Permit holders of nets found abandoned may be subject to penalties including fines, suspension or revocation of net fishing permit(s), and confiscation and forfeiture of abandoned nets.

Section 110. AQUARIUM FISH PROHIBITIONS

110.1 The sale or export of marine aquarium fish is prohibited.

110.2 An aquarium fish license is required by any person who captures aquarium fish for personal use or enjoyment.

110.3 No poisons may be used to collect aquarium fish, except for purposes of scientific research when a scientific research permit expressly allows such use.
110.4 All methods of collection of aquarium fish are prohibited except the following:
   a. Certain hand nets not previously registered by Conservation Officer.
   b. Small surround nets (8 meters in length);
   c. Barbless hook and line; and
   d. Other collection methods specifically allowed in a written condition to a permit.
Notisian Publicu put I propositu na regulation
Gi bandan peska

I Departamentun Lands and Natural Resources, Commonwealth of the Northern Mariana Islands, ma notififica I publicu generat nu I intention para hao ma amenda yan para hao ma na suha guaha na regulation ginagao gui 1 CMC Sectiona 2654, 2 CMC Sectiona 5104 (b) (7) yan I Administrative Procedures Act. Esti I ma propositu para pao ma amenda yan na suha ni dumadana yan esti na papit ha na claru I klasin peska ni para pao ma na para, kuntat ki ayu na peska I ma u’usa I chenculu, tekin, - - -, yan lokui ayu I para aquarium na guihan. Esti I ma propositu na regulation, kumu ma adopta, tiempri ha tagi I palu siha na regulation.

Todu ayu siha I man interisao para pao ma examina I ma propositu na regulasion guini, sinia ma tugui ya manahalom I testigun niha maseha kao yania pat ma kontra I regulasion ya hu ma tugui I Secretariat I Deparatmentun Lands yan Natural Resources guiyia Lower Base, Caller Box 10007, Saipan MP 96950 antis di trenta dias dispues di ma publica esti na Noticia gui halom I Commonwealth Register. I copian I propositu na regulasion sina ma chuli pat ma atan gui I Lower Base na Officinun I Secretariun I Departmentun Lands yan Natural Resources.

I dia pagu 26, Septembri, 2002 guiyia Saipan.

Submitti guinin as:

[Signature]
Sinot Thomas B. Pangelinan
Secretary I Departmentun Lands yan Natural Resources

Rinicibi as:

[Signature]
Sinot Thomas A. Tebuteb
Special na Assitanti’n I Gobietnu

Ma record gui as

[Signature]
Sinora Soledad B. Sasamoto
Registrar Corporation

Ginagao gui 1 CMC Section 2153, ni ma amenda, I propositu na regulasion ni I klasin peska ni para pao mana para yan I nets ni para pao mana para gui peska, yan ayu lokui I pao ma usa para I aqiuariim na guihan domadania yan esti na documentu, esta ma review yan ma appreba nu I Officinat I Abugadu generat.

I dia pagu 10/24/02

[Signature]
Sinora as Mona V. Mangiona
I acting na Abugadu Generat

COMMONWEALTH REGISTER Volume 24 Number 10 October 30, 2002 Page 19598
INFOTMACION PUT I MA PROPOSITU
SIHA NA TINULAIKA GUI I
REGULASION PUT KLASIN PESKA

Statutory Authority: 1 CMC Section 2653 and 2654 and 2 CMC Section 5104

I ma sinagan Para pao ma priben i mas protection I guihan. Put enao na para pao mana para I peska yan I nets.

Kadada na sumaria put I Ma propositu na regulasion I ma propositu na regulasion hana claruyi I klasin net fishing ni tisina esta ma sedi put I mamos ha lachai I guihan siha gui tasi yan baba para I agan, yan coral siha.

Para mas infotmasion agan si Sinot Thomas B. Pangelinan, Secretariu?
Depatamentun Lands yan Natural Resources Telephone numeru: 322-2438 Fax: 322-2633

I ginagagao gunin I regulation Statutes: 1 CMC Section 2653 yan I Lai' numeru 2-51, I Fish, Game and Endangered Species Act, ni ma codify gui CMC 5101 et seq.

Regulation: Ma publica gui I Commonwealth Register gui Abrit 20, 2000 gui pahina 17190-17194.

Order: I executive Order 94-3
Section 10. I ma usan I explosive, chemical, binenu, electrical shocking device, tanki’
manglo, nets, nu I mo estototba I habitat I guihan.

10.01 PROHIBI: I ma usan I explosive, binenu, electric shocking devices yan tankin manglo
yan lokui I ma usan nets ni ma identifica gui section (b)
ma prohibi guinin ma usa para pao ma koni I guihan.

(a) Taya sinia umusa explosive, binenu/guasa, electric shocking device pay
tankin manglo bentras pumespeska.
(b) Taya sinia umusa I drag net pat I beach seines, mas ma tungona kumo I
Chenchulun pat lagua, I trap net, mas ma tungona I Chenchulun
managam, yan I surround net, mas ma tungona kumo I Chenchulun
umesugon pat I Gill net mas ma tungona I Tekken, put para pao ma koni I
guihan pat otto na gaga tasi.
(c) Taya sinia kumoni, gumoti, pat fumahan guihan, gaga, pat hafa na
marine life ni ma koni gui ti ma sedi na manera.
(d) I ma gacha pumeska gui ti ma sedi na manera tiempri ma ammut nu I
kosasna kosas peska, ya tiempri I drenu ma na fan ammuta.

Section 20. I MA SEDI SIHA NA NETS PARA PESKA

Section 20.1 Casting nets / Talaya ma sedi. Scoop nets/landing nets (ayu I ma ‘u’usa para pao
ma koni I guihan halom gui boti) ni ti gaigui gui halom dos pie’ pat I tutat na square footage to
mas ki kuatro square feet.

20.1.1 Definitions: I monofilament na klasin net para peska tisina ma usa solo I net para talaya;
seoop nets, yan I net kanai. I fishing nets ni ma include guini na regulation saosaonao I
a. Chenchulun yan lagua - Drag net/Beach seine
b. Chenchulun managam - Trap net
c. Chenchulun Umesugon - Surround-net
d. Tekken - Gill Net

20.2 Chenchulun yan lagua - Drag nets/Beach seines:—— I ma usan I Chenchulun yan Lagua
ti ma sedi gui tasin I CNMI.

20.3 Tekken: I ma usan I tekken ti ma sedi gui I tasin I CNMI.

20.4 Size: I-nets ni sina ha stretch gui didid ki dos yan lamita potgadas ti ma sedi solo para I
talaya (throw net -pat cast net), lagua (seoop net -pat hand net) pat anguin pumespeska hao-gui
durantin I tiempun atulai, tiao, pat manakah.

20.5 20.2 Duebui di hao guaha LICENSE: I licensia sinia ma chuli para peska yan talaya. Unu
ha na presu para pao ma apasi para kada talaya ni para pao ma usa gui Durantin peska.
20-6 20-3—Registration I nets: guigun esta on licensia I yomu nets, I nets duebi di hao ma matka claru nui I tag I division, ni tiempi ha indica I numerun I licensia. I gaiyu I licensia duebi di hao notifica I Division insigidas komu I registration tag mapla guinin I talaya.

20-7 Identification I nets: todo I nets fera di talaya, seoop nets, yan hand nets, kada net duebi di hao claru, yan petmanenti I matkan I na’an I drenu yan I numerun I registration pat I numerun I licensia. Kada matka duebi di hao ma pega gui kada des pea.

20-8 I ti ma sedi:

a. duebi di hao ma pulan I nets gui durantin peska gui halom tasi.
b. I nets ni ma sodan na ti ha tatiyi esti na regualasion, pat ayu I ma soda sin licensia; registration tag, pat matka, siempi ma ammut ya ma na fan amuta hao nu I Conservation Officers guya I Division I Fish and Wildlife.
e. Todo I guihan, invertebrates, pat tinanum tasi, ni ti ma intendi para pao ma kanu duebi di hao manalalu gui manu ni ma chuli, komu laala ha pat kumo matai duebi di hao ma dispose lawfully.
f. I para pao usa para minagog I surround net duebi di hao mas dikiki ki 100 metro gui inanakuku ya duebi di hao osgui todo I definition I ginagagao para I nets guinin I Section 20-3
g. Ti duebi di haon stotba I aeu tasi.
h. Todo I net pat pidasu guinin I nets duebi di hao mana suha guinin I tasi dispues di I peska.

20-9-20.4 I ma abandona na nets: I ma abandona na nets gui halom I tasi pat gui halom I coastal zone I CNMI ti ma sedi. Todo I nets ni ma soda na ti ma attetendi gui halom I 150 pea na high water mark gui maseha manu na beach publicu ma considera abandona. I man gai permit nets ya ma gacha na ha abandona iyona net tiempi mana fan ammuta salapi, ma amut nu I net, yan ma amut nu iyonia licensian peska.

Section 110. Guihan aquarium:

110.1 Ti ma sedi I para pao bendi asunao para pao na huyung guinin I Commonwealth I aquarium fish.

110.2 I aquarium fish na licensia ma nasisita ni maseha hayu na petsonat para pao koni I guihan para iyona petsonat.

110.3 Ti sinia hon usa I binenu para pao ma koni esti I aquarium fish, fera di ayu I experiment I scientist, pat ha fa para estudio, kumu guaha permit.

110.4 Todo clasun peska para aquarium fish ti ma sedi fera di esti siha:

a. Guaha na hand net sinia me rehistra gui I Conservation Officer.
b. Dikiki na Chenchuiun Umesugon ni mas dikiki ki 8 meters.

e-b. ayu I barbless hook yan line
d-c. Todo I otro na klasin man oka pat pumeska ni ti especificao lao sinedi kuntat ki guaha tinigi para I pertmiti.
PUBLIC NOTICE OF PROPOSED AMENDMENTS
TO THE RULES AND REGULATIONS
GOVERNING CEMETERIES AND MORTUARIES OF THE
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

The Secretary of Public Health hereby gives notice to the general public that the Department of Public Health is proposing to amend the Rules and Regulations governing Cemeteries and Mortuaries, as originally published in the Commonwealth Register, Volume 23, No. 9, September 24, 2001. This amendment is made pursuant to the Department’s authority and directions set forth in the Commonwealth Code including, but not limited to, 1 CMC § 9301, 1 CMC § 9306, 1 CMC § 9313(c) and the Commonwealth Administrative Procedure Act, 1 CMC § 9101 et seq., and Executive Order 94-3.

The purpose of these amendments is to regulate and to promote uniformity for the burial ground marker and for efficiency in burial plot access and ground maintenance. These Rules and Regulations shall have the force and effect of law.

The proposed regulations may be inspected at, and copies obtained from the Secretary of the Department of Public Health, Commonwealth Health Center, Navy Hill, Saipan, MP 96950.

The Secretary of Public Health is soliciting comments on this proposed amendment to the Rules and Regulations for Cemeteries and Mortuaries from the general public. Anyone interested in commenting on this proposed amendment may do so in writing. Comments may be addressed to the Secretary of Public Health, Commonwealth Health Center, Navy Hill, Saipan, MP 96950. All comments must be received within 30 days from the date of this notice published in the Commonwealth Register.

Dated this 15th day of October, 2002.

Issued By: JAMES HOFSCHEIDER
Secretary, Department of Public Health

Certification by the Office of the Attorney General:

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

RAMONA V. MANGLONA
Deputy Attorney General

By: ROBBIN HUTTON
Assistant Attorney General

Date: 10/18/02
Notisian Pupbliku Put I Man Ma Ofresi Na Amendasión Siha Para I Areklamento Yan Regulasion Siha Ni Gumibiebietna I Simenteyu Yan Mortuary Siha Gi Commonwealth Gi Sankattan Siha Na Islas Marianas


I rason este siha na amendasión put para hu guaha areklu yan promote uniformity gi bandan I mohon naftan yan hu mihinilat yan hu guaha kampo para I ground maintenance. Este na areklamento yan regulación siha hu ineftåt gi bandan I lai.


Ninahalom As:  

\[\text{James Hofschneider, Sekritariu}\
\text{Dipåttamento I Public Health}\

Fecha: 10 29 01
Pine'lo As: [Signature]  
Soledad B. Sasamoto  
Rehistran I Koporasion  

Rinisibi As: [Signature]  
Thomas Tebuteb  
Espisiat Na Ayudante Para Atministrasion  
Ofisinan I Gobietno  

Fecha 10/29/02  
Fecha 10/29/02
PROPOSED AMENDMENTS TO THE RULES AND REGULATIONS
GOVERNING CEMETARIES AND MORTUARIES OF THE
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Citation of Statutory Authority: The proposed amendments to the Rules and Regulations Governing Cemeteries and Mortuaries are promulgated pursuant, but not limited to 1 CMC §9306, 1 CMC §9313(c) and the Commonwealth Administrative Procedure Act, 1 CMC §9101 et. seq., and Executive Order 94-3.


Brief Summary of the Rules: The rules and regulations provide the policies and procedures required to implement, regulate and supervise the operation of the CNMI Cemeteries and Mortuaries. These rules and regulations may be amended, modified or repealed as deemed appropriate by the CNMI Department of Public Health.

For Further Information, Contact: John Tagebuel, Bureau of Environmental Health. Telephone number 664-4877.

Citation of Related and/or Affected Statutes, Regulations and Orders: 1 CMC §9301 et. seq.; Commonwealth Register, Volume 23, No. 9, September 24, 2001.

Issued by: James Hofschneider
Secretary of Department of Public Health

Date: 10/30/02
The following changes are proposed for the Rules and Regulations Governing Cemeteries and Mortuaries as previously published in the Commonwealth Register, Volume 23, Number 9, September 24, 2001:

6.4.2.3. Markers for a burial plot within a public cemetery shall be contained entirely within the plot allowing at least one foot (1') of clearance from the edge of the boundary on each side. This distance is meant to prevent encroachment of markers from one burial plot onto adjacent plots and to facilitate ground maintenance shall be uniform in size and placement and shall have the following dimensions: three (3) inches in height, by a maximum of eighteen (18) inches in length by twelve (12) inches wide and shall be countersunk at least two inches into the ground. No headstones or other improvements are permitted on or adjacent to the burial plot. This will allow for easy mowing and maintenance of the burial grounds.

6.4.2.4. Markers within a public cemetery shall be no taller than 3' in height to prevent potential damage that may result from typhoons or gale-force winds. (deleted in entirety)
PUBLIC NOTICE

NOTICE OF INTENT TO REPEAL TOBACCO REGULATIONS IN THEIR ENTIRETY, AT COMMONWEALTH REGISTER VOLUME 21, NUMBER 05 AT PAGE 16773-16774, AND PROPOSE FOR ADOPTION NEW TOBACCO CONTROL RULES AND REGULATIONS, OF THE DEPARTMENT OF COMMERCE, ALCOHOL BEVERAGE AND TOBACCO CONTROL DIVISION

PURPOSE OF THE REPEAL
The Secretary of Commerce of the Department of Commerce finds it necessary to repeal the registered provision of Tobacco Regulations, at Comm. Reg. Vol. 21, No. 05, at 16773-16774, and to establish a permanent set of regulatory provisions consistent with P.L. 11-75 (effective date March 26, 1999) as amended, to be mandated by the Department of Commerce, Alcohol Beverage and Tobacco Control Division.

PROPOSAL FOR ADOPTION, NEW TOBACCO CONTROL RULES AND REGULATIONS
Therefore, the Secretary of Commerce of the Department of Commerce, by and in accordance with 1 CMC § 2454, § 9104 and Section 18 of Public Law 11-75 (effective date March 26, 1999), is proposing to adopt new Tobacco Control Rules and Regulations as the initial regulations necessary for the licensing, sales and distribution of tobacco products.

AVAILABILITY
The proposed regulations may be inspected at, and copies may be obtained from, the Department of Commerce, Alcohol Beverage and Tobacco Control Division, located at the Donni Hill Complex in Capitol Hill, adjacent from the former Marianas Public Lands Corporation (MPLC), or you may write and request for copies to, Department of Commerce, Alcohol Beverage and Tobacco Control Division, Caller Box 10007 C.K. Saipan, MP 96950. The Department of Commerce is soliciting comments on these proposed regulations from the general public.

PUBLIC COMMENTS
Anyone interested in commenting on these proposed regulations may do so in writing addressed to the Secretary of Commerce, Department of Commerce, Caller Box 10007 C.K. Saipan, MP 96950. Written comments may also be delivered to the Department of Commerce or faxed to 664-3067. All comments must be received within 30 business days from the date this notice is published in the Commonwealth Register.

The Department of Commerce, Alcohol Beverage and Tobacco Control Division intends to adopt these regulations.
Pursuant to 1 CMC § 2153, as amended by P.L. 10-50, the rules and regulations attached hereto have been reviewed and approved by the CNMI Attorney General.

Dated this 30th day of October, 2002.

RAMONA V. MANGLONA
Deputy Attorney General

By: BRIAN CALDWELL
Assistant Attorney General
Notisian Pupbliku

Notisia Put Intensión Para Hu Ma Tulaika I Regulación Siha Put Tobacco, Ni Tineteka Gi Rehistran Commonwealth Volume 21, Numiru 05 Gi Páhinan 16773-16774, Yan Ma Tulaika Para Hu Ma Adopta I Nuebu Na Areklamento Yan Regulación Siha Ni Ginibiebietna Put Tobacco Control Gi Dipåttamenton I Commerce, Alcohol Beverage and Tobacco Control Division

Rason Put I Tinilaika

I Sekritåriun i Commerce giuen I Dipåttamenton I Commerce ha sodda' na nisisåriu pari hu tulaika I ma rehistra na regulación siha put Tobacco, giya Rehistran Commonwealth Volume 21, Numiru 05 Gi Páhinan 16773-16774, yan mu establisi petmanente na regulación siha pari hu konsiste Lai Pupbliku 11-75 (fecha anai hu efektibu Måtsø 26, 1999), ni ma amenda pari hu ma oden giuen I Dipåttamenton I Commerce, Alcohol Beverage and Tobacco Control Division.

Rason Para I Inadoptasión I Nuebu Na Areklamento yan Regulación Siha Put Tobacco Control

Put rason na, i Sekritåriun i Commerce giuen I Dipåttamenton i Commerce, giuen yan kininfotme ni 1 CMC Sek. 2454, 9104 yan Sek. 18 ni Lai Pupbliku 11-75 (fecha anai hu efektibu Måtsø 26, 1999) ma ofrefresi pari hu ma adopta i nuebu na areklamento yan regulación siha put Tobacco Control put para hu tutuhon este na regulación anai nisisåriu i lisensia pari man bende yan distribution i Tobacco Control.

Availability

I man ma tulaika na regulación siha siña ma eksamina, yan siña ma chul'í' kopia siha gi I Dipåttamenton I Commerce, Alcohol Beverage and Tobacco Control Division, gi Donni Hill Complex giya Capitol Hill, fion I hagas na Ofisinan I Marianas Public Lands Corporation (MPLC), pat siña un tugi'í' yan rekuesta kopia siha gi Dipåttamenton I Commerce, Alcohol Beverage and Tobacco Control Division Caller Box 10007 C.K. Saipan, M.P. 96950. I Dipåttamenton I Commerce man solisitetea opinion siha put este man ma ofresi na regulación siha giuen I heneråt pubbliku.

Opinion Pupbliku Siha

Maseha háyi interesao man nahalom opinion put este siha ni man ma tulaika na regulación siha hu ma tugi'í' I Sekritåriun i Commerce gi I Dipåttamenton I Commerce, gi Caller Box 10007 C.K. Saipan, M.P. 96950. Siña ha lokkue ma hanågue tinigi opinion
siha guato gi Dipåttamenton I Commerce pat ma fax gi 664-3067. Todu i opinion siha debidi hu ma risibi gi halom trenta dias duranten ha'ånen chocho anai ma fecha este na notisia anai ma pupblisa gi Rehistran i Commonwealth.

I Dipåttamenton I Commerce, Alcohol Beverage and Tobacco Control Division ma intensiona para hu ma adopta este siha na regulación.

Ma Klaruyi As: 
Fermin M. Atalig
Sekritåriun i Commerce

Pine’lo As:
Soledad B. Sasamoto

Rinisibi As:
Thomas A. Tebuteb
Espisiat Na Ayudånte Para
Atministråtion Ofisinan i Gobietno

Sigun i 1 CMC Sek. 2153 ni ma amenda ginen i Lai Pupbliku 10-50, i areklamento yan regulåsion siha ni checheton esta ma ribisa yan apreba ginen i Abugådon Heneråt i CNMI.

Ma fecha este i mina 30 na dia gi October, 2002.

Ramona V. Manglona
Delegådon Abugådon Heneråt
By:

Assistant Attorney General
ARONGORONGOL Taulap

ARONGORONG REEL MÁNGEMÁNGIL EBWE AYÚÚWLÓ ALÉGHŮL TOBACCO LLŮL ALONGAL, MELLŮL COMMONWEALTH REGISTER VOLUME 21, NUMORO 05 PEIGH 16773 NGÁLI PEIGH 16774 ME POMWOL ADOPTION REEL ALÉGHŮL NEW TOBACCO CONTROL MELLŮL DEPATTAMENTOL COMMERCE, ALCOHOL BEVERAGE AND TOBACCO CONTROL DIVISION.

Bwuulú akkayúuló yeel
Sómwoolú Commerce mellól Deppatamentol Commerce ee schuungi bwe ee nisisiita bwe ebwe akkayúuló mángemáng we aa registered ló reel alléghůl Tobacco, mellól Commonwealth Register Vol. 21, No.05, reeal schéd ló 16773 ngali schéd 16774, me ebwe ayoora mángemángfisch iyéeewe permanent-ló iye ghil ngali alléghůl Toulap 11-75 (ebwe alléghló rál maram ye Mailap 26, 1999) iye aa liwel, sángi Depattamentol Commerce, Alcohõl Beverages me Tobacco Control Division.

Pomwol adoption, alléghůl New Tobacco Control
Iwe, Sómwoolú Commerce mellól Deppatamentol Commerce, sángi me apilúghuíghuíl CMC 2454, 9104 me táal 18 llól alléghůl Toulap 11-75 (ebwe alléghló rálil maram ye Mailap 26, 1999), iye ekke pomwol ebwe adotaay allégh ye ee nisisita ebwe licensia, akkaméélól me akkafangal Tobacco Products.

Bwuley eyoore copia kkaal
Pomwol allégh kkaal ngé emmwel ubwe amwuri me bweibwogh copial mereel, Deppatamentol Commerce, Alcohõl Beverages me Tobacco Control Division, iye elo Denni Hill Complex mellól Capitol Hill, iye ee aghilíghlh ngálí Marianas Public Lands Corporation (MPLC), emmwel ubwe íisch me tingor copial ngálí, Deppatamentol Commerce, Alcohõl Beverages me Tobacco Control Division Caller Box 10007 C.K. Saipan, M.P. 96950. Depattamentol Commerce ekke tingór mángemáng sángi pomwol allégh kkaal mereel Aramas Toulap.

Mangemangíir Toulap
Schóökka eyoore yaar mángemáng reel pomwol allégh kkaal ngé emmwel rebwe íisch ngálí Sómwoolú Commerce, Deppatamentol Commerce, Caller Box 10007 C.K. Saipan, MP 96950. Ayegh me mángemáng ngé emmwel ebwe akkafangoló reel Deppatamentol Commerce me ngare fax 664-3067. Alongal mangemang ebwe bweibwogh llól 30 ral atol angaang sángi ráalil ye ee arongowow mellól Commonwealth Register.
Department of Commerce, Alcohol Beverage and Tobacco Control Division and

ebwe adoptaay allègh kkal.

Aluhulughial

Fermin M. Atalig
Secretary of Commerce

Isáliyal

Sofiad B. Sasamoto

Bwughiyal

Thomas A. Tebuteb
Special Assistant for Administrative
Office Of the Governor

Mereel 1 CMC 2153, iye aa liwel sangi alleghul Toulap 10-50, allegh kkal iye aa takkal
amwuri me aluhulughulo sangi Attorney General.

Efféër llól ráálil ye 30 maram ye 07, 2002.

Ramona V. Manglona
Deputy Attorney General

BY:

BRIAN CALDWELL
ASSISTANT ATTORNEY GENERAL
To repeal the Tobacco Control Regulations in its entirety as registered in, comm. Reg. Vol. 21, No. 05, at 16773, 16774 [May 05, 1999], and replace them with the new Tobacco Control Rules and Regulations. The Department of Commerce proposes regulations pursuant to 1 CMC § 2454, (modified by section 302(c) of Executive Order 94-3 text printed in Reorganization Plan No. 2, E.O. 94-2, Comm. Reg. Vol. 16, No. 6, at 11931 [June 15, 1994], and codified in P.L. 11-75 (effective date March 26, 1999) to be codified at 4 CMC § 50131 et. Seg., 1 CMC § 9104, and 6 CMC § 3110, as amended.

The proposed Tobacco Control Rules and Regulations are made to effectuate the licensing and regulation requirements created in P.L. 11-75 (effective date March 26, 1999).

The proposed Tobacco Control Rules and Regulations propose to provide a plan for the regulation mandated by P.L. 11-75 (effective date March 26, 1999).

Mr. Jesus C. Muna, Director, Alcohol Beverage and Tobacco Control Division, Dept. of Commerce, 664-3026, 664-3061 (fax).

6 CMC § 3110, as amended, P.L. 11-75 (effective date March 26, 1999) to be codified at 4 CMC § 50131 et. Seg.
DEPARTMENT OF COMMERCE  
ALCOHOL BEVERAGE AND TOBACCO CONTROL DIVISION  

PROPOSED TOBACCO CONTROL RULES AND REGULATIONS  

I. GENERAL PROVISIONS  

Section 1. Authority:  

These proposed rules and regulations have been promulgated for adoption pursuant to 1 CMC, §§ 2454, 9104, and 6 CMC § 3110, Section 18, as amended.  

Section 2. Purpose:  

To establish uniform regulations in order to carry out the intent and purpose of Public Law 11-75 (effective date March 26, 1999) to be codified at 4 CMC § 50131 et. seq., 1 CMC § 9104, and 6 CMC § 3110, as amended.  

Section 3. Definitions:  

The definition applicable to a particular word set forth in 6 CMC § 3110 of the Commonwealth Code shall govern whenever any word contained in that section is used herein.  

II. LICENSES  

Section 1. License Required:  

a. A person shall not import, manufacture, or sell any tobacco or tobacco products without a license issued by the Alcohol Beverage and Tobacco Control Division. Any person found to be engaged in the sale, distribution, or other transfer of tobacco or tobacco products without a valid Tobacco Control License shall be liable for a fine of up to $1,000 per business establishment.  

Section 2. License Applications:  

a. Applications for any Tobacco Control License authorized under 6 CMC § 3110 of the Commonwealth Code shall be submitted upon proper forms to be provided and approved by the Alcohol Beverage and Tobacco Control Division of the Department of Commerce.
b. Each application must be properly and completely filled out and accompanied by any and all required data supplementing the application form. If the Director of the Alcohol Beverage and Tobacco Control Division or his law enforcement officers find that additional information is necessary, consideration of the application may be postponed and a reasonable period of time may be afforded the applicant to comply with this requirement.

c. A deposit fee of $5.00 is required per application requested. Full payment of license fee, depending on the license sought by the applicant, is payable at the time the license is issued. All license fees set forth are non-reduction fees and apply to all applicants regardless of when, during the calendar year, the applicant applies for a license.

Section 3. Type of License and Fee:

<table>
<thead>
<tr>
<th>CLASS</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1 - Wholesale Agent’s License</td>
<td>$300.00</td>
</tr>
<tr>
<td>(Authorizes to import, purchase from any manufacturer, agent or wholesaler and sell to retailers tobacco or tobacco products).</td>
<td></td>
</tr>
<tr>
<td>Class 2 - Retail Dealer (General License)</td>
<td>$100.00</td>
</tr>
<tr>
<td>(Authorizes to sell tobacco or tobacco products to the general public).</td>
<td></td>
</tr>
<tr>
<td>Class 3 - Retail Dealer (Vending Machine)</td>
<td>$75.00</td>
</tr>
<tr>
<td>(Authorizes to sell tobacco or tobacco products through personally owned vending machines).</td>
<td></td>
</tr>
<tr>
<td>Class 4 - Distributor (Vending Machine)</td>
<td>$100.00</td>
</tr>
<tr>
<td>(Authorizes to sell tobacco or tobacco products through vending machines that are leased or under consignment).</td>
<td></td>
</tr>
</tbody>
</table>

Section 4. License Duration:

The license is issued for a period of one year. It commences on the day the application is approved and expires the following year on the same day and month the license was approved. All licenses issued are non-transferable.

Section 5. Renewal:

To renew a license, the fee must be paid on or before the expiration date. Failure to do so will cause the license to be automatically suspended. However, the license may be reinstated by the Secretary of Commerce if the fee is fully paid within three (3) days after the date of expiration. If payment is not made within thirty-one days from the date of expiration, the Secretary of Commerce shall not issue a license except upon a new application.
Section 6. Qualifications of Licensees:

a. Prior to considering an application for a Tobacco Control License, a thorough investigation into an applicant’s background will be conducted by the Director of the Alcohol Beverage and Tobacco Control Division or his law enforcement officers. In addition, the Director or his law enforcement officers may inquire into an applicant’s:

1. prior criminal record;
2. location of the premises;
3. condition of premises; and
4. past business conduct and practices.

b. All individuals who are involved in any way as proprietors, managers, employees or agents of the business being considered for licensing, shall be listed by legal name in the current application on file with the Alcohol Beverage and Tobacco Control Division. No license shall be issued or renewed unless these listings are complete and legally accurate and reveal sufficient compliance with all pertinent provisions of 6 CMC §3110 and or these regulations as made applicable.

c. All applicants, as a condition for receiving a Class 3 Retail Dealer (vending machine) license, shall provide proof of ownership of such vending machine(s) prior to the issuance of this license.

d. All applicants, as a condition for receiving a Class 4 Distributor (vending machine) license, shall provide a lease or consignment agreement between the distributor and the retailer prior to the issuance of this license.

e. All applicants for Tobacco Control Licenses shall register the names of employees employed by his establishment and engaged in the selling of tobacco or tobacco products prior to the issuance of the license.

The Director of the Alcohol Beverage and Tobacco Control Division or his law enforcement officers will carefully consider the results of their investigation and may make a determination as to approval or disapproval of the application.

Section 7. Premises Qualifications:

a. Retail establishments engaged in the sell of cigarettes and other tobacco products shall secure all individual cigarette packages and other tobacco products in a locked cabinet or other secured casing located behind, underneath, or adjacent to the cashier counter. Cigarette sticks must be in their original packing and must be sold in packs or other containers in groups of not fewer than 20 cigarettes. In the case of roll-your-own tobacco, any package of roll-your-own tobacco must contain at least 0.60 ounces of tobacco.
b. Retail establishments engaged in the sell of cigarettes from vending machines shall secure such machines in premises accessible only to persons 18 years and older.

c. All applicants for any class type of license shall have signs reading "TOBACCO SALES PROHIBITED TO PERSONS UNDER THE AGE OF 18" conspicuously posted on the premises near the cash register and next to any tobacco or tobacco product. These posted signs shall be at least eleven (11) inches by eight and one-half (8.5) inches in dimension. The signs shall not be altered, removed or obstructed and shall remain visible at all times for public view.

d. All applicants for any class type of license shall have an English written billboard (sign board) mounted or displayed outside the business premises as indicated on the proposed (dba) on the application form.

Section 8. Issuance Restrictions:

The Alcohol Beverage and Tobacco Control Division shall not issue a license of any class to any applicant that falls into the following restrictions, except pursuant to the restrictions noted herein:

a. The applicant is not the real party in interest;
b. The applicant is under eighteen (18) years of age;
c. The applicant was a licensee whose license was revoked within the prior year;
d. The applicant’s retail establishment is within 300 feet from any public or private school building; provided, however, that the Secretary of Commerce or his designees may issue a license that contains a restriction prohibiting the sale of tobacco or tobacco products during school hours or other school activities.

Section 9. Review:

a. Upon inspection and investigation, the Director of the Alcohol Beverage and Tobacco Control Division or his law enforcement officers shall consider the application and render their decision, granting or denying the application, within 15 working days.

b. The Director of the Alcohol Beverage and Tobacco Control Division or his law enforcement officers may disapprove an application for a license, upon findings through adequate investigation, that such refusal is in the public interest.

c. If the Director of the Alcohol Beverage and Tobacco Control Division or his law enforcement officers decide in favor of the applicant, the Alcohol Beverage and Tobacco Control Division shall promptly notify the applicant or licensee of their decision. If the Director or his law enforcement officers decide otherwise, they shall issue an appropriate decision and order. The decisions and orders shall be accompanied by separate findings of fact and conclusions of law. The Alcohol Beverage and Tobacco Control Division shall, within reasonable time, send a certified copy thereof to the applicant or licensee.
d. Where an application for a license has been denied, the person aggrieved by such
denial shall be entitled to a review of the decision pursuant to the procedures established
under the Administrative Procedures Act, 1 CMC §§ 9108 - 9115.

Section 10. Responsibilities of the Licensee:

a. It shall be the responsibility of the licensee to notify the Director of the Alcohol
Beverage and Tobacco Control Division or his law enforcement officers in writing of any
and all changes in a licensed business ownership, management, agents, modification or
renovation of premises, relocation of establishment, or any other changes which materially
affect or modify the data on file and recorded as the basis for granting or renewal of such
license prior to the time such changes occur. Failure to do so within seven days of such
change shall require an immediate temporary suspension of license until the situation has
been rectified or appropriate action has been taken.

b. The licensee shall register or cause to be registered with the Alcohol Beverage and
Tobacco Control Division any new employee(s) engaged in the selling of tobacco or
tobacco products within twenty-four hours after employment.

c. Every license issued and in effect under this Title shall at all times be conspicuously
posted and exposed to view, convenient for inspection, on the licensed premises.

d. It shall be the responsibility of the licensee to ensure that all employees are familiar
with the provisions of Public Law 11-75 and its rules and regulations and that they are
capable of maintaining order and responsibility for compliance to such laws and regulations.

Section 11. Issuance of License:

The Alcohol Beverage and Tobacco Control Division may issue a license only to
the following:

a. To any member of a corporation or partnership;
b. To applicant or authorized representative with written authorization.

Section 12. Prohibitions:

a. At no time under any circumstances shall any tobacco or tobacco products be sold
or furnished by any licensee:

1) to any person under the age of 18;
2) in tobacco vending machines accessible to persons under the age of 18;
3) to any person without producing an official identification card prior to the
sale or transaction of tobacco products.

b. A licensee shall not permit any of its agents or employees who are under the age of
eighteen (18) to sell any tobacco or tobacco products while on duty on such premises.
Section 13. Suspension or Revocation of Licenses:

A license of any class may be suspended or revoked on any of the following grounds:

a. Violation of, causing or permitting a violation of, or failure or refusal by a licensee to comply with the provisions set forth in 6 CMC § 3110 or any of the regulations adopted under this title;

b. Misrepresentation of a material fact by any applicant in obtaining or renewing a license.

Section 14. Procedure on Revocation or Suspension of License:

The Secretary of Commerce may revoke any license or suspend the right of the licensee to use its license for the violation of any provision of 6 CMC § 3110 or any rule or regulation applicable thereto.

In every case where it is proposed to revoke or suspend the exercise of any license, the licensee shall be given:

a. Notice and hearing; the notice to be given at least five (5) days before hearing;

b. At the hearing, the licensee shall be entitled to be heard in person or through counsel and shall be given a full and fair opportunity to present any facts showing that the alleged cause or causes for the proposed action do not exist;

c. The testimony taken shall be under oath and taken stenographically or by machine, but the parties shall not be bound by strict rules for evidence;

d. Copies of any transcript made at the hearing shall be given to the licensee upon request and at the licensee’s expense.

e. In the event revocation or suspension of a license is found as an appropriate sanction for a violation of any applicable statute or regulation, the following civil sanctions and/or penalties will apply to violations relating to all classes of licenses occurring within a one year (365 day) period, as set forth below, except for vending machine licenses:

1. **First Offense:** Warning Letter issued to the business establishment;

2. **Second Offense:** A Civil Penalty of $500.00 maximum;

3. **Third Offense:** Seven (7) days suspension of license;

4. **Fourth Offense:** Revocation of license for up to one (1) year;

f. In the event revocation or suspension of a license is found as an appropriate sanction for a violation, the following civil sanctions and/or penalties will apply to violations relating to **vending machine Licenses** occurring within a one year (365 day) period:
1. **First Offense:** A Civil Penalty of $500.00;
2. **Second Offense:** A Civil Penalty of $750.00;
3. **Third Offense:** Ninety (90) days suspension of license; and
4. **Fourth Offense:** Revocation of license for up to one (1) year.

Section 15. **Conditions and Disposal of Confiscated Tobacco or Tobacco Products:**

a. All Tobacco or Tobacco Products confiscated in the CNMI may be returned to the proper owner under the conditions that a Tobacco License is obtained prior to the release and that all tobacco products are legally for sale.

b. All illegal Tobacco or Tobacco Products confiscated in the CNMI shall be disposed of at the discretion of the Secretary of Commerce by:

   Dumping or incinerating in public by the Secretary or his authorized representative in the presence of one employee of the Department of Public Safety, one employee from the Department of Public Health, Community Guidance Center, and one employee of the Office of the Attorney General.
COMMONWEALTH DEVELOPMENT AUTHORITY

The Commonwealth Development Authority (CDA), and the Division of Revenue and Taxation of the Department of Finance, of the Commonwealth of the Northern Mariana Islands pursuant to 4 CMC §3323 and in accordance with the Administrative Procedures Act (1 CMC §9101, et seq.) hereby notify the general public that the proposed amendments to the Qualifying Certificate Program Rules and Regulations as published in the Commonwealth Register, Volume 24, Number 07, July 29, 2002, at pages 19383 through and including 19391, and after expiration of appropriate time for public comment, were adopted by the CDA Board of Directors at its regular meeting on September 10, 2002, a quorum being present, without modification.


The adopted amended Rules and Regulations become effective ten (10) days after publication of this Notice in the Commonwealth Register.

Dated this 8th day of October 2002.

Juan S. Tenorio, Chairman
CDA Board of Directors

Maria Lourdes S. Ada
CDA Executive Director

Esther S. Ada, Director
Division of Revenue & Taxation

Thomas I. Tebuteb
Special Assistant for Administration
COMMONWEALTH DEVELOPMENT AUTHORITY AND
THE DIVISION OF REVENUE AND TAXATION,
DEPARTMENT OF FINANCE

CERTIFICATE OF ADOPTION

We, Juan S. Tenorio and Maria Lourdes S. Ada, Board Chairman and Executive
Director of the Commonwealth Development Authority, respectively, and Esther S. Ada,
Director of Revenue and Taxation of the Department of Finance which are promulgating
the Rules and Regulations of the Qualifying Certificate Program, published in the
Commonwealth Register, Volume 24, Number 07, on July 29, 2002, at pages 19383
through and including page 19391, by our signatures below, do hereby certify that the
proposed amendments to the Qualifying Certificate Program Rules and Regulations were
adopted by the CDA Board of Directors at its regular board meeting on September 10,
2002, without modification as set forth in the Public Notice of Adoption accompanying
this certificate. We hereby request and direct that the Public Notice and this Certificate of
Adoption be immediately published in the Commonwealth Register.

We declare under penalty of perjury that the aforementioned amendments to the
Rules and Regulations are true and correct and that this declaration was executed on the
8th day of October 2002, Saipan, Commonwealth of the Northern Mariana Islands.

Juan S. Tenorio, Chairman
CDA Board of Directors

Maria Lourdes S. Ada
CDA Executive Director

Esther S. Ada, Director
Division of Revenue & Taxation

Pursuant to 1 CMC § 2153, as amended by P.L. 10-50, the proposed amendments to the
Rules and Regulations as described in the foregoing Certificate of Adoption have been
reviewed and approved as to form and legal sufficiency by the CNMI Attorney General's
Office.

Deputy Attorney General

Date: 10/21/02

Ramona V. Manglona
Deputy Attorney General

COMMONWEALTH REGISTER
Volume 24 Number 10
October 30, 2002.
Page 19623
I COMMONWEALTH DEVELOPMENT AUTHORITY YAN I
DIBISIÒN I REVENUE AND TAXATION,
DIPATTAMENTON I FINANCE
NOTISIAN PUPBLIKU PUT INADOPTASIÓN I MAN MA AMENDA SIHA NA
AREKLAMENTO YAN REGULASIÒN PUT ASONTON
QUALIFYING CERTIFICATE PROGRAM
GI HALOM
I COMMONWEALTH DEVELOPMENT AUTHORITY

I Commonwealth Development Authority (CDA), yan i Dibísion i Revenue and
Taxation, gi Depattamenton i Finance, gi Commonwealth Gi Sankattan Siha Na Islas
Mariáñas sigun gi 4 CMC Sek. 3323 yan i kininsiste yan i Administrative Procedures
Act (1 CMC Sek. 9101, et. seq.) este na momento bai en notisia i pupbliku henerát na i
man ma introdusi siha na amendación put Qualifying Certificate Program ni ma pupblisa
gi Commonwealth Register, Volume 24, Numiru 07, gi Julio 29, 2002 gi pahinan 19383
enteru yan inklusu 19391, yan despues inipus i tiempo anai manañi’i’ i pupbliku para hu fàn
na hálom opinion, i CDA Board of Directors ha adopta, gi duránten anai man dänña gi
Septembre dia dies (10) 2002, man quorum, táya tinillaكا.

Kopia siha ni man ma amenda na Areklamento yan Regulación put i Qualifying
Certificate Program gaige na mutero (available) gi Ofisinan i CDA gi Gualo Rai, giya
Saipan M.P. 96950.

I man ma amenda na Areklamento yan Regulación siha ni ma adopta hu efektibu
gi dies (10) dias despues di ma pupblisa este na notisia gi Commonwealth Register.

Ma fecha gi mina ocho (8) dias gi Oktubre, 2002.

Juan S. Tenorio, Chairman
CDA Board of Directors

Maria Lourdes S. Ada
CDA Executive Director

Esther S. Ada, Director
Division of Revenue and Taxation
Thomas I. Tebuteb
Espisiat na Ayudânte Para Atministración

Pine'lo yan ma Record as:

Soledad B. Sasamoto
Rehistradoran I Koporación

Fecha

10/29/02

Fecha
I COMMONWEALTH DEVELOPMENT AUTHORITY (CDA)
YAN I DIVISIÓN I REVENUE AND TAXATION,
DIPÁTTAMENTON I FINANCE

INADOPASIÓN I SETTIFIKU

Hami as Juan S. Tenorio yan si Maria Lourdes S. Ada, i Kabesiyun i Board yan Executive Director i CDA, konrespetu, yan si Esther S. Ada, Direktot i Revenue and Taxation ginen i Dipáttamenton i Finance ni ma dekláklär i Areklamenton yan Regulasion siha put i Qualifying Certificate Program, ni ma pubplisa gi Commonwealth Register, Volume 24, Numiru 07, gi Julio 29, 2002, gi pahinan 19383 enteru yan inklusu pahinan 19391, ginen i fitman mami gi sanpapa, este na momento en na klaruyi na si man ma introdusi siha na amendasion put Areklamento yan Regulación siha man ma adopta ginen i CDA Board of Directors, gi dinanfiña niha gi Septembre dia dies (10) 2002, na taya tinilaika ni ma adopta put este na settifiku. Bai en rekuesta na i Notisian Pupbliku yan este na settifiku ni ma adopta para hu imidiemente ma pubplisa gi Commonwealth Register.

En dekláprü papa i penalty of perjury ni hafa ma mensiona siha put i Areklamento yan Regulación ni man ma amendna ma magáhet yan dinanche yan put este na declaración ma execute gi mina ocho (8) dias gi Octubre, 2002, gi Saipan, Commonwealth Gi Sankattan Siha Na Islas Mariáns.

Juan S. Tenorio, Chairman
CDA Board of Directors

Maria Lourdes S. Ada
CDA Executive Director

Esther S. Ada, Director
Division of Revenue and Taxation

Sigun i 1 CMC Sek. 2153, ni ma amendna ginen i Lai Pupbliku 10-50, i man ma introdusi siha na amendasion put Areklamento yan Regulación siha ni ma sangan mofona na inadopasion settifiku man ma ribisa yan apreba gi fotma yan sufisiente na ligát ginen i Ofisinan i Abugádon Henerát gi Commonwealth Gi Sankattan Siha Na Islas Mariáns.

Ramona V. Manglona
Delegádon Abugádon Henerát

Fecha: 10/21/02
Pine’lo as:

Soledad B. Sasamoto
Rehistradoran i Koporación

Ma risibi gi Ofisinan i gobierno gi as:

Thomas J. Tebuteb
Espisiat na Ayudânte Para Atministración

Fecha: 10/28/02
COMMONWEALTH DEVELOPMENT AUTHORITY
ME DIVISION-UL REVENUE AND TAXATION,
DEPATTAMENTOL FINANCE ARONGORONGOL
TOULAP REEL ADOPTION-UL REEL
LIWEL KKAAL NGÁLI ALLEGHÚL
QUALIFYING CERTIFICATE PROGRAM MELLÓL
COMMONWEALTH DEVELOPMENT AUTHORITY

Commonwealth Development Authority me Division-ul Revenue and Taxation mereel Depattamentol Finance mellól Commonwealth matawal wool falúw kka falúwasch Marianas sángi 4 CMC 3323 iye ee ghil mellól Administrative Procedure Act (1 CMC 9101, et seq.) ighila ekke arongaar Toulap reel pomwol liwil kkaal ngáli alleghúl Qualifying Certificate Program iwe aa fféérlo llól Commonwealth Register, Volume 24, numoro 07, Wuuń 29, 2002, llól schéél 19383 mebwal 19391, bwal takkallól arong ngliir Toulap reel isisilongol mángemáng, igha aa adoptló mereel CDA Board of Directors llól atol yaar mwiisch llól maram we Maan 10, 2002 iha re lo aongeer, nge ese bwal yoor liwel.

Copial liwel kkaal reel alleghúl Qualifying Certificate Program ikka eyoor mellól Bwulasiyol Commonwealth Development Authority, Amai raw, Seipel, MP 96950

Reel allegh kka aa liwel ikka aa adoptló iye ebwe alleghló mwiril seigh (10) ral reel ighiwe aa fféérlo arong llól Commonwealth Register.

Ráálil ye 8th llól maramal Sarobwel 2002.

Juan S. Tenorio, Chairman
CDA Board of Directors

Maria Lourdes S. Ada
CDA Executive Director

Esther S. Ada, Director
Division of Revenue & Taxation
Thomas I. Tebuteb  
Special Assistant for Administration

Soledad B. Sasamoto  
Registrar of Corporations

10/29/02  
Rál
COMMONWEALTH DEVELOPMENT AUTHORITY ME DIVISION-UL REVENUE AND TAXATION, DEPARTMENT OF FINANCE

APILUGHULUGHUL ADOPTION

Yáámem, Juan S. Tenorio me Maria Lourdes S. Ada, Board Chairman me Executive Director llól Commonwealth Development Authority, me Esther S. Ada, Depattamentol Revenue and Taxation mereel Depattamentol Finance, rekke arongaalo reed allehul Qualifying Certificate Program, ikka aa feerlo llól Commonwealth Register, Volume 24, numoro 07, wóol Wuun 29, 2002, llól schéél 19383 mebwal schéél 19391, sängi yáámem alughulughuló, iyeey aa alleghlo reed alleghkkewé aa lliwello iye aa adoptlo mereel CDA Board of Directors llól yaar yéelágh we wool Maan 10, 2002, nge esbwal yoor lliwel llól arongorongol Toulap reed adoption-ul apilughulughul, ay ghal tingór me afal bwe arongorongol Toulap me apilughulughul adoption ebwe published mellól Commonwealth Register.

Ay, akkapal ló faal penalty of perjury bwe meta kka autol aa liwel mellól allegh kkaal ee ellet me welewel nge aa alleghlo raal we wool 8th llól maramal Sarobwel, 2002, Seipel, Commonwealth of the Northern Mariana Islands.

Juan S. Tenorio, Chairman
CDA Board of Directors

Maria Lourdes S. Ada
CDA Executive Director

Esther S. Ada, Director
Division of Revenue and Taxation

Mereel 1 CMC 2153 iye aa liwil sangi Alleghul Toulap 10-50, liwel reed allegh kkaal ikka lo llól apilughulughul reed adoption iye aa takkal amwuri me alughulugh sangi Bwulasiyol CNMI Attorney General.

Ramona V. Manglona
Deputy Attorney General

Rál: 10-21-02

COMMONWEALTH REGISTER Volume 24 Number 10 October 30, 2002. Page 19631
Isáliyal sángi:

Soledad B. Sasamoto
Registrar of Corporations

Rál: 10/29/02

Bwulashiyol Gobetno:

Thomais I. Tebuteb
Special Assistant for Administration

Rál: 10/28/02
NOTICE AND CERTIFICATION OF ADOPTION OF THE AMENDMENTS TO THE RULES AND REGULATIONS GOVERNING THE GROUP HEALTH INSURANCE PROGRAM

I, Thomas I. Saures, the Acting Chairman of the Board of Trustees of the Northern Mariana Islands Retirement Fund, which is promulgating these amended Regulations of the Group Health Insurance Program, published in the June 17, 2002 Commonwealth Register, Volume 24, Number 6, at pages 19256 to 19376, as Emergency Interim Amendments, by signature below, hereby certify that the final amended Regulations of the Group Health Insurance Program was adopted by the Board of Trustees at its Special Meeting on August 23, 2002 and October 24, 2002. Modifications were made to reflect changes made after consideration of comments received, such as the inclusion of coverage of Hansen's Disease (8.01(G)(2)(n1)) and Parkinson's Disease (8.01(G)(2)(a2)), which were previously excluded, as well as correction of minor typographical and grammatical errors. I further request and direct that this Public Notice and Certification of Adoption be published in the Commonwealth Register and then be attached by both the Office of the Registrar of Corporations and by the Office of the Governor to the Rules and Regulations.

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed on the 24th day of October, 2002 at Saipan, Commonwealth of the Northern Mariana Islands.

THOMAS I. SAURES
Acting Chairman
Board of Trustees, NMIRF

Filed by: ___________________________ Received by: ___________________________
Soledad B. Sasamoto Thomas A. Tebute
Registrar of Corporations Special Assistant for Administration
Date: 10/29/02 Date: OCT. 28, 2002
CERTIFICATION BY THE OFFICE OF THE ATTORNEY GENERAL:

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

Dated this **25th** day of OCTOBER, 2002.

RAMONA V. MANGLONA
Deputy Attorney General

By:  

BEN SACHS
Assistant Attorney General
SYNOPSIS OF MODIFICATIONS
made to the Proposed Amendments to the Rules and Regulations Governing the Group Health Insurance Program, as published as Emergency Interim Amendments in the Commonwealth Register on June 17, 2002, Volume 24, Number 6, at pages 19256 to 19376. Adopted by the Board of Trustees as final on October 24, 2002.

Article 1 – Introduction: Changed name of “Vicente C. Camacho, Chairman” to “Thomas I. Saures, Acting Chairman”. Mr. Camacho is no longer with the Board of Trustees since July 2002.

Rule 5.04(3)(f) – Mental Health Care: Corrected typo at last line of second sentence in paragraph one “…as go treatment type and duration…” to “as to treatment type and duration…”

Rule 7.09 – Annual Maximums: Rephrased first sentence “The total benefits provided to an Enrollee under this Plan shall not exceed $50,000 or $100,000, Lifetime, depending on the Option chosen.” to “The total benefits provided to an Enrollee under this Plan shall not, under any circumstances, exceed $50,000 or $100,000, Annually, depending on the Option chosen.”

Rule 7.10 – Lifetime Maximums: Included the word “Lifetime” after “$500,000” in the first sentence.

Rule 8.01(G)(2)(n1) – Hansen’s Disease: Originally excluded in the Plan, but now is a covered benefit; renumbered exclusions accordingly.

Rule 8.01(G)(2)(a2) – Parkinson’s Disease: Previously excluded in the Plan, but now is a covered benefit; renumbered exclusions accordingly.

Rule 8.01(G)(2)(d3) – Excluded Prescription services: Renumbered to Rule 8.01(G)(2)(b3); and corrected misspelling under Rule 8.01(G)(2)(b3)(xvii) – “ore-authorized” to “pre-authorized”.

Rule 10.15: Chart, which was placed erroneously under Rule 10.10 moved to correct location, which is under Rule 10.15.
Rule 11.01: Rephrased first sentence, starting at line 5 from beginning of sentence:
"...as such under the requirements of the Federal Medicare Program, are certified or licensed by the proper government authority, render Services..."

to

"...as such under the requirements of the Federal Medicare Program, or are certified or licensed by the proper government authority, and render Services..."

Rule 11.13(A)(2) – Arbitration: Corrected number of days spelled out as “ninety” to “thirty” to reflect numerical number in parenthesis (30).
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ARTICLE 1 – INTRODUCTION

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

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

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

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

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

Thomas I. Saures
Acting Chairman, Board of Trustees
NMI Retirement Fund

Karl T. Reyes
Administrator
NMI Retirement Fund
ARTICLE 2 – DEFINITIONS

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

2.01. “Act” means Public Law 10-19, An Act to Transfer the Administration of the Government Health Insurance Programs to the Northern Mariana Islands Retirement Fund, which was enacted into law effective June 21, 1996, and all subsequent amendments.

2.02. “Administrator” means the Administrator of the NMI Retirement Fund or his or her designee. If the Fund has contracted with a Third Party Administrator to provide Services under the Plan, the term “Administrator” may, at times, refer to the Third Party Administrator.

2.03. “Allowable Expense” means any expense which the Board or Administrator determines to be reasonable and appropriate for administering the Program and for providing Covered Benefits in accordance with this Plan Document.

2.04. “Annual Maximum” means the dollar limitation on the total amount that the Program will pay for all Covered Benefits provided to any Enrollee in any Plan Year.

2.05. “Application Form” means the form prescribed by the Administrator and required to be submitted to the Administrator by any person wishing to enroll himself or herself and/or his or her Dependents in the Program.

2.06. “Board” means the Board of Trustees of the NMI Retirement Fund.

2.07. “Child” means a Subscriber’s unmarried

   a. natural child;
   b. legally adopted child or child placed for adoption;
   c. stepchild living with the Subscriber in a normal parent/child relationship; or
   d. child under his or her court-appointed legal guardianship;

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

2.08. “Claim Form” means the form prescribed by the Administrator, or any Third Party Administrator contracted by the Program, and required to be submitted to the Program or Third Party Administrator for payment of Covered Benefits.
2.09. "**Coinsurance**" means the percentage of the cost of Covered Benefits that must be paid by either the Enrollee or the Program.

2.10. "**Contribution**" means the share of the Premium required to be paid by the Government or the Subscriber.

2.11. "**Co-payment**" means the specified portion or percentage of the Eligible Charge that an Enrollee must pay to the Provider of Services.

2.12. "**Covered Benefits**" means the health care Services covered under the Program.

2.13. "**Dependent**" means a Subscriber's

   a. Spouse;
   b. Eligible Child(ren).

2.14. "**Disease**" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the vital functions, and causing or threatening pain and weakness. Other common terms for Disease and which may be considered to be a Disease are malady, affliction, illness, sickness and disorder.

2.15. "**Dispense**" or "**Fill**" means the counting, measuring, compounding, pouring, packaging and labeling required to prepare a drug for either direct or indirect delivery to a patient when authorized by a valid prescription from a licensed Practitioner.

2.16. "**Doctor**" means a duly licensed doctor of medicine (M.D.), medical officer (M.O.), or doctor of osteopathy (D.O.). Doctors of Optometry (O.D.) and Podiatry (D.P.M.) will also be considered a Doctor for purposes of the Plan, but only for the provision of services as stated to be allowed to be performed by the appropriate licensing board or agency in the location in which the service is performed, and only for the provision of services covered under the Plan. A doctor of dentistry (D.D.M. or D.D.S.) is also considered a Doctor for purposes of the dental work and oral surgery covered by the Program. Types of practitioners not specifically mentioned in this paragraph are not considered Doctors for purposes of the Program.

2.17. "**Drug**" or "**Medication**” means articles recognized in the official United States Pharmacopoeia, the official Homeopathic Pharmacopoeia of the United States, or official national Formula, or any supplement to any of them, being and labeled in accordance with the Federal Drug Administration requirements; or articles and devices intended for use in the diagnosis, cure, mitigation, treatment or prevention of diseases in humans; or articles intended for use as a component of
any article specified in this definition; or controlled substances as defined in the Rules and Regulations of the CNMI Medical Profession Licensing Board.

2.18. “Effective Date” means the date on which a person is accepted as a Subscriber, as established and recorded by the Administrator, and is the date, subject to all applicable waiting periods provided under this Plan, on which such Subscriber's eligibility for benefits under this Plan begins.

2.19. “Eligible Charge” means

a. the charge described in Article 11.10 below and is the charge used to calculate the Plan's benefit payment for most covered Services;

2.20. “Emergency” means the sudden and unexpected onset of a severe medical condition that, if not treated immediately, would be, in the opinion of a Doctor, life-threatening or result in a permanent disability; for example, a heart attack, severe hemorrhaging, poisoning, loss of consciousness or respiration, and convulsions are considered Emergencies.

2.21. “Employee” means a person who is receiving salary or wages from the Government and who is (a) employed by the Government and regularly scheduled to work 20 or more hours per week, or (b) an elected or appointed Government official. However, as to any period, the term “Employee” will not include any individual who, during such period, is classified or treated by the Government as an independent contractor, a consultant, a leased employee, or an employee of an employment agency or any entity other than the Government, even if such individual is subsequently determined to have been a common law employee of the Government during such period. This definition also excludes any individual who serves on a Government board or commission, but is not otherwise a Government employee, and any individual employed by the Government in violation of applicable law. Nothing in this definition will be construed to affect Retirees who are authorized by law to draw their retirement benefits while working for the Government in a non-employee classification. This definition is effective as of the Plan's original effective date.

2.22. “Enrollee” means any Employee, Retiree, Survivor, or Dependent whose enrollment in the Program has been approved by the Administrator and for whom all Premium payments are current, unless otherwise required by law or specifically approved by the Administrator if the failure to make Premium payments was no fault of the Subscriber.

2.23. “Enrollment Change Form” means the form prescribed by the Administrator and required to be submitted to the Administrator by any person wishing to change his or her benefit or enrollment option or to add or delete coverage of Dependents.
2.24. "Experimental" means any experimental, investigational or unproven Service which is considered by the HCFA Medicare Coverage Issues Manual to be not reasonable and necessary and, therefore, not approved for payment under U.S. Medicare.

2.25. "Fiscal Year" means any October 1 through the following September 30.

2.26. "Formulary" means a listing of prescription drugs and medications that are covered under the Plan and for which the Plan will either pay the appropriate portion of co-insurance or for which the Plan will reimburse the Enrollee the appropriate portion of co-insurance. Providers that are legally permitted and authorized to dispense medications will be reimbursed for medications prescribed from the Formulary, based upon the rate established by the Plan's Pharmacy Benefit Manager.

2.27. "Fund" means the NMI Retirement Fund.

2.28. "Generic" means a drug or medication prescribed by a Doctor that contains the chemical name for the drug, and is usually a lower cost equivalent to a Name Brand drug or medication. The active ingredient in the generic drug is the same as the active ingredient in the equivalent name-brand drug, even though the exact formula for the two drugs may not be identical.

2.29. "GHLI Trust Fund" means the CNMI Government Group Health and Life Insurance Trust Fund. The GHLI Trust Fund shall be segregated from other funds and held in trust and administered by the Administrator under the fiduciary supervision of the Board.

2.30. "Government" means the CNMI Government, its departments, agencies, instrumentalities, public corporations, municipal governments, and other CNMI Government entities and autonomous agencies.

2.31. "Hospital" means any inpatient acute care institution which:

   a. is not other than incidentally, a nursing home, rest home, or Skilled Nursing Facility; and
   b. is primarily engaged in providing facilities for surgery and for medical diagnosis and treatment of injured or ill persons by or under the supervision of Doctors; and
   c. has registered nurses always on duty; and
   d. is certified or licensed as a hospital by the proper governmental authority.

2.32. "Injury" means a wound or physical trauma resulting from an external force (such as a blow, collision, or impact) that is of sufficient magnitude to require the Services of a physician within a reasonable time. Subjective symptoms that occur spontaneously or from trivial movement or exercise and that are
physiological, pathological, toxic, or infective in origin are not to be considered
the result of external force and therefore shall not be considered an injury. The
fact that an ailment or condition may not fit this definition of "Injury" does not
necessarily mean that the ailment or condition is not covered under the Plan.

2.33. "**Lifetime Maximum**" means the dollar limitation on the total amount that the
Program will pay for all Covered Benefits provided to an Enrollee during the
Enrollee's lifetime.

2.34. "**Medical Director**" means a medical doctor, medical officer, and other medical
professional employed by the Plan or its Third Party Administrator, if any, to
review claims and determine medical necessity of Services.

2.35. "**Medically Necessary**" means, with respect to each Service, that the Service
meets all of the tests listed below. The fact that a Doctor prescribes, orders,
recommends or approves a Service does not, of itself, make it Medically
Necessary.

   a. **Health-Related.** The Service is provided for the diagnosis or treatment of
      an injury, illness, disease, ailment or condition, including pregnancy, and
      birth and congenital defects.

   b. **Appropriate.** The Service is (i) appropriate for the symptoms, (ii)
      consistent with the diagnosis, (iii) in accordance with generally accepted
      medical practice and professionally recognized standards in the
      geographic location where Services are provided, and (iv) expected to
      result in a meaningful and substantial improvement in the Subscriber's
      condition.

   c. **Adequate.** The Service does not exceed the supply, level of Service or
      amount of Service needed to provide safe and appropriate care.

   d. **Not for Convenience.** The Service is not provided mainly for the
      convenience or desire of the Enrollee, Enrollee's family, Enrollee's
      Provider, or other person or entity.

   e. **Not Experimental.** The Service is not Experimental.

   f. As further described in Article 11.09 of this Plan Document.

2.36. "**Mental or Nervous Disorders**" include the following conditions: neurosis,
psychoneurosis, psychopathy, psychosis, and emotional disorders of every kind,
irrespective of cause, except substance abuse and/or dependency.
2.37. "Name-Brand" means any drug or medication prescribed by a Doctor that contains a specific copyrighted name assigned to it by the drug's manufacturer. There may or may not be a generic equivalent for name-brand medications.

2.38. "Non-Participating or Non-Preferred Provider" means a provider of services who, when rendering a service covered by the Plan to an enrollee, does not have an agreement with the Plan or the Plan's Third Party Administrator, if any, to collect a specified amount.

2.39. "Non-Preferred Prescription" means any drug or medication prescribed by a Doctor that exceeds a certain dollar limit as established in the Plan's formulary, or as specified in this Plan.

2.40. "Off-island" means a location other than the Commonwealth of the Northern Mariana Islands. For example an Off-island hospital or provider refers to a hospital or medical provider located outside the CNMI, such as a provider located in Guam, Hawaii or the U.S. mainland.

2.41. "On-island" means a location in the Commonwealth of the Northern Mariana Islands. For example, an On-island provider or hospital refers to a provider or facility located within the CNMI, such as the Commonwealth Health Center.

2.42. "Open Season" means that period of time, designated by the Administrator, during which Employees may apply for enrollment in the Program for themselves and their Dependents and during which Subscribers may apply to change their benefit and enrollment options in the Program. Generally, an Open Season will be held in November each year.

2.43. "Out-Of-Pocket Maximum" means the total dollar amount of Eligible Charges that must be paid by the Subscriber for his or her family in a Plan Year toward eligible medical expenses. The out-of-pocket maximum only applies to Eligible Charges and the Subscriber must still pay for any non-eligible charges in addition to the out-of-pocket maximum.

2.44. "Participating or Preferred Provider" means a Provider of Services who, when rendering a Service covered by this Plan to an Enrollee, agrees with the Plan or the Plan's Third Party Administrator or Pharmacy Benefit Manager, if any, to collect not more than (a) a specified amount paid by the Plan and (b) the Enrollee's Copayment or Coinsurance as specified in this Plan.

2.45. "Pharmacist" means one who is Registered, Certified or Licensed by the appropriate licensing and regulatory authority in the jurisdiction in which the Services is being performed, and who legally may compound and dispense medications, following prescriptions issued by a duly licensed Doctor or Physician, or other authorized medical practitioner; and one who legally weighs, measures and mixes drugs and/or other medicinal compounds, and fills bottles or
capsules with correct quantities and compositions or the preparation; and one who legally dispenses prescription medications and advises self-diagnosing and self-medicating patients, or provides information on potential drug interactions, potential adverse drug reactions, and elements of patient's history which might bear on prescribing decisions when in an advisory capacity to a Physician; or as otherwise described and defined in the CNMI Medical Profession Licensing Board Rules and Regulations.

2.46. "Pharmacy" means a location properly licensed by the CNMI Medical Profession Licensing Board or the appropriate licensing and regulatory authority in the jurisdiction in which the facility is located, where prescription drugs are legally stored or possessed and dispensed or sold at retail, or displayed for sale at retail, or where prescriptions are compounded or dispensed.

2.47. "Pharmacy Benefit Manager (PBM)" means a company or firm that provides prescription benefit management services including, but not limited to, formulary development and management, prescription pre-authorization, prescription utilization review, prescription claims processing and payment, prescription cost controls.


2.49. "Physician Assistant" means a duly certified or licensed Physician Assistant, properly certified or licensed pursuant to the Rules and Regulations promulgated by the CNMI Medical Profession Licensing Board, or all criteria established in the jurisdiction in which the Physician Assistant is rendering services, including but not limited to certification requirements as established by the National Commission on Certification of Physician Assistants (NCCPA).

2.50. "Plan" means the group health insurance plan, which the Government offers to its Employees and Retirees and includes this Program and any and all Prior Programs. This term may be used interchangeably with the term "Program", as defined herein.

2.51. "Plan Document" means this CNMI Group Health Insurance Program Plan Document as amended by the Board from time to time. The term "Plan Document" includes any currently effective rules and regulations amending or interpreting this Plan Document, any supplements issued by the Program or Riders providing any supplemental coverage, if any.

2.52. "Plan Year" means the calendar year (January 1 through December 31), except that the "first" Plan Year will be the effective date of these regulations through the following December 31 in the year of first implementation of these regulations or any published revisions to these regulations. For a new Enrollee, the Plan Year begins when such Enrollee's coverage begins and continues through the following December 31.
2.53. "Premium" means the total amount of Contributions required to be paid into the GHLI Trust Fund for participation in the Program.

2.54. "Prescription" means a written order given individually for the person for whom prescribed or named, issued by a licensed Doctor, Physician, or other legally qualified medical practitioner, for a drug or medication, to be compounded, filled, dispensed or furnished by a legally qualified individual or Pharmacist. In addition, a Prescription may be for durable medical equipment. Prescription does not include medications or drugs for which a prescription is not required or that are lawfully obtainable without a prescription, such as "over-the-counter" remedies.

2.55. "Prior Program" means any Government Employee group health insurance program in effect prior to the effective date of this Program.

2.56. "Program" means the CNMI Government Employee group health insurance program described in this Plan Document. This term may be used interchangeably with the term "Plan", as defined herein.

2.57. "Provider" means a Doctor, Physician, Physician Assistant, Hospital, Skilled Nursing Facility, Pharmacy, or any other duly licensed person, institution or other entity qualified to provide the relevant Covered Benefits under the Program.

2.58. "Retiree" means a former Employee who is receiving annuity payments through the Northern Mariana Islands Retirement Fund as a result of service, age or disability. The term "Retiree" does not include a spouse or former spouse of a Retiree receiving an annuity as a result of a domestic relations court order.

2.59. "Services" means health care treatments, procedures, supplies, equipment, and products, and includes prescription drugs.

2.60. "Skilled Nursing Facility" means a licensed institution, other than a Hospital, which is not, other than incidentally, a custodial care Provider, and which, at a minimum, provides the following:
   a. inpatient medical care and treatment to convalescing patients;
   b. full-time supervision by at least one Doctor or registered nurse;
   c. 24-hour nursing care by licensed professional nurses; and
   d. complete medical records for each patient.

2.61. "Special Enrollment" means the rights conferred on any person by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2.62. "Spouse" means an Employee's or Retiree's current:
a. legal husband or wife from whom the Employee or Retiree is not legally separated; or
b. common-law husband or wife, provided the marriage is recognized as valid and lawful in the jurisdiction where it was made.

2.63. "Subscriber" means any Employee, Retiree or Survivor who is enrolled in the Program and in whose name the enrollment is registered.

2.64. "Surgical Services" means professional Services necessarily and directly performed by a physician in the treatment of an Injury or illness requiring cutting; suturing; diagnostic and therapeutic endoscopic procedures; debridement of wounds including burns; surgical management or reduction of fractures and dislocations; orthopedic casting; manipulation of joints under general anesthesia; or destruction of localized surface lesions by chemotherapy (excluding silver nitrate), cryotherapy, or electrosurgery.

2.65. "Survivor" means the Spouse of a deceased Retiree who is receiving Survivor's annuity benefits under the laws governing the NMI Retirement Fund and who has not remarried.

2.66. "Third Party Administrator" means an individual or company with particular expertise in the administration of health plans, typically tasked with utilization review (examining claims to detect and/or determine eligibility, accuracy, fraud, double billings, diagnosis and treatment consistency), case management, claims processing, and claims payment, in addition to any other responsibilities contracted for by a health plan or insurance company.
ARTICLE 3 – ELIGIBILITY

3.01. Employees Generally. All Employees are eligible to apply to enroll themselves and their Dependents in the Program.

3.02. Dependent Children. Any Child of a Subscriber who meets the definition of "Child" as defined in Article 2.07 and the definition of Dependent as defined in Article 2.13, and who is 18 years of age or younger and unmarried is eligible for coverage under this Plan.

   a. If a Child, upon reaching the age of 18 years, is incapable of self-sustaining employment because of mental retardation or physical handicap, is chiefly dependent upon the Subscriber for support and maintenance, and is unmarried, the Child shall be allowed continued coverage under this Plan so long as the Child continues to be so incapacitated, dependent, and unmarried. The Subscriber must furnish written evidence of such incapacity, dependency, and marital status to the Plan within 31 days of the Dependent's attaining the age of 18, and at any time thereafter upon request by the Plan but not more frequently than annually after the two year period following Child's attainment of the limiting age. The Child's coverage shall terminate when the Subscriber's coverage terminates or when the Child marries or is no longer incapacitated and dependent.

   b. A Dependent Child may remain eligible through age 24 provided said Dependent is unmarried, financially dependent upon the Subscriber, and is regularly attending an accredited educational institution as a "full time" student, maintaining at least twelve (12) units, or the definition of full-time as used by the accredited learning institution, whichever is greater. Proof of enrollment by means of a letter from the Registrar's Office of the school and signed by the Registrar for the appropriate semester is required at the beginning of each semester. Coverage for the Dependent shall continue during semester breaks, or times when school is not in session, pursuant to the institution's official schedule. However, if the Dependent does not enroll in the next semester or session immediately following said break, coverage shall terminate as of the last official class day of the semester or session immediately prior to the break, or on the last official day of the session in which the Dependent was last enrolled.

   c. A Child identified in a Qualified Medical Child Support Order as an eligible Dependent will be accepted upon submission of a certified copy of the Court Order.

3.03. Notice of Enrollment Rights. If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance
coverage, you may in the future be able to enroll yourself or your Dependents in this Program, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

3.04. Retiring Employees. An Employee who was enrolled in the Program on the day immediately preceding his or her date of retirement is eligible to continue enrollment in this Program for himself or herself, as a Retiree, and to continue the enrollment of any Dependents who were enrolled as of the last day of the Employee's employment.

3.05. Retirees and Their Dependents in Prior Program. A Retiree and his or her Dependents are eligible to enroll in the Program if they:

a. were enrolled in a Prior Program on the effective date of this Program; and
b. had no break in coverage under the Prior Program between the effective date of this Program and the effective date of coverage under this Program.

3.06. Retirees Not Enrolled in Government Plan. A Retiree who is not enrolled in a CNMI Government group health insurance Plan is eligible to apply for enrollment in this Program, provided he or she is enrolled 30 days from the effective date of his/her retirement. Enrollment will be effective on the day after the first annuity payment following approval.

3.07. Spouse Enrolled in this Program on Death of Retiree. A Spouse, upon becoming a Survivor, is eligible to continue enrollment in the Program for himself or herself and the deceased Subscriber's Dependents, provided such Survivor and Dependents were enrolled in the Program at the time of the Subscriber's death.

3.08. Survivors and Dependents in Prior Program. A Survivor who was enrolled in a Prior Program on the effective date of this Program, together with any of the deceased Retiree's Dependents, who were also enrolled in the Prior Program on that date, are eligible to enroll in this Program, provided they had no break in coverage under the Prior Program between the effective date of this Program and the proposed effective date of coverage under this Program.

3.09. Survivors and Dependents Not Enrolled in Government Plan. A Survivor of a deceased Retiree together with any of the Dependents of a deceased Retiree not enrolled in a CNMI Government group health insurance Plan are eligible to enroll in this Program.
3.10. **Newly Acquired Dependents.** An Employee or a Retiree may apply to enroll his or her newly acquired Dependents. A Survivor may apply to enroll a newborn Child provided the newborn is a natural Child of the deceased Subscriber.

3.11. **Eligibility for Special Enrollment.** An Employee or a Retiree and his or her Dependents may be eligible for Special Enrollment under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

3.12. **Proof of Eligibility.** The Administrator may require such documentation as he or she deems necessary to verify the eligibility of any person. If satisfactory documentation is received by the deadline specified by the Administrator, the person will be considered eligible as of the date of application for enrollment or enrollment change, whichever is applicable. If satisfactory documentation is received after the specified deadline, the person will be eligible as of the date of receipt of the documentation.

3.13 **Eligibility of Disabled Child.** Sufficient medical and/or legal proof of total disability and dependence must be submitted to the Administrator within thirty (30) days of the Child’s attainment of the limiting age and every year after that.

3.14. **No Guarantee of Enrollment.** Being eligible for enrollment does not guarantee that the application for enrollment will be approved. Employment by or retirement from the Government does not guarantee enrollment or continued enrollment. The enrollment requirements detailed in Article 4 must be met.
ARTICLE 4 – ENROLLMENT

4.01. Enrollment Options and Categories.

A. Options for coverage available under the Plan are as follows:

1. High Option – 80/20 coverage. The Plan pays 80% of Eligible Charges, and the Enrollee pays 20%.

2. Low Option – 70/30 coverage. The Plan pays 70% of Eligible Charges and the Enrollee pays 30%.

B. Categories of coverage.

1. Available Category and Option selections:

   a. Self Only, High Option
   b. Self Plus One, High Option
   c. Self Plus Four, High Option
   d. Self Plus Five Plus, High Option
   e. Self Only, Low Option
   f. Self Plus One, Low Option
   g. Self Plus Four, Low Option
   h. Self Plus Five Plus, Low Option

2. Category explanations:

   a. “Self Only” refers to the Subscriber only. Only one Enrollee may be covered under this category of the Plan.

   b. “Self Plus One” refers to a Subscriber with one (1) Dependent. The Dependent may be a Spouse or eligible Child, but a maximum of two (2) total Enrollees (including the Subscriber) may be covered under this category of the Plan.

   c. “Self Plus Four” refers to a Subscriber with up to four (4) Dependents. The Dependents may be a Spouse and eligible Children or all eligible Children, but a maximum of five (5) total Enrollees (including the Subscriber) may be covered under this category of the Plan.

   d. “Self Plus Five Plus” refers to a Subscriber with five (5) or more Dependents. The Dependents may be a Spouse and eligible Children or all eligible Children, but this category
must be selected in order to cover six (6) or more Enrollees (including the Subscriber) in the Plan.

3. Category Examples:

<table>
<thead>
<tr>
<th>Self Only</th>
<th>Employee only</th>
<th>1 total Enrollee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Plus One</td>
<td>Employee + Spouse</td>
<td>2 total Enrollees</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>Employee + eligible Child</td>
<td>2 total Enrollees</td>
</tr>
<tr>
<td>Self Plus Four</td>
<td>Employee + Spouse + up to 3 eligible Children</td>
<td>Up to 5 total Enrollees</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>Employee + up to 4 eligible Children</td>
<td>Up to 5 total Enrollees</td>
</tr>
<tr>
<td>Self Plus Five</td>
<td>Employee + Spouse + 4 or more eligible Children</td>
<td>No limit to the number of eligible Enrollees</td>
</tr>
<tr>
<td>Plus</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>Employee + 5 or more eligible Children</td>
<td>No limit to the number of eligible Enrollees</td>
</tr>
</tbody>
</table>

4.02. Forms. A person wishing to enroll himself or herself and/or his or her Dependents in the Program must file an Application Form with the Administrator. A Subscriber wishing to change his or her enrollment or that of his or her Dependents must file an Enrollment Change Form with the Administrator. Both forms are available from the Fund and any other office designated by the Administrator.

4.03. New Employee Enrollment Period and Effective Date of Coverage. A new Employee may apply, for himself or herself and his or her Dependents, to enroll in the Program within 30 days after his or her date of hire. Enrollment will be effective as of the first day of the pay period following approval of the application. However, no waiting period will be imposed if prohibited by law, such as the

4.04. Other Employee Enrollment Period and Effective Date of Coverage. Employees and their Dependents who are already enrolled in a Prior Program on the original effective date of this Plan are automatically enrolled in this Program. All other Employees who are not new Employees may only apply to enroll during an Open Season unless they are entitled to special enrollment under the Health Insurance Portability and Accountability Act of 1996. If an Employee applies to enroll during an Open Season, such enrollment will be effective as of the date specified by the Administrator unless the Employee is entitled to special enrollment under the Health Insurance Portability and Accountability Act of 1996. If an Employee is so entitled, then the Health Insurance Portability and Accountability Act of 1996's special enrollment rules will apply.

4.05. Special Enrollment Periods Following Loss of Other Coverage / Employees and Their Dependents. An Employee who is eligible for Special Enrollment under the Health Insurance Portability and Accountability Act of 1996 is required to request enrollment, by filing a written application form with the Administrator, for himself or herself and/or his or her Dependents not later than 30 days after the exhaustion of COBRA coverage, termination of other coverage as a result of the loss of eligibility for the other coverage or following the termination of employer contributions toward that other coverage. Enrollment in this Program is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

4.06. Rules for Persons Retiring from Government Employment. Enrollment in the Program will be automatically continued for an Employee who retires from Government employment and who was an Enrollee in the Program on the day before his or her date of retirement. Enrollment will also be automatically continued for such Retiree's Dependents, who were Enrollees as of the day before the Retiree's date of retirement. Retirees may elect not to have their enrollment and/or their Dependent's enrollment automatically continued by signing a form prescribed by the Administrator acknowledging that he or she understands the consequences as specified in this Article.

4.07. Rules for Retirees and Their Dependents in Prior Program. A Retiree whose last day of Government employment was before the effective date of this Program, and who has been covered under a Prior Program continuously since the effective date of this Program, may enroll himself or herself in this Program and may also enroll his or her Dependents, provided such Dependents were enrolled in the Prior Program on the day before the proposed date of enrollment in this Program. Application may be made at any time by filing an approved application form with the Administrator. Enrollment will be effective on the day after the first annuity payment date following approval. However, if such Retiree
later terminates his or her enrollment from this Program, he or she will never be allowed to re-enroll unless he or she otherwise becomes eligible.

4.08. **Rules for Retirees Not Enrolled in Government Plan.** A Retiree not enrolled in a CNMI Government group health insurance Plan may elect to enroll himself or herself and any of his or her Dependents, provided the Retiree applies for enrollment within 30 days from the effective date of his/her retirement. Enrollment will be effective on the day after the first annuity payment date following approval.

4.09. **Rules for Survivors and Dependents of Deceased Retirees.** A Survivor may elect to enroll or to continue enrollment for himself or herself and any of the former Subscriber's Dependents, provided the Survivor applies for enrollment within 30 days following (a) the date the Administrator approves the Survivor's application for Survivor annuity benefits or (b) the original effective date of this Plan Document. Enrollment will be effective on the day after the first annuity payment date following approval. A Survivor may apply to enroll any newly acquired Dependent only if such Dependent is a Child of the Subscriber.

4.10. **Rules That Apply When New Spouse Acquired.** An Employee or a Retiree enrolled in the Program who newly acquires a Spouse may apply to enroll such Spouse by filing an Enrollment Change Form within 30 days after the date of marriage. Enrollment of the Spouse will be effective as of the first day of the pay period following approval of the application. If such Spouse is not enrolled when first eligible, the Employee or Retiree may not apply to enroll the Spouse in the Program until an Open Season unless the Employee or Spouse is entitled to special enrollment under the Health Insurance Portability and Accountability Act of 1996. If an Employee is so entitled, then the Health Insurance Portability and Accountability Act of 1996's special enrollment rules will apply.

4.11. **Rules That Apply When New Child Acquired.** An Employee or a Retiree enrolled in the Program who newly acquires a Child may apply to enroll such Child by filing an Enrollment Change Form within 30 days after the Child is newly acquired. The Child's enrollment will be effective as of the date of birth or other acquisition, provided all past Contributions, from date of acquisition, are made at the time of application. If such Child is not enrolled when first eligible, the Employee or Retiree may not apply to enroll the Child in the Program until an Open Season unless the Employee or Child is entitled to special enrollment under the Health Insurance Portability and Accountability Act of 1996. If an Employee or Child is so entitled, then the Health Insurance Portability and Accountability Act of 1996's special enrollment rules will apply. This provision also applies to a newborn Child of a Survivor, provided the newborn is a natural Child of the deceased Subscriber.

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

4.13. **Dependent Child Over Age 18.** Enrollment for a Dependent Child over age 18, whose medical insurance under another group plan is being continued beyond the termination date of coverage under that plan by an extension of benefits provision, will be postponed until the date such extended coverage terminates.

4.14. **Special Enrollment Under Qualified Medical Child Support Orders.** A Child identified in a Qualified Medical Child Support Order as an eligible Dependent will be accepted upon submission of a Certified copy of the Court Order without regard to any Enrollment season restrictions.

4.15. **Medicare Part A / Mandatory Enrollment.** It is a condition of enrollment in the Program that if any Enrollee, including a Retiree, Spouse of a Retiree, or an Enrollee who has met Medicare's waiting period for end stage renal disease (ESRD), is eligible for Medicare Part A at no cost, such Enrollee must enroll in Medicare Part A.

4.16. **Failure to Enroll.** A non-retiring Employee whose last day of Government employment was on or after the effective date of this Program, and who was not an Enrollee in the Program on such last day of employment, will not be allowed to enroll in the Program unless he or she otherwise becomes eligible.

4.17. **Voluntary Termination of Enrollment / Retirees.** If a Retiree continues enrollment in this Program pursuant to Article 3, Section 3.02 and later terminates the enrollment, or if a Retiree elects not to continue enrollment in this Program, such Retiree will not be allowed to re-enroll unless he or she otherwise becomes eligible.

4.18. **Voluntary Termination of Enrollment / Survivors.** If a Survivor continues enrollment in the Program pursuant to Article 3, Section 3.04 and later terminates the enrollment, or if a Survivor elects not to continue enrollment in this Program, such Survivor will not be allowed to re-enroll unless he or she otherwise becomes eligible.

4.19. **Election to Terminate / Form for Retirees and Survivors.** Any Retiree or Survivor wishing to terminate his or her enrollment may do so by signing a form prescribed by the Administrator acknowledging that he or she understand the consequences as specified in this Article 4.
4.20. **Identification Cards.** The Administrator, or Third Party Administrator, if any, will provide each Enrollee with one identification card. If an Enrollee requires additional cards, a charge of $10 per card will be made by the Administrator, or the Third Party Administrator, if any, who shall deposit the money into the GHLI Trust Fund. Enrollees must return all identification cards to the Administrator on termination of enrollment.

4.21. **Retroactive Enrollments and Termination.** Retroactive enrollments and terminations are not allowed unless specifically provided for in the Plan.

4.22. **Approval of Enrollment or Enrollment Change.** Notwithstanding any other section of this Plan Document, no enrollment or enrollment change will become effective without the approval of the Administrator. If the Administrator has not acted on an Application Form or Enrollment Change Form within 30 days of its receipt, the application for enrollment or enrollment change shall be deemed denied.

4.23. **No Guarantee of Enrollment.** Employment by or retirement from the Government does not guarantee enrollment or continued enrollment.

4.24. **Enrollment Denied.** The Administrator may deny an application for enrollment because the applicant is ineligible, has exhausted his or her Lifetime Maximum under the Plan, has filed fraudulent claims or other documents with the Program or Prior Program or for any other reason the Administrator deems in the best interest of the Program.
ARTICLE 5 – BENEFITS

5.01. Basics. Only Eligible Charges for Medically Necessary Covered Benefits may be reimbursed, subject to the limitations and maximums imposed by Article 7 of this Plan Document. A procedure or Service may meet the definition of Medically Necessary but not be a fully Covered Benefit because it is subject to the limitations or maximums imposed by Article 7 of this Plan Document. A procedure or Service may meet the definition of Medically Necessary in this Plan Document but not be a Covered Benefit because it is excluded from coverage by Article 8 of this Plan Document.

5.02. Chart. The chart below is a brief summary of the major Covered Benefits. Enrollees should not rely only on this outline. Enrollees must review this entire Plan Document to fully understand the Covered Benefits including the limitations, maximums and exclusions that are detailed in Articles 6, 7 and 8 of this Plan Document.

A BRIEF SUMMARY OF COVERED BENEFITS

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

A. **Allowable Charges.** Subject to the definitions, limitations, maximums and exclusions of the Program, Eligible Charges for the following Hospital room and board charges are Allowable Expenses:

1. Room and board at the average semi-private rates, including meals, special diets and general nursing care.

2. Charges made by the Hospital as a condition of occupancy, such as those for identification bracelets and medical records.

3. Intermediate care unit, isolation unit, and intensive care or coronary care unit. Must be equipped and operated according to generally recognized Hospital standards acceptable to the Plan.

B. **Private Room Benefits:** Regardless of the reason a private room is used, the difference between its cost and the cost of the Hospital's average semi-private accommodation is not an Allowable Expense. If the Hospital has private rooms only, the Program will pay the average semi-private room rate based on the charges of a comparable Hospital in the same or a similar geographic area up to the maximum Hospital room and board Allowable Expense.

C. Except where otherwise stated, benefits are subject to the Plan's Schedule of Benefits. If Services are rendered by a non-participating Provider, the Enrollee also owes any difference between actual and Eligible Charges.
5.04. **Other Benefits.** Subject to the definitions, limitations, maximums and exclusions of the Program, Eligible Charges for the following Services, in or out of a Hospital, are Allowable Expenses:

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

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

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

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

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

   **Registered Nurses.** Professional Services of registered nurses, diagnostic x-rays and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other Medically Necessary tests that reveal need for treatment or are made because of definite symptoms of diseases or injury;
c. **Anesthesiology.** When an attending physician requires anesthesiology Services for a hospitalized patient, other than those provided by the Hospital, that benefit is subject to the Plan's Schedule of Benefits. If Services are rendered by a non-participating Provider, the Enrollee also owes any difference between actual and Eligible Charges.

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

d. **X-Ray.** X-ray, radium and radioactive isotope therapy, including materials and the Services of a technician;

e. **Surgical Items.** Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations;

f. **Prosthetic Devices.** Prosthetic devices, other than dental, which replace all or part of an internal body organ, including replacement of such devices;

g. **Durable Medical Equipment.** Rental or purchase, as decided by the Administrator, for the initial provision or replacement of the following standard durable medical equipment:

   i. wheelchairs
   ii. crutches/walkers, braces, trusses, casts, splints
   iii. suction machines
   iv. hospital beds/commodes
   v. oxygen and oxygen accessories
   vi. respirators
   vii. hearing aids (one device per ear every five (5) years)
   viii. cardiac pacemakers
   ix. artificial limbs, eyes, and hips, and similar non-experimental appliances
   x. iron lung, artificial kidney machine, pulmonary resuscitator and similar special medical equipment
   xi. muscle stimulators/regenerators

All such appliances and/or durable medical equipment must be for Services covered under this Plan and must be ordered by the attending physician. However, the Administrator or Medical Director must agree that the ordered item is Medically Necessary for the treatment of the Enrollee's illness or Injury. The Plan will not pay for any convenience items;
h. **Ambulance Service.** In Emergencies only, professional surface ambulance Service to the first Hospital where the Enrollee is treated and from that Hospital to another Hospital if Medically Necessary Services are not available at the first Hospital;

i. **Sterilization Services.** Tubal ligations;

j. **Reconstructive Surgery.** The Plan will pay benefits for reconstructive surgery only when it is required to restore, reconstruct and correct any bodily function that was lost, impaired, or damaged as a result of an illness or Injury. Reconstructive surgery for congenital anomalies (i.e., defects present from birth) are payable only when the defect severely impairs or impedes normal, essential bodily functions.

k. **Mental Health Services.** Services of a licensed Psychiatrist or Psychologist for treatment of mental, psychoneurotic or personality disorders. If services are provided by a psychologist, such services must be in accordance with a referral and specific instructions as to treatment type and duration by a doctor of medicine (M.D.).

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

i. The Plan shall pay eligible and covered charges for up to thirty (30) calendar days of eligible facility charges per year per enrollee

ii. Each day of inpatient hospital or facility charges, or equivalent services exchanged therefore, shall count against the 365 days per Calendar year maximum inpatient hospital benefits allowed under the Plan

iii. All co-payments for any services are the responsibility of the Enrollee. If services are rendered or provided by a non-participating provider, the Enrollee owes any difference between the actual charges and Eligible Charges

iv. Each day of inpatient hospital services may be exchanged for two (2) days of non-hospital residential services, two (2) days of partial hospitalization, or two (2) days of day treatment services in a Qualified Treatment Facility, provided that such exchange services include not less than four (4) hours of treatment per day. Each day of inpatient services may also be exchanged for two (2) outpatient visits, provided the Enrollee's condition is strictly that hospitalization would
become imminent if the outpatient services were interrupted and the outpatient services would reasonably preclude hospitalization. The Plan shall not, however, pay more for two (2) days of exchange services than if the services had been provided through one (1) day of hospital inpatient services.

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

3. Outpatient Services.

a. **Physical Therapy and Chiropractic.** Services of licensed physical therapists or licensed chiropractors for administration of physical therapy in accordance with a referral and specific instructions as to treatment type and duration by a doctor of medicine (M.D.) with a maximum of 15 visits at a maximum of $25 per visit, per Enrollee per Plan Year. Any person employed by CHC, the Rota Health Center or the Tinian Health Center as a physical therapist will be considered a licensed physical therapist;

b. **Durable Medical Equipment/Items.** Braces, such as leg, arm, back and neck braces, and artificial body parts, such as legs, arms and eyes, including replacements, if required, because of a change in the Enrollee's physical condition. All such appliances and/or durable medical equipment must be for Services covered under this Plan and must be ordered by the attending physician. However, the Administrator or Medical Director must agree that the ordered item is Medically Necessary for the treatment of the Enrollee's illness or injury. The Plan will not pay for any convenience items;

c. **Prescriptions.** Drugs and medicines which may be purchased only with a Doctor's prescription and as described in the Plan's formulary. Any prescription drug or medication that is excluded, or not contained, in the Plan's formulary shall not be covered under the Plan. Non-preferred prescriptions shall be covered at a different rate than generic or lower cost name-brand prescriptions. Beginning with the partial Plan year commencing in June 2002, and every plan year thereafter, a non-preferred prescription is any medication with a cost that exceeds $60.00. Any such medication will require the Enrollee to pay the highest level prescription drug
co-payment, as outlined in the Chart in Section 5.02 of this Plan Document;

d. Birth Control/Contraception. Vasectomies, tubal ligations, and prescription contraceptives;

e. Home Health Care. Services of home health agencies licensed as such by the applicable jurisdiction or approved by the Administrator.

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

i. The attending physician must certify in writing that the Enrollee:

1. is homebound due to an Injury or illness,
2. requires part-time skilled health Services, and
3. would require inpatient Hospital and Skilled Nursing Facility care if there were no home health care visits. The Federal Medicare definition of homebound shall apply.

ii. If an Enrollee requires home health care visits for more than 30 days, the physician must recertify that additional visits are required and must provide a continuing plan of treatment at the end of each such 30-day period of care.

iii. Visits must be provided by a qualified home health agency.

iv. No payment will be made for home health care Services furnished primarily to assist the Enrollee with personal, family, or domestic needs, such as general household Services, meal preparations, shopping, bathing, or dressing.

f. Mental Health Care. Subject to the limitations and maximums as otherwise provided in the Plan (See Article 7), Services of a licensed Psychiatrist or Psychologist for treatment of mental, psychoneurotic or personality disorders. If services are provided by a psychologist, such services must be in accordance with a referral and specific instructions as to treatment type and duration by a doctor of medicine (M.D.).
Enrollee owes any co-payments or co-insurance as set forth in the Plan’s Schedule of Benefits for covered outpatient facility, physician, psychologist, clinical social worker or registered nursing services. If services are provided by a non-participating provider, the Enrollee also owes any difference between the actual and Eligible Charges.

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

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

a. Dental work, including dental materials (such as fillings, crowns and false teeth) and oral surgery, for the following treatments, as a result of an accident or injury:

i. prompt emergency repair of accidental injury to sound, natural teeth;

ii. reduction of fractures of the jaw or facial bones as a result of accidental Injury;

iii. surgical correction of congenital anomalies;

iv. removal of stones from salivary ducts;

v. excision of impacted teeth that are not completely erupted, bony cysts of the jaw, torus palatinus, leukoplakia, or malignant oral tissue;

vi. freeing of oro-facial muscle attachments; and

vii. other surgery on tissues of the mouth, other than the gums, when not performed in connection with the extraction or repair of teeth.

b. In connection with all other dental work and oral surgery, the only Covered Benefits are for Hospital room and board as specified in Section 5.03.A. Benefits as provided in this Article for oral Surgical Services performed by a dentist shall be payable only when the dentist is performing emergency or Surgical Services that could also be performed by a physician (M.D. or D.O.). Hospital inpatient benefits as provided in Article 5 are available for dental Services only when a physician certifies in writing that the Enrollee has a separate medical condition that makes hospitalization necessary for the Enrollee to safely receive dental Services or that the oral surgery itself requires hospitalization.
5. Licensed Practical Nurses' Services.

a. Licensed Practical Nurse Service. Licensed practical Nursing services are covered if:

i. the relevant Hospital uses licensed practical nurses; or

ii. the attending Doctor has prescribed nursing Service, including Services of licensed practical nurses.

iii. The Administrator may determine that licensed practical nurses are covered in other cases, such as when the attending Doctor certifies in writing (i) that Services of a registered nurse were Medically Necessary but unobtainable, (ii) the names of the licensed practical nurses employed, and (iii) the time period for which the Services were prescribed.


a. Prenatal Care. Standard Prenatal care, as recommended by The American College of Obstetricians and Gynecologists, and the ensuing childbirth or miscarriage, and any medical conditions relating thereto. Diagnostic tests related to the unborn child are eligible for payment or reimbursement only when medically necessary and ordered by a Doctor or Physician.

b. Midwife Services. Services by a nurse-midwife will be eligible for coverage on the same basis as physician coverage. To be eligible for coverage, however, the Services must be rendered by a certified nurse-midwife who is properly licensed, is certified by the American College of Nurse-Midwives, and is formally associated with a physician for purposes of supervision and consultation.

c. Birthing Centers. Hospital benefits described in this Plan Document are also available for Services of a properly licensed birthing center approved by the Plan when such birthing center is used instead of regular Hospital facilities for childbirth. Benefits for birthing center Services are in lieu of payment for inpatient Hospital Services.

d. Hospital Stays. In connection with childbirth, mothers and newborn Children are entitled to Hospital and/or Birthing Center stays up to 48 hours following vaginal delivery and 96 hours following cesarean section. Extension of stays beyond those periods requires prior Plan review to determine medical necessity or appropriateness.
e. **Post Partum Care.** One routine post partum Doctor visit, per delivery is provided under the Plan.

f. **Newborn Child.** Nursery charges for days in which the mother and newborn are both confined are considered Hospital room and board expenses of the mother and not expenses of the newborn. All other expenses of the newborn will be considered his or her own and will only be considered Covered Benefits if such newborn meets the definition of Child and is enrolled by the Subscriber pursuant to Article 4, and if such charges are for Hospital and Doctor services provided in connection with routine newborn or nursery care. If properly enrolled pursuant to Article 4, all benefits provided elsewhere in this Plan are available to the Newborn Child from the date of birth including medical services for premature birth, illness, Injury, disease or birth defect.

g. **Child of Non-Spouse Dependent.** A newborn Child of a non-Spouse Dependent is not an Enrollee unless such Child meets the definition of Child and is enrolled by the Subscriber pursuant to Article 4.

7. **Preventive Care Services.**

a. **Annual Physical Check-Up.** One (1) annual physical exam, except as excluded in Article 8, including, but not necessarily limited to one:

i. blood pressure check
ii. chest x-ray
iii. cholesterol screening for Enrollees over 25 years of age
iv. mammogram in accordance with the American Cancer Society’s recommended schedule
v. PAP smear
vi. vision screening
vii. hearing screening

b. **Family Planning.** One (1) family planning counseling session, per lifetime;

c. **Childbirth.** Pre-natal care and one post partum visit per delivery;

d. **Smoking Cessation.** One (1) counseling session on smoking cessation per Enrollee, per lifetime; and

e. **Well-Child Care.** Well-child care program through age five (5), including immunizations for DPT, typhoid, cholera, polio, small pox,
mumps, measles, rubella, hepatitis, influenza, whooping cough, typhus, tetanus, chicken pox and any other immunizations required by the laws of the jurisdiction in which the child is domiciled, and screening for anemia, tuberculosis, and hearing and vision problems.

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

8. Skilled Nursing Facility Services. An Enrollee, confined in a Skilled Nursing Facility, shall be eligible for the same room and board and general nursing care benefits as if confined in a Hospital, if:

a. the Enrollee was admitted upon the authorization of a Doctor;

b. the Enrollee is attended by a Doctor while confined; and

c. the Enrollee's confinement in the Skilled Nursing Facility is not primarily for comfort, convenience, rest cure or domiciliary care.

d. an Enrollee remains in such facility more than 30 days, the attending physician must submit to the Administrator an evaluation report concerning the Enrollee at the end of each such 30-day period of confinement.


12. Transplant Services.

A. Recipient Services. Subject to compliance with each of the conditions set forth below, the following transplants are eligible for benefits:

i. Cornea;

ii. Heart;

iii. heart-lung;

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

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

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

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

i. Both the Enrollee and the specific transplant must meet the “Medical Necessity” criteria set forth in Article 2, Section 2.39;

ii. The transplant must be performed at a transplant facility that is under contract with the Plan or the Plan’s Third Party Administrator for that type of transplant and the contracted transplant facility has accepted the Enrollee as a transplant candidate;

iii. Any transplant that is classified as “experimental” or “investigative” in the circumstance presented, or as not proven to be safe and effective, will not be covered.

B. Donor Services. Eligible medical and hospital expenses of the donor, or services of an organ bank, will be paid or reimbursed only when the Enrollee is the recipient. Covered expenses for screening of donors shall be limited to expenses associated with the actual
If the donor is covered under another medical plan, that other plan shall be the primary plan and its benefits shall be applied before benefits under this plan apply. If the Donor is not covered under another medical plan and this Program is the primary plan, any benefits paid for Services provided to the Donor will count against the Annual and Lifetime Maximums of the Recipient Enrollee.

13. **Speech Therapy Services.** Speech therapy services from a speech therapist holding a Certificate in Clinical Competence from the American Speech and Hearing Association, or equivalent association or agency in the location the service is being rendered. Speech therapy services must be ordered by a Doctor or Physician under an individual treatment plan, must be medically necessary to restore an Enrollee's speech or hearing function which was lost or impaired due to illness or injury, and must be reasonably expected to improve the patient's condition through short-term care. (Long-term maintenance programs are NOT covered under the Plan). Speech therapy for children with developmental learning disabilities (development delay) is not a covered benefit.

14. **Allergy Testing and Treatment.** Allergy testing is limited to one series of tests per Calendar year. Allergy treatment and medication is covered on the same basis as other medical conditions under the Plan.

15. **Blood and Blood Products.** Blood and blood products (except when donated) and blood bank service charges are a covered benefit under the Plan, on the same basis as other medical care, if the blood being administered into the Enrollee is done so as part of a medically necessary procedure. Any additional charges for autologous blood (reserved for the Enrollee who donated the blood) are excluded as a benefit.

16. **Sleep Disorder Treatment.** Subject to the limitations and maximums as otherwise provided in the Plan (See Article 7), Services of a licensed, certified, registered or Plan approved Sleep Center, Clinic, Hospital Unit or Facility for the diagnosis and treatment of sleep disorders are a covered benefit, only if referred by a duly licensed Physician.

For purposes of this provision of the Plan, a sleep disorder shall be defined as any disorder that affects, disrupts or involves sleep, including, but not necessarily limited to chronic snoring, insomnia, sleep apnea, obstructive sleep apnea, sleep disordered breathing (SDB), restless leg syndrome, and sleepwalking.
ARTICLE 6 – COINSURANCE AND COPAYMENTS

6.01. The office visit Coinsurance must be paid by the Enrollee for each visit, including preventive care visits, made to or by a Doctor, physical therapist, chiropractor, psychologist, home health agency or other Provider while the Enrollee is not confined in a Hospital as an inpatient. The Coinsurance does not cover any ancillary costs that may be associated with such office visit, such as prescription drugs, diagnostic tests or x-rays.

6.02. The prescription drug Co-payment must be paid by the Enrollee for each prescription filled or refilled. Such Co-payment will cover a maximum of a one-month supply of the prescription drug if filled at a pharmacy and a ninety-day supply if ordered from the Plan’s mail order Prescription Service. If more than one prescription drug is needed, a separate Co-payment will apply to each prescription drug. If the prescription is for more than a one-month supply, and filled at a pharmacy, an additional Co-payment will apply to each additional month or part thereof.

6.03. Except as otherwise specifically provided in Article 7, Enrollees in the “High Option Plan” must pay a Coinsurance amount of 20% of Eligible Charges for all Covered Benefits specified in Article 5, Section 5.02.

6.04. Except as otherwise specifically provided in Article 7, Enrollees in the “Low Option Plan” must pay a Coinsurance amount of 30% of Eligible Charges for all Covered Benefits specified in Article 5, Section 5.02.

6.05. The Enrollee (and not the Program) is responsible for paying the Provider the amount of any Co-payments, Coinsurance, charges that exceed Eligible Charges, charges that exceed maximum amounts payable by the Program, and charges for non-Covered Benefits.

6.06. If an Enrollee is officially referred by the CHC Medical Referral Committee for Services outside the CNMI, the Enrollee must pay the Provider any Coinsurance or other amount due from the Enrollee under the Program. The Enrollee may then seek reimbursement from the CNMI Medical Referral Program.

6.07. Notwithstanding any other provision of this Plan Document, the Subscriber has ultimate responsibility for paying any amounts required by the Program for himself or herself and all of his or her enrolled Dependents.
ARTICLE 7 – LIMITATIONS AND MAXIMUMS

7.01. Inpatient Limitations.

A. On-Island Hospital Room and Board. The “High Option Plan” limits to $300 per day, and the “Low Option Plan” limits to $250 per day, the maximum amounts the Program will pay for room and board and general nursing care while an Enrollee is confined in an On-Island Hospital, unless the Enrollee is confined in a Hospital intensive care unit.

B. On-Island Intensive Care Room and Board. The “High Option Plan” limits to $900 per day, and the “Low Option Plan” limits to $750 per day, the maximum amounts the Program will pay for room and board and general nursing care while an Enrollee is confined in an On-Island Hospital intensive care unit.

C. On-Island Skilled Nursing Facility Room and Board. The “High Option Plan” limits to $150 per day for 60 days, and the “Low Option Plan” limits to $125 per day for 30 days, the maximum amounts the Program will pay for room and board and general nursing care while an Enrollee is confined in an On-Island Skilled Nursing Facility.

7.02. Physical Exam Limitation. The maximum amount the Program will pay for physical exams is limited to $150 per Enrollee per Plan Year.

7.03. Physical and Occupational Therapy and Chiropractic Limitations. The Program will pay the maximum amount of $25 per physical and occupational therapy visit or chiropractic visit for a maximum of 15 such visits per Enrollee per Plan Year.

7.04. Surface Ambulance Limitation. The maximum amount the Program will pay for any surface ambulance trip is $150 for ambulance service provided in the CNMI, and 80% of Eligible Charge in a location other than the CNMI.

7.05 Home Health Limitation. The maximum number of home health visits covered per Enrollee per Plan Year is limited to 150 visits.

7.06 Mental Health Limitations. Both the High Option Plan and Low Option Plan have a limit of $1000.00 per Enrollee per plan year as the maximum amount the Program will pay for Doctors’ and/or Psychologists’ Services in connection with inpatient or outpatient treatment of mental or nervous disorders. No mental health services shall be eligible for reimbursement hereunder unless
i. the Enrollee has a nervous or mental disorder classified as such in the current (at the time of diagnosis) version of the Diagnostic and Statistical Manual of the American Psychiatric Association, and

ii. the services are provided under an individualized treatment plan approved by a Physician, Psychologist, clinical social worker or advanced practice registered nurse.

iii. Epilepsy, senility, mental retardation or other developmental disabilities do not in and of themselves constitute a mental disorder.

7.07. **Sleep Disorder Limitations.** Upon Physician referral, the Plan will pay for a maximum of two (2), one-night visits, lifetime, per Enrollee, to a licensed and/or approved Sleep Center, for diagnosis and/or treatment of a Sleep Disorder.

A. The High Option Plan will cover the first such visit at Eighty percent (80%), with the Enrollee paying the twenty percent (20%) coinsurance;

B. The Low Option Plan will cover the first such visit at Seventy percent (70%), with the Enrollee paying the thirty percent (30%) coinsurance;

C. Both the High Option Plan and the Low Option Plan will cover fifty percent (50%) of a second visit, with the Enrollee paying fifty percent (50%) coinsurance for the second visit.

D. The maximum dollar benefit the Plan will pay in any case is $2,000.00, per Enrollee, per visit.

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

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

B. For Enrollees in the "High Option Plan", the family out-of-pocket maximums per category are defined in Article 5, Section 5.02.G.

C. For Enrollees in the "Low Option Plan", the family out-of-pocket maximums per category are defined in Article 5, Section 5.02.G.

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

A. Under the “High Option Plan”, the Annual Maximum that the Program will pay per Enrollee for all Covered Benefits, specified in Article 5, Sections 5.04.1 through 11 (combined), incurred during a Plan Year is $100,000.

B. Under the “Low Option Plan”, the Annual Maximum that the Program will pay per Enrollee for all Covered Benefits, specified in Article 5, Sections 5.04.1 through 11 (combined), incurred during a Plan Year is $50,000.

C. Once the Program has paid out the total amount of the Annual Maximum for an Enrollee, the Enrollee will not be entitled to coverage under the Program for the remainder of that Plan Year.

7.10. Lifetime Maximums.

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

A. Under the “High Option Plan”, the Lifetime Maximum that the Program will pay is $500,000 per Enrollee for all Covered Benefits, specified in Article 5, Sections 5.04.1 through 11 (combined), incurred during the Enrollee’s lifetime.

B. Under the “Low Option Plan”, the Lifetime Maximum that the Program will pay is $250,000 per Enrollee for all Covered Benefits, specified in Article 5, Sections 5.04.1 through 11 (combined), incurred during the Enrollee’s lifetime.

C. If an Enrollee terminates the Program and later re-enrolls, his or her Lifetime Maximum will be that amount remaining as of the last day the Enrollee was enrolled in the Program, including all reductions for payments of Covered Benefits, specified in Article 5, Sections 5.02A through F (combined), which were incurred prior to the date of termination and paid either before or after such date.
D. Once the Program has paid out the total amount of the Lifetime Maximum for an Enrollee, the Enrollee will not under any circumstances be entitled to coverage or indemnification under the Program for the remainder of his or her life.

7.11. **Full-Time Student Coverage Limitation.** A statement or certification is required from the Registrar's Office or school representative stating that the Dependent is enrolled for a minimum of twelve (12) semester units. Certifications must be submitted no later than thirty (30) days after commencement of such semester. Coverage for the Dependent shall continue during semester breaks, or times when school is not in session, pursuant to the institution's official schedule. However, if the Dependent does not enroll in the next semester or session immediately following said break, coverage shall terminate as of the last official class day of the semester or session immediately prior to the break, on the last official day of the session in which the Dependent was last enrolled.
ARTICLE 8: EXCLUSIONS

8.01. The limitations and exclusions provided under this Article shall be in addition to any limitations and exclusions provided elsewhere in this Plan.

A. The Plan will not pay benefits for any Services when the Enrollee is entitled to receive disability benefits or compensation (or forfeits his or her rights thereto) under any Workers' Compensation or Employer's Liability Law for Injury or illness. In the event the Enrollee formally appeals the denial of a claim for Workers' Compensation, the Enrollee shall notify the Administrator of such appeal. The Plan will then provide benefits under this Plan, but such benefits shall be considered an advance or loan to the Enrollee. If the claim is declared eligible for benefits under Workers' Compensation or Employer's Liability Law or if the Enrollee reaches a compromise settlement of the Workers' Compensation claim, the Enrollee agrees to repay the advance or loan the Plan has the Right of Subrogation.

B. The Plan will not pay benefits for any Services:

1. When Services for an Injury or illness are provided without charge to the Enrollee by any federal, state, territorial, municipal, or other government instrumentality or agency,

2. When Services for an Injury or illness would have been provided without charge or collection but for the fact that the person is an Enrollee under this Plan.

C. The Plan will not pay any benefits, to the extent that such benefits are payable, by reason of any false statement or other misrepresentation made in an application for membership or in any claims for benefits. If the Plan pays such benefits before learning of any false statement, the Subscriber agrees to reimburse the Plan for such payment.

D. The Plan is not an insurer against nor liable for the negligence or other wrongful act or omission of any Provider, Provider's Employee, or other person or for any act or omission of any Enrollee.

E. The Plan does not guarantee the availability or quality of or undertake to provide any Services of any third party including the availability of Preferred or Participating Providers.

F. The Plan will not pay benefits for Services required in the treatment of an Injury or illness that results from an act of war or armed aggression,
whether or not a state of war legally exists, or that occurs during a period of active duty of any armed force of any state or nation.

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

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

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

h. Any Service rendered by an immediate relative or member of the Enrollee's household. (The term "immediate relative" refers to the Enrollee's Spouse, parent, Child or sibling whether by blood, marriage or adoption). This exclusion does not apply to the charges made by a Provider that employs such relative or household member.

i. Any Service rendered by a practitioner who is not a Doctor, except as otherwise specifically provided in the Plan Document.

j. Any Service if a material statement made is false and would otherwise have rendered the Service ineligible.

k. Any Service not provided by, or directly supervised by, a Hospital or Doctor duly licensed to provide that Service in the jurisdiction where the Service was provided.

l. Any Service which is not Medically Necessary, except as otherwise specifically provided in the Plan Document.

m. Any Service, including Hospital, surgical, medical, laboratory, and x-ray Services, rendered in connection with an excluded Service.

n. Any Service for which no charge was made.

o. Any Service rendered or received while the individual was not enrolled in the Program.

p. Any Service for which the Enrollee has coverage through a public health program, CHAMPUS or other government or military program.

q. Any Services rendered to a Subscriber's dependent parent.

r. Any service related to treatment for any complications as a result of previous cosmetic, experimental, investigative services or other services not covered by the Plan, regardless of how long ago such service or procedure was performed.

s. Abortions (elective).
t. Acupuncture.
u. Air ambulance.
v. Air conditioners, humidifiers, dehumidifiers and purifiers.
w. Biofeedback and similar forms of self-care or self-help training, and any other related diagnostic testing.
x. Chiropractic care, except as otherwise specifically provided in the Plan Document.
y. Circumcision, ritual. Routine circumcision rendered at the time of, or shortly after birth, in conjunction with maternity and Newborn Child.
z. Consultations with Doctors by telephone, facsimile, e-mail or any other form of electronic transmission, or a Doctor's stand-by or waiting time.
a1. Eye refractions, contact lenses, eyeglasses and refractive surgery, such as radial keratotomy or Lasik, to correct vision problems.
b1. Cosmetic surgery and all cosmetic services.
c1. Custodial, domiciliary and convalescent care, including nutritional supplements and/or formulas used for nutritional supplement.
d1. Dental appliances.
e1. Dental care.
f1. Dental work or oral surgery, including endontic (root canal) and periodontic Services, except as otherwise specifically provided in the Plan Document.
g1. Dental Services, except for Services and surgical procedures as otherwise specifically provided in the Plan Document.
h1. Exercise equipment and other similar non-medical products or supplies. Vitamins, steroids, muscle-enhancing powders, muscle stimulation devices and other related items used
solely for the purpose of exercise are also not covered, even if prescribed by a Doctor.

i1. Experimental Services, including any clinical visits, inpatient stays, drugs, laboratory testing, x-rays, and other Services related to such Experimental Services.

j1. Fertility / Infertility Services, including diagnosis or treatment of infertility, fertilization by artificial means, such as artificial insemination, in-vitro fertilization and embryo transplants, and any and all other drugs or Services intended to induce pregnancy.

k1. Foot reflexology, or orthotics, except as related to specific diabetic conditions.

l1. Gastric bypass, stomach, or other organ stapling or reversal.

m1. Growth hormone therapy, except replacement therapy services due to hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy.

n1. Heat lamp treatments, except as provided in conjunction with covered maternity and delivery services.

o1. Hospice care.

p1. Implants, and any related services, supplies and drugs, sought for cosmetic purposes or to enhance or improve physical appearance.

q1. Liposuction.

r1. Living expenses.

s1. Massage treatments.

t1. Maternity Services for non-Spouse Dependent.

u1. Military service-connected disabilities for which the Enrollee is legally entitled to care from military medical facilities and for which military medical facilities are reasonably available to the Enrollee.
v1. Occupational therapy, except as otherwise specifically provided in the Plan Document.

w1. Orthopedic shoes, insoles and other similar external supportive devices for the feet.

x1. Other health and accidental insurance coverage and third party liability settlements.

y1. Palliative treatments.

z1. Personal comfort and convenience items, such as telephones, radios, televisions, and barber and beauty services.

a2. Physical exams, when required for obtaining or continuing employment, insurance, schooling, government licensing, or sporting activities.

b2. Physical therapy, except as otherwise specifically provided in the Plan Document.

c2. Private duty nursing.

d2. Rehabilitation therapy, except as otherwise specifically provided herein.

e2. Replacement of joints.

f2. Rest cures.

g2. Rest homes, sanitariums and other institutions that are not Hospitals or Skilled Nursing Facilities.

h2. Reversal of voluntary sterilization.

i2. Services rendered for drugs, food substitute or supplement or any other product which is primarily for weight reduction even if it is prescribed by a physician, including weight loss or weight control programs, services and food products.

j2. Services of an injury or illness resulting from the Enrollee's attempted suicide.
k2. Services for an injury or illness resulting from major natural disaster or from act of war (whether or not a state of war legally exists).

l2. Services for an injury sustained because of the Enrollee's participation, either as a driver or passenger, in racing, pace making or speed testing of any motor vehicle (including boats), whether such activity is formal and organized or informal and spontaneous.

m2. Services for an injury sustained because of the Enrollee's commission of a criminal act including driving under the influence of alcohol or other controlled substance.

n2. Services for an intentionally self-induced illness or self-inflicted injury, while the Enrollee was sane or insane.

o2. Services not Medically Necessary.

p2. Services or supplies for treatment or diagnosis of Temporomandibular Joint (TMJ) disorders or other conditions involving joints or muscles related to TMJ.

q2. Services or supplies not specifically described as covered in this Plan Description. (Example: Subscriber's grandchild for which no Court Ordered legal guardianship exists)

r2. Services and supplies provided to a Dependent of a non-Spouse Dependent. Dependents of non-Spouse Dependents are not eligible for coverage. When a Dependent, other than a Spouse of the insured, has a Child, that Child is a Dependent of a non-Spouse Dependent and is not eligible to become covered under this Plan.

s2. Services for sexual dysfunction or inadequacies.

t2. Substance Abuse Services. Any service related to alcohol, drug or intoxicating substance abuse, dependence or addiction. Hospital, treatment facility, medication, counseling and other related charges for these Services are also excluded.

u2. Telephone calls to or from a Doctor or a Doctor's office even if a Doctor charges for such calls.

v2. Training for custodial care or self-care such as for personal
hygiene.

w2. Transportation, except as otherwise specifically provided herein. No benefits will be paid in connection with airfare and transportation from the Commonwealth to off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. (travel expenses and/or subsistence).

x2. Transportation of the remains of any deceased person will in no way be paid by the Government Health Insurance.

y2. Transsexual Services, to include sex transformations or sex change operations and any and all prosthetic devices related to sexual transformations or sex change operations, or treatment of sexual dysfunction regardless of cause.

z2. Treatment of baldness, including hair transplants and topical ointments, concoctions, shampoos or other remedies.

a3. Tuberculosis.

b3. Excluded Prescription services:

i. Non-FDA-approved prescriptive contraceptive drugs or devices,

ii. Drugs and medicines for which a prescription from a Doctor is not required under U.S. federal law, or those excluded from coverage in any formulary selected, adopted, or implemented by the Plan.

iii. Drugs or medicines which may be lawfully obtained without a prescription order of a physician or doctor or dentist, except insulin,

iv. Therapeutic devices or appliances, including hypodermic needles or syringes, support garments, and other non-medical substances or items, regardless of their intended use, except for insulin syringes and insulin needles,

v. Administration of prescription drugs or injections,
vi. Drugs labeled: "Caution: Limited by Federal Law to Investigational Use," or, experimental drugs, even though a charge may be made to the Enrollee,

vii. Medication which is to be taken or administered to the Enrollee in whole or in part, while a patient (inpatient or outpatient) in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises a facility for dispensing pharmaceuticals. (Medication administered while an inpatient is submitted as a hospital expense and will be covered under the inpatient hospital benefit),

viii. Filling or refilling a prescription in excess of the amount, number or quantity of medication prescribed or specified by the Doctor or Physician, or any refill dispensed without the Doctor of Physician's authorization, or any refill dispensed after one year from the date of the written order of the Doctor or Physician,

ix. Prescription charges incurred after termination of coverage of the Enrollee,

x. Appliances, devices, bandages, heat lamps, braces or splints, except as otherwise specifically covered under this Plan,

xi. Vitamins, cosmetics, dietary supplements, health and Beauty aids, or smoking cessation aids,

xii. Drugs or medications dispensed by a Doctor or Dentist who is not a Registered Pharmacist, or otherwise permitted by law to legally dispense medications,

xiii. Weight control medications, supplements or concoctions,

xiv. Retin A for Subscribers or dependents over the age of 24 years;

xv. Drugs, medications, solutions of concoctions for treatment of hair loss;
xvi. Viagra, or other impotency drugs, medications, solutions or concoctions;

xvii. Injectable medications, unless pre-authorized as an eligible benefit, except insulin;

xviii. Any and all drugs or medications related to the treatment of infertility and/or sexual dysfunction.

H. The Plan shall not be required to pay any claim until it determines that the Enrollee was provided Services covered by this Plan. Payment will not be made for Services not actually rendered.

I. The Plan will not pay benefits when confinement in a Hospital or in a Skilled Nursing Facility is primarily for custodial or domiciliary care. Custodial or domiciliary care includes that care which consists of training of personal hygiene, routine nursing Services, and other forms of self-care or supervisory Services by a physician or nurse for a person who is not under specific medical, Surgical, or psychiatric treatment to reduce such person's disability and to enable such person to live outside an institution providing such care. However, benefits for confinement in a Hospital or Skilled Nursing Facility will be paid if such confinement is required because of a concurrent Injury or illness (whether related or not) which requires medical or Surgical Services otherwise provided as benefits under this Plan.
ARTICLE 9 – HEALTH CARE PROVIDERS

9.01. Any Provider world-wide is eligible to provide Covered Benefits to Enrollees, provided such Provider has not been eliminated as a Provider by the Administrator pursuant to Article 11, Section 11.11.A.

9.02. The Program does not maintain an employment or other relationship with any Provider.

9.03. The Program is not responsible for the negligence, intentional misconduct or any other action or inaction of any Provider.

9.04. The Program, as long as the Program has contracted with a Third Party Administrator, shall maintain a network of Preferred or Participating Providers. These providers will offer a variety of Services to Enrollees, including, but not necessarily limited to, routine medical care, specialty Services, in-patient and outpatient Services and Pharmaceutical Services.

9.05. The Program, as long as the Program has contracted with a Third Party Administrator that maintains contracts for services with Health Care Providers, will maintain and periodically update, a Provider Directory that lists all Preferred or Participating Providers in the Plan's network, and On-Island Providers that are qualified or approved to provide Services to Enrollees.
ARTICLE 10 – PREMIUMS

10.01. Premiums consist of Contributions from the Government and the Subscriber.

10.02. The amount of the Subscriber Contributions will be based on the Premium rates as determined by the Board.

10.03. The amount of the Government Contributions will be based on the Premium rates as determined by the Board.

10.04. Retroactive changes to the Premium rates are not permitted.

10.05. All Employee Contributions shall be made through deductions from the Employee’s paycheck, except that Employees on leave without pay shall pay 100% of the Premium to the GHLI Trust Fund and deliver it to the Fund on a monthly basis in advance.

10.06. All Retiree and Survivor Contributions shall be paid through deductions from their pension annuity payments. Government Contributions for Retirees and Survivors shall be made by the Fund.

10.07. Within five working days following the close of each pay period, each autonomous agency, public corporation and other Government entity that processes its own payroll shall remit to the Fund the total Premiums, including Contributions deducted from Employees’ paychecks for all enrolled, active Employees under their supervision. Also within such five working days, the Department of Finance shall remit to the Fund the total Premiums, including Contributions deducted from Employees’ paychecks for all other enrolled, active Employees. Payment shall be made to the GHLI Trust Fund and delivered to the Administrator. If such Premiums are not received by the Fund by the 10th working day following each pay period, interest will be charged on the amount due at a rate determined by the Board.

10.08. With each Premium remittance, each autonomous agency, each public corporation, any other Government entity that processes its own payroll, and the Department of Finance shall submit to the Administrator a list of all enrolled Employees for whom Premium is being paid. This list will be the definitive identification of all active Employees enrolled in the Program.

10.09. With each Premium remittance, the Administrator shall prepare a list of enrolled Retirees, Survivors and Employees on leave without pay, for whom Premiums were paid. This list will be the definitive identification of all those Retirees, Survivors and Employees on leave without pay enrolled in the Program.

10.10. The Administrator shall maintain a current list of all enrolled Dependents.
10.11. It is the responsibility of each applicable person or paying entity to make certain that Premiums are fully and timely paid.

10.12. The Administrator will issue a receipt of payment to each person or entity submitting Premiums to the GHLI Trust Fund.

10.13. The Administrator shall cause all Premiums received to be deposited into the GHLI Trust Fund.

10.14. The Board shall, at least annually, engage an experienced health insurance actuary or underwriter to review the financial status of the Program, to review this Plan Document, and to make such recommendations for changes as the Board deems necessary. Based on such recommendations, the Board may revise, as it deems necessary, (a) the Premium rates for the Program, (b) the Contributions required of Subscribers and the Government, and (c) this Plan Document.

10.15. The Chart below details the bi-weekly Contributions required from Subscribers and the Government, and the total Premium, beginning on the effective date of this Plan Document, which effective date is January 2, 2002.

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Option</th>
<th>Government Contribution</th>
<th>Total Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Only</td>
<td>High</td>
<td>$11.14</td>
<td>$43.93</td>
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<td></td>
<td>Low</td>
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<td>Self Plus One</td>
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<td>Self Plus Four</td>
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<td>$85.86</td>
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</table>
Unless determined otherwise by actuarial study and recommendation, the Government Contribution to Premiums shall increase by five percent (5%) annually, each such increase to become effective at the beginning of the Plan Year, with the first such increase being effective in January 2003. Said automatic increases shall continue annually until such time the Government's Contribution is equal to the Subscriber's Contribution.

### Contribution Rates

**Rates Effective June 1, 2002**

<table>
<thead>
<tr>
<th>Type of Enrollment</th>
<th>Enrollment Code Number</th>
<th>Bi-weekly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self Only</strong></td>
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<td></td>
</tr>
<tr>
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ARTICLE 11 – CLAIMS AND PAYMENT FOR SERVICES

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

11.02. Filing of Claims (General Rules).

A. All claims must be filed on Claim Forms as prescribed by the Administrator except as otherwise provided in this Article 11.

B. All claims must be accompanied by a Provider billing acceptable to the Administrator. Such billing must be itemized and must show at least the following:

1. Name of Enrollee.
2. Name; address, telephone number and professional license number of Provider.
3. Dates Services were received or rendered.
4. Nature of illness or injury and specific diagnosis.
5. Services and/or treatment provided.
6. Prescriptions filled, if applicable.
7. Physician’s or Authorized Representative’s Signature.

11.03. Payment of Claims (General Rules).

A. All claims eligible for reimbursement of Eligible Charges and Allowable Expenses, less any required Co-payment or Coinsurance, will be paid by the Administrator or by the Program’s Third Party Administrator, if any, from the GHLI Trust Fund, or other claims payment account as established by the Program and/or its Third Party Administrator, if any, to either the Provider or the Subscriber as specified in this Plan Document,
B. Should any claim overpayment to a Provider be discovered, the Administrator will attempt to recover it. However, regardless of whether recovery is made, the amount of such overpayment will not be charged to the Enrollee’s Annual Maximum or Lifetime Maximum.

C. Should any claim underpayment be discovered, the Administrator shall pay the shortfall when possible, and charge the amount of such payment against the Enrollee’s Annual Maximum and Lifetime Maximum.

D. All claims and accompanying documentation will be retained by the Administrator.

E. The Trust Fund reserves the Right to utilize the Services of a Third Party Administrator to handle and process payment of claims. In the event the Trust Fund employs such Service, any reference, herein in this Article 11, to the Administrator shall refer to that Third Party Administrator, to the extent permissible under this Plan Document and any contract or agreement for Services between the GHLI Trust Fund and the Third Party Administrator (“TPA”).

11.04. Filing of Claims by Providers.

A. Claims incurred at Government health facilities, including the Commonwealth Health Center, the Rota Health Center, and the Tinian Health Center, shall be filed directly with the Administrator by such facility on the Enrollee’s behalf, except, if the Program has contracted with a Third Party Administrator, all claims must be filed directly with that Third Party Administrator.

B. Private sector Providers and Providers outside the CNMI may file claims directly with the Administrator on the Enrollee’s behalf, except, if the Program has contracted with a Third Party Administrator, all claims must be filed directly with that Third Party Administrator.

C. Providers filing claims may file Claim Forms on their own insurance forms, provided such other forms are acceptable to the Administrator, or Providers may file claims electronically in accordance with the requirements of the Administrator, or the requirements as established with the Program’s Third Party Administrator, if any.

11.05. Payment of Claims to Providers.

A. Claims filed by Government health facilities will be paid to such facilities. Claims filed by other Providers will be paid to the applicable Subscriber unless payment has been assigned to the Provider as specified in Section 11.05.B below.
B. A Subscriber or the Subscriber's enrolled Spouse may assign payment of his or her benefits, or those of the Subscriber's enrolled Children, to a Provider by signing a written statement authorizing the Administrator, or the Program's Third Party Administrator, to pay the Provider rather than the Subscriber.

C. If a claim is paid to a Provider, the Administrator, or the Program's Third Party Administrator, will notify the Subscriber in writing of such payment.

D. Preferred and Participating Providers. When covered Services are rendered by a Preferred or Participating Provider, the Plan will pay benefits directly to the said Provider. Preferred and Participating Providers have agreed to limit their charges to Enrollees to not more than a specified amount. In addition, Preferred and Participating Providers have agreed not to collect from any Enrollee an amount exceeding the Enrollee's Copayment or Coinsurance in this Plan.

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

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

11.06. Filing of Claims by Enrollees/Dependents.

A. Claim Forms for reimbursement must be completed by the Subscriber or the Subscriber's enrolled Spouse and delivered to the Administrator.

B. Enrollees eighteen (18) years of age and over at the time of Service are required to sign each claim submitted unless they are incapable of doing...
so rather than stamping a claim form with the phrase "SIGNATURE ON FILE".

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

11.07. **Payment of Claims to Subscribers.**

A. Claims will be paid to the Subscriber for all claims filed by the Subscriber, or on his or her behalf, or for any of the Subscriber's Dependents, unless payment to the Provider has been assigned pursuant to Section 11.04.B above.

B. In the case of a deceased Subscriber, payment of claims filed by the Subscriber will be made to the Subscriber's estate, or otherwise as ordered by a Court of competent jurisdiction.

C. Any claim for benefits with respect to a Child covered by a Qualified Medical Child Support Order ("QMCSO") may be made by the Child or by the Child's custodial parent or court-appointed guardian. Any benefits otherwise! payable to the Subscriber with respect to any such claim shall be payable to the Child's custodial parent or court-appointed guardian.

11.08. **Timely Filing.** Claims must be filed promptly. The Administrator, or the Program's Third Party Administrator, will not accept claims filed more than one year following the date on which the Service was rendered.

11.09. **Medical Necessity of Services.** This Plan covers only medically necessary Services; the Plan will not cover any unnecessary Services nor will the unnecessary portion of any charge be paid. The fact that a physician may prescribe, order, recommend, or approve a Service does not in itself constitute medical necessity or make a charge an allowable expense under this Plan. An Enrollee may ask a physician to write to the Administrator for a determination regarding the medical necessity of a Service before it is performed. The Administrator will determine the medical necessity of the test or treatment based on the criteria and guidelines of the Federal agencies. To be considered medically necessary, a Service must meet all of the following criteria:

A. The Service or treatment must follow standard medical practice and be essential and appropriate for the diagnosis or treatment of an illness or Injury. Standard medical practice, with respect to a particular illness or Injury, means that the Service was given in accordance with generally accepted principles of medical practice in the United States at the time furnished.
B. The Service or treatment must not be "Experimental" (e.g., used in research or on animals), or "investigative" (e.g., used only on a limited number of people or where the long term effectiveness of the treatment has not been proven in scientific, controlled settings, and, where applicable, has not been approved by the appropriate government agency).

C. If there is more than one medically appropriate method of treating an Enrollee, the Plan's benefit will be based on the least expensive method, even if the health care Provider elects to treat the Enrollee by a more expensive method. Similarly, if the Services could be provided in more than one type of facility or setting (e.g., Hospital or physician's office), the Plan's benefits will be based on the least expensive facility or setting.

11.10. Eligible Charges. The Plan's benefit payments and the Enrollee's Co-payments for most Services are based on the Eligible Charges for the Services (i.e., the Enrollee pays a specified percentage or portion of the Eligible Charge for each Service). The Plan will not pay the portion of any charge that exceeds the Eligible Charge. General excise or other tax is not included in the Eligible Charge. An Enrollee is responsible for paying all taxes.

A. Definition. The Eligible Charge for a covered Service is, in most instances, the lower of the actual charge on the claim, the discounted charge negotiated by the Plan, the standard current reimbursement rate established by United States Medicare, or the charge listed for the Service in the Plans Schedule of Maximum Allowable Charges. For a covered Service which does not have a charge listed in the Schedule, the Plan will establish the Maximum Allowable Charge. The Plan also reserves the right to annually adjust the charges listed in the Schedule of Allowable Charges. In adjusting charges, the Plan will consider increases in the cost of medical and non-medical Services over the previous year, the relative difficulty of the Service compared to similar Services, changes in technology which may have affected the difficulty of the Service, payment for the Service under federal, state and other private insurance programs and the impact of changes in the charge on the Plan's health plan rates.

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

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

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

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

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

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

1. **Non-Preferred or Non-Participating Providers.** Benefits payments for covered services that are considered to be specialty or sub-specialty services and not routinely provided by the Commonwealth Health Center will be reimbursed to independent practicing physicians outside the CNMI based on an eligible charge as established by the Plan and based upon the reimbursement rate for the same or similar procedure in a location where the procedure is performed on a more routine basis.

2. **Preferred or Participating Providers.** Benefits payments for covered services that are considered to be specialty or sub-specialty services, and are not routinely provided by the Commonwealth Health Center, by Providers who are Participating Providers under a third party administration contract are based on the Eligible Charges and paid in accordance with the agreement between the Third Party Administrator and the Provider.

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

1. **Non-Preferred or Non-Participating Providers.** Benefits payments for covered services that are considered to be specialty or sub-specialty services and not routinely provided by the Commonwealth Health Center will be reimbursed to independent...
practicing physicians outside the CNMI based on an eligible charge as established by the Plan and based upon the reimbursement rate for the same or similar procedure in a location where the procedure is performed on a more routine basis.

2. **Preferred or Participating Providers.** Benefits payments for covered services that are considered to be specialty or sub-specialty services, and are not routinely provided by the Commonwealth Health Center, by Providers who are Participating Providers under a third party administration contract are based on the Eligible Charges and paid in accordance with the agreement between the Third Party Administrator and the Provider.

**F. Claims for Prescription Services.** Claims for Prescription Services will be reimbursed at the rates and under the guidelines established by the Program's Third Party Administrator or Pharmacy Benefit Manager (PBM).

1. **Preferred or Participating Providers.** Benefit payments to Participating Providers will be based upon the reimbursement amounts as agreed in any contract between the Provider and the Third Party Administrator or Pharmacy Benefits Manager.

2. **Non-Preferred or Non-Participating Providers.** Benefit payments to properly Registered or Licensed Pharmacies that are not Participating Providers shall include the amount established under the Third Party Administrator's or Pharmacy Benefits Manager's reimbursement rate schedule for both the medication and dispensing or filling costs, which rates are derived from the Average Wholesale Price (AWP) for prescription medications.

3. **Physician Dispensing.** Benefit payments to Physician's who conduct what is commonly referred to as "Physician dispensing" shall include the amount established under the Pharmacy Benefit Manager's reimbursement rate schedule for the medication, derived from the Average Wholesale Price (AWP) for prescription medications. No dispensing or filling fee shall be reimbursed to a Provider who conducts Physician dispensing of medications unless the Physician is authorized under the law to dispense the medication or fill the prescription. No reimbursement shall be made for Professional samples.

**11.11. False Claims.**

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

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


A. The Administrator will audit a reasonable sample of claims each month.

B. Should errors in claim payments be discovered, they shall be corrected in accordance with Sections 11.02.B and 11.02.C.

C. Should errors in claim payments be discovered, the Administrator shall provide the applicable claims processor with the necessary remedial instructions.


A. The Administrator shall have discretionary authority to determine all questions of eligibility of Enrollees, to determine the amount and type of benefits payable to any Enrollee or Provider in accordance with the terms of this Plan, and to interpret the provisions of this Plan as is necessary to determine benefits.

1. Review. Any preliminary determination that a Service or charge is unnecessary or otherwise not payable shall be reviewed at the Subscriber's request and approved or corrected by such review committees as are appointed or approved by the Administrator. A Subscriber has one year from the date the Plan processed the Subscriber's claim to request this review. Any determination made by such review committees, acting in good faith, shall be conclusive upon all interested parties, subject to review and redetermination by the Board, whose decision shall be final. Such final decision may be submitted to arbitration.

2. Arbitration. If a Subscriber is dissatisfied with the results of a review as defined in paragraph (1) above, the Subscriber may request a further appeal by arbitration, provided that such request must be submitted to the Administrator in writing within thirty (30) days of the final decision. If a Subscriber shall make such written
demand, the Subscriber and the Fund shall promptly agree upon a single arbitrator and if they shall fail to so agree within 30 days of the written demand, either party may apply to the Superior Court of the CNMI for appointment of an arbitrator. The questions for the arbitrator shall be whether, in the particular instance, the Board was in error upon an issue of law, acted arbitrarily or capriciously in the exercise of its discretion, or whether the Fund’s findings of fact were supported by substantial evidence. The dispute shall be promptly decided and judgment may be entered upon the award of the arbitrator with the Superior Court of the CNMI. The judgment of the arbitrator shall be final and binding upon all interested parties and no further court action may be taken. The fee payable to the arbitrator shall be borne equally by the Subscriber and the Plan; all other expenses of the arbitration, such as cost of reporter and transcript, shall be paid in the share and manner ordered by the arbitrator, except that any attorney or witness fees of a party shall be borne by that party.


A. Claims submitted by Providers must include the signature of the physician or authorized representative in the correct block on the Health Insurance Claim Forms. (HCFA 1500, UB92, HFCA 1450)

B. Statements of Account must be accompanied by a Claim Form signed by the physician or authorized representative in the correct block on the Claim Form, otherwise it will be rejected or sent back for proper documents, and substantiation.
ARTICLE 12 – MANAGED CARE

12.01. Managed Care Program Reviews. A prior review must be obtained from the Administrator for certain types of medical Services. The Administrator's prior review, often referred to as pre-certification or pre-authorization, is required before admission to a Hospital, or before receiving certain Surgical or diagnostic Services. The Plan may pay reduced benefits in cases where its prior review of otherwise covered Services is required, but is not obtained.

12.02. Benefits Reductions. Any benefits that would have been paid in connection with a Hospital admission, surgical procedure, or diagnostic Services may be reduced by $300 if a required review is not requested and obtained. This $300 benefit reduction will also be applied if the Plan is not notified of an emergency or maternity admission within 48 hours of the event or by the next working day, whichever is later.

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

A. Preferred and Participating Providers. When the Services are recommended or provided by a Preferred or Participating provider, that Provider is responsible for obtaining any required Managed Care Reviews on the Enrollee's behalf. The Preferred or Participating Provider is responsible for obtaining pre-admission certification for the Enrollee, and failure to do so will not impose a penalty on the beneficiary.

B. Non-participating Providers. When the Services are recommended or provided by a non-participating Provider, the Enrollee must assume responsibility for requesting any required review and for any reduction in benefits resulting from failure to do so.

12.03. Preadmission Review.

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

Where the admission cannot be scheduled in advance, e.g., in cases of emergency or maternity, the Enrollee or the Enrollee's physician shall notify the Administrator as soon as practical after admission but in no event later than 48 hours or one working day after the admission, whichever is later.
B. Approval of benefits for a Hospital admission will be based on whether the Hospital admission recommended by the physician is medically necessary and whether the care can be provided safely and effectively out of the Hospital.

C. The Administrator will notify the Enrollee and the Enrollee’s physician in writing if the Plan approves payment of benefits for the admission. The Enrollee shall present the written notification to the Hospital upon admission. The Enrollee and the Enrollee’s physician will also be notified if payment of benefits for the admission is not approved. The Subscriber shall be responsible for all charges related to any Hospital admission for which the Plan has indicated it will not pay benefits.

12.04. Surgical Review.

A. The Plan has identified certain kinds of Surgical Services which are sometimes performed even though non-surgical treatment may be equally effective. Before scheduling any Surgical Services, the Enrollee or the Enrollee’s physician shall notify the Administrator and request a Surgical Review. Where the admission cannot be scheduled in advance, e.g., in cases of emergency or maternity, the Enrollee shall notify the Administrator as soon as practical after the surgery, but in no event later than 48 hours or one working day after the surgery, whichever is later.

B. The Administrator will notify the Enrollee and the Enrollee’s physician of the results of its Surgical Review. The Administrator may approve or deny payment of benefits for the surgery, or may condition the payment of such benefits on the Enrollee’s receiving a second opinion on the necessity of surgery. An Enrollee may receive a second opinion at no cost to the Enrollee if the second opinion is arranged by the Administrator. After receiving a second opinion, the Enrollee and the Enrollee’s physician may decide whether to proceed with the surgery. The second opinion does not need to confirm the recommended surgery, however, the Enrollee shall be responsible for all charges related to Surgical Services for which the Plan has indicated it will not pay benefits. If a Surgical Review is not obtained, the Enrollee will have additional expenses as indicated in Article 12.02 above.

12.05. Inpatient Review.

A. The Administrator will periodically review each Enrollee’s Hospital medical records for the appropriateness of the inpatient care provided to the Enrollee and the appropriateness of continuing hospitalization. This review will occur within 48 hours after admission and at set intervals, until...
the Enrollee is discharged from the Hospital. The Administrator will also review discharge plans for the appropriateness of after-hospital care.

B. The review of the appropriateness of inpatient care and after-hospital care is for benefit payment purposes. If the Administrator has a question regarding the appropriateness of the continuing hospitalization or after-hospital care, or if the Administrator determines that benefits are not payable, the Enrollee and the Enrollee's physician will be notified. If the Administrator decides that the continuation of any Service or care is not medically necessary or appropriate, the Enrollee and the Enrollee's physician may still decide to continue with the Service or care, but benefits under this Plan will not be payable for that continued Service or care.

12.06. **Benefits Management Program.** The Administrator may assist an Enrollee by providing benefits for alternative Services that are medically appropriate but may not otherwise be covered under this Plan. Benefits for any alternative Services for an Enrollee's illness or Injury will be paid in lieu of benefits for regularly covered Services and will not exceed the total benefits otherwise payable for regularly covered Services.

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

12.07. If an Enrollee does not agree with a benefit determination made under the Preadmission Review, Surgical Review, Benefit Management Review, or Inpatient Review provisions above, the Enrollee may ask for a second review by the Plan's Administrator or Medical Director. The Administrator will notify the Enrollee of the results of such second review.
ARTICLE 13 – COORDINATION OF BENEFITS AND DOUBLE COVERAGE

13.01. When an Enrollee is covered by another group health insurance plan, including Medicare, the Coordination of Benefits Guidelines established by the National Association of Insurance Commissioners (NAIC) will be used to determine whether the Program will be the primary or secondary payor. These guidelines have included the following provisions:

A. The plan covering the Enrollee as an active employee will be the primary payor.

B. If a Child is covered under two plans, the plan of the parent whose birthday occurs first in the calendar year will be the primary payor.

C. If other guidelines fail to establish which plan is the primary payor, the plan covering the Enrollee for the longer time will be the primary payor.

13.02. If the Program is the primary payor, it will pay for Covered Benefits in accordance with this Plan Document. If the Program is the secondary payor, it will pay a reduced amount, so that, when added to the amount payable by the other plan, the total amount paid by both plans will not exceed the Provider's charges for Covered Benefits. In no event will the amount paid by the Program exceed the Allowable Expenses it would have paid had it been the primary payor. Also, in no event will the Program pay for non-Covered Benefits.

13.03. The double coverage provision applies whether or not a claim is filed under the other plan. As a condition of enrollment, a Subscriber authorizes the Administrator to obtain information as to benefits available from the other plan, and to recover overpayment, should they occur, from the other plan, on behalf of the Subscriber and any of his or her enrolled Dependents.

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

A. will disclose all coverage under any other plan;

B. consents to the Plan's releasing to any party or obtaining from any party any information which the Plan deems necessary for such purposes;

C. authorizes direct reimbursement to or from any other Plan when such direct payment is appropriate and necessary to facilitate the coordination and adjustments of the Plan's and other plan's payments under this section; and
D. will, upon request, execute and deliver such instruments or documents as may be required to satisfy the intent of this section.


A. The Federal Medicare Program will be considered the primary plan unless the Enrollee is an active Employee covered under this Plan. Where an Employee or Dependent is covered by both Medicare and this Plan, applicable Federal statutes will determine which plan is primary.

B. Any no-fault motor vehicle insurance coverage will be considered the primary plan and its benefits will be applied first. Before the Plan pays benefits under this Plan for any injury covered by no-fault insurance, the Plan will list the medical expenses that no-fault covers according to the date on which the expenses were incurred. The Plan will add up the no-fault expenses for each successive day until the day when the no-fault benefit maximum is exhausted. From that day on, covered Services received by the Enrollee will be eligible for payment under this Plan. The Plan will follow this procedure even when the no-fault insurer pays all of its benefits for non-medical expenses or when the actual order of payment differs.

C. If another person caused the motor vehicle accident and the Enrollee may recover damages from that person, any benefits for which the Enrollee may be eligible shall be subject to the provisions of Article 13. The Plan is not liable to pay any benefits for injuries caused by another person, but may assist the Enrollee by providing coverage he or she would have received as a benefit after the no-fault benefits have been exhausted as described in subparagraph B above, subject to the right of subrogation.

13.05. An Enrollee may not seek Double Coverage by being a Subscriber, and also being the Dependent of another Subscriber under this Plan. Only one category of enrollment and coverage will be permitted.
ARTICLE 14 – SUBROGATION

14.01. If an injury or illness of an Enrollee is or may have been caused by another person or party and the Enrollee has or may have a right to recover damages therefore against that person or party, the Plan shall not be liable to pay any benefits provided under this Plan. However, upon the execution and delivery to the Plan of all papers it requires to secure its rights of reimbursement, the Plan may pay benefits in connection with such injury or illness. If an Enrollee is injured or infected through the act or omission of another person or entity and recovers damages from the other person or entity, the Enrollee shall reimburse the Plan for the cost of the benefits provided by the Program in treating such condition. The amount of such reimbursement must equal the amount of the recovery or the Program's cost for such benefits, whichever is less. If the Plan pays any benefits because of such injury or illness, the Plan shall have a lien against any recovery to the extent of such payments. Such lien may be filed with such other person or party, his or her agent or insurance company, or the court; and such lien shall be satisfied from any recovery received by the Enrollee.

14.02. If there is no recovery of damages, the Plan shall be subrogated to the Enrollee's rights against the wrongdoer to the extent of the cost of the benefits provided by the Plan, including the right to sue in the Enrollee's name and to compromise the claim in order to indemnify the Plan for amounts paid.

14.03. It is a condition of enrollment in the Plan that each Enrollee agrees that he or she, his or her guardian, his or her Survivor, and his or her estate will execute and deliver an assignment of claim payment form, and any other necessary forms prescribed by the Administrator, to the Administrator upon request, and shall render all necessary assistance, other than pecuniary, to enable the Plan to secure the rights provided by this Article.
ARTICLE 15 – CHANGING BENEFITS AND ENROLLMENT

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

(SEE CHART ON NEXT PAGE)
# CHART ON CHANGING ENROLLMENT / BENEFITS

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<thead>
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<th>Events which permit enrollment or change in enrollment</th>
<th>Changes permitted by Subscriber or prospective Subscriber</th>
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<td>From SELF only to Self Plus One</td>
<td>NO (unless special enrollment permitted)</td>
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<tr>
<td>From SELF only to Plus Four</td>
<td>From SELF only to Plus Five</td>
<td>NO (unless special enrollment permitted)</td>
</tr>
<tr>
<td>From Plus Four OR Plus Five</td>
<td>From Plus Four or Plus Five Plus to SELF only</td>
<td>NO (unless special enrollment permitted)</td>
</tr>
<tr>
<td>From Plus Four to Plus Five</td>
<td>From Plus Four to Plus One</td>
<td>NO (unless special enrollment permitted)</td>
</tr>
<tr>
<td>From one OPTION to another</td>
<td></td>
<td>NO (unless special enrollment permitted)</td>
</tr>
</tbody>
</table>

- **Open Season**: YES YES YES YES YES YES YES YES November of each year or as otherwise specified by the Administrator.

- **Acquisition of Spouse or Child**: NO (unless special enrollment permitted) YES YES YES NO NO NO NO Within 30 days of acquisition (or according to HIPAA rules for special enrollment).

- **Loss of other coverage**: NO (Unless special enrollment permitted) YES YES YES N/A N/A N/A N/A According to HIPAA rules of special enrollment.

- **Divorce, legal separation, annulment, death of a Spouse or Child, a Child's loss of Dependent Status**: NO (Unless special enrollment permitted) NO (Unless special enrollment permitted) NO (Unless special enrollment permitted) YES YES YES NO Within 20 days of event (or according to HIPAA rules for special enrollment).

- **Change in status from Spouse to Survivor of former Retiree**: YES YES YES YES YES YES YES NO Within 30 days of (a) the date the Administrator approves the Survivor's application for survivor annuity benefits, or (b) the original effective date of this Plan Document.

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

A. If the Subscriber changes from one benefit option to another, such change is also applicable to all of the Subscriber’s enrolled Dependents.

B. The new benefit option will apply only to Services received after the change is effective.

C. Plan Year limitations and maximums for each Enrollee under the new benefit option will be reduced by the amount paid by the Program for the Enrollee for that Plan Year under the former benefit option.

D. Any amount remaining under the Lifetime Maximum under the former benefit option will be transferred to the new benefit option, however in no event will a transfer result in a Lifetime Maximum which exceeds the limits as specified in this Plan Document.

E. The effective date of the change will be the first day of the Government’s next pay period or, for Retirees and Survivors, the date of the next annuity installment payment, unless the change is made during an Open Season, in which case the change will be effective as the date specified by the Administrator.

15.03. In addition to the rules outlined in Section 15.01, the following rules also apply to changing enrollment options:

A. A Subscriber may cancel his or her enrollment and that of any of his or her enrolled Dependents at any time.

B. Enrollment changes made pursuant to a change in family status must be consistent with such change in status, and the Enrollee must provide any documentation required by the Administrator to substantiate such change in status.

15.04. To change benefit or enrollment options, the Subscriber must file an Enrollment Change Form with the Administrator.

15.05. No change in benefit or enrollment options will be effective without the approval of the Administrator. If the Administrator has not acted upon an application for change in benefit or enrollment option within 30 days of its receipt, the application shall be deemed denied.
ARTICLE 16 – ADMINISTRATION

16.01. The Board has ultimate and fiduciary responsibility for the administration and management of the Program and the GHLI Trust Fund. The Board will administer and manage the Program in accordance with this Plan Document and the Act. The Board may promulgate administrative or interpretive rules and/or regulations governing the Program, provided that such rules must be consistent with this Plan Document, the Act and other applicable law. Any such rules shall be applied as if they were part of the Plan Document.

16.02. The Administrator has the authority to make decisions, as necessary for the optimal functioning of the Program, within the authority granted him by the Act, this Plan Document and Board directives.

16.03. The Administrator is responsible for the daily functions of the Program including, but not limited to, receiving and depositing Premiums, receiving and processing claims, communicating and explaining the Program to current and prospective Enrollees, responding to inquiries, and guarding against Enrollee and Provider fraud.

16.04. The Administrator will create and maintain all necessary Program records including Premiums received, enrollment, claims processed, claims paid, and amounts accumulated toward each Enrollee's Coinsurance maximum, family out-of-pocket maximum, Annual Maximum, Lifetime Maximum, and any other maximums.

16.05. The Board, through the Administrator, has the authority to contract with private sector third party administrators to administer medical care within and outside the CNMI.

16.06. The Board, through the Administrator, has the authority to contract with private sector, third party insurers and/or administrators to insure and/or administer the Program.

16.07. Subject to the review and oversight of the Board, the Administrator shall have all discretionary powers necessary to administer the Program and control its operation in accordance with the terms of this Plan Document and applicable law, including but not limited to the power to (a) interpret the provisions of this Plan Document, (b) to determine any question relating to the administration or operation of the Program subject to Article 19, and (c) make and enforce decisions regarding who is eligible for benefits and the amount of benefits payable in any particular case. All decisions of the Administrator, any actions taken or omitted by the Administrator in respect of the Program and within the powers granted by the Act or under this Plan Document, and any interpretation of this Plan Document by the Administrator shall be conclusive and binding on
all persons other than the Board, and shall be given the maximum possible consideration allowed by law, subject to Article 20.

16.08. **Annual Budget.**

A. By September 30 each year, unless otherwise directed by the Board, the Administrator will prepare an annual budget for the operation of the Program to include the expected Premiums, claims, administrative costs, and other Allowable Expenses for approval by the Board. Such budget shall be for the next Fiscal Year.

B. The annual operating budget shall be approved, or revised and approved, by the Board on or before the beginning of each Fiscal Year. The approved budget will be transmitted by the Board to the Office of Management and Budget and to the Office of the Governor for informational purposes only.

C. In the event of a shortfall occurring during any Fiscal Year, the Administrator will prepare a revised budget to cover the shortfall. However, the total budget shall not exceed the estimated Premiums to be received during that Fiscal Year.

16.09. **GHLI Trust Fund.**

A. The GHLI Trust Fund was established in accordance with Section 5 of the Act for holding Premiums and any investment earnings thereon.

B. Moneys in the GHLI Trust Fund are to be expended for the payment of claims, premiums to third party health insurance companies (if any), reasonable costs of administration, and other Allowable Expenses related to the Program.

C. The Administrator shall maintain the GHLI Trust Fund at any recognized financial institution whose deposits are insured by an agency of the U.S. Federal Government. However, the full amount of money held in the GHLI Trust Fund need not be so insured.

D. The Administrator, under the direction of the Board, shall have sole and exclusive expenditure authority over the GHLI Trust Fund.

E. The Administrator shall establish an accounting system for the GHLI Trust Fund in accordance with Generally Accepted Governmental Accounting Standards and issue accounting reports to the Board as required but at least semiannually.
F. The Administrator shall report to the CNMI Legislature and Governor on the financial status of the GHLI Trust Fund within 60 days after the end of each Fiscal Year.

G. When the GHLI Trust Fund reaches $3 million dollars in excess of the amount estimated to cover obligations for one full year, the Board may invest such excess funds in other appropriate investment programs consistent with the fiduciary standards and procedural rules for investment of the NMI Retirement Fund assets.
ARTICLE 17 – AMENDMENTS

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

17.02. Significant amendments by the Legislature or by the Board, through rule making or regulation, will be communicated by the Administrator in accordance with Article 18, Section 18.02.
ARTICLE 18 – COMMUNICATIONS

18.01. Communications from Enrollees and any other interested persons regarding the Program should be addressed to the Administrator, CNMI Group Health Insurance Program, NMI Retirement Fund, 1st Floor, Retirement Fund Building, Capitol Hill, P.O. Box 501247, Saipan, MP 96950-1247, telephone (670) 664-8026, fax (670) 664-8074.

18.02. Any significant amendments to the Act or this Plan Document and any other pertinent information regarding the Program shall be communicated to Enrollees in accordance with the Administrative Procedure Act. In addition, they shall be posted in the Fund/GHLI offices as well as directly provided to Enrollees through Employees’ pay checks and Retirees’ annuity checks. The Administrator will make reasonable best efforts to notify Survivors, employees on leave without pay and other interested parties.

18.03. Workshops explaining the Program will be conducted periodically, usually during “new employees orientations”, which are usually held at least once every quarter. Similar workshops will also be held upon request by any Government department, agency or other entity.

18.04. Employee meetings will be held during Open Seasons during working hours through coordination between the Administrators and department and agency heads to explain the Program. All Employees may attend such meetings and ask any questions about the Program.
ARTICLE 19 – TERMINATION

19.01. Enrollment in the Program will terminate:

A. for an Enrollee if he/she no longer meets the definition of "Enrollee";

B. for an Enrollee if such individual files a "false claim" pursuant to Article 11, Section 11.11.B;

C. for an Enrollee if the Enrollee dies;

D. for all Enrollees if the Government terminates the Program;

E. for a Subscriber if the Subscriber terminates he or her enrollment;

F. for a Dependent if the Subscriber's enrollment terminates;

G. for a Dependent if the Subscriber terminates the enrollment of the Dependent;

H. for a Survivor and all Dependents of the former Subscriber if the Survivor remarries;

I. for an Employee 30 days after the Employee ceases to be employed by the Government, unless the former Employee qualifies as a Retiree.

19.02. Except as specified in Section 19.01.I above, all terminations of enrollment will be effective as of the first day of the pay period or semi-monthly annuity period following the event causing the termination.

19.03. If a Subscriber's enrollment terminates, coverage for all of such Subscriber's enrolled Dependents also terminates as of the Subscriber's date of termination except as specifically provided for Survivors in Article 4. A Subscriber whose enrollment has terminated will not be eligible to re-enroll until an Open Season is declared or unless the Subscriber otherwise becomes eligible. Notwithstanding the previous sentence, if the Subscriber's enrollment terminates because of non-payment or untimely payment of Subscriber Contributions while the Subscriber is on leave without pay pursuant to the Family and Medical Leave Act of 1993, or if the Subscriber qualifies under the Uniformed Services Employment and Reemployment Rights Act of 1993, the provisions of those acts will govern.

19.04. If an enrolled Dependent no longer meets the definition of "Dependent", the Subscriber must ensure that the Administrator is notified within 30 days of the date the change occurred. If the Administrator is not so notified, payment of
benefits for such Dependent will be denied retroactively to the date the change occurred, even though Premiums were paid, and Premiums will not be refunded. Also, any claim filed on behalf of such Dependent may be considered a "false claim" pursuant to Article 11, Section 11.11.B.

19.05. Except as specifically provided in Section 19.04 above, the Administrator will refund any pre-paid Subscriber Contributions within 60 days following termination of enrollment. Pre-paid Government Contributions will not be refunded.

19.06. The CNMI Legislature has the power to abolish the Program or amend the law creating and governing the Program at any time.
ARTICLE 20 – RECONSIDERATION AND APPEALS

20.01. If a claim for benefits, application for enrollment, enrollment change or continued enrollment is denied in whole or in part for reasons other than for failing to meet a stated time deadline, or if adverse action is otherwise taken against the claimant, the claimant or the claimant’s representative may submit a written request for reconsideration to the Administrator within 20 days after the notice of denial is issued or other adverse action is taken. The claimant or claimant's representative must state the reason he or she believes the denial was inappropriate and may submit any supporting data. An Enrollee has the right to be represented by an attorney of his or her choosing or by any person, including the Enrollee’s Service Provider or a representative of the Enrollee's Service Provider.

20.02. The Administrator will discuss the request for reconsideration with the claimant or claimant’s representative at an informal conference either by telephone or in person at the option of the claimant or the claimant’s representative. Such informal conference will be held within 30 days following the Administrator's receipt of the written request for reconsideration if at all possible. The Administrator shall require the written consent of the claimant or his or her authorized representative before discussing privileged or confidential medical information to any non-privileged third party.

20.03. The Administrator's decision on reconsideration shall be in writing and sent to the claimant or claimant’s representative, within 20 days of the informal conference. The Administrator shall state the specific reasons for his or her decision and refer to the provisions in the Act, the Plan Document or other rules or regulations on which the decision is based.

20.04. If the claimant is adversely affected by the Administrator’s decision on reconsideration, the claimant or claimant’s representative may appeal to the Board within 20 days of the Administrator’s decision on reconsideration, pursuant to the Administrative Procedures Act and other applicable law, rules and regulations. Such appeal must be in writing and sent to the Chairman, Board of Trustees, NMI Retirement Fund, P.O. Box 501247, Saipan, MP 96950-1247. The claimant shall also serve a copy of the appeal on the Administrator within the same time period.

20.05. Upon receipt of a notice of appeal, the Board may appoint a hearing officer to hold a hearing on the record or, in an appropriate case, the Board may itself conduct a hearing on the record. The hearing shall be conducted according to the procedures set forth in the Administrative Procedures Act and the claimant shall have all rights guaranteed thereunder.
20.06. Any further appeal or review of the Board's decision shall be made to the Commonwealth Superior Court in accordance with 1 CMC Section 9112(b) and 9113. If the Court finds in favor of the Plan, the Claimant shall be liable for attorney's fees and other costs incurred by the Plan in its defense. If the Court finds in favor of the Claimant, the Plan shall pay its own attorney's fees and other costs and those of the Claimant.
ARTICLE 21 – GOVERNING LAWS

21.01 Notwithstanding any other provision of this Plan Document, the Program will be administered in accordance with applicable CNMI and U.S. Federal Government laws, except in cases in which the CNMI has the authority to and has chosen to opt-out of such laws. Such laws include the Retirement Fund Act, the Public Health Service Act, the Health Insurance Portability and Accountability Act of 1996, the Mental Health Parity Act of 1996, the Family and Medical Leave Act of 1993, the Uniformed Services Employment and Re-employment Rights Act of 1993, the Americans with Disabilities Act of 1990, and the Pregnancy Discrimination Act of 1979.

21.02 In case of conflict between this Plan Document and any CNMI or U.S. Federal law, the law will govern.

21.03 Pursuant to Section 146.180 of the Public Health Service Act (PHSA), the Program will not participate in the Mental Health Parity Act (MHPA). Under the MHPA, mental health coverage, if provided as a covered benefit, is required to be provided on the same basis as medical and surgical coverage. Certain provisions of the PHSA permit self-funded government plans to opt-out of this requirement. In order to provide mental health benefits to members, in a manner the Plan can reasonably afford, the Plan has opted-out of the MHPA, and is therefore, if it meets all continuing requirements, exempt from providing mental health coverage on the same basis as medical coverage. Under such exemption, the Plan may limit the amount of coverage provided for mental health benefits to members.

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

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

Health Care Financing Administration
Department of Health & Human Services
Insurance Reform Implementation Task Force
Attn: David Holstein, Room SLL-17
7500 Security Blvd.
Baltimore, MD 21244-1850
Phone: (410) 786-1564
Fax: (410) 786-8001
ARTICLE 22 – AMENDMENTS AND EFFECTIVE DATE

22.01. These rules and regulations may be amended from time to time as the Board of Trustees deems appropriate.

22.02. These rules and regulations shall be effective 10 days following final publication in the Commonwealth Register pursuant to the Administrative Procedure Act at 1 CMC 9101, et. seq.
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<th>Category</th>
</tr>
</thead>
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<td>CENTRAL NERVOUS SYSTEM</td>
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<td>NUTRITIONAL PRODUCTS</td>
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<td>13</td>
<td>OPHTHALMIC MEDICATIONS</td>
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<td>EAR, NOSE AND THROAT MEDICATIONS</td>
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<td>Relative Cost</td>
<td>Generic Available*</td>
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<td><strong>Chapter 1</strong></td>
<td><strong>ANTIINFECTIVES</strong></td>
</tr>
<tr>
<td><strong>1.1 Penicillins</strong></td>
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<tr>
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<td>Amoxicillin/pen. clavulanate</td>
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</tr>
<tr>
<td>$$ $$</td>
<td>Cefdinir</td>
</tr>
<tr>
<td>$$ $$</td>
<td>Cefixime tablets</td>
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<td>Cefprozil</td>
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</tr>
<tr>
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<tr>
<td>$$ $$</td>
<td>Didanosine (ddI)</td>
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<tr>
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<td>Lamivudine</td>
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<td>Ritonavir</td>
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<tr>
<td>$$ $$</td>
<td>Zalcitabine (ddC)</td>
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<tr>
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<td><strong>1.11 Antimalarial</strong></td>
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<tr>
<td>$$</td>
<td>Pyrimethamine</td>
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<td>Primaquine Phosphate</td>
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<td>Pyrimethamine/ sulfadoxine</td>
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<tr>
<td>$$</td>
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<tr>
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<td>Mefloquine</td>
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<tr>
<td><strong>1.12 Amebicides</strong></td>
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<tr>
<td>$$</td>
<td>Iodoquinol</td>
</tr>
<tr>
<td><strong>1.13 Anthelmintics</strong></td>
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<tr>
<td>$$</td>
<td>Thiabendazole</td>
</tr>
</tbody>
</table>
1.14 Miscellaneous Antimicrobials

- Praziquantel
- Trimethoprim
- Dapsone
- Thalidomide
- Isoniazid/Rifampin
- Metronidazole
- Atovaquone
- Interferon Alfa-2B
- Interferon/ribavirin
- Peginterferon Alpha-2b

**Infectious agents are covered according to plan specifications.

Chapter 2
ANTINEOPLASTICS AND IMMUNOSUPPRESSANTS

All FDA-Approved, non-injectable Antineoplastics and immunosuppressants are eligible for coverage.

2.1 Antineoplastics

- Altretarnine
- Anastrozole
- Bicalutamide
- Busulfan
- Capecitabine
- Chlorambucil
- Cyclophosphamide
- Estramustine
- Etoposide
- Flutamide
- Letrozole
- Levamisole
- Lomustine
- Melphalan
- Mercaptopurine
- Mitotane
- Pipobroman
- Procarbazine
- Testolactone
- Thioguanine
- Toremifene citrate
- Tretinoin
- Uracil Mustard

2.2 Immunosuppressants

- Azathioprine
- Cyclosporine
- Cyclosporine oral solution
- Mycophenolate
- Sirolimus

Chapter 3
ENDOCRINE MEDICATIONS

3.1 Systemic Corticosteroids

3.1.1 Glucocorticosteroids

- Prednisolone syrup
- Fludrocortisone

3.2 Androgens

- Testosterone, transdermal
- Testosterone, transdermal
- Testosterone Gel

3.3 Estrogens

- Estrogens conjugated
- Esterified Estrogens
<table>
<thead>
<tr>
<th>Classification</th>
<th>Products</th>
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<tbody>
<tr>
<td>Estrogens / Progesterone Combinations</td>
<td>Estropipate ORTHO-EST, OGEN  Estradiol, transdermal VIVELLE  Estradiol, transdermal ESTRADERM  Estrogens PREMARIN VAGINAL CREAM</td>
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<td>Estradiol Transdermal Combinations</td>
<td>Ethinyl Estradiol FEMHRT  Premarin/Medroxyprogesterone PREMPHASE/PREMPRO</td>
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<td>Estrogen / Androgen Combinations</td>
<td>Estrogen / Androgen Combinations  ESTRATEST, -HS  methyltestosterone</td>
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<td>Oral Contraceptives</td>
<td>Oral Contraceptives are covered according to plan specifications</td>
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<tr>
<td>Mono-Phasic Oral Contraceptives</td>
<td>Norgestimate/ethinyl estradiol  Norbindione/ethinyl estradiol  Ethinyl estradiol  Levonorgestrel/ethinyl estradiol  Ethinyl estradiol / norethindrone  Norgestimate/ethinyl estradiol</td>
</tr>
<tr>
<td>3.16 Endometriosis Therapy</td>
<td>3.17 Other Endocrine Drugs</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>$$$$ Ridoctrine</td>
<td>$$$$ Bromocriptine</td>
</tr>
<tr>
<td>$$$$ Nafarelin</td>
<td>$$$$ Desmopressin tablets</td>
</tr>
<tr>
<td>$$$$ Danazol</td>
<td>$$$$ Calcitonin, salmon nasal spray</td>
</tr>
</tbody>
</table>

Other Endocrine Drugs

- **Bromocriptine**: PARLODEL
- **Desmopressin tablets**: DDAVP
- **Calcitonin, salmon nasal spray**: MIACALCIN NASAL SPRAY
- **Risedronate**: ACTONEL
- **Alendronate**: FOSAMAX
- **Raloxifene**: EVISTA

**Injectables are covered according to plan specifications**

## Chapter 4

### CARDIOVASCULAR MEDICATIONS

#### 4.1 Cardiac Glycosides

<table>
<thead>
<tr>
<th>Drug</th>
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<td>LANOXIN</td>
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#### 4.2 Nitrates

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitroglycerin</td>
<td>NITROSTAT</td>
</tr>
<tr>
<td>Nitroglycerin spray</td>
<td>NITROLINGUAL SPRAY</td>
</tr>
<tr>
<td>Isosorbide monohydrate</td>
<td>IMDUR, MONOKET, ISMO</td>
</tr>
<tr>
<td>Isosorbide dinitrate SR</td>
<td>DILATRATE SR</td>
</tr>
</tbody>
</table>

#### 4.3 Betablockers

4.3.1 Beta-1 Specific

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metoprolol ER</td>
<td>TOPROL XL</td>
</tr>
</tbody>
</table>

4.3.2 Non-Selective

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisoprolol</td>
<td>ZEBETA</td>
</tr>
<tr>
<td>Penbutolol</td>
<td>LEVATOL</td>
</tr>
<tr>
<td>Carvedilol</td>
<td>COREG</td>
</tr>
</tbody>
</table>

#### 4.4 Calcium Antagonists

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diltiazem, SR</td>
<td>DILACOR XR, TIAZAC, CARDIZEM CD, SR</td>
</tr>
<tr>
<td>Isradipine</td>
<td>DYNACIRC, CR</td>
</tr>
<tr>
<td>Amlodipine</td>
<td>NORVASC</td>
</tr>
<tr>
<td>Nimodipine</td>
<td>NIMOTOP</td>
</tr>
<tr>
<td>Felodipine</td>
<td>PLENDIL</td>
</tr>
</tbody>
</table>

#### 4.5 Antidysrhythmic Drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proncainamide HCL extended release</td>
<td>PROCANBID</td>
</tr>
<tr>
<td>Tocainide</td>
<td>TONO CARD</td>
</tr>
<tr>
<td>Moricizine</td>
<td>ETHMOZINE</td>
</tr>
<tr>
<td>Flecaïnide</td>
<td>TAMBOCOR</td>
</tr>
<tr>
<td>Mexiletine HCL</td>
<td>MEXITIL</td>
</tr>
</tbody>
</table>

#### 4.6 Angiotensin Converting Enzyme Inhibitor

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benazepril</td>
<td>LOTENSIN</td>
</tr>
<tr>
<td>Lisinopril</td>
<td>ZESTRIL</td>
</tr>
<tr>
<td>Quinapril</td>
<td>ACCUPRIL</td>
</tr>
<tr>
<td>Ramipril</td>
<td>ALTACE</td>
</tr>
</tbody>
</table>

4.6.1 Angiotensin Converting Enzyme Inhibitors Combination

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benazepril/HCTZ</td>
<td>LOTENSIN/HCT</td>
</tr>
<tr>
<td>Captopril/HCTZ</td>
<td>CAPOZIDE</td>
</tr>
<tr>
<td>Lisinopril/HCTZ</td>
<td>ZESTORETIC</td>
</tr>
</tbody>
</table>

4.6.2 Angiotensin II Antagonists (ARB)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valsartan</td>
<td>DIOVAN</td>
</tr>
<tr>
<td>Irbesartan</td>
<td>AVAPRO</td>
</tr>
</tbody>
</table>

4.6.3 Angiotensin II Antagonist Combination

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valsartan/HCTZ</td>
<td>DIOVAN HCT</td>
</tr>
<tr>
<td>Irbesartan/HCTZ</td>
<td>AVALIDE</td>
</tr>
</tbody>
</table>

#### 4.7 Angiotensin Converting Enzyme Inhibitor/Calcium Channel Blocker

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amlodipine/Benazepril</td>
<td>LOTREL</td>
</tr>
</tbody>
</table>

#### 4.8 Antiadrenergic Agents-Centrally Acting

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine Patch</td>
<td>CATAPRES TTS</td>
</tr>
<tr>
<td>Guanfacine</td>
<td>TENEX</td>
</tr>
</tbody>
</table>
**4.9 Antiadrenergic Agents-Peripheral Acting**

- Tamsulosin  

**4.10 Alpha Blockers**

- Phenoxybenzamine  

**4.12 Diuretics**

**4.12.1 Loop Diuretics**

- Torsemide  

**4.12.2 Thiazide & Related Diuretics**

- Methyldihiazide/deserpine  

**4.13 Cholesterol Lowering Agents**

**4.13.1 HMG CoA Reductase**

- Fluvasatin  

**4.13.2 Other Cholesterol Lowering Agents**

- Niacin timed release  

**4.14 Miscellaneous Cardiovascular Drugs**

- Aspirin, Baby Aspirin  

---

**Chapter 5**

**RESPIRATORY MEDICATIONS**

**5.1 Antihistamines**

Consider OTC PRODUCTS as first line therapy

**5.1.1 Single-Entity Products**

- Fexofenadine  

- Loratadine  

- Cetirizine  

**5.1.2 Combination Products**

- Pseudoephedrine/Chlorpheniramine  

- Azatadine/pseudoephedrine  

**Lower Sedating Combination Antihistamines:**

- Acrivastine/pseudoephedrine  

- Fexofenadine/pseudoephedrine  

- Loratadine/pseudoephedrine  

**5.1.3 Nasal Antihistamines**

- Azelastine  

**5.2 Decongestant Products**

**5.3 Antitusives & Expectorants**

- Guaifenesin  

- Dextromethorphan  

- Hydrocodone/guaiifenesin  

- Hydrocodeone/phenylephrin/pyrilamine  

- Phenylephrine/CPM/hydrocodeone  

**5.4 Antiasthmatics**

**5.4.1 Adrenergic Stimulants-Inhalers**

- Metaproterenol  

- Piritrterol  

- Ipratropium & albuterol inh.  

- Albuterol  

- Formoterol fumarate  

- Salmeterol  

**5.4.3 Adrenergic Stimulants-Oral Tabs**

- Terbutaline  

---
Chapter 6
GASTROINTESTINAL MEDICATIONS

6.2 Antiulcer Drugs
6.2.1 H2 Antagonists
$$\text{Famotidine-OTC}\quad \text{PEPCID AC-OTC}

6.2.2 Proton Pump Inhibitors
$$\text{Lansoprazole}\quad \text{PREVACID}
$$\text{Pantoprazole}\quad \text{PROTONIX}

6.2.3 H. pylori treatments
$$\text{Ranitidine Bismuth Citrate}\quad \text{TRITEC}
$$\text{Lansoprazole, Clarithromycin, Amoxicillin}\quad \text{PREVPAC}

6.2.4 Other GI products
$$\text{Misoprostol}\quad \text{CYTOTEC}

6.3 Antiemetic
$$\text{Thiethylperazine}\quad \text{TORECAN}
$$\text{Scopolamine}\quad \text{TRANS-DERM SCOP}
$$\text{Ondansetron}\quad \text{ZOFRAN, ZOFRAN ODT}

6.4 Digestants
$$\text{Lipase/pancreas/amylose}\quad \text{COTAZYM, PANCREASE, VIOKASE, CREON}

6.5 Antispasmodics & Drugs Affecting GI Motility
6.6 Sulfonamide / Mesalamine Products
$$\text{Mesalamine CR}\quad \text{ASACOL}
$$\text{Mesalamine CR}\quad \text{PENTASA}
$$\text{Olsalazine sodium}\quad \text{DIPENTUM}
$$\text{Mesalamine}\quad \text{ROWASA}

Chapter 7
GENITOURINARY

7.1 Vaginal Antiinfectives
OTC PRODUCTS MAY BE USED AS FIRST LINE THERAPY
$$\text{Fluconazole}\quad \text{DIFLUCAN 150 TAB}
$$\text{Terconazole}\quad \text{TERAZOL}
$$\text{Clindamycin}\quad \text{CLEOCIN VAG CREAM}
$$\text{Metrodizole}\quad \text{METROGEL-VAGINAL}

7.2 Anticholinergic-Antispasmodics
$$\text{Tolterodine}\quad \text{DETROL}

7.5 Miscellaneous Genitourinary
$$\text{Doxazosin mesylate}\quad \text{CARDURA}
$$\text{Tamsulosin HCL}\quad \text{FLOMAX}
$$\text{Finasteride}\quad \text{PROSCAR}
$$\text{Sildenafil}\quad \text{VIAGRA (Covered according to plan design.)}
Chapter 8
CENTRAL NERVOUS SYSTEM

8.2 Antidepressants

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clomipramine</td>
<td>ANAFRANIL</td>
</tr>
<tr>
<td>Citalopram</td>
<td>CELEXA</td>
</tr>
<tr>
<td>Nefazodone</td>
<td>SERZONE</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>PAXIL</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>EFFEXOR, -XR</td>
</tr>
<tr>
<td>Bupropion</td>
<td>WELLBUTRIN, -SR</td>
</tr>
<tr>
<td>Sertraline</td>
<td>ZOLOFT</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>REMERON, -SolTab</td>
</tr>
</tbody>
</table>

8.3 Monoamine Oxidase Inhibitors

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tranylcypromine</td>
<td>PARNATE</td>
</tr>
</tbody>
</table>

8.5 Antipsychotics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loxapine</td>
<td>LOXITANE</td>
</tr>
<tr>
<td>Mesoridazine</td>
<td>SERENTIL</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>ZYPREXA</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>SEROQUIL</td>
</tr>
<tr>
<td>Risperidone</td>
<td>RISPERDAL</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>GEODON</td>
</tr>
</tbody>
</table>

8.6 Sedatives & Hypnotics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estazolam</td>
<td>PROSOM</td>
</tr>
<tr>
<td>Zaleplon</td>
<td>SONATA</td>
</tr>
<tr>
<td>Zopidem</td>
<td>AMBIEN</td>
</tr>
</tbody>
</table>

8.7 CNS Stimulants

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methylphenidate</td>
<td>METADATE ER /CD,</td>
</tr>
<tr>
<td>Dextroamphetamine</td>
<td>DEXEDRINE</td>
</tr>
<tr>
<td>Amphetamine mixture</td>
<td>ADDERALL</td>
</tr>
<tr>
<td>Pemoline</td>
<td>CYLERT</td>
</tr>
<tr>
<td>Modafinil</td>
<td>PROVIGIL</td>
</tr>
</tbody>
</table>

8.8 Other CNS Drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donepezil HCL</td>
<td>ARICEPT</td>
</tr>
<tr>
<td>Rivastigmine</td>
<td>EXELON</td>
</tr>
<tr>
<td>Galantamine</td>
<td>REMINYL</td>
</tr>
</tbody>
</table>

8.9 Smoking Deterrents: Coverage based on plan design.

- Nicotine- Transdermal, Inhaler & Nasal Spray
- NICOTROL, HABITROL

Chapter 9
ANALGESICS

9.1 Non-Narcotic Analgesics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butalbital/APAP/caffeine</td>
<td>ESGIC-PLUS</td>
</tr>
<tr>
<td>Butalbital/APAP</td>
<td>AXOCET</td>
</tr>
<tr>
<td>Tramadol HCL</td>
<td>ULTRAM</td>
</tr>
</tbody>
</table>

9.2 Narcotic Analgesics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butalbital/APAP/caffeine/codeine</td>
<td>FIORICET/CODEINE</td>
</tr>
<tr>
<td>Morphine S04 SR</td>
<td>KADIAN</td>
</tr>
<tr>
<td>Oxycodone HCL CR</td>
<td>OXYCONTIN</td>
</tr>
<tr>
<td>Fentanyl transdermal System</td>
<td>DURAGESIC, ACTIQ</td>
</tr>
</tbody>
</table>

9.3 Non-Steroidal Anti-Inflammatory Drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naproxen Enteric Coated</td>
<td>EC NAPROSYN</td>
</tr>
<tr>
<td>Diclofenac/misoprostol</td>
<td>ARTHROTEC</td>
</tr>
<tr>
<td>Diclofenac</td>
<td>VOLTAREN</td>
</tr>
<tr>
<td>Nabumetone</td>
<td>RELAFEN</td>
</tr>
</tbody>
</table>

9.3.1 Non-Steroidal Anti-inflammatory Drugs Cox-2 Inhibiting

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celecoxib</td>
<td>CELEBREX</td>
</tr>
<tr>
<td>Rofecoxib</td>
<td>VIOXX</td>
</tr>
</tbody>
</table>
9.4 Antirheumatics
$$ Penicillamine CUPRIMINE$$
$$ Hydroxychloroquine PLAQUENIL$$
$$ Auranofin RIDAURA$$
$$$$$$ Etanercept ENBREL**$$
$$$$$$ Leflunomide ARAVA$$
9.5 Drugs to Prevent and Treat Gout
$$ Ergotamine/caffeine CAFERGOT,$$$$
$$ Ergotamine tartrate ERGOMAR$$
$$ Almotriptan AXERT$$
$$ Naratriptan AMERGE$$
$$$$$$ Dihydroergotamine intranasal MIGRANAL SPRAY$$
$$$$$$ Zolmitriptan ZOMIG, -ZMT$$
$$$$$$ Sumatriptan injection/tablets IMITREX**$$

**Injectables are covered according to plan specifications

Chapter 10
NEUROMUSCULAR
10.1 Anticonvulsants
$$ Phenytoin DILANTIN$$
$$$$$$ Primidone MYOSOLINE$$
$$$$$$ Zonisamide ZONEGRAN$$
$$$$$$ Divalproex sodium DEPAKOTE$$
$$$$$$ Ethosuximide ZARONTIN$$
$$$$$$ Carbamazepine, SR TEGRETOL XR$$
$$$$$$ Gabapentin NEURONTIN$$
$$$$$$ Topiramate TOPAMAX$$
$$$$$$ Lamotrigine LAMICTAL$$
$$$$$$ Diazepam Rectal Gel DIASTAT$$
$$$$$$ Levetiracetam KEPPIRA$$
$$$$$$ Oxcarbazepine TRILEPTAL$$
10.2 Antiparkinson Drugs
$$$$$$ Pergolide PERMAX$$
$$$$$$ Ropinirole REQUIP$$
$$$$$$ Pramipexole MIRAPEX$$
$$$$$$ Tolcapone TASMAR$$
$$$$$$ Entacapone COMTAN$$
10.3 Skeletal Muscle Relaxants
$$ Dantrolene DANTRIUM$$
10.4 Anticholinesterase Muscle Stimulants
$$ Pyridostigmine MESTINON$$
10.5 Multiple Sclerosis Agents
$$$$$$ Glatiramer** COPAXONE**$$
$$$$$$ Interferon Beta-1B** BETASERON**$$
$$$$$$ Interferon Beta-1A** AVONEX**$$

**Injectables are covered according to plan specifications

Chapter 11
NUTRITIONAL PRODUCTS
11.1 Prenatal Vitamins
$$ Prenatal vitamins NIFEREX PN, PN FORTE$$
$$ Prenatal vitamins PRECARE$$
11.2 Vitamins
$$ Vitamin K MEPHYTON$$
$$ Calcitrol ROCALTROL$$
$$ Vit B12/Vitamin C CHROMAGEN$$
11.3 Minerals
$$ Sodium Fluoride LURIDE (tablets & drops)$$
11.5 Misc. Nutritional
$$$$$$ Levocarnitine CARNITOR$$
Chapter 12
HEMATOLOGICAL AGENTS

12.1 Hematopoetic

$ Vitamin A
$ Folic acid/B-12/iron
$ Leucovorin calcium (folinic acid)
$ Erythropoietin

12.2 Anticoagulant Drugs
$ Warfarin
$ Enoxaparin

12.3 Antiplatelet Drugs
$ Clopidogrel
$ ASA/ER Dipyridamole

12.3.1 Miscellaneous Antiplatelet Agents
$ Cilostazol
$ Anagrelide

** Injectables are covered according to plan specifications

Chapter 13
OPHTHALMIC MEDICATIONS

13.1 Alpha-adrenoceptor Agonists
$ Brimonidine Tartrate

13.2 Anti-inflammatory Agents

13.2.1 Non-steroidal Anti-inflammatory Drugs
$ Ketorolac
$ Diclofenac

13.3 Anti-allergic Agents
$ Ketotifen Fumarate
$ Levocabastine
$ Lodoxamine
$ Olopatadine HCL
$ Ketorolac

13.3.1 Ophthalmic Mast Cell Stabilizers
$ Nedocromil

13.4 Antimicrobial Agents

13.4.1 Antibiotics and Antibiotic Combinations
$ Ofloxacin

13.4.2 Antibiotic-Corticosteroid Combinations
$ Tobramycin & Dexamethasone

13.4.3 Antivirals
$ Trifluridine
$ Vidarabine

13.5 Artificial Tear Products/Lubricants

13.6 Beta-adrenoreceptor Antagonists
$ Betaxolol Suspension or Solution

13.7 Carbonic Anhydrase Inhibitors
$ Brinzolamide

13.8 Dilating Agents

13.10 Prostaglandins
$ Latanoprost

13.12 Prostaglandins
$ Bimatoprost
Chapter 14
EAR, NOSE AND THROAT MEDICATIONS

14.1 OTIC Antiinfectives
$$
Ofloxacin Otic
FLOXIN OTIC
$$

14.2 OTIC Steroid-Antiinfective Combinations
$$
Triethanolamine/ chlorobutanol
CERUMENEX
$$
Acetic Acid
VOSOL
$$

14.5 Corticosteroids, Inhaled Nasal
$$
Budesonide
RHINOCORT
$$
Beclomethasone dipropionate
VANCENASE, -AQ -DS BECONASE -AQ
$$
Fluticasone
FLONASE
$$
Mometasone
NASONEX
$$

14.6 Miscellaneous Nasal
$$
Cromolyn
NASALCROM
$$
Atrovent 0.03% Nasal Spray
ATROVENT 0.03% NASAL SPRAY

Chapter 15
DERMATOLOGICALS

All topical dosage forms of listed items are formulary items

15.1 Anti-Acne Medications
$$
Erythromycin benzoyl peroxide
BENZAMYCIN
$$
Azelaic acid 20%
AZELEX
$$
Tretinoin
RETIN-A
$$
Metronidazole
METROCREAM, METROLOTION, METROGEL
$$
Adapalene
DIFFERIN
$$
Isotretinoin
ACCUTANE
$$

15.2 Topical Antiinfectives
$$
Mupirocin
BACTROBAN
$$

15.3 Topical Antifungals
$$
Sulconazole nitrate
EXELDERM
$$
Clotrimazole
LOPRAX
$$
Econazole Nitrate
SPECTAZOLE
$$
Clotrimazole/ betamethasone
LOTRISONE
$$
Oxiconazole
OXISTAT
$$
Ketoconazole
NIZORAL
$$

15.4 Topical Antivirals
$$
Acyclovir
ZOVIRAX
$$

15.5 Topical Corticosteroids
GROUP I (VERY HIGH POTENCY)
$$
Diflorasone Diacetate
FLORONE, -E
$$
Augmented betamethasone dipropionate
DIPROLENE, -AF
$$
Diflorasone diacetate
PSORCON
$$
Halobetasol
ULTRAVATE
GROUP II (HIGH POTENCY)
$$
Halcinonide
HALOG, -E
$$
Triamcinolone acetonide
ARISTOCORT-HP
GROUP III (MEDIUM POTENCY)
$$
Alclometasone Dipropionate
ACLOVATE
$$
Flucinolone acetonide
DERMA-SMOOTHE
$$
Prednicarbate
DERMATOP
$$
Mometasone furoate
ELOCON

15.6 Topical Corticosteroids in Combination
$$
Hydrocortisone/pramoxine
EPIFOAM
$$

15.7 Scabicides/Pediculocides
Treatment of choice is OTC Nix
$$
Crotamiton
EURAX
$$

COMMONWEALTH REGISTER Volume 24 Number 10 October 30, 2002 Page 19730
<table>
<thead>
<tr>
<th>15.8 Anorectal</th>
<th>15.9 Anti-Psoriatics</th>
<th>15.10 Miscellaneous Topicals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permethrin</td>
<td>Anthralin</td>
<td>Ammonium lactate</td>
</tr>
<tr>
<td>Anorectal</td>
<td>Tazarotene gel</td>
<td>Salicylic Acid</td>
</tr>
<tr>
<td>Hydrocortisone Acetate</td>
<td>DRITHO-CREME</td>
<td>Aluminum Chloride</td>
</tr>
<tr>
<td>Hydrocortisone/pramoxine</td>
<td>TAZORAC</td>
<td>Fluorouracil</td>
</tr>
<tr>
<td>Hydrocortisone</td>
<td>Hydrocortisone intrarectal foam</td>
<td>Podofilox</td>
</tr>
<tr>
<td>Hydrocortisone/pramoxine</td>
<td>CORTIFOAM</td>
<td>Imiquimod</td>
</tr>
<tr>
<td>Hydrocortisone intrarectal foam</td>
<td>CORTENEMA</td>
<td>Masoprolol</td>
</tr>
<tr>
<td>Hydrocortisone retention enema</td>
<td>LAC-HYDRIN</td>
<td>Tacrolimus</td>
</tr>
<tr>
<td>Pramoxine</td>
<td>ANUSOL HC SUPP</td>
<td>PROTOPIC (Prior Authorization Required)</td>
</tr>
<tr>
<td>Hydrocortisone/pramoxine</td>
<td>PROCTO-CREAM HC</td>
<td>REGRANEX GEL</td>
</tr>
<tr>
<td>Hydrocortisone intrarectal foam</td>
<td>PROCTO-CREAM HC 2.5%</td>
<td></td>
</tr>
</tbody>
</table>
TROPICAL STORM (25W)

EMERGENCY DECLARATION NO. 01-2002

DATE: 09/27/2001

SUBJECT: Executive of the Commonwealth of the Northern Marianas' Emergency Operation Plan

WHEREAS, the Governor of the Commonwealth of the Northern Marianas declared readiness TROPICAL STORM CONDITION II for the Islands of ALAMAGAN AND AGRIHAN effective 1:00 P.M., SEPTEMBER 27, 2002; and

WHEREAS, in accordance with provisions of the Commonwealth of the Northern Marianas' Emergency Operation Plan, the declaration automatically puts into execution the operational portions of the Plan;

NOW, THEREFORE, pursuant to the executive powers vested in the Governor, it is directed that the operational portions of the CNMI Emergency Operation Plan be executed, effective 1:00 P.M., SEPTEMBER 27, 2002, on the islands of ALAMAGAN and AGRIHAN, continuing so long as required by the emergency situation.

PAUL A. MANGLONA
Acting Governor
Commonwealth of the Northern Marianas

Call Box 10007 Saipan, MP 96950  Telephone: (670) 664-2200/2300  Facsimile: (670) 664-2211/2311
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Juan N. Babauta
Governor

Diego T. Benavente
Lieutenant Governor

TROPICAL STORM HIGOS (25W)

EMERGENCY DECLARATION NO. 02-2002 DATE: 09/28/2001

SUBJECT: Executive of the Commonwealth of the Northern Mariana Islands’ Emergency Operation Plan

WHEREAS, the Governor of the Commonwealth of the Northern Mariana Islands declared readiness TROPICAL STORM CONDITION I for the Islands of ALAMAGAN AND AGRIHAN effective 1:00 A.M., SEPTEMBER 28, 2002; and

WHEREAS, in accordance with provisions of the Commonwealth of the Northern Mariana Islands’ Emergency Operation Plan, the declaration automatically puts into execution the operational portions of the Plan;

NOW, THEREFORE, pursuant to the executive powers vested in the Governor, it is directed that the operational portions of the CNMI Emergency Operation Plan be executed, effective 1:00 A.M., SEPTEMBER 28, 2002, on the islands of ALAMAGAN and AGRIHAN, continuing so long as required by the emergency situation.

PAUL A. MANGLONA
Acting Governor
Commonwealth of the Northern Mariana Islands
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Juan N. Babauta
Governor

Diego T. Benavente
Lieutenant Governor

TYPHOON HIGOS (25W)

EMERGENCY DECLARATION NO. 03-2002 DATE: 09/28/2001

SUBJECT: Executive of the Commonwealth of the Northern Mariana Islands’ Emergency Operation Plan

WHEREAS, the Governor of the Commonwealth of the Northern Mariana Islands declared readiness TYPHOON CONDITION I for the Islands of ALAMAGAN AND AGRIHAN effective 7:00 A.M., SEPTEMBER 28, 2002; and

WHEREAS, in accordance with provisions of the Commonwealth of the Northern Mariana Islands’ Emergency Operation Plan, the declaration automatically puts into execution the operational portions of the Plan;

NOW, THEREFORE, pursuant to the executive powers vested in the Governor, it is directed that the operational portions of the CNMI Emergency Operation Plan be executed, effective 7:00 A.M., SEPTEMBER 28, 2002, on the islands of ALAMAGAN and AGRIHAN, continuing so long as required by the emergency situation.

PAUL A. MANGLONA
Acting Governor
Commonwealth of the Northern Mariana Islands
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Juan N. Babauta
Governor

Diego T. Benavente
Lieutenant Governor

TYPHOON HIGOS (25W)

EMERGENCY DECLARATION NO. 04-2002

DATE: 09/28/2001

SUBJECT: Executive of the Commonwealth of the Northern
Mariana Islands’ Emergency Operation Plan

WHEREAS, the Governor of the Commonwealth of the Northern Mariana Islands
declared readiness ALL CLEAR CONDITION for the Islands of ALAMAGAN
AND AGRIHAN effective 7:00 P.M., SEPTEMBER 28, 2002; and

WHEREAS, in accordance with provisions of the Commonwealth of the Northern
Mariana Islands’ Emergency Operation Plan, the declaration automatically puts into
execution the operational portions of the Plan;

NOW, THEREFORE, pursuant to the executive powers vested in the Governor, it is
directed that the operational portions of the CNMI Emergency Operation Plan be
executed, effective 7:00 P.M., SEPTEMBER 28, 2002, on the islands of ALAMAGAN
and AGRIHAN, continuing so long as required by the emergency situation.

PAUL A. MANGLONA
Acting Governor
Commonwealth of the Northern
Mariana Islands