HEALTHCARE FUND (HF) REGULATIONS

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PART I. GENERL PROVISIONS

Section 101. Authority

The following rules and regulations are promulgated pursuant to and in accordance with the Administrative Procedure Act, as codified in 6 PNC §101 ff. and RPPL No. 8-14, as codified in Title 41, Chapter 9 of the PNC. These rules and regulations have been promulgated by the Republic of Palau Healthcare Financing Governing Committee (hereinafter "Committee") and shall have the force and effect of law.

[41 PNC § 908]

Section 102. Purpose and Scope

The purpose of these rules and regulations is to ensure effective and efficient implementation and administration of the National Healthcare Financing Act, RPPL 8-14 (HCFA) by its Committee and by the Social Security Administration, as the administrative agency mandated with the responsibility and duty of administering the provisions of the HCFA.

[Source 41 PNC § 908]

Section 103. Definitions

Unless otherwise provided, the definitions as set forth in 41 PNC § 702 and 41 PNC § 901 are incorporated in and made a part of these regulations by reference. Other definitions specifically applicable to these regulations are:

(1) Account holder. The individual identified as the owner of a particular medical savings account.

(2) Approved provider. An individual or organization that is licensed or otherwise officially recognized as meeting the required standards to provide and charge for medical care to others by the jurisdiction where the provider is located.

(3) Dependent. A spouse, child under the age of eighteen, or child under the age of twenty two who is a bona fide student, of the account holder.

(4) Designated beneficiary (or "beneficiary"). A dependent or other individual authorized to access an account holder's Medical Savings Account.

[Source 41 PNC § 901]

Section 104. To Whom Applicable

Unless contrary to the purpose and intent of the HCFA, these regulations are to be enforced by employees of the Social Security Administration and of the Ministry of Health of the Republic of Palau and shall be made available for public inspection upon request at the offices of the Social Security Administration during regular hours of operation.

[6 PNC §123]

Section 105. Uniformity

All provisions of these rules and procedures shall be interpreted and applied in a uniform, nondiscriminatory manner.

[Article IV, Section 5. ROP Constitution]

Section 106. Severability

If any provision of these rules and procedures or the application thereof is held invalid, the invalidity does not affect other provisions or applications of these rules and procedures which can be given effect without the invalid provision or application, and to this end the provisions of these rules and procedures are severable.

Section 107. Amendment

Any provision of these regulations may be amended consistent with the Administrative Procedures Act, as codified in 6 PNC §§101 ff.

Any person may request the adoption, amendment, or repeal of any of these regulations by submitting a written petition to the Committee specifying in detail the rule to be adopted, amended or repealed and the basis for such request.

Amendments to these regulations shall be consistent with statutes and with regulations adopted by the Ministry of Health and the Social Security Administration as they relate to administration of the HCFA.

Section 108. Sovereign Immunity

The Committee is a governmental entity, that when acting in its official capacity, is protected by the doctrine of sovereign immunity unless otherwise provided by statute.

Section 109. Effective Date

These rules and procedures shall take effect upon their approval by a majority vote of the Committee, consistent with the Administrative Procedures Act. All actions prior to the effective date of these rules and procedures shall not be subject to these newly promulgated rules and procedures.

Section 110. Record Keeping

The Administrator shall maintain records of all employees and of all contributors, including self employed persons for a minimum of ten (10) years. The Administrator shall maintain all other records in accordance to SSA Record Retention & Destruction Policy

Section 111. Availability of Records

All statistical information and reports routinely produced for administrative purposes shall be made available upon written request and upon payment of the costs of reproducing the report. Requests, other than requests for personally identifiable financial and medical information, and any other submissions shall be directed to the Administrator and shall generally be made available upon written request and upon payment of the costs of gathering and reproducing the information.

[6 PNC §121(a)]

Section 112. Information or Records Not Publicly Available

(1) Personally identifiable financial and medical information shall be kept confidential and may only be released with the express written consent of the subject of the information as indicated by his or her signature on the form approved for that purpose. No written consent shall be valid for more than one year.

(2) If the individual is a minor, only the express written consent of a parent with custody or a court-appointed guardian will be accepted for the purpose of releasing financial or medical information on the individual.

(3) If the individual is adjudged incompetent, only the written authorization of a court appointed guardian will be accepted for the purpose of releasing financial or medical information on him or her.

(4) Personally identifiable financial and medical information may be released for the purposes of the functions and operations under the HCFA. For example, the funds available in a medical savings account may be transmitted to and from the Ministry of Health and the individual's treatment providers.

(5) Personally identifiable financial and medical information including a Medical Number, may also be released to any person as required by court order from a duly recognized jurisdiction and as otherwise authorized by the Committee.

[41 PNC §960]

PART II. ORGANIZATION

Section 201. Governing Law

The provisions of the HCFA, as may be amended from time to time, and these regulations govern the administration of the HCFA.

Section 202. Formation of the Healthcare Financing Committee

(1) The Committee is established to administer the HCFA, except for investments, which are within the exclusive authority of the Social Security Board.

(2) Its membership consists of the Minister of Finance or his or her designee, the Minister of Health or his or her designee, the Social Security Administrator, one representative appointed by the Governor's Association, and one representative appointed by the Chamber of Commerce.

(3) Committee members shall elect one member to be Chairman and another to be Vice Chairman at the first meeting. Subsequent elections shall take place whenever another individual becomes a member of the Committee or after two years,

(4) whichever comes first.

[41 PNC §§ 901 and 907]

Section 203. Chairman of the Board

The Chairman shall preside over all meetings of the Committee and shall sign all contracts, deeds, and other instruments unless otherwise authorized by the HCFA, these regulations, or as designated by the Chairman.

Section 204. Vice Chairman of the Board

The Vice Chairman shall perform the duties of the Chairman in the absence of the Chairman. In the case of dismissal, resignation, or death of the Chairman, the Vice Chairman shall serve as Chairman until a new Chairman is elected by a majority of the membership.

Section 205. General Powers of the Committee

The Committee provides, maintains, operates, and reports on the financial sound healthcare systems established by the HCFA and provides an orderly means to finance and deliver comprehensive healthcare coverage to the people of the Republic of Palau.

[41 PNC §908(a)]

Section 206. Fiduciary Duties

Members of the Committee shall be expected to conduct themselves with the highest standard of care and loyalty in performing their duties.

Section 207. Memorandum of Understanding

A Memorandum of Understanding among the Ministry of Finance, Ministry of Health and the Social Security Administration shall address coordination of the following functions:

(1) The duties and responsibilities of each of the agencies when operating under the HCFA;

(2) Producing an annual report within 90 days after the end of each fiscal year to the President of the Republic of Palau, the President of the Senate, and the Speaker of the House of Delegates of the Olbiil Era Kelulau detailing the financial status of the Fund, its investments, MSA participation, medical care utilization, and other matters as requested; and,

(3) Coordinating any other activities among the agencies necessary to meet the objectives of the HCFA.

[41 PNC §§911 & 912]

Section 208. Duties and Responsibilities of the Committee

The Committee exercises and performs the following powers and duties in the name of the Medical Savings Account (MSA) and National Health Insurance (NHI) of the Republic of Palau:

(1) transact any business;

(2) enter into any contracts for management, medical or ancillary service providers, third party administrators, auditing, actuarial, investment, legal, or any other advice or services;

(3) issue subpoenas and administer the oaths appropriate for the administration of the two plans;

(4) bond any employee of the Administration in such cases and in such amounts as necessary;

(5) have the authority to promulgate by-laws, procedures, policies, or rules and regulations, which shall have the force and effect of law, necessary to carry out any duty, operation, or function as required under this Act;

(6) carry out adjudicative proceedings;

(7) maintain bank accounts and a bank overdraft for the normal operations; and

(8) delegate any power, function, duty, or responsibility as necessary to ensure the administration and operation of the two plans and funds.

(9) to assure that any and all HCFA functions being performed by external entities are being performed in the best financial interest of the Health Care Fund and its MSA/NHI members whether performed by other government agencies through a Memorandum of Understanding, by a contracted Consultant or Third Party Administrator or otherwise.

(10) approve recommendations, official documents, and other actions that require approval by the Committee.

[41 PNC §908]

Section 209. Meetings, Official Action of the Committee

(1) The Minister of Finance, Minister of Health, and Social Security Administrator shall call the first meeting of the Committee. Subsequently, the Committee shall meet at the call of the Chairman or a majority of the members of the Committee. The time and place of such meeting shall be designated by the Chairman.
(2) Three (3) members of the Committee shall constitute a quorum for the purposes of conducting business and exercising its powers and for other purposes. A majority vote of members present shall be required for any decision by the Committee. Minutes of all meetings shall be recorded.
(3) The minutes of each meeting shall be recorded by the Secretary or a person designated by the Chairman. The minutes shall be prepared for distribution at least two (2) days prior to the next Committee meeting. Such minutes and recordings shall be kept by the Board for a minimum of ten (10) years for record keeping purposes.

[Sections 210 through 219 Reserved for future use]

Section 220. Administrator

The Social Security Administrator (Administrator) shall be responsible for the general day-today administration and operation of the healthcare financing system. In addition, the Committee may delegate, by written instrument, to the Administrator such powers, duties and responsibilities as are necessary and proper to carry out the effective and proper operation of the healthcare financing system.

[41 PNC §909(a)]

Section 221. Duties of Administrator

The Administrator shall be delegated duties and responsibilities which shall include, but are not limited to, the following:

(1) To oversee the general administration of the HCFA and to carry into operation the goals objectives, and policies established by the HCFA and the Committee;
(2) To oversee and direct the day-to-day activities and operation of the HCFA including the direction and supervision of all of the administrative and technical activities; this includes the activities performed by other government agencies through a Memorandum of Understanding or activities by a contracted Consultant or Third Party Administrator and to recommend to the Committee, any amendments, terminations or replacements of such agreements.
(3) To select, hire, terminate and discipline employees at his or her discretion, but subject to such personnel guidelines and procedures as may be promulgated by the Committee;
(4) To contract for professional (including legal, auditing, and accounting), technical, and advisory services, and to plan, organize, coordinate, and control the services of such employees and independent contractors subject to such guidelines and procedures as may be adopted by the Social Security Board or the Committee;
(5) To attend, unless excused by the Committee, all meetings of the Committee and submit reports on the affairs of the MSA/NHI as requested;
(6) To keep the Committee advised on the needs of the MSA/NHI;
(7) To ensure that all rules, procedures, policies, and by-laws are enforced;
(8) To receive and maintain all files and records including those of all employers and all employees subject to 41 PNC, Chapter 9, these regulations, and all other applicable regulations and laws;
(9) To make available for public inspection all rules and all other written statements of policy or interpretations formulated, adopted, or used and all final orders, decisions, and opinions of general applicability or effect upon the public;
(10) To audit records, issue subpoenas and administer oaths appropriate to the administration of the MSA/NHI;
(11) To furnish an annual report and audited statement of accounts to the President and the Olbiil Era Kelulau within ninety (90) days of books closing;
(12) To institute whatever legal proceedings he or she shall deem necessary and proper to collect delinquent contributions and interest due and owing to the MSA from any employer or to collect any other sums owed to the MSA/NHI;
(13) To maintain bank accounts as deemed necessary for the purposes of administration of the HCFA, including the establishment of a separate bank account in a bank that is FDIC insured for all monies used to fund operations;
(14) To hold hearings and make decisions in accordance with 41 PNC, Chapter 9 and these regulations for the purpose of determining any question involving any right, benefit, or obligation of any person subject to 41 PNC, Chapter 9;
(15) To make proper adjustments whenever an error has been made; provided, however, that no adjustment shall be made when adjustment or recovery would be contrary to law;
(16) To make recommendations to the Committee for legislation to improve the MSA/NHI and to directly lobby the Olbiil Era Kelulau to enact such legislation;
(17) To annually formulate a list of specific goals and objectives for the MSA/NHI for review by the Committee; and
(18) To perform such other and additional duties as may be required or delegated by the Committee.
(19) To contract with medical and ancillary providers including other medical facilities such as hospitals and surgical centers or third party administrators as necessary.

(20) To attend and assist in the affairs of the Medical Referral Committee and to certify to such committee that each case, at the time of referral, meets the provisions of the HCFA and its regulations.
(21) To develop and issue Benefit and Policy Interpretation Bulletins (hereinafter "BIPS") when more detail or clarification is needed over time. The BPIS are to be used as guides by the Plan and its providers to make coverage and policy determinations under the Plan.

[6 PNC §122 and 41 PNC §§909, 911, & 959]

Section 222. Delegation by Administrator

The Administrator may, by written instrument, delegate to any employee any of his or her powers and functions under 41 PNC, Chapter 9 and these regulations. A delegation is revocable, in writing, at will. It may apply to the whole of the Republic of Palau or in part and is subject to such limitations and conditions as deemed proper and necessary by the Administrator. No delegation made by the Administrator prevents the exercise of performance of a power or function by the Administrator.

[41 PNC §909(c) & 725]

Section 223. Budget

The Administrator shall prepare and submit to the Social Security Board, the Committee and to appropriate authorities, on forms and in the manner and at such times as may be prescribed, or in such form as the Administrator deems proper, a detailed budget estimate and the amount required to be appropriated for the next ensuing fiscal period, from October 1st through September 30th of the following year, for proper operations including:

(1) the audited accounts for the prior fiscal year;
(2) a statement showing the estimates of contributions, other income, and expenditures for the fiscal year in progress, together with any summaries, schedules, and supporting information deemed necessary; and,
(3) a budget showing the estimated income and expenditures for the next fiscal year.

[41 PNC §909(e)]

Section 224. Audits, Accounts & Reports

The Administrator shall maintain accounts and records relating to all funds and transactions under the HCFA. Such accounts and records shall be subject to audit by an independent auditor appointed by the Social Security Board.

[41 PNC §958(a)]

Section 225. Actuary

The Social Security Board and Committee shall jointly appoint an Actuary, who meets the requirements developed and agreed to by the Social Security Board and the Committee, on terms and conditions as agreed upon in writing between the Administrator and the Actuary. Any report submitted to the Social Security Board following an actuarial valuation shall also be submitted to the Committee, to the Olbiil Era Kelulau and to the President of the Republic of Palau, with any appropriate recommendations for changes or amendments.

[RPPL 8-14, Section 4(b)]

Section 226. Auditor

(1) The Social Security Board and Committee shall jointly appoint an independent auditor, who meets the requirements developed and agreed to by the Social Security Board and the Committee, on terms and conditions as agreed upon in writing between the Administrator and the Auditor. The auditor shall audit the accounts within ninety (90) days after the end of each fiscal year.

(2) The Administrator shall, as soon as practicable, submit the accounts and the Auditor's report to the Olbiil Era Kelulau and the President of the Republic of Palau. The accounts and report shall also be made available to the general public upon request.

(3) The Administrator shall receive any annual reports from the Public Auditor on the financial balance of the MSA and provide such reports to the Committee and the Social Security Board.

[41 PNC §958]

Section 227. Legal Counsel

The Administrator is encouraged to employ a full or part-time attorney to advise and handle legal affairs. However, if for any reason the Administrator is unable to employ a private, in-house attorney, the Attorney General's Office shall provide legal services upon request.

[41 PNC §909(a)]

Section 228. Professional Services

The Administrator may contract for professional (including legal, auditing, and accounting), technical, and advisory services on behalf of the MSA/NHI. All contracts for professional services shall be in writing and clearly indicate: (1) the work the professional is contracted for; (2) the course of action the Committee has agreed to take; (3) a statement that the professional has no conflicts of interest in pursuing any matter under the contract; and (4) the compensation the professional is to receive. The Administrator shall require such contract professionals to submit written summaries of the status of the work at regular intervals. At the completion of such professional services, the Administrator shall obtain all files, documents, work product, or other instruments that are the Administration's rightful property.

[41 PNC §§908 & 909]

PART III. GENERAL BENEFITS

Section 301. General Eligibility

(1) General MSA Eligibility. All employed and self-employed individuals shall contribute to an MSA for the benefit of that account holder and his or her spouse and dependent children, if any, and in accordance with regulations established by the Social Security Administration. In addition, the account holder may designate additional beneficiaries for his or her MSA, in accordance with regulations established by the Social Security Administration or the Committee.

(2) NHI Eligibility for Employed Persons and Their Dependents. All account holders and their dependents shall be eligible for coverage under NHI based on the deduction of the subscription costs from the account holder's MSA in accordance with these regulations.

(3) NHI Eligibility for Individuals age 60 and Over, Disabled or Unemployed. Citizens who are 60 and older and not working; citizens who are disabled and not working; and citizens who are currently unemployed shall be eligible for coverage under NHI based on the payment of subscription costs by the National Government or any other government entity.

(4) NHI Eligibility for All Other Permanent Residents. All other individuals who are permanent residents of Palau may enroll for coverage under NHI in accordance with these regulations.

[41 PNC §§917(b), 918(b), 951, and 952]

Section 302. Eligibility on More than One MSA

An individual may be a designated beneficiary on more than one MSA. Payments shall first be deducted from the MSA where the individual is the account holder and then shall be deducted from any MSA where the individual is a spouse and mandatory designated beneficiary. Last, payments shall be deducted from any other MSA where the individual is a designated beneficiary.

[41 PNC §940]

Section 303. Income Guidelines for Co-payments and Use Schedules

(1) The committee shall develop a Schedule of Benefits for MSA/NHI based on negotiated fee schedules established with medical providers. The Sliding Fee Schedule adopted by the Minister of Health, in effect on the date RPPL 8-14 was enacted, shall be used to establish the amounts that may be authorized by the covered individual to be deducted from his or her MSA account.

(2) In addition, the Cost Schedule adopted by the Minister of Health, in effect on the date RPPL 8-14 was enacted, shall be considered when the Committee establishes a Reimbursement Schedule containing the amounts approved for reimbursement for a covered service under NHI.

(3) The amounts established in the Sliding Fee Scale and Reimbursement Schedule may be amended from time to time, with the approval of the Committee.

[41 PNC §939(b)]

Section 304. Retroactive Payments

No payments shall be made from any MSA or under NHI for expenses incurred or services performed prior to the date an individual's eligibility begins.

[41 PNC §§939 & 955b]

PART IV. MEDICAL SAVINGS ACCOUNTS

Section 401. When Funds Available

(1) Funds held within an MSA shall become available for use by the account holder and his or her designated beneficiaries no later than the beginning of the first full calendar quarter after the month in which the contributions were paid by the employer.

(2) When the account holder changes his or her designation of beneficiaries, the funds within that MSA account shall become available for use to all beneficiaries a day after a change has been made. However, if the reported change is made within thirty (30) days of the end of a calendar quarter, the change shall not take effect until the beginning of the second calendar quarter after the report is made.

[41 PNC §§918(b) & 940]

[Section 402 Reserved for Future Use]

Section 403. Order of Priority for Payment from an MSA

After the subscription cost for NHI for the account holder and his or her spouse and dependents are deducted, other payments requested to be made from an MSA by the account holder and designated beneficiaries shall be made in the following order of priority during each calendar quarter:

(1) Subscription cost for NHI for any other designated beneficiary, which is not covered by that designated beneficiary's own MSA;

(2) Private health insurance premiums for the account holder and his or her spouse and dependents;

(3) Private health insurance premiums for any other designated beneficiary, which is not covered by that designated beneficiary's own MSA;

(4) Payment for covered services as defined in Section 507 provided by BNH to the account holder, in the order service was provided, and then provided by BNH to his or her spouse and dependents, in the order service was provided;

(5) Payment for covered services as defined in Section 507 provided by BNH for any other designated beneficiary, in the order service was provided, which is not covered by that designated beneficiary's own MSA;

(6) Payment for covered services as defined in Section 507 provided by any other approved on-island provider for the account holder and his or her spouse and dependents, in the order the service was provided;

(7) Payment for covered services as defined in Section 507 provided by any other approved on-island provider for any other designated beneficiary, which is not covered by that designated beneficiary's own MSA, in the order the service was provided; and,

(8) Any other payment for covered services as defined in Section 507, in the order service was provided.

[41 PNC §§939(b) & 952(b)]

Section 404. Payment of Premiums for Private Health Insurance Coverage

(1) An account holder may authorize payment of premiums for private health insurance coverage for him or herself, dependents and other designated beneficiaries from his or her MSA by submitting a written request to the HF on the form approved for that purpose. Upon receiving the written authorization, the Administrator shall request that the private health insurer submit a request for payment for the premium to the HF. The HF shall then make payment to any insurer who agrees to accept such payment, for all premiums authorized by account holders.

(2) A withdrawal of this authorization shall be submitted in writing by the account holder on the form approved for that purpose and shall take effect for the next regularly scheduled payment after the written withdrawal is received by the HF.

(3) If the insurer does not agree to accept payment of premiums from the 10 within thirty days of the request, the HF shall provide written notification to the account holder and shall not make any payment to the insurer.

(4) The HF shall not submit payment to an insurer unless the insurer agrees in advance, in writing, to accept such payment and submits a request for payment directly to the HF on a form approved for that purpose.

(5) The HF shall not reimburse the account holder, an employer, or any other person for premiums already paid to an insurer and shall not pay a premium to anyone other than directly to the insurer.

(6) The HF may enter into agreements with companies providing health insurance coverage on Palau governing payment of premiums under this section.

[41 PNC §939]

Section 405. Payments to Ministry of Health

The account holder or any designated beneficiary may authorize a payment to BNH in writing on a form approved for that purpose for any healthcare service not excluded by these regulations. Upon receipt of proof of providing the covered service and the authorization for payment using the form approved for that purpose, including electronic transmission of the proofs, the HF shall pay BNH the approved amount for that covered healthcare service. Authorized payments from MSAs to BNH may be aggregated and paid as may be determined by agreement of the Ministry of Health and the Administrator.

[41 PNC §939]

Section 406. Payments to Other Providers on Palau and Outside of Palau

The account holder or any designated beneficiary may authorize payment in writing using a form approved for that purpose for any healthcare service not excluded by these regulations to other approved providers on Palau. The approved provider shall submit a request for payment to the HF for all covered services, which includes proof of providing the covered service and the authorization for payment, on a monthly or quarterly basis using a form approved for that purpose. The HF shall pay the approved provider on a monthly or quarterly basis, as agreed by the provider and the HF. However, the amount paid for the covered service shall not exceed the amount that is deemed Usual, Customary, or Reasonable for that service.

[41 PNC 957(a) (b)]

Section 407. Limitations on Withdrawals

(1) If an account holder or any designated beneficiary authorizes payment from an MSA for services not covered or not from an approved provider, the HF shall advise the account holder and the provider that payment is not approved.

(2) The HF shall not withdraw funds from an MSA unless authorized in writing by the account holder or a designated beneficiary.

(3) The HF shall not withdraw funds from an MSA account if the withdrawal results in a negative balance in the MSA.

PART V. NATIONAL HEALTH INSURANCE BENEFITS

Section Summary of Plan Description.

(1) Part V and its SubParts and sections contained herein, is a summary plan description of the National Health Insurance Plan (hereinafter "Plan"). This summary explains what health services are covered and not covered, and what portion of the health care costs a covered individual will pay and what portion the Plan will pay. It also explains many of the rights, obligations, and conditions between covered individuals and the Plan.

(2) The Plan Administrator will develop and issue Benefit and Policy Interpretation Bulletins over time when more detail or benefit clarification is needed. The BPIBs are to be based upon: (a) available publications relating to coverage determinations; (b) applicable laws and regulations; (c) research, studies and evidence from other sources and (d) the practicalities of providing healthcare services to the citizens of Palau. The BPIBs are intended to be modified as technologies, capabilities, cost structures, and financial pictures change, or when further clarification to benefits and policies are needed.

[41 PNC §55 (c)]

SubPart A TERMS, CONDITIONS & PROVISIONS

Section 502. Terms, Conditions and Provisions

(1) Benefit Period is the period of one year starting on October 1st and ending September 30th of each year. If a Covered Service commenced prior to September 30th and treatment ended after September 30th, the entire Covered Service will be part of the prior Benefit Period.

(2) Member Cost Share
For certain Covered Services, a covered individual may be required to pay a part of the Maximum Allowed Amount as a cost share amount (for example, Deductible, Copayment, and/or Coinsurance).
The Deductibles, Copayments and Coinsurance for the type of Covered Services is outlined on the Plan's Schedule of Benefits in Section 509. Some Covered Services do not require any deductible, copayment or coinsurance.
(a) Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which the covered individual must pay for before the Plan will pay for those Covered Services in each Benefit Period.
(b) Coinsurance – A specific percentage of the Maximum Allowable Amount for a Covered Services a covered individual must pay. Coinsurance normally applies after the Deductible
(c) Copayment – A specific dollar amount of the Maximum Allowable Amount for a Covered Service which a covered individual must pay. The Copayment normally applies after the Deductible. The Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowable Amount.

(d) Out of Pocket Limit – A specified dollar amount of expense incurred by a covered individual for Covered Services as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a covered individual, then no additional Coinsurance, or Copayments are required for that person unless otherwise specified in the Schedule of Benefits.

(3) Maximum Allowable Amount / Allowed Amount / Usual-Customary-Reasonable Charges (UCR)

The Plan's payments for Covered Services will be based on the Maximum Allowable Amount. This is the amount that the Plan determines is the maximum payable for each Covered Service.

The Maximum Allowable Amount or UCR is the lesser of the actual charge or first applicable amount below:

(a) the amount the Plan pays a provider under a contract with that provider; or

(b) the amount the Plan pays a contracted provider for the same services in a similar location, or

(c) the amount the U.S. Centers for Medicare and Medicaid Services reimburses its participating providers for the same service or supplies in the same geographical U.S. area; or

(d) if none of the above apply, the amount the Plan determines as a fair amount. This amount will be based on any information source available and will reflect the complexity or severity of treatment, the level of skill and experience required for the treatment, and comparable providers' fees and costs in the geographical area to deliver care.

(4) Notice of Claim & Proof of Loss

The Plan is not liable under unless it receives written notice that Covered Services have been rendered. The notice must be submitted within 90 days of receiving the Covered Services, and must have the data needed to determine benefits.

(5) Member's Cooperation

By virtue of enrollment under the Plan, each covered individual agrees to complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under any other insurance, benefit plan or other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

(6) Physical Examination

When a claim is pending, the Plan reserves the right to request a covered individual to be examined by an appropriate Provider. This will be requested as often as reasonably required.

(7) Plan's Sole Discretion

The Plan may, as approved by its Referral Committee, cover services and supplies not specifically covered. This will apply if it is determined that such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a covered individual.

(8) Recovery of Overpayments

If a benefit payment is made by the Plan, which exceeds the benefit amount entitled, the Plan has the right to require the return of the overpayment; deduct from an account holder's MSA, or to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family. Such right does not affect any other right of recovery with respect to such overpayment.

[41 PNC §55 (c)]

SubPart B. ELIGIBILITY & ENTITLEMENT

Section 503. When Coverage Begins

(1) Initially, NHI coverage shall begin April 1, 2011 for those individuals who pay subscription costs for both the October-December 2010 and January-March 2011 quarters.

(2) NHI coverage shall begin on the first day of the first calendar quarter following two full, consecutive quarters of payment of the subscription costs, for individuals who were not eligible under subsection (1) above, such as those who did not earn remuneration during both the October-December 2010 and January-March 2011 quarters.

(3) Initially, NHI coverage shall begin on April 1, 2011 for individuals eligible based on payment of subscription costs by the National Government, provided the individual was eligible for payment of subscription costs by the National Government for both the October-December 2010 and January-March 2011 quarters.

(4) NHI coverage shall begin on the first day of the first calendar quarter following two full, consecutive quarters of payment of the subscription costs by the National Government, for nonworking elderly, nonworking disabled, and currently unemployed who were not initially eligible under subsection (3) above. For example, an eligible individual who was not age 60 until January 2011 and did not otherwise pay subscription costs beginning in the October-December 2010 quarter will not have coverage beginning on April 1, 2011. His or her coverage shall begin on July 1, 2011, at the earliest, based on payment of subscription costs by the National Government unless coverage under government has been retroactively paid to allow immediate coverage.

(5) NHI coverage shall begin on April 1, 2011 for individuals who pay for two full, consecutive quarters, based partly on subscription costs paid by the National Government and partly based on deductions from an MSA during the October-December 2010 and January-March 2011 quarters.

(6) Self Employed Individuals may only enroll at the beginning of a Benefit Period.

[41 PNC §§955(b)]

Section 504. **Amount of Subscription Costs**

(1) On a quarterly basis, or more often as agreed between the National Government and SSA, the National Government shall pay 2.25 % of the mean annual remuneration, as determined by the HF Governing Committee, in subscription costs for coverage for each eligible individual citizen.

(2) For employees and for the self-employed, the amount shall be 2.25% of remuneration, as defined by the Social Security Act.

(3) An individual who does not have payments withheld through employment or paid by the National Government, may report and pay the subscription costs quarterly to the HF using the form provided for that purpose to obtain coverage for him or herself beginning no earlier than October 1, 2010. The subscription cost for an individual under this subsection (3) shall be 2.25% of the official minimum wage at the time the report is filed and payment is made.

[41 PNC §952]

Section 505. When Coverage Ends Under NHI

(1) Covered Individuals may be Terminated from the Plan for the following reasons:
   (a) Following two quarters of non-payment of subscription fees. The Termination Date will be the last day for which subscription fees had been paid.
   (b) Upon notice from the Administrator to an Account Holder that an individual(s) does not meet the eligibility requirements of the Plan. The Termination Date shall be no less than thirty days from the date of such notice.

(2) If a Covered Individual is Terminated due to (1)(a) above and becomes a Covered Individual again due to employment or self-employment, that Covered Individual will be treated as a newly Covered Individual under the Plan.

[41 PNC§952(f)]

Section 506. Dependents

(1) To be eligible to enroll as a Dependent, one must be:

   (a) The Account holder's Legal Spouse.

   (b) The Account holder's Domestic Partner: Domestic Partnership means a person of the opposite sex who has signed the Domestic Partner Affidavit certifying that: he or she is the sole Domestic Partner and has been for twenty-four (24) months or more; he or she is at least eighteen (18) years old; he or she is mentally competent; is not related by blood closer than permitted by law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the account holder.

   For purposes under the Plan, a Domestic Partner shall NOT be treated the same as a Legal Spouse, and the children of a Domestic Partner who are not the account holder's children are not eligible for coverage. A Legal Spouse may be covered immediately after marriage. A Domestic Partner may only begin coverage at the beginning of a Benefit Period.

   (c) The Account holder's or the account holder's Legal Spouse's children under the age of twenty-two (22), including natural children, stepchildren, newborn and legally adopted children.

   (d) Children under the age of twenty-two (22) for whom the Account holder or the Account holder's Legal Spouse is the legal guardian or as otherwise required by law. Legal Guardianship must be for "Full Guardianship" and must not be limited or shared.

(e) A child of a covered Dependent (i.e., a grandchild of the covered Account holder or the Account holder's covered Legal Spouse) until the Dependent child (not the grandchild) reaches age twenty-two (22).

(f) An unmarried Dependent who cannot work to support themselves due to mental or physical disability. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within thirty (30) days after the Dependent would normally become ineligible.

(2) To obtain coverage for children, The Plan may require that the Account holder complete a "Dependency Affidavit" and/or provide the Plan with a copy of any documents The Plan may require such as court documents, birth certificates, marriage certificates, or tax filings.

[41 PNC §55 (c)]

SubPart C. COVERED & NON-COVERED SERVICES and APPLICABLE

Section 507. Covered Services

(1) This section, along with Section 550 – "Limitations & Exclusions" , outlines health care services for which the Plan will and will not provide Benefits. All Benefits and Covered Services are subject to the Deductibles, Coinsurance, Copayments, Maximums, exclusions, limitations, terms, conditions and provisions as shown on the Schedule of Benefits of Section 509 and in these regulations.

Benefits for Covered Services are based on the Maximum Allowable amount. To receive maximum Benefits for Covered Services, a covered individual must follow the terms set forth in these regulations including obtaining any required pre-approvals.

To be covered, the service must be medically necessary. "Medically necessary" means health care services or products provided to an covered individual for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is (a) Consistent with generally accepted standards of medical practice; (b) Clinically appropriate in terms of type, frequency, extent, site and duration; (c) Demonstrated through scientific evidence to be effective in improving health outcomes; (d) Representative of "best practices" in the medical profession; and (e) Not primarily for the convenience of the covered individual or physician or other health care practitioner.

(2) Health Services

Not all the benefits outlined are covered under the National Health Insurance Plan or reimbursable under account holders' Medical Savings Accounts. Applicability or coverage of benefits are dependent on (a) Each Service, (b) If the service was rendered in Palau or Off-island, (c) If it pertains to NHI or MSA. The Schedule of Benefits in Section 509 specifies the details of each service.

Health Services include:

(a) Office Visits and Doctor Services
(b) Inpatient Hospital Services
(c) Alternatives to Inpatient Hospital Stays which includes Skilled Nursing Facility (SNF),
(d) Home Health Care and Hospice Care
(e) Emergency Care
(f) Outpatient Diagnostic Services
(g) Prescription Drug Benefit
(h) Preventive Care Services
(i) High Level Therapy Services
(j) Short-Term Outpatient Rehabilitation Therapy Services
(k) Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies
(l) Transportation Services including Ground Ambulance and Air transportation
(m) Wellness and Disease Management
(n) Transplant Services

A more detailed explanation of each Health Service above is contained in the initial Schedule of Benefits attached to these regulations.

Section 508. Covered Services at BNH

(1) The Plan will not reimburse BNH for any capital costs or costs of personnel employed by the Ministry of Health.
(2) The cost of inpatient medical services to be reimbursed to BNH is determined by applying the most recent Reimbursement Schedule. The Reimbursement Schedule shall be established by agreement of the Minister of Health, Minister of Finance and Administrator as a supplement or annex to the Memorandum of Understanding and may be amended from time to time.
(3) Covered services at BNH includes other professional services, supplies, appliances, equipment, drugs or biologicals provided by a third party provider and not directly from BNH.

Section 509. Schedule of Benefits

Schedule of Benefits	In Palau	Off-island	MSA
Coverage Maximums	Unlimited	$35,000 per member per year	Up to MSA Balance
Out-of-Pocket Maximum (OOP Max)			
Inpatient Hospital Stays	Up to $400 based on Income	Up to $4,000 based on Income	N/A
Hospital Expenses	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Subject to OOP Max Pre-approval Required	Payable
Room and board;			
Use of intensive care or special care units;			
Diagnostic Services;			
Medical, surgical, and central supplies;			
Treatment services;			
Hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, occupational therapy, physical therapy, speech therapy, inhalation therapy, cardiac rehabilitation, and radiotherapy services;			
Oxygen and oxygen therapy;			
Medication used when you are an Inpatient, such as drugs, biologicals, and vaccines;			
Newborn care, including routine well-baby care;			
Discharge Planning;			
Physician Services:			
In-patient (as part of Hospital Bill)			
In-patient (Billed Separately)			
Alternative to Hospital Stays and Services			
	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Subject to OOP Max Pre-approval Required	Payable
Out-patient Surgical Center			
Home Healthcare			
Skilled Nursing Facility			
Hospice			

Schedule of Benefits	In Palau	Off-island	MSA
Emergency Care			
Emergency Room Services	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Notification Required ASAP	Payable
Non-emergency care at an Emergency Room	80% of Covered Charges Subject to OOP Max	Not Covered	Payable
Urgent Care Services	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Notification Required ASAP	Payable
Physician Services Outpatient Consultations Specialty Consultations	Not Covered	80% of Covered Charges Subject to OOP Max Additional Pre-approval Required*	Payable
Diagnostic Testing			
Outpatient Diagnostic Lab Work and Radiological Services	Not Covered	80% of Covered Charges Subject to OOP Max Additional Pre-approval Required*	Payable
Major Outpatient Diagnostic Testing (see list)	Not Covered	80% of Covered Charges Subject to OOP Max Additional Pre-approval Required*	Payable
Prescription Drugs (Pharmacy)			
Formulary Generic Drugs	Not Covered	Not Covered	Payable
Formulary Brand Name Drugs	Not Covered	Not Covered	Payable
Non-Formulary Drugs	Not Covered	Not Covered	Payable
Specialty Drugs	Not Covered	Not Covered	Payable
Preventive Care	100% of Covered Charges Limited only to Certain Services	Not Covered	Payable
Specialized Outpatient Therapy			
Radiation	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Subject to OOP Max Additional Pre-approval Required*	Payable
Chemotherapy	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Subject to OOP Max Additional Pre-approval Required*	Payable

Schedule of Benefits	In Palau	Off-island	MSA
Infusion Therapy	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Subject to OOP Max Additional Pre-approval Required*	Payable
Inhalation Therapy	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Subject to OOP Max Additional Pre-approval Required*	Payable
Hemodialysis for ESRD	Not Covered	Not Covered	Not Covered
Short-Term Outpatient Therapy Physical Therapy Cardiac Therapy (not in-patient) Occupational Therapy Speech Therapy Pulmonary rehabilitation Cognitive therapy Chiropractic / Osteopathic / Manipulation therapy Acupuncture	Not Covered	80% of Covered Charges Subject to OOP Max Additional Pre-approval Required*	Payable
Supplies and Equipment			
Durable Medical Equipment	Not Covered	Not Covered	Payable
Orthotics	Not Covered	Not Covered	Payable
Prosthetics	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Subject to OOP Max Pre-approval Required	Payable
Diabetic Equipment and Supplies	Not Covered	Not Covered	Payable
Mental Health and Substance Abuse Services			
Outpatient Services	Not Covered	Not Covered	Payable
Inpatient / Partial Inpatient Services	Not Covered	Not Covered	Payable
Transportation Services			
Ground Ambulance	N/A	80% of Covered Charges Subject to OOP Max Pre-approval Required	Payable
Airfare Benefit	N/A	Up to100% based on Qualifying Criteria and Income	Payable

Schedule of Benefits	In Palau	Off-island	MSA
Wellness and Value Added Programs Wellness Center	100% of Covered Charges Subject to OOP Max	Not Covered	Payable
Transplant Services	Not Covered	Not Covered	Payable
Orthopedic Surgery	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Subject to OOP Max Pre-approval Required	Payable
Congenital Anomalies	80% of Covered ChargesSubject to OOP Max	80% of Covered Charges Subject to OOP Max Pre-approval Required	Payable
Dental Care (Due to accident/injury)	80% of Covered Charges Subject to OOP Max	80% of Covered Charges Subject to OOP Max Pre-approval Required	Payable

[Sections 510-529 Reserved for Future Use]

Section 530. Covered Off-island Care and Other Services that Require Approval

NHI reimburses for Off-island Care and Other Services that may require approval if the following conditions are met.

(1) Services must be approved by the Medical Referral Committee. In the approval of services, whether the services will be pre-approved or post-approved, the Medical Referral Committee should reasonably assure that the services to be approved (a) Comply with existing laws and regulations, (b) Are Medically Necessary, and (c) Are administered in the most practical, cost effective Setting for that particular medical case.

(2) The Administrator, through the Medical Referral Committee, shall only certify or approve medical services for off-island treatment, whether the services will be preapproved or post-approved: (a) That meet the requirements of (1) above, (b) That are Covered under the Plan and meet all conditions of coverage under the Plan, and (c) That are administered in the most practical, cost effective Facility for that particular case.

[41 PNC§913]

Section 531. Covered Medical Evacuation

(1) For approved off-island referrals, NHI reimburses for the cost of one round-trip economy class airline ticket for the covered individual at the lowest published economy fare on the date of travel subject to the Travel Co-payment Schedule in Section 543.

(2) If a stretcher is medically necessary for medical transportation, then NHI reimburses for the costs of round-trip economy class airline tickets at the lowest published economy fare on the date of travel for the number of seats necessary to meet airline requirements subject to the Travel Co-payment Schedule in Section 543.

(3) If a medical attendant is medically necessary, then NHI shall also reimburse for the cost of one round-trip economy class airline ticket for one individual at the lowest published economy fare on the date of travel subject to the Travel Co-payment Schedule in Section 543.

(4) If the covered individual is a minor, NHI shall also cover the cost of one round-trip economy class airline ticket at the lowest published economy fare on the date of travel for the parent or guardian who accompanies the minor at the time of the medical evacuation subject to the Travel Co-payment Schedule in Section 543.

(5) Inter-island medical evacuation costs within Palau are not reimbursable.

[41 PNC§955]

Section 532. Non-referred, Emergency Off-island Care

The plan will only pay for services provided to treat a bone-fide emergency. The plan will only pay up to charges that are usual, customary or reasonable. The Referral Committee will use any and all available resources and information to determine (a) whether a bone-fide emergency situation existed and (b) determine a fair and reasonable charge for the service.

[41 PNC§955]

Section 533. When Coverage is Secondary

(1) At the time of service, a covered individual shall disclose whether he or she has a healthcare or medical coverage plan including but not limited to those provided through a foreign government, such as that provided by US Medicare, civil service, military service, or a workers' compensation plan.

(2) If the medical services provided by an approved provider are subject to coverage under a preexisting plan, then the Plan will Coordinate Benefits. The Plan will develop guidelines for the Coordination of Benefits and issue such guidelines as to not duplicate coverage.

(3) The HF shall work with the Ministry of State to coordinate secondary coverage for healthcare services provided to an insured individual covered by a plan through a foreign government.

[41 PNC§955]

[Sections 534 through 539 Reserved for Future Use]

SubPart D. CO-PAYMENTS

Section 540. Co-payment for Inpatient Care

NHI reimburses BNH for each covered stay after a copayment from the individual of 20% of the total cost up to a ceiling of $200.00 to $400.00, depending on household income, and after excluding the costs of personnel employed by the Ministry of Health as determined by the Co-payment Schedule in Section 542. The Ministry of Health determines the amount of, and collects, this copayment from the individual receiving services.

[41 PNC §955(a)(1)]

Section 541. Co-payment for Off-island Referrals

NHI reimburses for the covered costs of off-island medical care, including medical evacuation services, provided to an insured individual, directly to BNH, subject to the conditions, limitations, and exceptions set forth in these regulations, after a copayment of 20% of total cost of services up to a ceiling of $1,000.00 to $4,000.00, depending on household income for each covered stay as determined by the Co-payment Schedule in Section 542 and "Travel Co-payment Schedule" contained in Section 543. The Plan determines the amount of, and collects, this copayment from the individual.

Section 542. Co-payment Schedule

Bracket	Household Earned Income (US$/quarter)	Ceiling for Inpatient	Ceiling for Referrals
1	$0 - $1399	$200	$1000
2	$1400 - $2799	$300	$2000
3	$2800 - $4199	$400	$3000
4	$4200+	$400	$4000

[41 PNC §955(a)(2)]

Section 543. Travel Co-payment Schedule

The co-payment for "Care Approved Under Section 553" below will include any additional cost for minors.

Bracket: Household Income per Quarter	Care Approved by Referral Committee	All Other Care
1: $0 - $1,399	$50.	Not Covered
2: $1,400 - $2,799	$100.	Not Covered
3: $2,800 - $4,199	$200.	Not Covered
4: $4,200+	$400.	Not Covered

[Sections 544 through 549 Reserved for Future Use]

SubPart E. EXCLUSIONS & LIMITATIONS

Section 550. Limitations & Exclusions

In this section items that are not covered by the Plan are listed. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. These exclusions apply to coverage provided under NHI and the cost of reimbursable services under MSA unless the excluded item is indicated as "Payable" under the MSA column.

(1) Abortion Services, supplies, Drugs, and other care for voluntary abortions and/or fetal reduction surgery. This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother as recommended by a Doctor.

(2) Acts of War, Disasters, or Nuclear Accidents In the event of a major disaster, epidemic, war, or other event beyond our control, a good faith effort to give will be provided for Covered Services. The plan will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.
a. Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

(3) Administrative Charges

a) Charges to complete claim forms,
b) Charges to get medical records or reports,
c) Membership, administrative, or access fees charged by Doctors or other Providers.

Examples include, but are not limited to, fees for educational brochures or calls to provide test results.

(4) Alternative / Complementary Medicine Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

a) Holistic medicine,
b) Homeopathic medicine,
c) Hypnosis,
d) Aroma therapy,
e) Massage and massage therapy,
f) Reiki therapy,
g) Herbal, vitamin or dietary products or therapies,
h) Naturopathy,
i) Thermography,
j) Orthomolecular therapy,
k) Contact reflex analysis,
l) Bioenergial synchronization technique (BEST),
m) Iridology-study of the iris,
n) Auditory integration therapy (AIT),
o) Colonic irrigation,
p) Magnetic innervation therapy,
q) Electromagnetic therapy,
r) Neurofeedback / Biofeedback.

(5) Care received before the Effective Date or after coverage ends, except as written in this Plan.

(6) Services received from Providers that are not licensed by law or otherwise to provide Covered Services. Examples include, but are not limited to, massage therapists, physical therapist technicians, and athletic trainers.

(7) Charges over the Maximum Allowed Amount for Covered Services or what is deemed as Usual, Customary, or Reasonable. MSA Payable.

(8) Charges Not Supported by Medical Records or described in medical records.

(9) Services for Cochlear Implants. MSA Payable.

(10) Complications of Non-Covered Services - Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non- Covered Service and would not have taken place without the non-Covered Service. MSA Payable.

(11) Contraceptives Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants. MSA Payable.

(12) Cosmetic Services Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how an individual looks. No benefits are available for surgery or treatments to change the texture or look of skin or to change the size, shape or look of facial or body features. This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy or to surgery to correct congenital defects and birth abnormalities

(13) Court Ordered Testing or care unless Medically Necessary.

(14) Treatment of an injury or illness that results from a crime that is committed, or attempted to commit.

(15) Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

(16) Charges incurred for dental services except for surgical procedures as a result of accidental injury to natural teeth or jaw; such services do not include capping, bridges or retainers as benefits. MSA Payable.

(17) Educational Services or supplies for teaching, vocational, or self-training purposes.

(18) Experimental or Investigational Services or supplies. MSA Payable.

(19) Eyeglasses and Contact Lenses Eyeglasses and contact lenses to correct eyesight. This Exclusion does not apply to lenses needed after a covered eye surgery. MSA Payable.

(20) Orthoptics and vision therapy.

(21) Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

(22) Services prescribed, ordered, referred by or given by a member's immediate family, including spouse, child, brother, sister, parent, in-law, or self.

(23) Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
a) Cleaning and soaking the feet.
b) Applying skin creams to care for skin tone.
c) Other services that are given when there is not an illness, injury or symptom involving the foot.

(24) Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes. MSA Payable.

(25) Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses. MSA Payable.

(26) Free Care Services one would not have to pay for if not enrolled in this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services one gets from Workers Compensation, and services from free clinics.

(27) Health Club Memberships and Fitness Services Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor.

(28) Hearing Aids or exams to prescribe or fit hearing aids. MSA Payable.

(29) Infertility Treatment Testing or treatment related to infertility.

(30) Maintenance Therapy - Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps keep current level of function and prevents loss of that function, but does not result in any change for the better.

(31) Charges for missed or cancelled appointments.

(32) Services that are not Medically Necessary.

(33) Nutritional and/or dietary supplements.

(34) Oral Surgery Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth. MSA Payable.

(35) Personal Care and Convenience items.

a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

b) First aid supplies and other items kept in the home for general use (bandages, cotton tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),

c) Home workout or therapy equipment, including treadmills and home gyms,

d) Pools, whirlpools, spas, or hydrotherapy equipment.

e) Hypo-allergenic pillows, mattresses, or waterbeds,

f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

g) During an inpatient hospital stay, telephone or communication charges; extra beds, blankets or pillows; extra meals or drinks; nail care; cost for physical or digital copies or of film, x-ray, CT, MRI or Reports.

(36) A private hospital room when a semi-private room is appropriate.

(37) Prosthetics for sports or cosmetic purposes.

(38) Residential Treatment Centers.

(39) Sex Change Services and supplies for a sex change and/or the reversal of a sex change.

(40) Sexual Dysfunction Services or supplies for male or female sexual problems.

(41) Smoking Cessation Programs unless otherwise approved by the Plan.

(42) Stand-by charges of a Doctor or other Provider.

(43) Sterilization Services to reverse an elective sterilization.

(44) Temporomandibular Joint Treatment including fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures). MSA Payable.

(45) Travel Costs Mileage, lodging, meals, and other Member-related travel costs except as specifically approved by the Plan. MSA Payable.

(46) Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.]

(47) Vision Services. MSA Payable.

(48) Weight Loss Programs, whether or not under medical supervision.

(49) Weight Loss Surgery or Bariatric surgery. MSA Payable.

(50) Charges for expenses in connection with Chronic Brain Syndrome, or custodial care charges resulting from senile deterioration, unless otherwise noted as covered in this policy;

(51) Charges for allergy testing and treatment; MSA Payable.

(52) Treatment of End-Stage Renal Disease including but not limited to hemodialysis treatment. MSA Payable.

[41 PNC §§955(c) and 956]

Section 552. Special Provisions for Organ Transplants

(1) Organ transplants are excluded from coverage. However, the Committee may specify a specific number of kidney transplants that may be approved for reimbursement to BNH during an upcoming calendar period, provided that the sustainability of the HF can be maintained with the inclusion of that number of kidney transplants.
(2) In addition, prior to specifying the number of kidney transplants which may be approved, the Minister of Health, the Minister of Finance and the Administrator shall enter into an agreement establishing specific criteria for eligibility of a covered individual for an approved transplant. The criteria shall require a good prognosis, shall limit approval to one transplant per covered individual, shall require the individual to demonstrate active compliance with recommended healthy lifestyle choices and active participation in disease prevention measures, and such other criteria as may be determined by the parties.
(3) All other exclusions and limitations found elsewhere in these regulations shall apply.

Section 553. Special Provisions for Diagnostic Referrals

Care for off-island diagnostic purposes is excluded. In addition, follow-up treatment and evaluations following a covered off-island referral treatment may not be covered. However, where BNH lacks access to medically necessary diagnostic equipment or specialist services and no timely, reasonable substitute for the equipment or specialist services are available, either electronically or on Palau or, in the Plan's determination, that the continuity of care be provided by the off-island provider, then the off-island referral may be approved for reimbursement, subject to other exclusions and limitations found elsewhere in these regulations.

Section 554. Medical Referral Committee Standards

Payments for covered off-island medical care shall be made only for covered services approved by the Plan when applying the medical standards in effect on the date RPPL 8-14 was enacted until such time as the standards are formally updated.

[41 PNC §955(a)(2)]

Section 555. Amounts Payable by NHI

(1) The Administrator, with approval from the Committee, shall negotiate and enter into agreements or contractual relationships for off-island medical services with one or more providers to protect the sustainability of the HF and to seek the lowest cost for services while maintaining service quality.

(2) Until provider contracts are established, the Committee shall determine the amounts which are payable for medical care provided through off-island referrals, but the Plan shall continue to determine the cost of care by negotiating with providers on a case-by-case basis.

[41 PNC §§955 and 957]

Section 556. Maximum Benefits For Off-island Referrals.

In addition to other exclusions and limitations, the amount reimbursable for covered costs shall be subject to a maximum benefit of $35,000 for each calendar year. This maximum benefit may be adjusted by the Governing Committee provided the adjustment is part of an overall review and adjustment of coverage limitations and is demonstrated to be fiscally sustainable through an actuarial study.

[41 PNC §955(c)]

[Sections 556 through 600 Reserved for Future Use]

PART VI. CLAIMS PROCESSING FOR MSAs

Section 601. General Provisions for Claims Approval

(1) The account holder or beneficiary shall authorize payment to be deducted from an MSA account in writing at the time service is provided using the form from the provider and approved by the HF for that purpose. The form shall also authorize, but not require, the provider to verify sufficient funds are available an MSA account.

(2) The provider shall submit shall submit a request for payment to the HF for all covered services, which includes proof of providing the covered service and the authorization for payment, on a monthly or quarterly basis using a form approved for that purpose. The HF shall pay the approved provider on a monthly or quarterly basis, as agreed by the provider and the HF.

(3) If sufficient funds are not available in the individual's MSA accounts to make full payment, the Administrator may do the following, in his or her discretion:

a. Notify the provider that payment is denied due to an insufficient balance in the individual's MSA accounts; or

b. delay payment for up to thirty (30) days, provided that sufficient deposits are expected in an MSA account to make full payment.

(4) The Plan may amend the provisions of this section with the issuance of a Benefit and Policy Interpretation Bulletin.

[41 PNC§939]

Section 602. No Payment of Unauthorized Claims

No payment shall be made for services from any MSA unless the account holder or designated beneficiary authorized payment in writing on a form approved for that purpose by the HF.

[Sections 603 through 700 Reserved for Future Use]

PART VII. CLAIMS PROCESSING FOR NHI

Section 701. General Provisions for Claims Approval

BNH shall aggregate and submit all claims for covered services at BNH for payment on a monthly or quarterly basis in an electronic format which provides the following information:

(1) Name, date of birth, Social Security Number and/or BNH clinic number of individual receiving inpatient or off-island referral services;
(2) Dates of each covered service;
(3) Listing of each covered service provided using standardized codes and classifications as approved by the Committee;
(4) Diagnoses of the individual which support receiving each covered service;
(5) Certification that the co-payment has been collected from the individual receiving services;
(6) Amount and source of any other payments received for each covered service; and,
(7) Any other information the Administrator deems reasonable and necessary for processing payment.
(8) The Plan may amend the provisions of this section with the issuance of a Benefit and Policy Interpretation Bulletin.

NHI shall reimburse BNH for covered services to covered individuals on a monthly or quarterly basis, as may be agreed by the HF and BNH.

[41 PNC§955]

Section 702. Reimbursement to covered individuals.

(1) The HF may reimburse covered individuals for covered services where payments were made directly to a provider. In addition to a valid Proof of Payment, the covered individual shall be required to submit the same information as the approved provider, prior to reimbursement.
(2) However, the HF may enter into agreements with insurers licensed to provide coverage in the Republic of Palau to reimburse an insurer for covered services by an approved provider to a covered individual, which have already been paid by the insurer. If the insurer and the HF enter into such an agreement, the insurer shall be required to submit the same information as the approved provider, prior to reimbursement.

[41 PNC§955]

[Sections 703 through 800 Reserved for Future Use]

PART VIII. DETERMINATIONS, NOTICES, COMPLAINTS & APPEALS

Section 801. Administrative Procedures Act Applies

Determinations, notices, complaints and appeals involving any right, benefit or obligation under 41 PNC, Chapter 9, or these regulations are governed by the adjudicative process found in the Administrative Procedures Act, as codified in 41 PNC, Title 6, Subchapter III.

[41 PNC §908]

PART X. IMPROVEMENT EFFORTS

Section 1101. Authority For Improvement Efforts.

RPPL 8-14, in Section 4, requires that the Social Security Board and Committee shall continue to explore other possible options for improving the scope and financial sustainability of the National Medical Savings Fund and National Health Insurance, including, but not limited to, pursuing funding under the Compact of Free Association with the United States. Further, any changes which have financial implications for the Fund, whether by bill or by regulation, shall be accompanied by a report from an actuary prior to approval.

Section 1102. Purpose.

According to RPPL 8-14, Section 1, the Olbiil Era Kelulau established the healthcare financing system to address the increasing costs of delivering healthcare and the escalating accounts receivable at the Ministry of Health. The mechanisms are a combination of MSAs and insurance for catastrophic care, with the continued safety net of governmental spending. These ensure continued access to healthcare and foster development of public and private providers. In addition, the population is to be encouraged to adopt healthy lifestyles and take personal responsibility for his or her own health.

Section 1103. Actions to be Taken.

To further those goals and objectives, the HF shall collaborate with the Minister of Health and other governmental, non-profit, and for-profit entities to monitor usage and collect information relevant to making decisions for improving both the MSA and NHI programs; seek financial and other support to expand covered services; and review and consider modifying subscription rates after two years of operations. Specifically, the HF shall promote, encourage and use standard coding and classifications, shall participate in the Pacific National Health Accounts Network, and shall monitor and report on the following factors after two years of operations:

(1) the annual financial balance resulting for the operations of National Health Insurance;
(2) the amount of return achieved on the investment of reserves;
(3) proposed changes in benefit provisions that will likely affect the financial situation of the NHI in the future; and,
(4) proposed reductions in subscription costs for individual participating in preventive care programs, as certified by the Ministry of Health.

[41 PNC §955d]