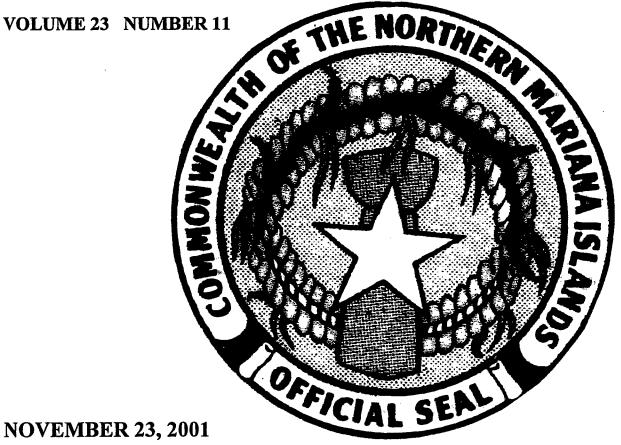
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS SAIPAN, MARIANA ISLANDS 96950



COMMONWEALTH

REGISTER

COMMONWEALTH REGISTER Volume 23 Number 11 NOVEMBER 23, 2001

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COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Department of Public Safety



Commissioner

Pedro P. Tenorio Governor

Jesus R. Sablan Lieutenant Governor

PUBLIC NOTICE

PROPOSED RULES AND REGULATIONS GOVERNING THE ADMINISTRATIVE PROCEDURE OF THE COMMONWEALTH FIRE SAFETY CODE

Emergency (24 hrs.) 911 DPS Main Switchboard (670) 664-9000

 Office of the Commil The Department of Public Safety, Fire Division's Fire Prevention Section, hereby

 664-9022
 proposes to adopt rules and regulations that will govern the administration,

 Police Division
 implementation, and enforcement of the Fire Safety Code of the Commonwealth of the

 Fire Division
 Northern Mariana Islands. Public Law No. 11-56, to include all sections in the Uniform

 Fire Division
 Fire code and Standards published by the International Conference of Building Official

 and the Western Fire Chief's Association. The rules and regulations to be promulgated
 are authorized pursuant to section 7304 of Public Law No. 11-56 "Commonwealth Fire

Bureau of Motor Venicies Safety Code act of 1998

Training and Develop IIIn written comments and/or recommendations regarding the proposed rules and regulations are to be submitted within thirty (30) days after the date of this publication in Administrative Suppthe Commonwealth Register to Department of Public Safety, Fire Division, Fire

Prevention Section, Jose M. Sablan's Building, Caller Box 100007, Saipan MP 96950.

	Rota DPS Tel: (670) 532-9433 Certified By:	Date: <u>/ • - / 6 - 0 /</u>
	Fax: (670) 532-9434 Herman P. Sablan, Director of Fire	
	Tinian DPS Tel: (670) 433-9222 Fax: (670) 433-9259 Approved By: Charles Wingram Jr. DPS Commissioner	Date:/0-17-01
	Filed By:	Date: <u>/// 4/8/</u>
	Received By: Jose I. Deleon Guerrero, SAA Governor's Office	Date: 11/13/01
	Pursuant to 1CMC § 2153 as amended by PL 10-50, the rules and	regulations attached
	hereto have been reviewed and approved by the CNMI Attorney	•
:	Herbert D. Soll, Attorney General	Date: \underline{W} 9,200
	v	

Commonwealth Register

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November 23, 2001 Page 18610

P.O. Box 791 Civic Center Susupe, Saipan, MP 96950 Telephone (670) 664-9000 (24 hrs.) Facsimile: (670) 664-9019



COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Department of Public Safety



Pedro P. Tenorio Governor

Jesus R. Sablan Lieutenant Governor

Emergency (24 hrs.) 911

NUTISIAN PUBLIKU

MAPROPONEN ARECKAMENTO YAN REGULASION I PARA U GOBIETNA I KONDISION YAN MANERAN COMMONWEALTH FIRE SAFETY CODE

DPS Main Switchboard (670) 664-9000 I Dipatamenton Public Safety, Fire Division Fire Prevention na seksiona, ginen este na Office of the Com propopne para u adapta I areklamento yan regulasion I para u gubientna administrasion, 664-9022 implementasion, yan maenfuetsan I Fire Safety Code Commonwealth I Sankattan siha no Police Division Islan Marianas, Lai Publiku No. 11-56, para u enklusu todu I seksiona siha put Uniform 664-9001 Fire Code yan Areklamento ni pinepblikan International Conference of Building Official Fire Division 664-9003 Chiefs' Association. I areklamento yan regulasion ni para u fanma cho'gue ginen Division of Correctionaturisan Seksiona 7304 gi Lai Publiku No. 11-56 "Commonwealth Fire Safety Code." 664-9058 Bureau of Motor Veh Fodu I manmatuge' siha na komentu / rekomendasion put I manmapropopne siha na 664-9066 arekamento yan regulasion u fanma satmiti halom trenta (30) dias despues di mapublika Training and Development na nutisia gi Rehistran Commonwealth para guatu gi Dipatamenton Public Safety, 664-9094 Fire Division, Fire Prevention Section, Jose M. Sablan's Building, Caller Box 10007, Administrative Support aipan, MP 96950. Le of Special Programs 664-9120 Fecha: 10 - 16 - 0Sinettfikka as : Rota DPS Tel: (670) 532-9433 Herman Pl Sablan Fax: (670) 532-9434 Dirktot, DPS Fire Division Tinian DPS Tel: (670) 433-9222 Fecha: 10-17-01 Fax: (670) 433-9259 Mabreba as Charles W Ingram, DPS Commissioner Fecha: 11/14/01 Ma file as Rehistradoran Kotporasion Fecha: 11/13/01 Rinisibi as Øfisina/Gobetno

Sigun 1 CMC papa seksiona 2153 ni inamenda ni Lai Publiku 10-50, I areklamento yan regulasion ni chechetton guine esta manmarisibi yan apreba ginen Ofisinan Attorney General giva CNMI.

/s/ Allan Dollison Herbert D. Soll Attorney General

Commonwealth register

Fecha: 11/9/01

Volume 23 Number 11 November 23, 2001 Page 18611 P.O. Box 791 Civic Center Susupe, Saipan, MP 96950

Telephone (670) 664-9000 (24 hrs.) Facsimile: (670) 664-9019



Pedro P. Tenorio Governor

Jesus R. Sablan Lieutenant Governor

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DPS Main Switchboard (670) 664-9000

Office of the Commissioner 664-9022

Police Division 664-9001

Fire Division 664-9003

Division of Correction 664-9058

Bureau of Motor Vehicles 664-9066

Training and Development 664-9094

Administrative Support 664-9000

O), j Special Programs 664-9120

Rota DPS Tel: (670) 532-9433 Fax: (670) 532-9434

Tinian DPS Tel: (670) 433-9222 Fax: (670) 433-9259

Isáliyal

Sangi

Bwughiyal

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COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Department of Public Safety



ARONGORONGOL TOULAP

POMWOL ALLÉGHÉL LEMELMIL MWÓGHÚTÚGHÚTÚL ADMINISTRATIVE MELLÓL COMMONWEALTH SAFETY CODE

Bwulasiyol Public Safety Fire Division, Fire Prevention Section, eghal arongaar toulap reel igha ebwe adopt li Alléghúl kkaal iye ebwe lemeli administration, implementation, enforcement mellól Fire Safety Code mellól Commonwealth Metawal Wóól Falúwal Marianas, alléghúl toulap 11-56, reel ebwe schuulong alongal tálil sangi Uniform Fire Code bwal standards iwe a published mereel International Conference of Building Official bwal Western Fire Chief's Association. Allégh kkaal igha ebwe arongoló nge e mwetto bwángil mereel aileewal Tálil 7304 mellól Alléghúl Toulap 11-56 "Commonwealth Fire Safety Code Act llól rágh we 1998.

Alongal ischilongol me/ngare mángemáng bwelle reel pomwol allégh kkaal ebwe isisilong llól ótol eliigh rál la e toolong Publication mellól Commonwealth Register ngali Bwulasiyol Public Safety, Fire Division, Fire Prevention Section, Jose M. Sablan's Building, Caller Box 10007, Seipél, MP 96950.

> : Herman P. Sablan Director, DPS Fire Division : Charles W. Ingram DPS Commissioner

: <u>Soledad B. Sasamoto</u> Registrar of Corporation : <u>Jose I Defeor Guerrero</u> Ral: 10 -16 -01

Ral: 10-17-0/

Ral: 11/14/01

Ral: 1/13/01

Bwelle reel 1 CMC §2153 iye a lliiwel mereel PL. 11-50, allágh kkaal ikka e appasch nge atakkal amweri me alúghúlúgh mereel Bwulasiyol CNMI Attorney General.

/s/ Allan Dollison <u>Herbert D. Soll</u> Attorney General

11/9/01 Ral:

Commonwealth Register

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COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Department of Public Safety



PUBLIC NOTICE

PROPOSED RULES AND REGULATIONS GOVERNING THE ADMINISTRATIVE PROCEDURE OF THE COMMONWEALTH FIRE SAFETY CODE

11-56.

uniform

11-56.

Emergency (24 hrs.) 911

DPS Main Switchboard (670) 664-9000

Office of the Commissioner 664-9022

Police Division 664-9001

Fire Division 664-9003

Division of Correction 664-9058

Bureau of Motor Vehicles 664-9066

Training and Development 664-9094

Administrative Support 664-9000

0 Special Programs 664 . . 20

Rota DPS Tel: (670) 532-9433 Fax: (670) 532-9434

Tinian DPS Tel: (670) 433-9222 Fax: (670) 433-9259 Citation of Statutory Authority:

Statement of Goals & Objectives:

Brief Summary of the Rules

And Regulations:

For Further Information

Citation of Affected/Related

Contact:

Statutes/Codes:

Submitted by:

To safeguard to a reasonable degree life and property from the hazards of fire and explosions arising from storage, handling and use of hazardous substances, materials and devices, and from any conditions hazardous to life and property in the use or occupancy of any buildings and premises.

To establish rules and regulations pursuant to the

Commonwealth Fire Safety Code, Public Law No.

To establish rules and regulations to provide

as

Commonwealth Fire Safety Code, Public Law No.

mandated

bv

the

standards

Director Herman P. Sablan, Fire Division. number 664-9003/9004/9032 Telephone or facsimile number 664-9019.

Public Law No. 11-56, Uniform Fire Code and Standards published by the International Conference of Building Official and the Western Fire Chief's Association.

W. Ingram, Jr.

Date: 10-17-01

Charles DPS Commissioner

Commonwealth Register

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> Caller Box 10007 Civic Center Susupe, Saipan, MP 96950 Telephone (670) 664-9000 (24 hrs.) Facsimile: (670) 664-9019



Pedro P. Tenorio Governor

Jesus R. Sablan Lieutenant Governor COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Department of Public Safety



Commissioner

ARONGORONGOL TOULAP

Pomwol Allégh kkal e lemelil Mwóghútúghútúl Administrative mellól

Commonwealth Fire Safety Code.

Emergency (24 hrs.) 911

DPS Main Switchboard (670) 664-9000

Office of the Commissioner 664-9022

Kkapasal autol Búangil:

Eghus arong reel yall goals

Weimwoshól yaal allégh:

me objectives:

Fire Division 664-9003

Police Division 664-9001

Division of Correction 664-9058

Bureau of Motor Vehicles 664-9066

Training and Development 664-9094

Administrative Support 64 * 9000

Up.Le of Special Programs 664-9120

Rota DPS Tel: (670) 532-9433 Fax: (670) 532-9434

Tinian DPS Tel: (670) 433-9222 Fax: (670) 433-9259

Raal ammataf faigni:

Bwángil ikka e affected Eweewe reel Status/Codes: Ebwe fféér allégh reel sangi aileewal Commonwealth Fire Safety code, Alléghúl toulap 11-56.

Ebwe fféér allégh reel ebwe ayoora Uniform Standard iya aileewal Commonwealth Fire Safety Code, Alléghúl toulap 11-56.

Ebwe léghééy iyaala tool melaw llól ghatch bwal piságh mereel allúwelúwul anget bwal meta kka eghal lléshewow mellól leliyel isislóól meta bwal yááyáál meta kka e allúwélúw substances materials bwal peirágh, bwal mereel meta kka e allúwélú ngali melaw me meta kka yááyáál ngare meta kka e lo llól iimw bwal llól bwuley.

Director Herman P. Sablan, Fire Division Telephone no. 664-9005/9004/9003/9032 ngare facsmile no. 664-9009.

Alléghúl Toulap 11-56, Uniform Fire Code bwal Standard iew a published mereel International Conference of Building Official bwal Western Fire Chief's Association.

Ingram Jr. Chai DPS Commissioner

10-17-01 Ral:

Sangi:

Commonwealth register Volume 23 Number 11

November 23, 2001 Page 18614

P.O. Box 791 Civic Center Susupe, Saipan, MP 96950 Telephone (670) 664-9000 (24 hrs.) Facsimile: (670) 664-9019



COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Department of Public Safety



Pedro P. Tenorio Governor

Jesus R. Sablan Lieutenant Governor

NUTISIAN PUBLIKU

MAPROPONE SIHA NA AREKLAMENTO YAN REGULASION I PARA U Emergency (24 hrs.) 911 GOBIETNA I ADMINISTRASION YAN MANERA YAN KONDISION GI COMMONWEALTH FIRE SAFETY CODE.

Office of the Commissioner 664-9022

DPS Main Switchboard (670) 664-9000

Ginen hayi I aturidat

Police Division 664-9001 Fire Division

664-9003

Sinagan put minito yan Division of Correc Öbyektibu 664-9058

Bureau of Motor Vehicles 664-9066

Training and Development 664-9094

Administrative Supp Didide ' na sinagan put FF ' 9000 Areklamento van regulasion , ... e of Special Programs 664-9120

Rota DPS Tel: (670) 532-9433 Fax: (670) 532-9434

Tinian DPS Tel; (670) 433-9222 Fax: (670) 433-9259 Put mas eemfotmasion

Agang si

Sinangan put I maninafekta Siha na Lai/Regulasion yan Otden siha

Para u maestablesi areklamento yan regulasion sigun I Commonwealth Fire Safety Code, Lai Publiku Numiru 11-56.

Para u maestablesi areklamento yan regulasion gi para u guaha parehu na kinalamenten sigun dinimanda ginen Commonwealth Fire Safety Code, Lai Publiku Numiru 11-56.

Para u protehe I risonable siha na chi'gi piniligrun lina'la yan propiedat ginen kimason pat pakpak ginen storage yan mapachan manpiligru siha na materiat yan kosas, yan maseha hafa man na'ma'nao na kondision kontra lina'la yan propiedat komu ma usa yan guaha hi halom hafa na fasilidat yan uriya.

Direktot Herman P. Sablan, Fire Division. Guine na numirun tilifon I 664-9003/9004/9032 pat I numirun facsmile gi 664-9009.

Lai Publiku Numiru 11-56, Uniform Fire Code yan Standards ni mapublika ginen International Conference of Building Official yan Western fire Chiefs' Association.

Mabreba as

10-17-01 Fecha:

Charles W. Ingkan, DPS Commissioner

Commonwealth Register Volume 23 Number 11 November 23, 2001 Page 18615

> P.O. Box 791 Civic Center Susupe, Saipan, MP 96950 Telephone (670) 664-9000 (24 hrs.) Facsimile: (670) 664-9019

Section 1000. Authority:

The Department of Public Safety Fire Division, Fire Prevention Section shall have the legal authority to enforce laws and regulations promulgated pursuant to the authority of Public Law 11-56, "Commonwealth Fire Safety Code" and all other adopted codes and standards.

Section 1001. Purpose:

The purpose of these rules and regulations is to govern the administration, implementation of governing Public Law 11-56, "Commonwealth Fire Safety Code."

Section 1002. Cooperation with other agencies;

- A. Other government agencies involved in reviewing plans for a new building and/or renovation of an existing building, or construction of underground and above ground storage tanks for flammable liquid and combustible liquid shall inform the applicant/business owner to obtain clearance from Fire Prevention Section in writing of such plans which pertain to Fire Safety in nature.
- B. Officials of other government agencies involved in permitting and/or Licensing of the following activities mentioned in section 1010, shall ensure clearance from the Fire Prevention Section is obtained prior to issuing permits and/or license.

Section 1003. Existing Buildings:

- A. The Fire Chief or his representative from the Fire Prevention Section shall have the authority to inspect existing building if he/she believes an imminent danger exist or has reason to believe that it is an unsafe building.
- B. At anytime a complaint is received by the Fire Division, Fire Prevention Section regarding a building having hazardous or unsafe conditions, The Fire Director or his designee may request to the owner to inspect the premises.

Section 1004. Unsafe Structures:

A. Any building, dwelling, or structures found unsafe will be given notice of abatement. This notice will serve as a temporary closure of building and or operation until such time deficiencies rendering it unsafe is rectified.

Section 1005. Certificate of Fire:

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A. Any person whose house, property, or business establishment is damaged by fire will be given 3 working days prior to picking up Certificate of Fire report from the Fire Prevention office. This document will be sufficient for justification in requesting assistance from any organization.

B. The office of Fire Prevention Section will not issue investigation report to any person without written permission from the Commissioner of Public Safety and/or Director of Fire. It will be the responsibility of the client to obtain approval from the Commissioner of Public Safety and/or Director of Fire before any report, other than certificate of Fire report, to be released.

Section 1006. Fireworks:

- A. It shall be unlawful for any person or business to distibute, store, or sell Class "C" Fireworks without a valid permit from the Fire Prevention Office.
- B. It shall be unlawful for any person or businss to store, use, or sell Class "B" fireworks without approval from the Governor's office. After approval from the governor, office of Fire Prevention Section must be adviced regarding such activities.

Section 1007. Fire Hydrant:

- A. It shall be unlawful for any person to use or draw water from any fire hydrants without proper written permission from the Director of Fire. Any person found will be cited for tampering with fire appurtanences.
- B. Any person who wish to use or draw water from a fire hydrant must obtain permit from the Fire Division. They will also be required to obtain clearance from the Commonwealth Utilities Corporation prior to obtaining permit from Fire Division.
- C. It shall be the responsibility of Fire Division to perform periodic maintenance on fire hydrants to determine serviceability, water pressure during peak and regular hours, landmark hydrants so that locating it would not be a problem during night or inclement weather. Any hydrants found with major damage shall be reported to proper agency for repair or removal.
- D. Any person or motorist responsible for damaging any hydrants will be liable for the cost of repairing the hydrant or for a new replacement.

Section 1008. Inspections For New Permits

I. First Inspection

- A. The Inspector shall conduct the inspection, if code compliance has been obtained, the permit will be processed. There is no charge for this First Inspection, it is included in the permit fee which payment must be received by the Commonwealth of the Northern Marianas Island (CNMI) Treasury, before permit is issued (see Issuance of permit schedule).
- B. If code compliance has not been obtained, the inspector shall identify for the person responsible for the premises, specific violation of the applicable code, and, providing adequate time between inspection, dependent on the hazard and danger created by the

violations and the complexity of the work to be done, but generally, within 15 to 30 days or as felt adequate by the business owner, a schedule for "First Reinspection" date and time, to verify code compliance. Note: First Reinspection fee shall be payable to the CNMI Treasury, when code compliance is obtained and before permit is issued (see Inspection Fee Schedule).

C. In all cases, inspection report(s) shall be filled out by the inspector, signed by all parties indicated on the report form(s); and a copy given to the person responsible for the premises.

II. Second Inspection or First Reinspection

- A. If code compliance has been obtained, the process proceeds with the issuance of permit. Payment of permit and First Reinspection fees shall be payable to the CNMI Treasury, before the permit is issued (see Inspection Fee and Fees for Issuance of Permits schedules).
- B. If code compliance has not been obtained by the Second Inspection or the First Reinspection, the inspector shall, providing adequate time for compliance between inspections, dependent on the hazard and danger create by the violation and the complexity of work to be done, but generally, within 15-30 days or as felt appropriate by the business owner, schedule a Second Reinspection date and time, to verify code compliance. Note Second Reinspection fee shall be payable to the CNMI Treasury, when code compliance is obtained and before permit is issued (see Inspection Fee Schedule).
- C. In all case, inspection report(s) shall be filled out by the inspector, signed by all parties indicated on the report from(s); and a copy given to the person responsible for the premises.

III. Third Inspection or Second Reinspection

- A. If code compliance has been obtained, the process proceeds with the issuance of permit. Payment of permit, First and Second Reinspection fee must be payable to the CNMI Treasury, before permit is issued (see Inspection Fee and Fees for Issuance of permits Schedules).
- B. If code compliance has not been obtained on the Third Inspection or the Second Reinspection, the inspector shall, providing adequate time for compliance between inspections, dependent on the hazard and danger created by the violation and the complexity of the work to done, but generally, within 1-15 days or as felt appropriate by the business owner, schedule a Third Reinspection date and time, to verify code compliance. Note: Third Reinspection will be at a fee double the Second Reinspection fee and payable to the CNMI Treasury, when code compliance is obtained and before permit is issued. Reinspections thereafter will likewise be double the proceeding reinspection fee (see Inspection Fee Schedule).

C. In all case, inspection report(s) shall be filled out by the inspector; signed by all parties indicated on the report form(s); and a copy given to the person responsible for the premises.

IV. Fourth Inspection or Third Reinspection

- A. If code compliance has been obtained, the process proceeds with the issuance of permit. Payment of permit. First, Second, and Third Reinspection fees must be shall be payable to the CNMI Treasury, before permit is issued (see Inspection Fee and Fees for Issuance of Permit Schedules). Note: Third Reinspection shall be at a fee double the Second Reinspection fee. Reinspections thereafter will likewise be double the proceeding reinspection fee (see Inspection Fee Schedule).
- B. If code compliance has not been obtained by the Fourth Inspection or Third Reinspection, the reinspection will continue in the fashion as previous inspection until compliance with the fire code has been obtained.
- C. In all cases, inspection report(s) shall be filled out the inspector; signed by all parties indicated on the report form(s); and a copy given to the person responsible for the premises.

Section 1009. Unannounced Inspections for Existing Permit Holders

Unannounced inspections may conducted by any designated official of the Department of Public Safety Fire Division Fire Prevention Section on any building and premises. business, activity, engagement, or function regulated by the applicable code at all reasonable times. The Fire Division's intention is to protect the integrity of its fire prevention program; to take reasonable measures to ensure that fire code compliance is continually maintained and not just occasionally on or about permit renewal date or on notice of inspection possibility; and to address citizen concerns or complaints.

I. First Inspection

- A The inspector shall conduct the inspection. If code compliance is being maintained or if code compliance is obtained during this inspection, the inspector shall fill out an inspection report(s) indicating business owner and premises are in compliance with the applicable code; issue a citation, fines depending on the violations found if necessary; obtain all signatures indicated on the report form(s); and issue a copy of the report(s) to the person responsible for the premises and, fines. No inspection fee shall be imposed in this case.
- B. If code compliance is not being maintained and cannot be obtained during this inspection, the inspector shall impose a first inspection fee; and identify for the person responsible for the premises, specific violations of the applicable code and, dependent of the hazard and danger created by the violations and the complexity of the work to

be done, but generally, it is shall be the discretion of the inspector to impose the time frame for next inspection.

- C. Citations normally will not be issued on the first inspection. When routine violations of the applicable fire code are encountered, citations will generally be issued upon the second inspection or first reinspection. If violations are encountered.
- D. Payments of fines must be paid to the CNMI Treasury 30 days of the first reinspection. If permit renewal date should fall within the 30 days, fines, and the regular permit fee shall all be due upon request for permit renewal.
- II. Second Inspection or First Reinspection.
- A. If code compliance has been obtained, the inspector shall fill out an inspection report indicating business owner and premises are in compliance with the applicable fire code; issue a citation, fines depending on the violations found; impose first reinspection fee; and inform the person responsible for the premises that repeat violations encountered in the future inspection may result in fines.
- B. If code compliance has not been obtained by the second inspection or the first reinspection, the inspector shall issue a citation, fines depending on the violation(s) of the applicable code; impose a first reinspection fee; and providing adequate time for compliance between inspections, dependent on the hazard and danger created by the violation and the complexity of the work to be done, but generally to be determined by the inspector, schedule a second reinspection date and time to verify compliance.
- C. Payment of fines, First Inspection and First Reinspection fees must be paid to the CNMI Treasury within 30 days of First Reinspection. If permit renewal date should fall within the 30 days, fines, first Inspection and First Reinspection fees and the regular permit fee shall all be due upon request for permit renewal.
- D. In all cases, an inspection report shall be filled out by the inspector; signed by all parties indicated on the report form(s); and a copy given to the person responsible for the premises.

III. Third Inspection or Second Reinspection

- A. If code compliance has been obtained, the inspector shall fill out an inspection report indicating business owner and premises are in compliance with the applicable fire code; impose a second reinspection fee; inform the person responsible for the premises that repeat violations encountered in future inspections may result in further fines.
- B. If code compliance has not been obtained by the third inspection or the second reinspection, the inspector shall impose a second fee; providing adequate time for compliance between inspections, dependent on the hazard and danger created by the violation and the complexity of the work to be done to be determined by the inspector,

schedule a third reinspection date and time to verify compliance; and issue a citation, a fine based on the fine fee schedule.

- C. The inspector should mention the possibility of permit being revoked and cessation of business operations. The fines issued at this point will be added to those already issued.
- D. Payment of fines, First Inspection, First and Second Reinspection fees must be paid to the CNMI Treasury within 30 days of Second Reinspection. If permit renewal date should fall within the 30 days, Fines, First Inspection, First and Second Reinspection fees and the regular permit fee shall all be due upon request for permit renewal.
- E. In all cases, inspection report(s) shall be filled out by the inspector; signed by all parties indicated on the report form(s); and a copy given to the person responsible for the premises.

IV. Fourth Inspection or Third Reinspection

- A. If code compliance has been obtained, the inspector shall fill out an inspection report indicating business owner and premises are in compliance with the applicable fire code; impose a third reinspection fee; inform the person responsible for the premises that repeat violations encountered in future inspections may result in further fines, permit being revoked and cessation of business operations.
- B. Payment of fines, First Inspection, First, Second Third Reinspection fees must be paid to the CNMI Treasury within 30 days of Third Reinspection. If permit renewal date should fall within the 30 days, Fines, First Inspection, First, Second and Third Reinspection fees and the regular permit fee shall all be due upon request for permit renewal.
- C. If code compliance has not been obtained by the fourth inspection or the third reinspection, the inspector shall impose a third reinspection fee; issue the person reponsible for the premises a "NOTICE OF CLOSURE"; and order him/her to cease business operations due to a revoked permit; and place a sign at the entry points of the establishments stating, in effect, closure by order of the Department of Public Safety Fire Division Fire Prevention Section, and the reason(s) for closure.
- D. The business owner shall not resume business operations until hazards have been abated; a fourth reinspection is conducted and applicable code compliance has been obtained, it shall be the business owner's responsibility to call the Fire Prevention Section to coordinate the date and time of fourth reinspection; all fines, first inspection, first, second, third and fourth reinspection fees are paid, submitting receipts of payment as proof of payment; and an authority from the Fire Prevention Section has removed all posted signs and tags from the establishment.
- E. In all cases, inspection report(s) shall be filled out by the inspector; signed by all parties indicated on the form(s); and a copy given to the person responsible for the

premises. Inspector should inform the business owner or person responsible for the premises that repeat violations encountered in future inspections may result in fines.

Section 1010. Unannounced Inspections For Others Regulated by the UFC.

Unannounced inspections may be conducted by any designated official of the Department of Public Safety Fire Division, Prevention Section on any building and premises, business, activity, engagement, or function regulated by the applicable code at all reasonable times. The D.P.S Fire Division, Prevention Section's intention is to protect the integrity of its Fire Prevention Program; to take reasonable measures to ensure that all fire code compliance is confinually maintained and not just occasionally on or about Business License clearance date or on notice of inspection possibility; and to address concerns or complaints.

I. First Inspection

- A. The inspector shall conduct the inspection. If code compliance is being maintained or code compliance is obtained during this inspection, the inspector shall fill out an inspection report(s) indicating the owner, operator, occupant, and premises or other person responsible for that which is regulated by the applicable code, are in compliance with code. No inspection fee will be required.
- B. If code compliance is not being maintained and cannot be obtained during this inspection, the inspector shall impose a First Reinspection fee; and identify for the owner, operator, occupant or person responsible for the premises or other person responsible for that which is regulated by the applicable code, specific violation of the code and, dependent on the hazard and danger created by the violations and complexity of the work to be done, but generally within 15-30 days, schedule a First Inspection date and time to verify code compliance. NOTE: First Reinspection will be at a fee in accordance with Section 1013 under "First Reinspection."
- C. Citations normally will not be issued on the first inspection. When routine violations of the applicable fire code are encountered, citations will generally be issued after the second reinspection or depending on the violation involved.
- D. In all cases, proof of fee payment or reciept shall be presented to the Fire Prevention Office before the Second Inspection or First Reinspection is conducted; inspection report(s) shall be filled out by the inspector; signed by all parties indicated on the report form(s); and a copy given to the person responsible for that premises which is regulated by the code.

II. Second Inspection or First Reinspection

A. If code compliance has been obtained, the inspector shall fill out an inspection report indicating owner, operator, occupant, and premises or other responsible for that which

is regulated by the applicable code, are in compliance with the code. Fee in accordance with Section 1013 under "First reinspection" shall be imposed.

- B. Payment of fines and First Reinspection fees must be received by the CNMI Treasury, within 30 days after the First Reinspection was conducted. If involved is a business, and Business License clearance date should fall within the 30 days, fines and First Reinspection fees shall all be due upon request for Business License clearance.
- C. If code compliance has not been obtained on the Second Inspection or the First Reinspection, the inspector shall issue a "Warning of Violation", depending on violation of the applicable code; imposed a Second Reinspection or Third Inspection fee and, providing adequate time for compliance between inspections, dependent on the hazard and danger created by the violation and complexity of the work to be done, but generally, within 10-15 days, schedule a Third Reinspection date and time to verify code compliance.
- D. In all cases, Inspection report(s) shall be filled out by the inspector; signed by all parties indicated on the report form(s); and a copy given to the person responsible for that premises which is regulated by the code.

III. Third Inspection or Second Reinspection

- A. If code compliance has been obtained, the inspector shall fill out an inspection report indicating owner, operator, occupant, or person responsible for the premises or other person responsible for that which is regulated by the applicable code, are in compliance with the applicable fire code;
- B. If code compliance has not been obtained by the Third Inspection or the Second Reinspection, the inspector shall impose a Second Reinspection fee; schedule a Third Reinspection date and time to verify compliance, providing adequate time for compliance between inspections, dependent on the hazard and danger created by the violation and the complexity of the work to be done, but generally, within 15-30 days; and issued a citation, a fine based on the Fine Fee Schedule.
- D. If involved is a business, the inspector should mention the possibility of business license being revoked and cessation of business operation. (See Section 1013 for fines for each violations of the applicable code).

IV. Fourth Inspection or Third Reinspection

- A. If code compliance has been obtained, the inspector shall fill out an inspection report indicating owner, operator, occupant or person responsible for the premises or other person responsible for that which is regulated by the applicable code, is/are in compliance with the code.
- B. If involved is a business, and code compliance has not been obtained by the Fourth Inspection or the Third Reinspection, the inspector shall issue the person responsible

for the premises a "NOTICE OF CLOSURE'; and order him/her to cease business operation due to hazards; and place a sign of establishment stating, in effect, <u>closure</u> by order of the DPS Fire Division Prevention Section and the reason(s) for closure.

- D The business owner shall not receive Business License clearance from the DPS Fire Division Prevention Section nor resume business operation until hazards have been abated; a Fourth Reinspection is conducted and applicable code compliance has been obtained (business owners are responsible to contact DPS Fire Division Prevention Section to coordinate the date and time); all fine payable to CNMI Treasury have been recieved, and an authorized DPS Fire Division Prevention Section Official has removed all posted signs and tags from the establishment.
- E. In all cases, proof of payment or reciepts must be presented to the Fire Prevention Section before any inspection could be conducted; inspection report(s) shall be filled out by the inspector; signed by all parties indicated on the report form(s); and copy given to the person responsible for that which is regulated by the code. Inspector should inform the business owner or person responsible for the premises that repeat violations encountered in future inspections may result in fines.

Section 1011. Inspections For Permit Renewal

I. First Inspection

- A. The Inspector shall conduct the inspection. If applicable code compliance is being maintained or if code compliance is obtained during this inspection, the inspector shall fill out an inspection report(s) indicating business owner and premises are in compliance with the applicable code; issue a citation, fines depending on the violation if necessary; obtain all signatures indicated on the report form(s); and issue a copy of report(s) to the person responsible for the premises and, if applicable, inform the same that repeat violations that encountered in future inspection may result in fines. There is no charge for this First Inspection, it is included in the permit fee which must be received, along with fines, by the Commonwealth Northern Mariana Island (CNMI), Treasury, before permit is renewed (see issuance of Permit Schedule).
- B.
- If code compliance is not being maintained and cannot be obtained during this inspection, the inspector shall identify for the person responsible for the premises, specific violation of the applicable code; issued a citation, fines depending on violation if necessary; and, providing adequate time between inspection, dependent on the hazard and danger created by the violation and the complexity of the work to be done, but generally, within 15-30 days, schedule a First Reinspection date and time, to verify code compliance.

First Reinspection fee and fines shall be payable to the CNMI, Treasury when code compliance is obtained and before permit is issued (see Inspection Fee Schedule)

- C. Citations normally will not be issued on the First Inspection. When routine violation of the applicable fire code are encountered, citations will generally be issued upon the Second Inspection or First Reinspection, if violations are encountered. Exception: Citation issued for violations which present imminent life hazards such as trespassing in a closed area, smoking in closed or restricted areas, failure to obey the lawful orders of a fire inspector, faulty equipment or procedures, repeated violations of a similar nature will not required prior notice.
- D. In all cases, inspection report(s) shall be filled out by the inspector; signed by all parties indicated on the report form(s); and a copy given to the person responsible for the premises.

IV. Second Inspection or First Reinspection.

- A. If code compliance has been obtained, the inspector shall fill out an inspection report indicating business owner and premises are in compliance with the applicable fire code; issue a citation, fines depending on violations if necessary; impose a First Reinspection fee; inform the person responsible for the premises that repeat violations encountered in future inspection may result in fines.
- B. Payment of fines, First Reinspection fee and regular permit fee must payable to the the CNMI, Treasury before permit is renewed (see Inspection Fee and Fees for the Issuance of permit schedule.
- C. If code compliance has not been obtained by the Second Inspection or the First Reinspection, the inspector shall issue a citation, a fine depending on the violation of the applicable code; impose a First Reinspection fee; and providing adequate time for compliance between inspections, dependent on the hazard and danger created by the violation and the complexity of work to be done, but generally, within 1-15 days, schedule a Second Reinspection date and time, to verify compliance. Note Second Reinspection fees will the double First Reinspection fee (see Inspection Fee Schedule). Continued violations encountered upon Second Reinspection may result in citation, fines based on violation(s).
- D. In all case, inspection report shall be filled out by the inspector, signed by all parties indicated on the report form(s); and a copy given to the person responsible for the premises.

III. Third Inspection or Second Reinspection

- A. If code compliance has been obtained, the inspector shall fill out an inspection report indicating business owner and premises are in compliance with the applicable fire code; impose a Second Reinspection fee; inform the person responsible for the premises that repeat violations encountered in the future inspection may result in fines.
- B. Payment of fines, First Reinspection and Second Reinspection fees, and regular permit fee must be received by the CNMI Treasury, before permit is renewed (see Inspection Fee Schedule and Fine Schedule).

- C. If code compliance has not been obtained by the Third Inspection or the Second Reinspection, the inspector shall impose a Second Reinspection fee; providing adequate time for compliance between inspections dependent on the hazard and danger created by the violation, but generally, within days, schedule a Third Reinspection date and time to verify compliance; and issue a citation, a fine based on the violation.
- D. The inspector should mention the possibility of permit being revoked and cessation of business operation. The fine(s) issued at this point will be added to those already issued. Note Third Reinspection fee shall be double the Second Reinspection Fee (see inspection Fee schedule).
- E. In al cases, the inspection report(s) shall be filled out by the inspector, signed by all parties indicating on the report form(s); and a copy given to the person responsible for the premises.

IV. Fourth Inspection or Third Reinspection.

- A. If code compliance has been obtained, the inspector shall fill out an inspection report indicating business owner and premises are in compliance with the applicable fire code; impose a Third Reinspection fee; inform the person responsible for the premises that repeat violations encountered in future inspections may result in further fines, permit being revoked and/or cessation of business operations.
- C. Payment of fines, First, Second and Third Reinspection fees, and regular permit fee must be received by the CNMI, Treasury before permit is renewed.

Section 1012. Permits;

General; Any person, firm, or corporation who plans to engage in any of the following activities listed below, shall obtain permit from the Fire Division Fire Prevention Section. Prior to issuance of any permit, an application for permits and other necessary documents required by the Fire Prevention section must be submitted for review and scheduling of inspection if deemed necessary. Fees for each activity shall be payable to the

TYPE OF PERMIT	FEE	DURATION	CODE SECTION
Aerosol Products To store or handle an aggregate quantity of level 2 or level 3 aerosol products in excess of 500 lbs. net wt	\$20.00	Annually	UFC ARTICLE 88
Aircraft Refueling Vehicles To operate aircraft refueling Vehicles.	\$20.00	Annually	UFC ARICLE 24
Aircraft Repair Hangar	\$20.00	Annually	UFC

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To use any structure as an aircraft Hangar for]		ARTICLE 24
Servicing or repair aircraft.			
Asbestos Removal	\$20.00	Annually	UFC
To conduct asbestos-removal operations.			ARTICLE 87
Automobile Wrecking Yark	\$20.00	Annually	UFC
To operate an automobile wrecking yard.			ARTICLE 34
Bowling Pin or Alley Refinishing	\$10.00	Each Occurance	UFC
To conduct a bowling pin refinishing or bowling			ARTICLE 26
alley resurfacing operation involving use and			
application of flammable liquids or materials.	L		
Candles and Open Flame Devices in Assembly areas	\$20.00	Annually	UFC
To use open flame or candles in connection with			ARTICLE 25
Assembly areas, dining areas of restautants or			
Drinking establishements.	L		
Carnivals and Fairs	\$10.00	Each Occurance	UFC
To conduct a carnival or fair (plans of grounds			ARTICLE 25
Required)	ļ		E
To conduct a concession booth.	\$10.00	Each Occurance	
Cellulose Nitrate Film	\$20.00	Annually	UFC
To store, handle, use or display			ARTICLE 33
Cellulose Nitrate Storage or Handling	\$20.00	Annually	UFC
To store or handle more than 25 lbs.	ļ		ARTICLE 27
Christmas Trees	\$10.00	Each Occurance	UFC
To use natural or resin-bearing cut trees in Public			APPENDIX IV-B
Areas.	i		ŀ
Combustible Fiber	\$20.00	Until Revoked	UFC
To store or handle more than 100 cu. Ft			ARTICLE 28
(exception: exterior storage of hay, straw, and			
similar agricultural materials).	1		
Combustible Materials	\$20.00	Annually	UFC
To store more than 2500 cu. Ft. gross volume of			ARTICLE 11
Cumbustible empty packing cases, boxes, barrels or	1		
Similar containers, or rubber or cork. or other	1	ļ	
Similarly combustible material.		1	
Commercial Rubbish-Handling Operation	\$20.00	Annually	UFC
To operate a commercial handling operation			ARTICLE 11
Compressed Gases			UFC
If compressed gases is in excess of amounts listed in			ARTICLE 74, 80,
UFC Table 105-A. Note: Additional requirements			and 82.
and exceptions in UFC Articles 74, 80, and 82.			
To store, transport on site, dispense, use or handle		ſ	
To install, repair, abandon, remove, place temporarily			
out of service, close or substantially modify a	1		
compress gas system.	1		
	.		
Corrosive-Any amount	\$20.00	Annually	
Flammable-More than 200 cu. Ft.			
(except cryogenic fluids and liquified petroleum gas.			
Highly Toxic-any amount	\$20.00	Annually	
Inert- More than 6,000 cu. Ft.	\$20.00	Annually	
Oxidizing (including oxygen)-More than 500 cu. Ft.	\$20.00	Annually	
Pyrophoric- Any amount	\$20.00	Annually	
Radioactive- Any amount	\$20.00	Annually	
	1 630 00	I Ammunallu	
Toxic- Any amount Unstable (reactive)- Any amount	\$20.00 \$20.00	Annually Annually	

Cryogens To produce, store, or handle cryogens in excess of the Amounts listed in Table 105-B. Exceptions: where federal or local regulations apply, and for fuel systems for vehicle.			UFC ARTICLE 75
Corrosive Over 1 gallon inside building Over 1 gallon outside building	\$20.00	Annually	
Flammable Over 1 gallon inside building Over 60 gallon outside building	\$20.00	Annually	
Highly Toxic Over 1 gallon inside building Over 1 gallon outside building	\$20.00	Annually	
Non-Flammable Over 60 gallon inside building Over 5000 gallon outside building	\$20.00	Annually	
Oxidizer (include oxygen) Over 50 gallons inside building Over 50 gallons outside building	\$20.00	Annually	
Dry Cleaning Plants To engage in business or to change to a more Hazardous substance.	\$20.00	Annually or Each Occurance	UFC ARTICLE 36
Dust Producing Operations To operate a grain elevator, flour starch mill, feed mill or plant pulverizing aluminum, coal, cocoa, magnesium, spices, sugar, or other material producing combustible dust as define in article 2.	\$20.00	Annually	UFC ARTICLE 30 and 76
Explosives or Blasting Agents Note: Additional requirements and exceptions in UFC Article 80.			UCF ARTICLE 77 and 80
Permit shall be obtained: To manufacture, posses, store, sell, display or Otherwise dipose of explosive materials at any Location.	\$20.00	Each Occurance	
To transport explosive materials	\$20.00	Each Occurance	
To use or handle explosive materials	\$20.00	Each Occurance	
To operate a terminal for handling explosive material.	\$20.00	Annually	
Fire Hydrants and Water-Control Valves To use a fire hydrant or operate a water control valve Intended for fire-suppression purposes. (joint Approval with authority having jurisdiction)	\$10.00	Each Occurance	Public Law 11-56 Section 7311 UFC ARTICLE 9
Fireworks To conduct Fireworks display.(Fireworks 1.3G) Note: For Fireworks 1.3G Class "B", an approval Must be obtained from the governor prior to issuance	\$100.00	Each Occurance	Public Law 11-98 Section 7312 UFC ARTICLE 78.

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Of permit.			
To use, store, handle fireworks 1.4G. (permit shall be Required by wholesalers and/or distrubuters of Fireworks 1.4G, commonly known as Class "C" Fireworks).	\$20.00	Annually	
Flammable and Combustible Liquids			UFC
Exceptions:			ARTICLE 79
 As otherwise provided in other laws or regulations. Alcoholic beverages in retail sales or storage uses. provided the liquids are packaged in an individual containers not exceeding 4 liters. Medicines, foodstuffs and cosmetics containing not more than 50 percent by volume of water-miscible liquids and with the remainder of the solution not being flammable in retail sales or storage uses when packeaged in individual 			
 containers not exceeding 4 liters. 4. Storage and use of fuel-oil tanks and containers connected to oil-burning equipment. Such storage and use shall be in accordance with Article 61 and the Mechanical code. For abandonment of tanks, article 79 shall apply. 			
 Refrigerant liquids and refrigerant oils within an approved closed-cycle refrigeration system complying with the Mechanical code. See Article 63. 			
 Storage and display of aerosol products. See Article 88 Materials which are solid at 100 degrees F. or above. Storage of liquids that have no fire point when tested in accordance with nationally recognized standards. See section 9003, standard a.4.5 			
 Liquids without flash points that can be flammable under some conditions, such as certain halogenated hydrocarbons. 			
Permits shall be obtained: To use or operate, install, repair or modify a pipeline for the transportation of flammable or combustible liquids.	\$20.00	Annually	
To store, handle or use Class I liquids More than 5 gallons in a building. More than 10 gallons outside of a building. Exceptions: (1) Storage or use of class I liquids in the Fuel tank of a motor vehicle, aircraft, motorboat, Mobile power plant or mobile heating plant unless Such storage, in the opinion of the chief, would cause An unsafe condition. (11) The storage or use of paints. Oils, varnishes or similar flammable mixtures when Such liquids are stored for maintenance, painting or Similar purposes for a period of not more than 30 Days.	\$20.00 \$20.00	Annually Annually	
To store, handle or use class II or class III-A liquids More than 25 gallons in a building Exceptions: (1) Fuel oil used in connection with oil-burning Equipment.	\$20.00	Annually	
More than 60 gallons outside a building. Exception: Fuel oil used in connection with oil -burning equipment.	\$20.00	Each Occurance	
To remove class I or class II liquids from an	\$20.00	Each Occurance	<u> </u>

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Underground storage tank used for fueling motor			
Vehicles by any means other than the approved,			
Stationary on-site pumps normally used for			
Dispensing purposes.			
Dispensing purposes.			
To install assistant alter or promoto tools vehicles	\$20.00	Annually	
To install, construct, alter or operate tank vehicles,	\$20.00	Annuany	
Equipment, tanks, plants, terminals, wells, fuel			
-dispensing stations, refineries, distilleries and similar			
facilities where flammable and combustible liquids			
are produced, processed, transported, stored,		1	
dispensed, or used.			
To install, alter, remove, abandon, place temporarily	\$20.00		
out of service or otherwise dispose of a flammable or			
combustible liquid tank.			
	\$20.00	Each Occurance	
0-5,000 gal.			
5,001-10,000 gal.	\$20.00	Each Occurance	
Over 10,000 gal.	\$20.00	Each Occurance	
To change the type of contents stored in a flammable			
or combustible liquid tank to a material other than			
that for which the tank was designed and contructed.	1		
0-5,000 gai.	\$20.00	Each Occurance	
5,001-10,000	\$20.00	Each Occurance	
Over 10,000	\$20.00	Each Occurance	
Fruit Ripening Processes		Luci ottalinite	UFC
In heated rooms and ripening processes where	1		ARTICLE 46
Ethylene gas is introduced into the room to assist the	1	1	ARTICLE 40
Ripening process.			
To operate a fruit ripening process.	\$20.00	Annually	
Fumigation or Thermal Insecticidal Fogging			UFC
Note: see article 80 for additional requirements and	1		ARTICLE 47
Exceptions.			/IICHCEE 4/
Exceptions.			
	\$20.00	A	
To Operate a business of fumigation or thermal	\$20.00	Annually	1
Insecticidal fogging or to maintain a fumigation room,	1		
vault or chamber in which a toxic or flammable			
fumigant is used.	l	1	<u> </u>
Hazardous Materials		1	UFC
To store, transport on site, dispense, use or handle	1		ARTICLE 80
Hazardous materials or to install, repair, abandon,	1		
Remove, place temporarily out of service, close or	1		
Substantially modify a storage facility or other area	ł	1	-
Regulated by UFC Article 80 when the hazardous	l l		ļ
Materials in use or storage exceed amounts listed in		1	
UFC Table 105-C.			
Note: The hazardous materials that exceeds the permit amount			
shall be used in determining the hazard classification. If more than		ł	
one hazardous material involved, the material that fil within the			
highest hazard classification described herein shall be used.	1	1	
The measurement method used in the UFC for the respective		1	
Hazardous materials shall be applicable.	1		1
Minor Hazard	\$20.00	Annualtri	
	\$20.00 \$20.00	Annually Annually	

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Gases: not to exceed 200 cu. Ft. of permit amount.\$20.00AnnuallyModerate Hazard Solid: 501-5000 lbs. (excess of permit amount)\$30.00AnnuallyLiquid: 56-550 gals. (excess of permit amount)\$30.00AnnuallyGases: 201-2000 cu. Ft. (excess of permit amount)\$30.00AnnuallyMajor Hazard Solid: 5001-52000 lbs. (excess of permit amount)\$40.00AnnuallyMajor Hazard Solid: 5001-2500 gals. (excess of permit amount)\$40.00AnnuallyCases: 2001-10000 cu. Ft. (excess of permit amount)\$40.00AnnuallyExtreme Hazard Solid: 25001 lbs. and over (excess of permit amount)\$50.00AnnuallyExtreme Hazard Solid: 25001 cu.ft. and over (excess of permit amount)\$50.00AnnuallySpecial Hazard Based on type of occupancy, size, location, quantity and degree of hazard.\$100.00AnnuallyHazardous Production Materials To use any building or portion there of exceeding 2,500 sq.ft. for high-piled combustible storage (floor plan required)\$20.00AnnuallyHot-Work Operations Permits are required for hot work including, but not limited to:\$20.00AnnuallyARTICLE 81Construction there of the curve of the
Solid: 501-5000 lbs. (excess of permit amount) Liquid: 56-550 gals. (excess of permit amount) Gases: 201-2000 cu. Ft. (excess of permit amount)\$30.00 \$30.00Annually AnnuallyMajor Hazard Solid: 5001-25000 lbs. (excess of permit amount) Liquid: 551- 2750 gals. (excess of permit amount) Gases: 2001-10000 cu. Ft. (excess of permit amount)\$40.00 \$40.00Annually AnnuallyExtreme Hazard Solid: 25001 lbs. and over (excess of permit amount) Liquid: 2751 gals. and over (excess of permit amount)\$50.00 \$50.00Annually AnnuallyExtreme Hazard Solid: 25001 lbs. and over (excess of permit amount) Liquid: 2751 gals. and over (excess of permit amount)\$50.00 \$50.00Annually AnnuallySpecial Hazard Based on type of occupancy, size, location, quantity and degree of hazard.\$100.00 \$20.00Annually AnnuallyHazardous Production Materials To store, handle or use in group H, Div. 6 occupancy 2,500 sq.ft. for high-piled combustible storage (floor plan required)\$20.00Annually AnnuallyHot-Work Operations Permits are required for hot work including, but not limited to:\$20.00Annually ARTICLE 49
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work is conducted
work is conducted.
Use of portable hot-work equipment inside a \$20.00 Annually
Structure.
Exception: Work that is conducted under a construction permit
issued by the building official.
Fixed site bot work equipment such as welding \$20.00 Annually
Fixed-site not-work equipment such as welding
Booths.
Hot-work conducted within a Hazardous fire area. \$20.00 Annually
Liquified Petroleum Gas UFC
To store, use, handle or dispense LP-gas ARTICLE 82
Portable containers equal to or more than 125-gal. \$20.00 Annually
Aggegate water capacity but not more than 4,000
-gals. aggregate water capacity nor a container more
than 2,000-gals. water capacity.
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of vessels, floats, piers or wharves APPENDIX II-C	To use open-flame devices for maintenance or renair	\$20.00	Annually	ARTICLE
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To use portable barbeques braziers or cooking \$20.00 Annually	or vessers, mores, preis or whatves		1	
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	To use portable barbecues, braziers or cooking	\$20.00	Annually	
Devices on vessels, floats, piers or wharves.	Devices on vessels, floats, piers or wharves.			
Motor Vehicle Fuel-Dispensing Stations UFC				UFC
To dispense flammable or combustible liquids, \$20.00 Annually ARTICLE 52		\$20.00	Annually	1
			· · · · · · · · · · · · · · · · · · ·	
Liquified petroleum gases or compressed natural gas				1
at motor vehicle fuel-dispensing stations.			1	
(plans and specifications required)	(plans and specifications required)		1	
	-		1	
Note: Such operations shall include both public and private	Note: Such operations shall include both public and private		1	
Accessible operations, automotive, marine fuel-dispensing stations.				
Open Burning UFC				UFC
(not including barbecue) ARTICLE 11				
	(not merading our occue)		1	
	To another the burning	65.00	Ammuniter	
To conduct open burning \$5.00 Annually or	10 conduct open burning	1 22.00	Annually or	

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(Joint approval with Division of Environmental Quality).		Each Occurance	
Note: Open burnig is the burning of a bonfire, rubbish fire or other fire in an outdoor location where fuel being burned is not contained in an incinerator, outdoor fireplace, barbecue grill or barbecue pit.			
Organic Coatings To manufacture more than one gallon of organic Coating in a working day. Exception: Processes manufacturing nonflammable or water- Thinned coating and operations applying coating materials.	\$20.00	Annually	UFC ARTICLE 50
Ovens, Industrial Baking or Drying To operate an industrial baking or drying oven.	\$20.00	Annually	UFC ARTICLE 62
Note: Industrial baking and drying which are heated with oil or gas fuel or which during operation contain flammable vaports from the products being baked or dried. (Plans of details and calculations required)			
Parade Floats To use a parade float for public performance, Presentation, spectacle, entertainment, or parade each float.	\$10.00	Each Occurance	UFC ARTICLE 11
Repair Garages To use a structure as a place of business for servicing or repairing motor vehicles.	\$20.00	Annually	UFC ARTICLE 29
Rifle Ranges To establish, maintain or operate a rifle range. Note: Application must be referred to Police Division for approval	\$20.00	Annually	UFC APPENDIX II-D
Spraying or Dipping To conduct a spraying or dipping operation utilizing Flammable or combustible liquids or combustible Powders	\$20.00	Annually	UFC ARTICLE 45
Tire Storage (outdoor) To use an open area or portion thereof to store tires in excess of 1,000 cu.ft. (plans required)	\$20.00	Annually	UFC ARTICLE 11
Refregeration Equipment A permit is required for regrigeration unit or system installations having a refrigerant circuit containing more than 220 lbs. of group A1 or 30 lbs. of any other group refrigerant.(plans and specification Required) To install or operate a mechanical refrigeration unit	\$20.00	Annually	UFC ARTICLE 63
or system.			
Tent, Canopies, and Temporary Membrane Structures To erect or operate a tent or air-supported temporary Membrane structure or a canopy.(except for			UFC ARTICLE 32
camping)	\$20.00	Each Occurnce	
Tent or air-supported membrane more than 200 sq.ft.	\$20.00	Each Occurance	
Canopy over 400 sq.ft.			
Note: Permit not to exceed 180 days within a 12 month period.		<u> </u>	

Section 1012. Fines for Violations of the Code.

UFC		
SECTION	OFFENSE	

Section 2701	pin-refinishing rooms. Violation of provisions for cellulose nitrate plastics (pyroxylin) storage and	\$50.00
Section 2701	handling.	\$20.00
Section 2801	Violation of provisions for the storage and handling of combustible fibers.	\$50.00
Section 2901	Violation of provisions for garages used for service or repair of motor	\$75.00
S	vehicles.	676.00
Section 3001	Violation of provisions for woodworking plants and exterior lumber storage. Violation of provisions for tents and temporary membrane structures having	\$75.00
Section 5201	an area in excess of 200 sq. ft., and canopies in excess of 400 sq. ft	\$75.00
Section 3301	Violation of provisions for the storage and handling of cellulose nitrate	\$75.00
	motion picture film (nitrate film).	
Section 3401	Violation of provisions for automobile wrecking yards.	\$50.00
Section 3501	Violation of provisions for the temporary use of the common pedestrian area within a covered mall building for promotional, educational, assembly, sales or similar activities.	\$75.00
Section 3601.1	Violation of provisions for dry-cleaning plants and systems.	\$75.00
Section 4501.1	 Violation of provisions for: The application of flammable or combustible paint, varnish, lacquer, stain or other flammable or combustible liquid applied as spray by compressed air, airless, or hydraulic atomization, steam, electrostatic or other methods or means in continuous or intermittent process, Dip tank operations in which articles or materials are passed through contents of tanks, vats or containers of flammable or combustible liquids, including coating, finishing, treatment and similar processes, and The application of combustible powders by powder spray guns, electrostatic powder spray guns, fluidized beds. 	\$75.00
Section 4601	Violation of provisions for fruit-ripening processes in heated rooms and ripening processes where ethylene gas is introduced into a room to assist the ripening process.	\$75.00
Section 4701	Violation of provisions for fumigation and thermal insecticidal fogging operations.	\$75.00
Section 4801	Violation of provisions for the storage, handling and processing of magnesium, including the pure metal and alloys of which the major part is magnesium.	\$75.00
Section 4901	Violation of provisions for welding and cutting operations.	\$75.00
Section 5001	Violation of provisions for processes manufacturing protective and decorative finishes or coating for industrial, automotive, marine, transportation, institutional, household or other purposes, including the handling of flammable or combustible liquids, combustible solids and dust. Exception: Processes manufacturing nonflammable or water-thinned coating and operations applying coating materials.	\$75.00
Section 5101	Violation of provisions for semiconductor fabrication facilities and comparable research and development areas classified as Group H, Division 6 Occupancies.	\$75.00
Section 5201	Violation of provisions for automotive, marine, and aircraft motor vehicle fuel-dispensing, including both public accessible and private operations. (UFC Standard 52-1)	\$75.00
Section 6101	Violation of provisions for oil-burning equipment other than internal combustion engines, oil lamps and portable devices such as blow torches, melting pots and weed burners.	\$ 75.00
	Violation of provisions for the location, construction and operation of	
	industrial baking and drying ovens which are heated with oil or gas fuel or	\$75.00

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_	which during operation contain flammable vapors from the products being baked or dried. (UFC Standard 62-1)	
	Violation of provisions for refrigeration unit and system installation having a	
	refrigerant circuit containing more than 220 ponds of Group A1 or 30 pounds	
Section 6301	of any other group refrigerant.	\$75.00
Section 0501	Exception: The chief is authorized to exempt temporary or portable installation.	\$75.00
· · · ·	Violation of provisions for stationary lead-acid battery systems having a	
Section 6401	liquid capacity of more than 100 gallons used for facility standby power.	\$75.00
Section 6401		\$75.00
0 1. 7401 1	emergency power or uninterrupted power supplies.	
Section 7401.1	Violation of provision for storage, use and handling of compressed gases	
	containers, cylinder, tanks, and systems. Including those gases regulated in	675.00
	UFC. Partially full compressed gas containers, cylinders and tanks containing	\$75.00
	residual gases shall be considered as full for the purposes of the controls	
	required.	
	Violation of provisions storage, use and handling of cryogenic fluids.	
	Partially full containers, having residual cryogenic fluids shall be considered	
Section 7501	as full for the purposes of the controls required.	
	Exception: Fluids within an approved closed-cycle refrigeration system	\$75.00
	complying with the mechanical code are not regulated by Article 75.	
Section 7601.1	Violation of provisions for prevention of dust explosions.	\$75.00
	Violation of provisions for manufacture, possession, storage, sale,	
	transportation and use of explosive materials.	
	Exception: 1. The armed forces of the United States, Coast Guard or National	
	Guard; 2. Explosive in forms prescribed by the official United States	
	Pharmacopoeia; 3. The sale, possession or use of fireworks 1.4G (Class C	
	common fireworks); 4. The possession, transportation, storage, and use of small	
	arms ammunition when packaged in accordance with DOT packaging	
Section 7701.1	requirements; 5. The possession, storage, transportation and use of not more than 5	\$75.00
beenen //oili	pounds of commercially manufactured sporting black powder, 20 pounds of	<i>ψ/<i>3</i>.00</i>
	smokeless powder and 10,000 small arms primers for hand loading of small arms	
	ammunition for personal consumption; 6. The transportation and use of explosive materials by the United States Bureau of Mines and federal, state and local law	
	enforcement and fire agencies acting their official capacities; 7. Special industrial	
	explosive devices which in the aggregate contain less than 50 pounds of explosive	
	materials; 8. The possession, transportation, storage and use of blank industrial	
	power load cartridges when packaged in accordance with DOT packaging	
	requirement; 9. When preempted by federal regulation; 10. The use and handling	
	of fireworks 1.3G (Class B Fireworks) as set forth in Article78.	
	Violation of provisions for fireworks and temporary storage, use and handling	
Section 7801	of pyrotechnic special effects materials use in motion pictures, television, and	\$75.00
	theatrical and group entertainment productions.	
	Violation of provisions for storage, use, dispensing, mixing and handling of	
	flammable and combustible liquids.	
	Exception: 1. As otherwise provided in other laws or regulation; 2. Alcoholic	
	Beverages in retail sales or storage uses, provided the liquids are packaged in	
	individual containers not exceeding 4 liters; 3. Medicines, foodstuffs and cosmetics	
	containing not more than 50 percent by volume of water-miscible liquids and with the	
	remainder of the solution not being flammable, in retail sales or storage uses when	
	packaged in individual containers not exceeding 4 liters; 4. Storage and use of fuel	
	tanks and containers connected to oil-burning equipment. Such storage and use shall	
	be in accordance with	
Section 7001 1	Article 61 and Mechanical Code. For abandonment of tanks, article 79 Sholl apply 5. Reference liquids and reference tails within an approved	\$75.00
Section 7901.1	Shall apply, 5. Refrigerant liquids and refrigerant oils within an approved	\$/ 3. 00
	Closed-cycle refrigeration system complying with the mechanical code. See	
	Article 63; 6. Storage and display of aerosol products, see article 88; 7. Materials which are solid at 100 °F or above; 8- storage of liquids that have no fire	
	point when tested in accordance with nationally recognized standards. See section	
	9003, standard a.4.5; 9. Liquids without flash points that can be flammable under	
	some conditions, such as certain halogenated hydrocarbons and mixtures containing	
	halogenated hydrocarbons.	

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1-0	Standardized signs shall be provided in new and existing buildings that are	
U.F.C Appendix I-C	Violation of provisions for signs to provide information to the occupants and fire department personnel to minimize confusion during emergencies.	\$75.00
	department vehicle access.	
	Group B Office or Group R, Division 1 occupancies, each having floors used for human occupancy located more than 75 feet above the lowest level of fire	
I-B	buildings constructed prior to the adoption of appendix I-B and which house	Ψ75.00
U.F.C Appendix	comply with section 6. Violation of Provisions for life-safety requirements for existing high-rise	\$75.00
	Group R Division 3 occupancies, except that Group R Division 3 occupancies shall	
	of the Uniform Building Code. Exception: Group U occupancies and occupancies regulated by Appendix I-B, and	
I-A	other than high-rise, which do not conform with the minimum requirements of the Uniform Building Code.	
U.F.C Appendix	Violation of provisions for life-safety requirements for existing buildings,	\$75.00
	section 9001.2.	
	prima facie evidence of compliance with the standard of duty set forth in	
3001011 9001.3	recognized standards. Compliance with these recognized standards shall be	\$12.00
Section 9001.3	resonably safe for life, limb, health, property, and public welfare. Violation of provisions of the recognized standards listed in section 9003 are	\$75.00
	materials of building, structure, equipment, processes, and methodologies be	
	standards listed in section 9003 is that the design, construction and quality of	
Section 9001.2	Violation of provisions of Standard of Duty established for the recognized	\$75.00
	referred to in this code as a "UFC standard."	
	in volume 2 of this code, are hereby declared to be part of this code and are	
Section 9001.1	Violation of provisions for the <u>Uniform Fire Code Standards</u> referred to in various parts of this code, which are also listed in Section 9002 and published	\$/2.00
Section 9001.1	classification level are not regulated by Article 88.	\$75.00
	Exception: Level 1 aerosols in cartons which are clearly marked to identify their	
Section 8801.1	Violation of provisions for storage and retail display of aerosol products.	\$75.00
	demolition.	
Section 8701	Violation of provisions for buildings undergoing construction, alteration or	\$75.00
	Exception: Low-voltage wiring, such as communications and signal wiring.	
Section 8501	Violation of provisions for permanent and temporary use of electrical appliances, fixtures, motors and wiring.	\$75.00
9	source used in projection.	£75.00
	the projection of ribbon-type cellulose nitrate film, regardless of the light	
	projection equipment which develops hazardous gases, dust or radiation and	
00000010101	safety film in conjunction with electric arc, xenon or other light source	
Section 8401	Violation of provisions for the use of ribbon-type cellulose acetate and other	\$75.00
00001011 0201	installation of equipment pertinent to system for such uses.	<i></i>
Section 8201	Violation of provisions for storage, handling, transportation of LP-gas and the	\$75.00
	with Article 80.	
	accordance with article 88, flammable and combustible liquids shall be in accordance with Article 79, and hazardous materials shall be in accordance	
	storage. In addition to the requirements of Article 81, aerosol shall be in	\$75.00
Section 8101	Violation of provisions for building containing high-piled combustible	
	accordance with the manufacture's instructions and label directions.	
	abatement, erosion control, soil amendment or similar applications when applied in	
	are unlimited when packaged individual containers not exceeding 4 liters; 2. Application and release of pesticide products and materials intended for use in weed	
	and with the remainder of the solution not being flammable, in retail sales occupancies	
	cosmetics, containing not more than 50 percent by volume of water-miscible liquids	
	Exception: 1. The quantities of alcoholic beverages, medicines, foodstuffs and	
	hazardous materials and information needed by emergency response personnel.	
	dangerous conditions related to storage, dispensing, use and handling of	\$75.00

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<u> </u>	four or more stories in height. Such signs shall be installed in stairways to	
	identify each stair landing and indicate the upper and lower termination of the	
	stairway.	
U.F.C Appendix	Violation of provisions for safeguards to prevent the occurrence of fire and to	\$75.00
II-A	provide adequate fire -protection facilities to control the spread of fire which	\$75.00
	might be caused by recreational, residential, commercial, industrial, or other	
	activities conducted in hazardous fire areas.	
U.F.C Appendix	Violation of provisions for protection of flammable and combustible liquid	\$75.00
U-B	tanks in locations subject to flooding.	\$75.00
U.F.C Appendix	Violation of provisions for marina facilities.	\$75.00
II-C		
U.F.C Appendix	Violation of provisions for rifle ranges.	\$75.00
II-D	Violation of provisions for Hazardous Materials Inventory Statement (HMIS)	\$75.00
U.F.C Appendix II-E		\$12.00
п-е	and Hazardous Materials Management Plans (HMMP) which are required by the chief pursuant to Article 80 shall be provided for hazardous materials.	
	Exception: 1. Materials which have been satisfactorily demonstrated not to present a	
	potential danger to public health, safety or welfare, base upon the quantity or condition	
	of storage, when approved, 2. Chromium copper, lead, nickel and silver need not be	
	considered hazardous materials for he purposes of Appendix II-E unless they are	
	stored in friable, powder or finely divided state.	
U.F.C Appendix	Violation of provisions for the storage and dispensing of motor fuels into the	\$75.00
II-F	fuel tanks of motor vehicles from protected aboveground tanks located	
	outside buildings.	
U.F.C Appendix	Violation of provisions for secondary containment for underground tank	\$75.00
II-G	system containing flammable or combustible liquids. Also see C.F.R. Title	
	40, part 280, and UFC section 8001.4.5.1 for additional requirements related	
	to secondary containment tanks containing hazardous materials other than	
	flammable and combustible liquids.	
U.F.C Appendix	Violation of provisions for site assessment for determining the potential fire	\$75.00
II-H	or explosion risk from a leak, spill or discharge from an underground	• • • • • •
	flammable or combustible liquid storage tank. Also, see UFC section	
	7901.7.4.	
U.F.C Appendix	Violation of provisions for equipment having maximum ozone-generating	\$75.00
II-I	capacity of 1/2 pound or more over a 24 hour period.	
	Exception: Ozone-generating equipment used in Group R, Division 3	
	occupancies.	
U.F.C Appendix	Violation of provisions for storage of flammable or combustible liquids in	\$75.00
II-J	tanks located within below-grade vaults.	
U.F.C Appendix	Violation of provisions for the procedure determining fire-flow requirements	\$75.00
III-A U.F.C Appendix	for building or portions of building hereafter constructed. Violation of provisions for fire hydrant location and distribution.	\$75.0
III-B	violation of provisions for the nyuralit location and distribution.	\$75.0
U.F.C Appendix	Violation of provisions for inspection, testing and maintenance of water-	\$75.00
III-C	based fire-protection systems.	
U.F.C Appendix	Violation of provisions for basement pipe inlets. Also, see UFC section 1005.	\$75.00
III-D		
U.F.C Appendix	Violation of provisions for exposed floor surfaces of buildings, including	\$75.00
IV-A	coverings which are applied over a previously finished floor.	
	Exception: Interior floor finish materials of a traditional type, such as wood, vinyl,	
UEGA "	linoleum, terrazzo, and other resilient floor covering materials.	075.00
U.F.C Appendix	Violation of provisions for the use of natural or resin-bearing cut trees in	\$75.00
IV-B	public buildings.	-
U.F.C Appendix V-A	Violation of provisions of Nationally recognized standards of good practice.	\$75.00
U.F.C Appendix	Violation of provisions for hazardous materials classifications. To provide	\$75.00
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VI-A	information, explanations and examples to illustrate and clarify the hazard	
	categories contained in Article 80. The hazard categories are base upon the	
	code of Federal Regulations, Title 29. Where the numerical classifications are	
	included.	

Section 1014. Citation Process

A. SCOPE

The following regulations were done to prevent creating conflicting regulations with the U.F.C and at the same time, present for public awareness, review and use, a document that is useful in explaining pertinent department rules, regulations and procedures relative to inspections and citations.

The U.F.C., Uniform Building Code and other codes adopted under Public Law 11-56 were developed, and shall continually updated, with concern for consistency amongst these codes. The Fire Prevention Section intends to continue this practice, and thus, has developed these editions, and consequently, in conjunction with the editions of other codes, the department will make amendments to this document as new editions of the U.F.C. are automatically adopted; or, whenever amendments are necessary to address departmental administrative and operational needs, consistent with the U.F.C. 1997 and supplemental editions, and as determined by the chief.

This code prescribes regulations consistent with nationally recognized good practice for the safeguarding to a reasonable degree of life and property from the hazard of fire and explosion arising from the storage, handling and use of hazardous substances, materials and devices, and from conditions hazardous to life or property in the use or occupancy of buildings or premises.

The provisions of this regulation shall supplement any and all laws relating to firesafety and shall apply to all persons without restriction unless specifically exempted. (U.F.C. section 101.2 scope.)

B. PURPOSE

- 1. To gain compliance with federal and local codes and regulations, when all reasonable efforts have been unsuccessful.
- 2. A course of action to be taken when a condition exists that causes a threat to life or property from fire and explosion.
- 3. It is the intent of the department to achieve compliance by traditional means of inspection, notification, granting of reasonable time to comply and reinspection. A citation shall be used only after all reasonable means to gain compliance have failed or, with proper justification, at the discretion of the fire chief. Only those members of the fire division specifically designated by the fire chief may issue citation.

C. ADMINISTRATION AND ENFORCEMENT

The chief is authorized to administer and enforce this code. Under the chief's direction, the fire department is authorized to enforce all ordinances of the jurisdiction pertaining to:

- 1. The prevention of fires,
- 2. The suppression or extinguishment of dangerous or hazardous fires,
- 3. The storage, use and handling og hazardous materials,
- 4. The installation and maintenance of automatic, manual and other private fore alarm systems and fire-extinguishing equipment,
- 5. The maintenance and regulation of fire escapes,
- 6. The maintenance of fire protection and the elimination of fire hazards on land and in buildings, structures and other property, including those under construction,
- 7. The maintenance of exits, and
- 8. The investigation of the cause, origin and circumstances of fire and unauthorized releases of hazardous materials.

For authority related to control and investigation of emergency scenes, see section 104. (U.F.C. section 103.2.1.1 General.)

D. CORRECTIVE ORDERS AND NOTICES

When the chief finds in any building or any premises combustibles, hazardous or explosive materials or dangerous accumulations of rubbish; or finds unnecessary accumulations of wastepaper, boxes, shaving or any highly flammable materials which are so situated as to endanger life or property; or finds obstruction to or on fire escapes, stairs, passageways, doors, or windows that reasonably tend to interfere with the operations of the fire department or the egress of the occupants of such building or premises; finds that the effectiveness of any exit door, attic separation or any fire separation wall is reduced; or finds that this code is being violated, the chief is authorized to issue orders as necessary for the enforcement of the fire prevention laws and ordinances governing the same and for the safeguarding of life and property from fire. (U.F.C section 103.4.1 Authorization to issue corrective orders and notices. U.F.C. section 103.4.1.1 General.)

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. <u>UNSAFE HEATING OR ELECTRICAL EQUIPMENT AND STRUCTURAL</u> <u>HAZARDS</u>

When the chief deems any chimney, smokestack, stove, oven, incinerator furnace or other heating device, electric fixture or any appurtenance thereto, or anything regulated under a nationally recognized standard in or upon any building, structure or premises not specifically mentioned in this code, to be defective or unsafe so as to create a hazard, the chief is authorized to serve upon the owner or the person having control of the property a written notice to repair or alter as necessary and shall notify any other authority enforcing codes regulating such equipment. The chief is authorized to affix a condemnation tag prohibiting the use thereof until such repairs or alterations are made. When affixed, such tag shall only be removed by the order of the chief when the hazard to which the order pertains has been eliminated in as approved manner. Until removed, that item or device which has caused the hazard shall not be used or be permitted to be used.

When an apparent structural hazard is caused by the faulty installation, operation or malfunction at any of the items or devices listed in this subsection, the chief shall immediately notify the building official to investigate such hazard and cause such hazard to be abated as required by the BuildingCode. (U.F.C. section 103.4.1.2 unsafe heating or electrical equipment and structural hazards.)

F. <u>COMPLIANCE WITH ORDERS AND NOTICES</u>

Orders and notices issued or served as provided by this code shall be complied with by the owner, operator, occupant or other person responsible for the condition or violation to which the order or notice pertains, In cases of extreme danger to persons or property, immediate compliance is required.

If the building or other premises is not owner occupied, under lease or otherwise, and the order or notice requires additions or changes in the building or premises which would immediately become real estate and be the property of the owner of the building premises, such orders or notices shall be complied with by the owner. (U.F.C. section 103.4.3.1 Compliance with orders and notices.)

EXCEPTION: When the owner and the occupant have agreed otherwise between themselves, in which event the occupant shall comply.

G. COMPLIANCE WITH TAGS

A building, premises or thing shall not be used when in violation of this code as noted on a tag affixed in accordance with Section 103.4.1. (U.F.C. Section 103.4.3.2. Compliance with tags.)

Permit applicants and the applicants' agents and employees shall carry out the proposed activity in compliance with this code and other laws or regulations applicable thereto, whether specified or not, and in complete accordance with approved plans and specifications. Permits which purport to sanction a violation of this code or any applicable law or regulation shall be void and approvals of plans and specifications in the issuance of such permits shall likewise be void. (U.F.C. Section 105.2.3. Compliance.)

H. POLICE POWERS

The fire chief and members of the fire prevention shall have the powers of a police officer in performing their duties under this code.

When requested to do so by the chief, the chief of police is authorized to assign such available police officers as necessary to assist the fire department in enforcing the provisions of this code.

I. <u>AUTHORITY TO INSPECT</u>

The fire prevention section shall inspect, as often as necessary, buildings and premises, including such other hazards or appliances designated by the chief for the purpose of ascertaining and causing to be corrected any conditions which would reasonably tend to cause fore or contribute to its spread, or any violation of the purpose or provisions of this code and of any other law or standard affecting firesafety. (U.F.C. Section 103.3.1.1. Authority to inspect.)

J. <u>RIGHT OF ENTRY</u>

Whenever necessary to make an inspection to enforce any of the provisions of this code, or whenever the chief has reasonable cause to believe that there exists in any building or upon any premises any condition which makes such building or premises unsafe, the chief is authorized to enter such building or premises at all reasonable times to inspect the same or to perform any duty authorized by this code, provided that if such building or premises is occupied, the chief shall first present proper credentials and demand entry; and if such building or premises is unoccupied , the chief shall first make a reasonable effort to locate the owner or other persons having charge or control of the building or premises and demand entry. If such entry is refused, the chief shall have recourse to every remedy provided by law to secure entry.

If the owner or occupant denies entry, the chief is authorized to obtain a proper inspection warrant or other remedy provided by law to secure entry. Owners, occupants or any other persons having charge, care or control of any building or premises shall, after proper request is made as herein provided, promptly permit entry therein by the chief for the purpose of inspection and examination pursuant to this code.

For the purpose of Section 103.3.1.2. [Tight of Entry], the term "Chief" shall include the chief officer of the fire department serving the jurisdiction and the officers named in Section 103.2.1.2. And 103.2.2.22 (U.F.C. Section 103.3.1.2 Right of Entry.)

K. SERVICE OF ORDERS AND NOTICES

Orders and notices authorized or require by this code shall be given or served upon the owner, operator, occupant or other person responsible for the condition or violation either by verbal notification, personal service, or delivering the same to and leaving it with a person of suitable age and discretion upon the premises: or, if no such person is found on the premises, by affixing a copy thereof in a conspicuous place on the door to the entrance of said premises and by mailing a copy thereof to such person by registered or certified mail to the person's last known address.

Orders or notices that are given verbally shall be confirmed by service in writing as herein provided. (U.F.C. Section 103.4.2 Service of orders and notices.)



Commonwealth of the Porthern Mariana Islands OFFICE OF THE GOVERNOR Division of Environmental Quality



P.O. Box 501304 C.K., Saipan, MP 96950-1304 Tels.: (670) 664-8500 /01 Fax: (670) 664-8540

PUBLIC NOTICE

PROPOSED AMENDMENTS TO THE COMMONWEALTH OF THE NORTHERN MARIANA ISLAND'S DRINKING WATER REGULATIONS

The Director of the Division of Environmental Quality (DEQ), Office of the Governor, Commonwealth of the Northern Mariana Islands (CNMI), hereby notifies the public that DEQ proposes to amend the CNMI Safe Drinking Water Regulations. The amendments are proposed pursuant to the authority of the CNMI Environmental Protection Act, P.L. 3-23, 2 CMC §§ 3101 *et seq.* (as amended by P.L. 11-103), 1 CMC §§ 2646 to 2649, and Public Law 11-108.

Section 7.1 of the Drinking Water Regulations, 14 Com. Reg. at 10283 (Dec. 15, 1992), as amended by 17 Com. Reg. at 13709 (Sept. 15, 1995), sets forth the fees for laboratory analyses performed by DEQ. The amendments revise section 7.1 of the Drinking Water Regulations to eliminate the laboratory fee schedule and allow the Director to set reasonable fees for laboratory analyses and revise those fees on a semi-annual basis.

In accordance with 1 CMC § 9104(a), the public has the opportunity to comment on the proposed amendments. Copies of the amendments are available at the offices of the Division of Environmental Quality, located on the third floor of the Morgen Building, San Jose, Saipan. Written comments should be submitted to: Director, Division of Environmental Quality, P.O. Box 1304, Saipan MP, 96950. Comments must be received by DEQ within thirty (30) days of the date this notice is published in the Commonwealth Register.

Issued by:

Date: 11/13/01

Antonio I. Deleon Guerrero, Acting Director Division of Environmental Quality

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

W. 14,2001

rm and legal dufficiency by the Office of the Attorney General.

Attorney General

Commonwealth Register

Volume 23 Number 11

November 23, 2001 Page 18642

Filed by:

Date: 11/20/01

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Soledad B. Sasamoto Registrar of Corporations

Received at the Governor's Office by:

Date: 11/19/01

Jose F. Guerrero/ Special Assistant for Administration



Commonwealth of the Northern Mariana Islands OFFICE OF THE GOVERNOR Division of Environmental Quality



P.O. Box 501304 C.K., Saipan, MP 96950-1304 Tels.: (670) 664-8500 /01 Fax: (670) 664-8540

NUTISIAN PUPBLIKU

PRIMOPONEN AMENDASION GI REGULASION PARA I PROTEKSION HANOM MAGIMEN HALOM COMMONWEALTH I SUMANGKATTAN SIHA NA ISLAS MARIANAS

I Direktot Division of Environmental Quality (DEQ), Ofisinan Gubetno, Commonwealth i Sumangkattan siha na Islas Marianas (CNMI), ginen este ha infofotma i pupbliku na i DEQ ha propopone para u amenda i Regulasion para i proteksion Hanom Magimen gi CNMI. I amendasion siha manma propone sigun aturidat CNMI Environmental Protection Act, Lai Pupbliku 3-23, 2 CMC papa seksiona 3101 *et seq.* (ni inamenda ni Lai Pupbliku 11-103), 1 CMC papa seksiona 2646 asta 2649, yan Lai Pupbliku 11-108.

Seksiona 7.1 gi Regulasion para i proteksion Hanom Magimen, 14 Com. Reg. gi 10283 (Disembre 15, 1992), ni inamenda ni 17 Com Reg. gi 13709 (Septembre 15, 1995), hana guaha apas ma analisan labatorio ni chine'guen DEQ. I amendasion ha ribisa seksiona 7.1 gi Regulasion para i proteksion Hanom Magimen para u na'suha i listan apas yan sedi i Direktot para guiya u na'guaha resonapble na apas ma analisan labatorio yan ribisa ayu siha na apas kada mediu sakkan.

Sigun 1 CMC papa seksiona 9104(a), i pupbliku mana'e oputtunidat para u fanmamatinas komento put i priniponen amendasion siha. Guaha kopian i amendasion siha gi Ofisinan Division of Environmental Quality, mina' tres bibenda gi Morgen Building, San Jose, Saipan. Todo i manma tuge' siha na komento debi di u fanmasatmiti guato para: Direktot, Division of Environmental Quality, P.O. Box 1304, Saipan MP, 96950. I komento siha debi di u fanmarisibi gi DEQ halom trenta (30) dias despues di ma fechan este na nutisia gi Rehistran Commonwealth.

Linaknos as:

Fecha: 11/13/01

Antonio I Deleon Guerrero, Acting Director Division of Environmental Quality

Sigun 1 CMC papa seksiona 2153, ni inamenda ni Lai Pupbliku 10-50, i regulasion ni chechetton guine esta manmaribisa yan apreba komu ligat yan sifisientan na fotam ginen Ofisinan Abugadon Henerat.

Fecha: 11/14/01

/s/ Allan Dollison Herbert D. Soll Abugadon Henerat Pine'lo as: Fecha: 11/30/01

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Soledad B. Sasamoto Rehistradoran Kotporasion

Marisibi gi Ofisinanan Gubetno as:

Fecha: 11/19/01

Jose I/Deleon Guerrero Espisiat na Ayudanten Administrasion

DIVISION OF ENVIRONMENTAL QUALITY PROPOSED AMENDMENTS TO SECTION 7.1 OF THE CNMI DRINKING WATER REGULATIONS

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Citation of Statutory Authority:	The Director of the Division of Environmental Quality (DEQ) proposes amendments to the CNMI Drinking Water Regulations pursuant to the CNMI Environmental Protection Act, P.L. 3-23, 2 CMC §§ 3101 <i>et seq.</i> (as amended by P.L. 11-103), 1 CMC §§ 2646 to 2649, and Public Law 11-108.
Short Statement of Goals and Objectives:	The amendments are intended to simplify the procedure for changing the fees that the DEQ laboratory charges for water sample analyses.
Brief Summary of the Adopted Regulations:	The amendments eliminate the fee schedule in section 7.1 of the regulations and authorize the Director of DEQ to establish reasonable fees and revise them semi-annually. Fees may be changed to reflect changes in costs, new analysis methods, and the operational expenses of the laboratory
For Further Information Contract:	Antonio I. Deleon Guerrero, Acting Director, Division of Environmental Quality.
Citation of Related and/or Affected Statutes, Regulations, and Orders:	Authorizing statutes are listed above. This action amends section 7.1 of the CNMI Drinking Water Regulations, 14 Com. Reg. at 10283 (Dec. 15, 1992), as amended by 17 Com. Reg. at 13709 (Sept. 15, 1995).

DEQ proposes to amend section 7.1(a) of the DW Regulations as follows:

7.1 Certified Laboratories

For the purpose of determining compliance with the maximum contaminant levels set forth in Part 5-hereinbefore, samples may be considered only if they have been analyzed by a laboratory certified by the Division, or EPA, except that measurement for chlorine residual may be performed by any person acceptable to the Division.

(a)The following fees have been established for laboratory analysis performed by the Division.

Parameter	<u> </u>
Total Coliform	\$50.00
Fecal Coliform	<u>\$50.00</u>
Residual Free Chlorine	\$20.00
Temperature	<u>\$10.00</u>
Turbidity	<u> </u>
Dissolved Oxygen	<u>\$20.00</u>
PH	<u>\$20.00</u>
Salinity	\$20.00
Total Dissolved Solids	\$20.00
Conductivity	\$20.00
Chlorides	\$35.00
Total Hardness	\$35.00
Nitrates (NO3N)	<u> </u>

(a) Division Laboratory Fees

The Division shall charge reasonable fees for laboratory analyses performed by the Division's laboratory. Fees shall be set by the Director and revised as necessary, but not more frequently than semi-annually, to reflect changes in costs, new analysis methods, and the operational expenses of the laboratory.

(b) Fee Publication

The Division will make an original schedule of laboratory fees available to the public no later than January 1, 2002. Thereafter, revisions shall be available to the public when issued. The schedule and any revisions will be available on request at each of the Division's offices.



northern Mariana Islands "Investing For The Future Financial Security Of Our Members"

PUBLIC NOTICE OF PROPOSED AMENDMENTS TO THE RULES AND REGULATIONS **GOVERNING THE GROUP HEALTH INSURANCE PROGRAM**

The Board of Trustees of the NMI Retirement Fund, hereby gives notice to the general public and particularly members of the CNMI Group Health Insurance Program that they have adopted the proposed amendments to the rules and regulations governing the Group Health Insurance Program during their regular board meeting held on September 19, 2001 and October 25, 2001. The attached proposed amendments would modify, clarify, add, and renumerate the rules and regulations as published in the Commonwealth Register, Volume 19, Number 08, dated August 15, 1997.

The Board is soliciting comments and recommendations regarding these proposed amendments to the rules and regulations, which must be received by the Fund within 30 days of the first publication of this notice. Copies of these proposed amendments may be obtained at any of the NMI Retirement Fund offices on Saipan, Tinian and Rota.

Dated this Ind day of ______ 2001.

Vicente C. Camacho Chairman, Board of Trustees, NMIRF

Takeo N. George

Acting Administrator, NMI Retirement Fund

RECEIVED BY:

Jose I Deleon Guerrero Special Assistant to the Governor 01 Date

FILED BY:

Soledad B. Sasamoto Registrar of Corporations Date: 1/20

Commonwealth Register

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CERTIFICATION BY THE OFFICE OF THE ATTORNEY GENERAL:

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

Lovergher Dated this 15th day of ,2001.

HERBERT D. SOLL Attorney General

By:

Allan Dollison Assistant Attorney General



NUTISIAN PUPBLIKU

PRINIPONEN AMENDASION GI AREKLAMENTO YAN REGULASION I PARA U GOBIETNA PRUGRAMAN GROUP HEALTH INSURANCE PROGRAM

I Kuetpon Trustees gi NMI Retirement Fund, ginen este, ha nutitisia i pupbliku henerat yan pattikulamente i membron CNMI Group Health Insurance Program na esta ma adapta i mapropopone siha na amendasion gi areklamento yan regulasion i para u gobietna I Prugraman Group Health Insurance duranten i regulat na huntan-niha gi Septembre 19, 2001 yan Oktubre 25, 2001. I chechetton siha na priniponen amendasion para u modifika, na klaru, aomenta yan ma agon malista i areklamento yan regulasion ni mapupblika gi Rehistran Commonwealth, Baluma 19, Numiru 08, ni ma fecha gi Augusto 15, 1997.

I Kuetpo ha sosoyo komento yan rekomendasion pot i priniponen este siha na amendasion gi areklamento yan regulasion, ya debi u fanma risibi gi Fund halom trenta (30) dias despues di i primet na pupblikasion este na nutisia. Kopian i mapropopone siha na amendasion siña manma chu'le gi Ofisinan NMI Retirement Fund giya Saipan, Tinian yan Luta.

Ma fecha gi mina <u>ma</u>na dia <u>Maviembre</u>, 2001.

Vicente C. Carnacho / Chairman, Board of Trustees, NMIRF

JJ5792

Takeo N. George Acting Administrator, NMI Retirement Fund

RINISIBI AS:

Jose I/Deleon Guerrero Special Assistant to the Governor Fecha: <u>I//Iq/01</u>

RINIKOT AS:

Soledad B. Sasamoto Registrar of Corporations Fecha: // 20/0/

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Settifikasion i Ligat Ufisina Atbogadu Hinerat CNMI

Konsiste yan i 1 CMC § 2153, koma inamenda nu i Lai Pupbliku 10-50, i priniponen amendasion siha gi areklamento yan regulasion ni chechetton guine esta manmaribisa yan apreba komu put I fotma yan sinufisienten ligat nu I Ufisina Atbogadu Hinerat CNMI.

Mafecha gi este i mina' <u>15</u> na dia gi <u>NOVIEMBRE</u>, 2001.

HERBERT D. SOLL Atbogadu Hinerat

/s/ ALLAN DOLLISON

As: Allan Dollison Asistanten Atbogadu Hinerat

Volume 23 Number 11



ARONGORONGOL TOULAP

Northern Mariana Islands

"Investing For The Future Financial Security Of Our Members"

REEL POMWOL FFÉÉRUL LLIWEL MELLÓL ALLÉGH YE EBWE LEMELI LEMELEMIL GROUP HEALTH INSURANCE PROGRAM

Board of Trustees llól NMI Retirement Fund, nge ekke arongaar toulap me membrool CNMI Group Health Insurance Program bwe re <u>adaptli</u> pomwol fféérúl lliiwel llól autol allégh ye ebwe lemeli lemelemil Group Health Insurance Program igha re yeelághil mwiisch llól maramal Maan (September) 19, 2001 ebwe Sarobwel (October) 25, 2001. Pomwol fféérúl lliiwel kka e appasch nge ebwe féérú sefáliiy, affata, atotoolong me aghatchú sefealiiy allégh kkaal igha e rongowow llól Commonwealth Register, Volume 19, Nuumuro 08, e féérú llól maramal Elúwel (Agusto) 15, 1997.

Mwisch yeel ng rekke tingór ngáliir toulap bwe rebwe atotoolong mángmáng me tiip reel pomwol fféérúl lliiwel kka llól autol allégh, nge ebwe atotoolong ngálli Fund llól eliigh (30) rál sángi igha e rongo ló arongorong yeel. Kopiyaal pomwol fféérúl lliiwel kkal nge emmwel schagh bwe aramas rebwe ló bweibwogh sángi Bwulasiyool NMI Retirement Fund ikka elo Seipél, Tchúlúyól me Luuta.

E fféér ráálil ye <u>Ind-</u>maram ye <u>Mavienihrl</u> 2001.

Vicente C. Camacho Chairman, Board of Trustees, NMIRF

Guerrero

MJJgz

Takeo N. George Acting Administrator, NMI Retirement Fund

BWUGHIIYAL:

Jose]

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Soledad B. Sasamoto

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Appelúghúlúgh sángi Bwulasiyool Attorney ye CNMI

Sángi bwángil 1 CMC § 2153 igha e lliiwel sángi autol Allégh Toulap 10-50, ne pomwol fféérúl lliiwel kka llól autol allégh ikka e appasch ighaal nge a takkal mwir me angúúngú sángi Bwulasíyool Attorney ye CNMI bwe e fil me angúúngú.

E fféér ráálil ye 15 maram ye NOV. 2001.

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HERBERT D. SOLL Attorney General

/s/ ALLAN DOLLISON

Mereel: Allan Dollison Assistant Attorney General



Northern Mariana Tolando E T R E N T F V N D "Investing For The Future Financial Security Of Our Members"

Proposed Amendments to the Rules and Regulations Governing the CNMI Group Health Insurance Program

Citation of Statutory Authority:

The CNMI Group Health and Life Insurance Trust Fund has statutory power to promulgate and effect Rules and Regulations, pursuant to 1 CMC § 8424.

Statement of Goals and Objectives: The NMI Retirement Fund is required by P.L. 10-19 to establish and administer the CNMI Group Health and Life Insurance Trust Fund. The purpose of the Plan is to provide financial assistance to Enrollees to help them pay for necessary basic health care. The Program is designed to be self sufficient, and therefore, must establish rates sufficient to pay for administration of the Program and particularly claims incurred by Enrollees in the Plan. The goals and objectives of these rules is to provide guidelines in managing a bona fide benefit plan that complies with local and federal laws.

These proposed amendments to the rules and regulations will provide guidelines necessary for the administration of health insurance program and to provide clear and precise description of benefits applicable to all participants.

Contact Takeo N. George, Acting Administrator, NMI Retirement Fund, Telephone 664-3863 or Fax 664-8080.

The Rules and Regulations Governing the Group Health Insurance Program as adopted in the Commonwealth Register, Volume 19, Number 08, dated August 15, 1997 and also Rule 7.05 of the Rules and Regulations as published in the Commonwealth Register, Volume 19, Number 10, dated October 15, 1997.

Submitted by:

and Orders:

Summary of Rule:

For Further Information:

Citation of Related and/or Affected Statutes, Regulations

Takeo N. George/ Acting Administrator, NMI Retirement Fund

Date

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PROPOSED AMENDMENTS

TO THE

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RULES AND REGULATIONS (PLAN DOCUMENT) OF THE GROUP HEALTH AND LIFE INSURANCE PROGRAM

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Proposed Amendments (Additions/Clarifications/Modifications/Deletions) to Existing Rules; and Proposed New Rules:

- Rule 2.02 Definition: Administrator Added "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".
- Rule 2.03 Definition: Allowable Expense Added "Board" in determining reasonable and appropriate administration of the Program together with the Administrator.
- Rule 2.07 Definition: Child Changed age limit to "18".
- Rule 2.11 Definition: Copayment Changed definition to mean "the specified portion or percentage of the Eligible Charge that an Enrollee must pay to the Provider of Services".
- Rule 2.13 Definition: Dependent Changed Child to "Eligible Child(ren)"; and Deleted Subsections c(1) to (3) and d(1) and (2).
- (New) Rule 2.15 Definition: 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.
- (New) Rule 2.16 Definition: Eligible Charge means
 - a. the charge described in Article 11.09 below and is the charge used to calculate the Plan's benefit payment for most covered Services;
 - b. the Plan's published fee schedule for Services rendered in the CNMI, or for Services available in the CNMI but rendered in another location.
- (New) Rule 2.24 Definition: 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.
- Rule 2.26 Definition: Medically Necessary Added Subsection (f) "As further described in Article 11.09 of this Plan Document". [would become Rule 2.31]
- (New) Rule 2.28 Definition: Injury means an injury 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 48 hours. Subjective symptoms that occur spontaneously or from trivial movement or exercise and that are physiological, pathological, toxic, or infective origin are not to be considered the result of external force and therefore shall not be considered an injury.

- (New) Rule 2.30 Definition: Medical Director means a medical doctor, medical officer, or other medical professional or employed by the Plan or its Third Party Administrator, if any, to review claims and determine medical necessity of Services.
- (New) Rule 2.33 Definition: 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.
- (New) Rule 2.34 Definition: Non-Participating 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.
- Rule 2.34 Definition: Plan Added "This term may be used interchangeably with the term "Program", as defined herein". [would become Rule 2.39]
- (New) Rule 2.35 Definition: Non-Preferred Prescriptions 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.
- Rule 2.36 Definition: Reasonable and Customary Charge Deleted in its entirety; replaced by "Eligible Charges" [New Rule 2.16]; all sections containing the word "Reasonable and Customary Charge" are replace with "Eligible Charge".
- (New) Rule 2.37 Definition: 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.
- Rule 2.38 Participating Provider means a Provider of Services who, when rendering a Service covered by this Plan to an Enrollee, agrees with the Plan 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.
- Rule 2.39 Definition: Program Added "This term may be used interchangeably with the term "Plan", as defined herein". [would become Rule 2.44]
- (New) Rule 2.52 Definition: 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.

- (New) Rule 3.02 Eligibility: 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 19, 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.
- *Rule 3.02.a Eligibility: Dependent Children –* Changed age from 19 to "18".
- Rule 3.02.b Eligibility: Dependent Children Added "or on the last official day of the session in which the Dependent was last enrolled".
- Rule 3.06 Eligibility: Retirees not Enrolled in Government Added "Provided he or she is enrolled 30 days from the effective date of his or her retirement date. Enrollment will be effective on the day after the first annuity payment following approval".

- Rule 4.01 Enrollment: Changed / Clarified enrollment options and categories; changed category coverage from Self and Family to Self Plus Four (High and Low Options); added new category coverage to include Self Plus One and Self Plus Five Plus (High and Low Options); added definitions and examples for each category.
- Rule 4.08 Enrollment: Rules for Retirees not Enrolled in Government Plan Added "Provided he or she is enrolled 30 days from the effective date of his or her retirement date. Enrollment will be effective on the day after the first annuity payment following approval".
- Rule 4.13 Enrollment: Dependent Child Over Age 19 Changed age to "18".
- (New) Rule 4.14 Enrollment: 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.
- Rule 5.02 Benefits: Covered Benefits (Chart) –

Changed 5.02(A) – High Option to "Program pays 80% of the first \$20,000 per Enrollee of Eligible Charges incurred during a Plan Year and 100% of Eligible Charges thereafter"; and for Low Option to "Program pays 70% of the first \$20,000 per Enrollee of Eligible Charges incurred during a Plan Year and 100% of Eligible Charges thereafter"

Changed 5.02(B) – High Option to "Program pays 80% of the Eligible Charges incurred during a Plan Year"; and for Low Option to "Program pays 70% of the Eligible Charges incurred during a Plan Year"

Changed 5.02(C) – High and Low Options to "Enrollee pays \$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."

Added to 5.02(D), (E) and (F) – High Option "Program pays 80% of Eligible Charges"; and Low Option "Program pays 70% of Eligible Charges"

Changed 5.02(G) – High Option to "Maximum family out-of-pocket expense per category each Plan Year: Self Only - \$4,000, Self Plus One - \$8,000, Self Plus Four - \$12,000, and Self Plus Five Plus - \$16,000"; for Low Option to "Maximum family out-of-pocket expense per category each Plan Year: Self Only - \$6,000, Self Plus One - \$12,000, Self Plus Four - \$18,000, and Self Plus Five Plus - \$24,000"

Changed 5.02(H) – Increased Annual Maximums: High Option to "\$100,000" and Low Option to "\$50,000"

Changed 5.02(I) – Increased Lifetime Maximums: High Option to \$500,000 and Low Option to "\$250,000"

- Rule 5.03 Benefits: Hospital Room and Board Benefits Changed to include the word "Inpatient".
- (New) Rule 5.03.A(3) Benefits: Hospital Room and Board Benefits Added new subsection stating, "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."
- (New) Rule 5.03.C Benefits: Hospital Room and Board Benefits Added new subsection which stating, "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."
- Rule 5.04.1(a) Benefits: Other Benefits Hospital Services: Added list of additional supplies and Services charged by Hospitals (i.e., surgical supplies, dressings, oxygen, antibiotics, etc.).

(New) Rule 5.04.2(a) – Benefits: Other Benefits - 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 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;

- Rule 5.04.2(c) Benefits: Other Benefits Surgical and Medical: Added "Anesthesiology" section. [would become Rule 5.04.2(d)]
- Rule 5.04.2(g) Benefits: Other Benefits Surgical and Medical: Added clarification "For the initial provision or replacement" and new section regarding ordering equipment (medical). [would become Rule 5.04.2(h)]

(New) Rule 5.04.2(k) – Benefits: Other Benefits – Dental Work and Oral Surgery Services:

k. 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.

- Rule 5.04.3(a) Benefits: Other Benefits Outpatient Services (re licensed psychologists for mental disorders, etc.): Deleted in its entirety.
- Rule 5.04.3(b) Benefits: Other Benefits Outpatient Services (re licensed physical therapists/ chiropractors): Added "Maximum 15 visits at a maximum of \$25 per visit, for a total benefit of \$375 per Enrollee per Plan Year". [would become Rule 5.04.3(a)]
- Rule 5.04.3(c) Benefits: Other Benefits Outpatient Services (re Braces/Artificial Body Parts): Added clarification regarding ordering of equipment (medical). [would become Rule 5.04.3(b)]
- Rule 5.04.3(d) Benefits: Other Benefits Outpatient Services (re Drugs/Medicine): Added clarification regarding purchase of medicine and use of formulary. [would become Rule 5.04.3(c)]
- Rule 5.04.3(f) Benefits: Other Benefits Outpatient Services (re licensed home health agencies): Added "Home Health Care" section. [would become 5.04.3(e)]
- Rule 5.04.4 Benefits: Dental Work and Oral Surgery Services Added limitations of benefits and definitions of Dentistry and Dental Surgery.
- Rule 5.04.4(a)(i), (ii) Benefits: Dental Work and Oral Surgery Services Added clarification on dental work coverage for only Emergency repair as a result of accidental injury.
- Rule 5.04.4(b) Benefits: Dental Work and Oral Surgery Services Added clarification on benefits for emergency Surgical Services and hospital inpatient benefits.

Rule 5.04.6(c) – *Benefits:* Other Benefits – Maternity Services:

c. A newborn child of a non-Spouse....[would become 5.04.6(f)]

(New) Rule 5.04.6(c), (d), and (e) – Benefits: Other Benefits – Maternity Services:

- c. Services by a nurse-midwife will be eligible for coverage on this 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.
- d. 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.

e. 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.

(New) Rule 5.04.8(d) – Benefits: Other Benefits – Skilled Nursing Facility Services:

- 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.
- (New) Rule 5.04.9 Benefits: Other Benefits Chemotherapy and Other U.S. Federal Government Approved Cancer Treatments.

(New) Rule 5.04.10 – Benefits: Other Benefits – Dialysis and Supplies.

- (New) Rule 5.04.11 Benefits: Other Benefits Prescription Contraceptive Services.
- Article 6 Copayment and Coinsurance: Changed title to "Coinsurance and Copayments".
- Rule 6.02 Coinsurance and Copayments: Added at end of second sentence "if filled at a pharmacy and a ninety-day supply if ordered from the Plan's mail order Prescription Service"; and "and filled at a pharmacy," after the word supply in fourth sentence.
- Rule 7.02 Limitation and Maximums: Limitations of Mental Health Benefits Deleted in its entirety.
- Rule 7.03 Limitations and Maximums: Limitations of Non-Spouse Maternity Benefits Deleted in its entirety.
- Rule 7.05 Limitations and Maximums: Physical and Occupational Therapy and Chiropractic Limitations – Changed maximum amount to "\$25 per visit, with maximum of 15 visits". [would become Rule 7.03]
- Rule 7.06 Limitations and Maximums: Surface Ambulance Limitation Changed maximum amount to "\$150 per trip that's provided in the CNMI, and 80% of Eligible Charge in a location other than the CNMI". [would become Rule 7.04]
- Rule 7.08 Limitations and Maximums: Coinsurance Maximums Deleted in its entirety.
- (New) Rule 7.09 Limitations and Maximums: 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.

- Rule 7.10.A & B Limitations and Maximums: Annual Maximums Changed annual maximum increasing it to \$100,000 for High Option and \$50,000 for Low Option. [would become Rules 7.07.A & B]
- Rule 7.11.A & B Limitations and Maximums: Lifetime Maximums Changed lifetime maximum increasing it to \$500,00 for High Option and \$250,000 for Low Option. [would become Rules 7.08.A & B]
- (New) Rule 8.01 Exclusions: The limitations and exclusions provided under this Article shall be in addition to any limitations and exclusions provided elsewhere in this Plan.
 - A. The Plan will not pay benefits for any Services when the Enrollee is entitled to receive disability benefits or compensation (or forfeits his or her rights thereto) under any Workers' Compensation or Employer's Liability Law for Injury or illness. In the event the Enrollee formally appeals the denial of a claim for Workers' Compensation, the Enrollee shall notify the Administrator of such appeal. The Plan will then provide benefits under this Plan, but such benefits shall be considered an advance or loan to the Enrollee. If the claim is declared eligible for benefits under Workers' Compensation or Employer's Liability Law or if the Enrollee reaches a compromise settlement of the Workers' Compensation claim, the Enrollee agrees to repay the advance or loan the Plan has the Right of Subrogation.
 - B. The Plan will not pay benefits for any Services:
 - 1. When Services for an Injury or illness are provided without charge to the Enrollee by any federal, state, territorial, municipal, or other government instrumentality or agency, or
 - 2. When Services for an Injury or illness would have been provided without charge or collection but for the fact that the person is an Enrollee under this Plan.
 - C. The Plan will not pay any benefits, to the extent that such benefits are payable, by reason of any false statement or other misrepresentation made in an application for membership or in any claims for benefits. If the Plan pays such benefits before learning of any false statement, the Subscriber agrees to reimburse the Plan for such payment.

- D. The Plan is not an insurer against nor liable for the negligence or other wrongful act or omission of any Provider, Provider's Employee, or other person or for any act or omission of any Enrollee.
- E. The Plan does not guarantee the availability or quality of or undertake to provide any Services of any third party including the availability of Preferred or Participating Providers.
- F. The Plan will not pay benefits for Services required in the treatment of an Injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists, or that occurs during a period of active duty of any armed force of any state or nation.

Original Rule 8.01 now becomes Rule 8.01.G

- Rule 8.01.B(26) Exclusions: Custodial, domiciliary and convalescent care Added "formulas used for supplemental". [would become Rule 8.01.G.2(30)]
- Rule 8.01.B(34) Exclusions: Growth Hormones Added clarification "therapy, except replacement therapy services due to hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy." [would become Rule 8.01.G.2(41)]
- Rule 8.01.B(35) Exclusions: Hearing Aids Added at the end of the sentence ", or those excluded from coverage in any formulary selected or adopted by the Plan." [would become Rule 8.01.G.2(43)]
- Rule 8.01.B(44) Exclusions: Organ transplants Added clarification whereas "No benefits will be paid for Services and supplies provided in the course of an organ transplant or donation whether for an Enrollee who is donating an organ or for someone who is receiving or donating an organ for transplantation into an Enrollee." [would become Rule 8.01.G2(56)]
- Rule 8.01.B(61) Exclusions: Sexual dysfunction Services Added "or inadequacies". [would become Rule 8.01.G2(80)]
- Rule 8.01.B(63) Exclusions: Added "to or from a Doctor or a Doctor's office" after Telephone calls. [would become Rule 8.01.G.2(82)]
- Rule 8.01.B(65) Exclusions: Transportation, except as otherwise specifically provided herein – Added clarification whereas "no benefits for airfare and transportation from CNMI to off-island and for any other non-medical expenses such as taxis, hotels, etc. (travel expenses)". [would become Rule 8.01.G.2(85)]
- Rule 8.01.B(66) Exclusions: Transsexual Services Added "Sex transformations or sex change operations". [would become Rule 8.01.G2(87)]

Rule 8.01.G(2) – *Exclusions*: Proposed Clarifications / Additions of Exclusions:

- Any Services rendered to Subscriber's dependent parents
- Circumcisions, routine or ritual
- Congenital defects or abnormalities, other than as specified in section 5.04(2)(k)
- Consultations with Doctors by telephone or facsimile
- Dental appliances
- Dental Care
- Dental Services, except for surgical procedures as a result of accidental injury to natural teeth or jaw
- Hansen's Disease
- HIV & HTLV Testing and AIDS and AIDS-related care
- Implants and any related services, supplies and drugs, sought for cosmetic purposes or to enhance or improve physical appearance
- Maternity Services for non-Spouse Dependent
- Mental Health Coverage. Mental retardation and non-corrective mental deficiency
- Other health and accidental insurance coverage and third party liability settlements
- Parkinson's Disease
- Replacement of Joints
- 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
- Services not Medically Necessary
- Service or supplies for treatment or diagnosis of Temporomandibular Joint (TMJ) disorders or other conditions involving joints or muscles related to TMJ
- Services or supplies not specifically described as covered in this Plan Description (Example: Subscriber's grandchild for which no Court Ordered legal guardianship exists)
- 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
- Testing of donor blood
- Transportation of the remains of any deceased person will in no way be paid by the Government Health Insurance
- Tuberculosis
- (New) Rule 8.01.H Exclusions: 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.
- (New) Rule 8.01.1. Exclusions: 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.

Rule 10.15 – Premiums: Chart for Bi-weekly Contributions – Amended Contribution Rates Chart and effective date; Changed Program to say "Plan Document"; Deleted "provided the effective date of this Plan Document is prior to January 1, 1998"; Added new enrollment categories, code numbers and contributions to include Self Plus One High (202) and Low (206) Options, Self Plus Four High (203) and Low (207) Options, Self Plus Five Plus High (204) and Low (208) Options; Added effective date of "January 2, 2002"; Changed code number for Self Only Low Option to 205; Added new paragraphs as follows:

"Beginning with the second Plan Year of this Plan (January 2003), the Government Contribution and total Premium for each category and option of coverage shall be as follows:

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

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 2004. Said automatic increases shall continue annually until such time the Government's Contribution is equal to the Subscriber's Contribution."

Article 11 - Claims: Changed title to "Claims and Payment for Services".

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

Original Rule 11.01 now become Rule 11.02, and so forth.

Rule 11.01.B(2) – Claims: Filing of Claims (General Rules) – Name of Provider: Added "address, telephone number and professional license number". [would become Rule 11.02.B(2)]

(New) Rule 11.02.B(7) – Claims and Payment for Services: Filing of Claims (General Rules) –

7. Physician's or Authorized Representative's Signature.

(New) Rule 11.03.E – Claims and Payment for Services: Payment of Claims (General Rules) –

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").

(New) Rule 11.05.D – Claims and Payment for Services: Payment of Claims to Providers –

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-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 nonparticipating Providers will be a specified portion or percentage of the Eligible Charge for the Service. The Enrollee is responsible for paying the specified Copayments or Coinsurance plus any amount by which the Provider's charge exceeds the Eligible Charge. Payment of claims for Services covered by this Plan and rendered by a non-participating Provider:

- 1. are not assignable;
- 2. shall be made by the 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.

Original Rule 11.05 now becomes Rule 11.06.

Rule 11.05 – Claims: Filing of Claims by Enrollees – Added "/Dependents" after the word Enrollees. [would become Rule 11.06]

(New) Rule 11.06.B & C – Claims and Payment for Services: Filing of Claims by Enrollees/Dependents – Added new subsections.

- 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.

(New) Rule 11.07.C – Claims and Payment for Services: Payment of Claims to Subscribers –

- 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.
- (New) Rule 11.09 Claims and Payment for Services: 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.
- (New) Rule 11.10 Claims and Payment for Services: Eligible Charges. The Plan's benefit payments and the Enrollee's Copayments for most Services are based on the Eligible Charges for the Services (i.e., the Enrollee pays a specified percentage or portion of the Eligible Charge for each Service). The Plan will not pay the portion of any charge that exceeds the Eligible Charge. General excise or other tax is not included in the Eligible Charge. An Enrollee is responsible for paying all taxes.
 - A. Definition. The Eligible Charge for a covered Service is the lower of the actual charge on the claim, the discounted charge negotiated by the Plan, 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 Services Provided by Off-island 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.

Rule 11.08.B. – Claims: False Claims – Added at end of sentence ", 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". [would become Rule 11.11.B]

Rule 11.10.A to C – Claims: Sample Illustrations of Claims Payments – Deleted in its entirety.

(New) Rule 11.13 – Claims and Payment for Services: Review and Arbitration –

- A. The Administrator shall have discretionary authority to determine all questions of eligibility of Enrollees, to determine the amount and type of benefits payable to any Enrollee or Provider in accordance with the terms of this Plan, and to interpret the provisions of this Plan as is necessary to determine benefits.
 - 1. Review. Any preliminary determination that a Service or charge is unnecessary or otherwise not payable shall be reviewed at the Subscriber's request and approved or corrected by such review committees as are appointed or approved by the Administrator. A Subscriber has one year from the date the Plan processed the Subscriber's claim to request this review. Any determination made by such review committees, acting in good faith, shall be conclusive upon all interested parties, subject to review and redetermination by the Board, whose decision shall be final. Such final decision may be submitted to arbitration.
 - Arbitration. If a Subscriber is dissatisfied with the results of a review as 2. defined in paragraph (1) above, the Subscriber may request a further appeal by arbitration, provided that such request must be submitted to the Administrator in writing within ninety (90) 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.

(New) Rule 11.14 – Claims and Payment for Services: Provider Signature –

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

(New) Article 12 – Managed Care: Added entire new section.

- 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 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. If a Preadmission Review is not obtained, the Enrollee will have additional expenses as indicated in this Article 12.

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

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

12.04. Surgical Review.

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

obtained, the Enrollee will have additional expenses as indicated in Article 12.02 above.

12.05. Inpatient Review.

- A. The Administrator will periodically review each Enrollee's Hospital medical records for the appropriateness of the inpatient care provided to the Enrollee and the appropriateness of continuing hospitalization. This review will occur within 48 hours after admission and at set intervals, until the Enrollee is discharged from the Hospital. The Administrator will also review discharge plans for the appropriateness of after-hospital care.
- B. The review of the appropriateness of inpatient care and after-hospital care is for benefit payment purposes. If the Administrator has a question regarding the appropriateness of the continuing hospitalization or after-hospital care, or if the Administrator determines that benefits are not payable, the Enrollee and the Enrollee's physician will be notified. If the Administrator decides that the continuation of any Service or care is not medically necessary or appropriate, the Enrollee and the Enrollee and 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.

Original Article 12 – Coordination of Benefits and Double Coverage, now becomes Article 13, and so forth.

Article 12 Title – Double Coverage: Changed title to "Coordination of Benefits and Double Coverage". [would become Article 13].

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Rule 12.03 – Coordination of Benefits and Double Coverage: Authorization to Obtain Information – Added additional authorizations by Enrollee for purposes of enforcing and determining applicability of this Article by Administrator. [would become Rule 13.03]

(New) Rule 13.04 – Coordination of Benefits and Double Coverage: Special Provisions Regarding Medicare and No-Fault Motor Vehicle Insurance Coverage.

- A. The Federal Medicare Program will be considered the primary plan unless the Enrollee is an active Employee covered under this Plan. Where an Employee or Dependent is covered by both Medicare and this Plan, applicable Federal statutes will determine which plan is primary.
- B. Any no-fault motor vehicle insurance coverage will be considered the primary plan and its benefits will be applied first. Before the Plan pays benefits under this Plan for any Injury covered by no-fault insurance, the Plan will list the medical expenses that no-fault covers according to the date on which the expenses were incurred. The Plan will add up the no-fault expenses for each successive day until the day when the no-fault benefit maximum is exhausted. From that day on, covered Services received by the Enrollee will be eligible for payment under this Plan. The Plan will follow this procedure even when the no-fault insurer pays all of its benefits for non-medical expenses or when the actual order of payment differs.
- C. If another person caused the motor vehicle accident and the Enrollee may recover damages from that person, any benefits for which the Enrollee may be eligible shall be subject to the provisions of Article 13. The Plan is not liable to pay any benefits for injuries caused by another person, but may assist the Enrollee by providing coverage he or she would have received as a benefit after the no-fault benefits have been exhausted as described in subparagraph B above, subject to the right of subrogation.
- (New) Rule 13.05 Coordination of Benefits and Double Coverage: 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.
- Rule 13.01 Subrogation: Reimbursement of Benefits Added section regarding right to recover damages due to injury or illness caused by another person; and lien against any recovery to the extent of such payments. [would become Rule 14.01]
- Rule 14.01 Changing Benefits and Enrollment: Chart Benefit Options: Revised Enrollment / Benefits Chart to include changes and additions as follow: Changed Self Plus Family to "Self Plus Four"; Added categories for "From Self only to Self Plus One", "From Self only to Plus Five", "From Plus Four or Plus Five to Self only", "From

Plus Four or Plus Five to Self Plus One", and from "Plus Four to Five Plus More"; changed From Self only to Family to "From Self only to Plus Four". [would become Rule 15.01]

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- Rule 14.02.D Changing Benefits and Enrollment: Lifetime Maximum Remaining Amounts Added that "no transfer of amounts exceeding limits as specified in the Plan". [would become Rule 15.02.D]
- Rule 14.03.B Changing Benefits and Enrollment: Enrollment Changes Added "requirement of additional documents for substantiation of change in status". [would become Rule 15.03.B]

COMMONWEALTH REGISTER

VOLUME 23

GROUP HEALTH AND LIFE INSURANCE PROGRAM

AMENDED RULES AND REGULATIONS (PLAN DOCUMENT)

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GROUP HEALTH AND LIFE INSURANCE PROGRAM

Plan Document

NORTHERN MARIANA ISLANDS RETIREMENT FUND COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

September 19, 2001

COMMONWEALTH REGISTER VOLUME 23 NUMBER 11 NOVEMBER 23, 2001. PAGE 18677

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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.

Vicente C. Camacho Chairman, Board of Trustees NMI Retirement Fund Takeo N. George Acting 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 and required to be submitted to the Fund 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. **"Copayment"** 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. **"Doctor"** means a duly licensed doctor of medicine (M.D.), medical officer (M.O.) or doctor of osteopathy (D.O.). 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.
- 2.15. "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.
- 2.16. "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;
 - b. the Plan's published fee schedule for Services rendered in the CNMI, or for Services available in the CNMI but rendered in another location.
- 2.17. "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.
- 2.18. "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.

- 2.19. **"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.
- 2.20. **"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.
- 2.21. **"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.
- 2.22. "Fiscal Year" means any October 1 through the following September 30.
- 2.23. "Fund" means the NMI Retirement Fund.
- 2.24. "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.
- 2.25. "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.
- 2.26. "Government" means the CNMI Government, its departments, agencies, instrumentalities, public corporations, municipal governments, and other CNMI Government entities and autonomous agencies.

- 2.27. "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.
- 2.28. **"Injury"** means an injury 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 48 hours. Subjective symptoms that occur spontaneously or from trivial movement or exercise and that are physiological, pathological, toxic, or infective origin are not to be considered the result of external force and therefore shall not be considered an injury.
- 2.29. **"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.
- 2.30. **"Medical Director"** means a medical doctor, medical officer, and other medical professional or employed by the Plan or its Third Party Administrator, if any, to review claims and determine medical necessity of Services.
- 2.31. "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 or disease, 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.
- 2.32. **"Mental or Nervous Disorders"** include the following conditions: neurosis, psychoneurosis, psychopathy, psychosis, emotional disorders of every kind, irrespective of cause, and substance abuse.
- 2.33. **"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.
- 2.34. **"Non-Participating 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.
- 2.35. **"Non-Preferred Prescriptions"** 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.
- 2.36. **"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.
- 2.37. **"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.
- 2.38. **"Participating Provider"** means a Provider of Services who, when rendering a Service covered by this Plan to an Enrollee, agrees with the Plan 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.
- 2.39. **"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.

- 2.40. **"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.
- 2.41. "**Plan Year**" means the calendar year, except that the first Plan Year will be the effective date of these regulations through December 31, 2002. For a new Enrollee, the Plan Year begins when such Enrollee's coverage begins and continues through the following December 31.
- 2.42. **"Premium"** means the total amount of Contributions required to be paid into the GHLI Trust Fund for participation in the Program.
- 2.43. "**Prior Program**" means any Government Employee group health insurance program in effect prior to the effective date of this Program.
- 2.44. **"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.
- 2.45. "**Provider**" means a Doctor, Hospital, Skilled Nursing Facility, or any other duly licensed person, institution or other entity qualified to provide the relevant Covered Benefits under the Program.
- 2.46. **"Retiree"** means a former Employee who is receiving annuity payments through the 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.
- 2.47. **"Services"** means health care treatments, procedures, supplies, equipment, and products, and includes prescription drugs.
- 2.48. **"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.
- 2.49. **"Special Enrollment"** means the rights conferred on any person by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- 2.50. "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.
- 2.51. **"Subscriber"** means any Employee, Retiree or Survivor who is enrolled in the Program and in whose name the enrollment is registered.
- 2.52. "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.
- 2.53. **"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.

ARTICLE 3 – ELIGIBILITY

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

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

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

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

ARTICLE 4 – ENROLLMENT

4.01. Enrollment Options and Categories.

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

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

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

- 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

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

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

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

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

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

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

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

ARTICLE 5 – BENEFITS

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

		HIGH OPTION PLAN	LOW OPTION PLAN
Α.	All Hospital, surgical, medical,	Program pays 80% of the first \$20,000	Program pays 70% of the first \$20,000
laboratory, and other Services,		per Enrollee of Eligible Charges incurred	per Enrollee of Eligible Charges
except for those Services specified in		during a Plan Year, and 100% of Eligible	incurred during a Plan Year, and 100%
5.02B through F below.		Charges thereafter.	of Eligible Charges thereafter.
В.	Office Visits	Program pays 80% of the Eligible	Program pays 70% of the Eligible
		Charges incurred during a Plan Year.	Charges incurred during a Plan Year.
C.	Prescription drugs	Enrollee pays \$3 for generic, \$7 for	Enrollee pays \$3 for generic, \$7 for
		name brand and \$15 for non-preferred	name brand and \$15 for non-preferred
		prescriptions dispensed by a	prescriptions dispensed by a
		participating provider OR \$5 for generic,	participating provider OR \$5 for
		\$10 for name brand and \$20 for non-	generic, \$10 for name brand and \$20
		preferred prescriptions dispensed by a	for non-preferred prescriptions
		non-participating provider, for a 30-day	dispensed by a non-participating
		supply from a pharmacy or a 90-day	provider, for a 30-day supply from a
		supply from the Plan's mail-order Rx	pharmacy or a 90-day supply from the
		service.	Plan's mail-order Rx service.
D.	Hospital room and board	Program pays 80% of Eligible Charges,	Program pays 70% of Eligible
		with a maximum of \$300 per day.	Charges, with a maximum of \$250 per
			day.
Ë.	Intensive Care Unit room	Program pays 80% of Eligible Charges,	Program pays 70% of Eligible
	and board	with a maximum of \$900 per day.	Charges, with a maximum of \$750 per
			day.
F.	Skilled Nursing Facility room	Program pays 80% of Eligible Charges,	Program pays 70% of Eligible
	and board	with a maximum of \$150 per day.	Charges, with a maximum of \$125 per
			day
G.	Family Out-of-pocket Maximum	Maximum family out-of-pocket expense	Maximum family out-of-pocket
		per category each Plan Year:	expense per category each Plan Year:
		Self Only - \$4,000	Self Only - \$6,000
		Self Plus One - \$8,000	Self Plus One - \$12,000
		Self Plus Four - \$12,000	Self Plus Four - \$18,000
		Self Plus Five Plus - \$16,000	Self Plus Five Plus - \$24,000

A BRIEF SUMMARY OF COVERED BENEFITS

H.	Annual Maximum	Program pays a maximum of \$100,000 per Enrollee.	Program pays a maximum of \$50,000 per Enrollee.
1.	Lifetime Maximum	Program pays a maximum of \$500,000 per Enrollee.	Program pays a maximum of \$250,000 per Enrollee.

5.03. Inpatient Hospital Room and Board Benefits.

- A. **Allowable Charges.** Subject to the definitions, limitations, maximums and exclusions of the Program, Eligible Charges for the following Hospital room and board charges are Allowable Expenses:
 - 1. Room and board at the average semi-private rates, including meals, special diets and general nursing care.
 - 2. Charges made by the Hospital as a condition of occupancy, such as those for identification bracelets and medical records.
 - 3. Intermediate care unit, isolation unit, and intensive care or coronary care unit. Must be equipped and operated according to generally recognized Hospital standards acceptable to the Plan.
- B. **Private Room Benefits.** Regardless of the reason a private room is used, the difference between its cost and the cost of the Hospital's average semi-private accommodation is not an Allowable Expense. If the Hospital has private rooms only, the Program will pay the average semi-private room rate based on the charges of a comparable Hospital in the same or a similar geographic area up to the maximum Hospital room and board Allowable Expense.
- C. Except where otherwise stated, benefits are subject to the Plan's Schedule of Benefits. If Services are rendered by a non-participating Provider, the Enrollee also owes any difference between actual and Eligible Charges.
- 5.04. **Other Benefits.** Subject to the definitions, limitations, maximums and exclusions of the Program, Eligible Charges for the following Services, in or out of a Hospital, are Allowable Expenses:
 - 1. Hospital Services.
 - a. Services (other than room and board) furnished by the Hospital for treatment in the Hospital or its outpatient department, such as drugs, medicines, laboratory work, use of operating and recovery rooms, surgical supplies, Hospital anesthesia Services and supplies, dressings, oxygen, antibiotics, Hospital blood transfusion Services, and diagnostic and therapy benefits for which the Hospital charges on its own behalf.

2. Surgical and Medical Services.

a. **Surgical Services.** Except where otherwise stated, benefits are subject to the Plan's Schedule of Benefits for surgical Services required for the diagnosis or treatment of an Enrollee's illness or lnjury. 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 of Doctors such as surgery, consultations and home, office and Hospital visits;
- c. 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;
- d. Anesthetic, oxygen, intravenous injections and solutions, blood (and blood derivatives) not donated or replaced, and administration of these.

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.

- e. X-ray, radium and radioactive isotope therapy, including materials and the Services of a technician;
- f. Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations;
- g. Prosthetic devices, other than dental, which replace all or part of an internal body organ, including replacement of such devices;

- h. 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
 - iii. suction machines
 - iv. hospital beds/commodes
 - v. oxygen and oxygen accessories
 - vi. respirators

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;

- i. 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;
- j. Tubal ligations; and
- k. **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.

3. **Outpatient Services.**

- a. 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 10 visits at a maximum of \$25 per visit, for a total benefit of \$250 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. 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. 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 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 Plan year of January 2002, 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. Vasectomies; and

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

Home Health Care. 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.
- lii. Visits must be provided by a qualified home health agency.

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

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

6. Maternity Services.

- a. Standard Prenatal care, and the ensuing childbirth or miscarriage, and any medical conditions relating thereto.
- b. Nursery charges for days on 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.
- c. Services by a nurse-midwife will be eligible for coverage on this 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.
- d. 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.
- e. 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.

f. 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.**

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- a. One (1) annual physical exam, except as excluded in Article 8, including 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. One (1) family planning counseling session;
- c. Pre-natal care and one post partum visit per delivery;
- d. One (1) counseling session on smoking cessation; and
- e. Annual well-child care program through age three, including immunizations for DPT, typhoid, cholera, polio, small pox, mumps, measles, and rubella and screening for anemia, tuberculosis, and hearing and vision problems.
- 8. **Skilled Nursing Facility Services.** An Enrollee, confined in a Skilled Nursing Facility, shall be eligible for the same room and board and general nursing care benefits as if confined in a Hospital, if:
 - a. the Enrollee was admitted upon the authorization of a Doctor;
 - b. the Enrollee is attended by a Doctor while confined; and
 - c. the Enrollee's confinement in the Skilled Nursing Facility is not primarily for comfort, convenience, rest cure or domiciliary care.
 - d. an Enrollee remains in such facility more than 30 days, the attending physician must submit to the Administrator an evaluation report concerning the Enrollee at the end of each such 30-day period of confinement.

- 9. Chemotherapy and Other U.S. Federal Government Approved Cancer Treatments.
- 10. Dialysis and Supplies.

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11. Prescription Contraceptive Services.

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 Copayment must be paid by the Enrollee for each prescription filled or refilled. Such Copayment 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 Copayment will apply to each prescription drug. If the prescription is for more than a one-month supply, and filled at a pharmacy, an additional Copayment 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 Copayments, Coinsurance, charges which exceed Eligible Charges, charges which 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. **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 a Hospital, unless the Enrollee is confined in a Hospital intensive care unit.
- B. 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 a Hospital intensive care unit.
- C. Skilled Nursery 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 a 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 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.

7.07. Annual 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 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.

7.08. Lifetime Maximums.

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

- A. Under the "High Option Plan", the Lifetime Maximum that the Program will pay is \$500,000 per Enrollee for all Covered Benefits, specified in Article 5, Sections 5.04. 1 through 11 (combined), incurred during the Enrollee's lifetime.
- B. Under the "Low Option Plan", the Lifetime Maximum that the Program will pay is \$250,000 per Enrollee for all Covered Benefits, specified in Article

5, Sections 5.04. 1 through 11 (combined), incurred during the Enrollee's lifetime.

- C. If an Enrollee terminates the Program and later re-enrolls, his or her Lifetime Maximum will be that amount remaining as of the last day the Enrollee was enrolled in the Program, including all reductions for payments of Covered Benefits, specified in Article 5, Sections 5.02A through F (combined), which were incurred prior to the date of termination and paid either before or after such date.
- D. Once the Program has paid out the total amount of the Lifetime Maximum for an Enrollee, the Enrollee will not under any circumstances be entitled to coverage or indemnification under the Program for the remainder of his or her life.
- 7.09. **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, or
 - 2. When Services for an Injury or illness would have been provided without charge or collection but for the fact that the person is an Enrollee under this Plan.
 - C. The Plan will not pay any benefits, to the extent that such benefits are payable, by reason of any false statement or other misrepresentation made in an application for membership or in any claims for benefits. If the Plan pays such benefits before learning of any false statement, the Subscriber agrees to reimburse the Plan for such payment.
 - D. The Plan is not an insurer against nor liable for the negligence or other wrongful act or omission of any Provider, Provider's Employee, or other person or for any act or omission of any Enrollee.
 - E. The Plan does not guarantee the availability or quality of or undertake to provide any Services of any third party including the availability of Preferred or Participating Providers.
 - F. The Plan will not pay benefits for Services required in the treatment of an Injury or illness that results from an act of war or armed aggression,

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

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

1. Charges.

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

2. Services.

- 1. Any drugs, medicines, or supplies available without a Doctor's prescription, even if prescribed by a Doctor.
- 2. Any inpatient Service provided by an institution that is not a Hospital or Skilled Nursing Facility.
- 3. Any Service not recommended and approved by a Doctor who is practicing within the scope of his or her license.
- 4. Any Service for which the Enrollee has no legal obligation to pay.
- 5. Any Service for which the government of the jurisdiction in which the Service was provided prohibits payment.
- 6. 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.

- 7. Any Service rendered because of war, or an act of war, occurring after the effective date of the Enrollee's coverage in the Program.
- 8. 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.
- 9. Any Service rendered by a practitioner who is not a Doctor, except as otherwise specifically provided in the Plan Document.
- 10. Any Service if a material statement made is false and would otherwise have rendered the Service ineligible.
- 11. 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.
- 12. Any Service which is not Medically Necessary, except as otherwise specifically provided in the Plan Document.
- 13. Any Service, including Hospital, surgical, medical, laboratory, and x-ray Services, rendered in connection with an excluded Service.
- 14. Any Service for which no charge was made.
- 15. Any Service received while the individual was not enrolled in the Program.
- 16. Any Service for which the Enrollee has coverage through a public health program, CHAMPUS or other government or military program.
- 17. Any Services rendered to a Subscriber's dependent parent.
- 18. Abortions (elective).
- 19. Acupuncture.
- 20. Air ambulance.

- 21. Air conditioners, humidifiers, dehumidifiers and purifiers.
- 22. Allergy testing and treatment.
- 23. Biofeedback and similar forms of self-care or self-help training.
- 24. Chiropractic care, except as otherwise specifically provided in the Plan Document.
- 25. Circumcision, routine or ritual.
- Congenital defects or abnormalities, other than specified in section 5.04(2)(k).
- 27. Consultations with Doctors by telephone, facsimile, e-mail or any other form of electronic transmission.
- 28. Contact lenses, eyeglasses and refractive surgery, such as radial keratotomy, to correct visual problems.
- 29. Cosmetic surgery and all cosmetic Services.
- 30. Custodial, domiciliary and convalescent care, including nutritional supplements and/or formulas used for nutritional supplement.
- 31. Dental appliances.
- 32. Dental care.
- 33. Dental work or oral surgery, including endontic (root canal) and periodontic Services, except as otherwise specifically provided in the Plan Document.
- 34. Dental Services, except for Services and surgical procedures as otherwise specifically provided in the Plan Document.
- 35. 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 or adopted by the Plan.
- 36. Exercise equipment and other non-medical products or procedures.

- 37. Experimental Services, including any clinical visits, inpatient stays, drugs, laboratory testing, x-rays, and other Services related to such Experimental Services.
- 38. Fertility / Infertility Services, including fertilization by artificial means, such as artificial insemination, in-vitro fertilization and embryo transplants, and other Services intended to induce pregnancy.
- 39. Foot reflexology.
- 40. Gastric bypass, stapling or reversal.
- 41. Growth hormone therapy, except replacement therapy services due to hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy.
- 42. Hansen's Disease.
- 43. Hearing aids.
- 44. Heat lamp treatments.
- 45. HIV & HTLV Testing and AIDS and AIDS-related care.
- 46. Hospice care.
- 47. Implants, and any related services, supplies and drugs, sought for cosmetic purposes or to enhance or improve physical appearance.
- 48. Liposuction.
- 49. Living expenses.
- 50. Massage treatments.
- 51. Maternity Services for non-Spouse Dependent.
- 52. Mental health and substance abuse Services. Hospital and other facility charges for these Services are also excluded.
- 53. Mental Health Coverage, including, but not limited to Mental retardation and non-corrective mental deficiency,

emotional disorders, mental or emotional counseling, and any form of substance abuse and related counseling.

- 54. 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.
- 55. Occupational therapy, except as otherwise specifically provided in the Plan Document.
- 56. Organ transplants. No benefits will be paid for Services and supplies provided in the course of an organ transplant or donation whether for an Enrollee who is donating an organ or for someone who is receiving or donating an organ for transplantation into an Enrollee.
- 57. Orthopedic shoes, insoles and other similar external supportive devices for the feet.
- 58. Other health and accidental insurance coverage and third party liability settlements.
- 59. Palliative treatments.
- 60. Parkinson's Disease.
- 61. Personal comfort and convenience items, such as telephones, radios, televisions, and barber and beauty services.
- 62. Physical exams, when required for obtaining or continuing employment, insurance, schooling, government licensing, or sporting activities.
- 63. Physical therapy, except as otherwise specifically provided in the Plan Document.
- 64. Private duty nursing.
- 65. Rehabilitation therapy, except as otherwise specifically provided herein.
- 66. Replacement of joints.
- 67. Rest cures.

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- 68. Rest homes, sanitariums and other institutions that are not Hospitals or Skilled Nursing Facilities.
- 69. Reversal of voluntary sterilization.
- 70. 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.
- 71. Services of an injury or illness resulting from the Enrollee's attempted suicide.
- 72. 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).
- 73. 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.
- 74. 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.
- 75. Services for an intentionally self-induced illness or selfinflicted injury, while the Enrollee was sane or insane.
- 76. Services not Medically Necessary.
- 77. Services or supplies for treatment or diagnosis of Temporomandibular Joint (TMJ) disorders or other conditions involving joints or muscles related to TMJ.
- 78. Services or supplies not specifically described as covered in this Plan Description. (Example: Subscriber's grandchild for which no Court Ordered legal guardianship exists)
- 79. 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.

- 80. Services for sexual dysfunction or inadequacies.
- 81. Speech therapy.
- 82. Telephone calls to or from a Doctor or a Doctor's office even if a Doctor charges for such calls.
- 83. Testing of donor blood.
- 84. Training for custodial care or self-care such as for personal hygiene.
- 85. 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).
- 86. Transportation of the remains of any deceased person will in no way be paid by the Government Health Insurance.
- 87. Transsexual Services, to include sex transformations or sex change operations.
- 88. Tuberculosis.
- 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.

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.

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

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

Beginning with the second Plan Year of this Plan (January 2003), the Government Contribution and total Premium for each category and option of coverage shall be as follows:

Unless determined otherwise by actuarial study and recommendation, the Government Contribution to Premiums shall increase by five percent (5%) annually, each such increase to become effective at the beginning of the Plan Year, with the first such increase being effective in January 2004. Said automatic increases shall continue annually until such time the Government's Contribution is equal to the Subscriber's Contribution.

Contribution Rates Rates Effective January 2, 2002

Type of Enrollment	Enrollment Code Number		Bi-weekly Cost
Self Only High Option 201		Government Contribution Subscriber Contribution Total Premium	\$ 5.57 <u>\$ 32.79</u> \$ 38.36
Self Plus One High Option			\$ 10.08 <u>\$ 59.34</u> \$ 69.42
Self Plus Four High Option	203	Government Contribution Subscriber Contribution Total Premium	\$ 14.60 <u>\$ 85.88</u> \$ 100.48
Self Plus Five Plus High Option	204	Government Contribution Subscriber Contribution Total Premium	\$ 19.12 <u>\$112.42</u> \$131.54
Self Only Low Option	205	Government Contribution Subscriber Contribution Total Premium	\$ 3.50 <u>\$ 20.63</u> \$ 24.13
Self Plus One Low Option	206	Government Contribution Subscriber Contribution Total Premium	\$ 5.95 <u>\$ 35.14</u> \$ 41/09
Self Plus Four Low Option 207		Government Contribution Subscriber Contribution Total Premium	\$ 8.40 <u>\$ 49.65</u> \$ 58.05
Self Plus Five Plus Low Option 208		Government Contribution Subscriber Contribution Total Premium	\$ 10.85 <u>\$ 64.16</u> \$ 75.01

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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., D.P.M., D.D.M., or D.D.S.), Skilled Nursing Facilities, Doctors of chiropractic, advanced practice registered nurses and physical or occupational therapists who qualify as such under the requirements of the Federal Medicare Program, are certified or licensed by the proper government authority, render Services within the lawful scope of the respective licenses, and are approved by the Plan will be covered. Benefits may be available for Services rendered by other Providers as shown in specific sections of this Plan.

11.02. Filing of Claims (General Rules).

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

11.03. Payment of Claims (General Rules).

- A. All claims eligible for reimbursement of Eligible Charges and Allowable Expenses, less any required Copayment or Coinsurance, will be paid by the Administrator from the GHLI Trust Fund 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.
 - B. Private sector Provider and Providers outside the CNMI may file claims directly with the Administrator on the Enrollee's behalf.
 - 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.

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 to pay the Provider rather than the Subscriber.

- C. If a claim is paid to a Provider, the 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 nonparticipating 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-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-participating Provider:

- 1. are not assignable;
- 2. shall be made by the 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 will not accept claims filed more than one year following the date on which the Service was rendered.
- 11.09. **Medical Necessity of Services.** This Plan covers only medically necessary Services; the Plan will not cover any unnecessary Services nor will the unnecessary portion of any charge be paid. The fact that a physician may prescribe, order, recommend, or approve a Service does not in itself constitute medical necessity or make a charge an allowable expense under this Plan. An Enrollee may ask a physician to write to the Administrator for a determination regarding the medical necessity of a Service before it is performed. The Administrator will determine the medical necessity of the test or treatment based on the criteria and guidelines of the Federal agencies. To be considered medically necessary, a Service must meet all of the following criteria:
 - A. The Service or treatment must follow standard medical practice and be essential and appropriate for the diagnosis or treatment of an illness or Injury. Standard medical practice, with respect to a particular illness or Injury, means that the Service was given in accordance with generally accepted principles of medical practice in the United States at the time furnished.
 - B. The Service or treatment must not be "Experimental" (e.g., used in research or on animals), or "investigative" (e.g., used only on a limited number of people or where the long term effectiveness of the treatment has not been proven in scientific, controlled settings, and, where applicable, has not been approved by the appropriate government agency).
 - C. If there is more than one medically appropriate method of treating an Enrollee, the Plan's benefit will be based on the least expensive method,

even if the health care Provider elects to treat the Enrollee by a more expensive method. Similarly, if the Services could be provided in more than one type of facility or setting (e.g., Hospital or physician's office), the Plan's benefits will be based on the least expensive facility or setting.

- 11.10. **Eligible Charges.** The Plan's benefit payments and the Enrollee's Copayments for most Services are based on the Eligible Charges for the Services (i.e., the Enrollee pays a specified percentage or portion of the Eligible Charge for each Service). The Plan will not pay the portion of any charge that exceeds the Eligible Charge. General excise or other tax is not included in the Eligible Charge. An Enrollee is responsible for paying all taxes.
 - A. **Definition.** The Eligible Charge for a covered Service is the lower of the actual charge on the claim, the discounted charge negotiated by the Plan, 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 Services Provided by Off-island 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.

11.11. False Claims.

- A. The Administrator may discontinue covering the Services of any Provider who submits a false claim. The Administrator will make reasonable best efforts to notify all Enrollees of such change. Thereafter, claims for Services received through such former Provider will not be paid. The Administrator will maintain a list of all such ineligible Providers.
- B. The Administrator may terminate the enrollment of any Enrollee who submits a false claim, immediately upon the discovery and verification of such false claim. Coverage will seize on the day the Administrator terminates enrollment of the Subscriber and/or the Enrollee, and any claims submitted by the Subscriber or Enrollee after the date the

Administrator terminates enrollment shall be denied for lack of coverage, and the Program shall have no obligation for payment of any such claims.

11.12. Claims Auditing.

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

11.13. Review and Arbitration.

- A. The Administrator shall have discretionary authority to determine all questions of eligibility of Enrollees, to determine the amount and type of benefits payable to any Enrollee or Provider in accordance with the terms of this Plan, and to interpret the provisions of this Plan as is necessary to determine benefits.
 - 1. **Review.** Any preliminary determination that a Service or charge is unnecessary or otherwise not payable shall be reviewed at the Subscriber's request and approved or corrected by such review committees as are appointed or approved by the Administrator. A Subscriber has one year from the date the Plan processed the Subscriber's claim to request this review. Any determination made by such review committees, acting in good faith, shall be conclusive upon all interested parties, subject to review and redetermination by the Board, whose decision shall be final. Such final decision may be submitted to arbitration.
 - 2. **Arbitration.** If a Subscriber is dissatisfied with the results of a review as defined in paragraph (1) above, the Subscriber may request a further appeal by arbitration, provided that such request must be submitted to the Administrator in writing within ninety (30) days of the final decision. If a Subscriber shall make such written demand, the Subscriber and the Fund shall promptly agree upon a single arbitrator and if they shall fail to so agree within 30 days of the written demand, either party may apply to the Superior Court of the CNMI for appointment of an arbitrator. The questions for the arbitrator shall be whether, in the particular instance, the Board was in error upon an issue of law, acted arbitrarily or capriciously in the exercise of its discretion, or whether the Fund's findings of fact were supported by substantial evidence. The dispute shall be

promptly decided and judgment may be entered upon the award of the arbitrator with the Superior Court of the CNMI. The judgment of the arbitrator shall be final and binding upon all interested parties and no further court action may be taken. The fee payable to the arbitrator shall be borne equally by the Subscriber and the Plan; all other expenses of the arbitration, such as cost of reporter and transcript, shall be paid in the share and manner ordered by the arbitrator, except that any attorney or witness fees of a party shall be borne by that party.

11.14. Provider Signature.

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

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

ARTICLE 14 – SUBROGATION

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

ARTICLE 15 – CHANGING BENEFITS AND ENROLLMENT

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

(SEE CHART ON NEXT PAGE)

CHART ON CHANGING ENROLLMENT / BENEFITS

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

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

- 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.

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ARTICLE 18 – COMMUNICATIONS

- 18.01. Communications from Enrollees and any other interested persons regarding the Program should be addressed to the Administrator, CNMI Group Health Insurance Program, NMI Retirement Fund, 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.

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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 information 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.

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. Such laws include the Act, 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, the Mental Health Parity Act of 1996, the Health Insurance Portability and Accountability Act of 1996 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.

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ARTICLE 22 – AMENDMENTS AND EFFECTIVE DATE

- 22.01. These rules and regulations may be amended from time to time as the Board of Trustees deems appropriate.
- 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.

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS CIVIL SERVICE COMMISSION

NOTICE OF EMERGENCY AND NOTICE OF RULE IMPLEMENTATION OF FINANCIAL AUSTERITY MEASURES

On November 7, 2001 the Governor issued a request declaring the need for financial austerity measures that affect the Civil Service System.

Under the authority of 1 CMC §8117, and Personnel Service System Rules and Regulations, Part XII.A the Civil Service Commission hereby notifies the general public that all provisions of the Personnel Service System Rules and Regulations that require increases in employees' salaries due to permanent or temporary promotions, acting or detail assignments, reallocation or reclassification of positions, and step increases based on attendance at workshops or other training programs are suspended. Expiration of the suspension will not entitle employees to retroactive salary adjustments for salary increases suspended by this action.

This rule is made and filed pursuant to 1 CMC §9102. Since this is a rule that is a statement of general applicability that implements, interprets, or prescribes law or policy, the provisions of 1 CMC §9104 relating to the adoption of regulations does not apply.

EMERGENCY: This rule implementing Financial Austerity Measures is adopted as an emergency rule based on the Governor's memorandum and the anticipated reduction in Commonwealth income. This rule would normally take effect ten days after publication in the Commonwealth Register. It is in the public interest that the rule become effective upon filing with the Registrar of Corporations, subject to the approval of the Attorney General and the concurrence of the Governor.

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		Civil Service Commission P.O. Box 5150 CHRB Saipan, MP 96950	1
	В	Building No. 1211. Capitol Facsimile: (670) 322-332	
Date:	November 8, 2001	Submitted By:	Malla
Date:	11/14/01	Approved By:	Vicente M. Sablan Chairman Pedro P. Tenorio Governor

DATE: 10/13/01 **RECEIVED BY:** DELEON GUERRERO JOSE Special Assistant for Administration Date: ////4/01 Filed by: Soledad B. Sasamoto **Registrar of Corporations**

Pursuant to 1 CMC §2153, as amended by PL10-50, the following rules and regulations have been reviewed and approved as to form and legal sufficiency by the CNMI Attorney General's Office.

13 2001

 Herbert D. Soll Attorney General

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS CIVIL SERVICE COMMISSION

RULE IMPLEMENTATION OF FINANCIAL AUSTERITY MEASURES

The provisions of the Personnel Service System Rules and Regulations that require increases in employees' salaries due to permanent or temporary promotions, acting or detail assignments, reallocation or reclassification of positions, and step increases based on attendance at workshops or other training programs are suspended until further notice. Expiration of the suspension will not entitle employees to retroactive salary adjustments for salary increases suspended by this action.

Dated: November 8, 2001

Vicente M. Sablan, Chairman Civil Service Commission

CIVIL SERVICE COMMISSION

NOTICE OF RULE IMPLEMENTATION OF FINANCIAL AUSTERITY MEASURES

Statutory Authority:	1 CMC §8117 and Personnel Service System Rules and Regulations Part XII.A			
Short Statement of Goals and Objectives:	Implementing financial austerity measures affecting the Civil Service System			
Brief summary of the Rule:	The suspension of certain provisions of the Personnel Service System Rules and Regulations that require increases in employees' salaries.			
For Further Information Contact:	Cecilia L. Blas, Acting Executive Director Civil Service Commission Building Number 1211, Capitol Hill Phone 322-4363 Fax 322-3327			
Citation of Related and Affected Statutes & Regulations:	Personnel Service System Rules and Regulations Part IV.B5, B6, B7, B8, B12 & B15.			
Need for Emergency Adoption:	Yes. Based on Governor's November 7, 2001 memorandum, an emergency exists			

Date: November 8, 2001

Submitted by:

Vicente M. Sablan, Chairman Civil Service Commission