PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Plan Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Plan Sponsor/Plan Administrator: Blue Lake Rancheria

_____ _____

Signed (authorized representative of Plan Sponsor) Date

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YOU SHOULD ALSO BE AWARE OF THE FOLLOWING REQUIREMENTS WHICH MAY APPLY TO YOUR PLAN…

• It is important that your Plan Document be reviewed and signed in a timely manner to assure that booklets can be prepared, printed and distributed to employees to assure compliance with ERISA requirements.
Within 30 days of a request, the administrator of any employee benefit plan must furnish to the Secretary of the Dept. of Labor, any documents relating to the Plan, including but not limited to, the latest Summary Plan Description (the booklet) and any summaries of Plan changes not contained in the Summary Plan Description, the bargaining agreement, trust agreement, contract or other instrument(s) under which the Plan is established or operated.

• In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Covered Persons and beneficiaries must be furnished a summary of the change not later than 60 days after the adoption of the change. This does not apply if you provide summaries of modifications or changes at regular intervals of not more than 90 days. "Material modifications" are those, which would be construed by the average Covered Person as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

• Employee welfare benefit plans must file annual reports with the IRS on IRS/DOL/PBGC Form 5500.

The 5500 forms must be filed by the last day of the seventh month following the end of the Plan Year. An extension of up to 2.5 months may be granted for the filing of such forms.

NOTE: The Secretary of Labor may assess a civil penalty against a Plan Administrator for failure or refusal to file an annual report.

• A summary of the audited financial report (generally prepared in conjunction with the 5500 filing) must be given to Covered Persons two months after the deadline (including extensions granted by the IRS) for filing the Form 5500.

If you have any questions or concerns about these accounting requirements, talk to your broker/consultant, claims (contract) administrator, or accounting professional.

Blue Lake Rancheria Health Plan

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION
EFFECTIVE: 12:01 A.M., January 1, 2024

CONTRACT ADMINISTRATOR:

&

PROVIDER NETWORK/UTILIZATION REVIEW SERVICES:

Humboldt Independent Practice Association
Phone: (707) 443-4563
Fax: (707) 442-2047

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WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Covered Person can obtain additional information about Plan coverage of a specific drug, treatment, procedure, preventive service, etc., from the following office. No charge will be made for providing the information.

Humboldt Independent Practice Association

2662 Harris St.
Eureka, CA 95503
Phone: (707) 443-4563
Fax: (707) 442-2047

SPECIAL NOTICES

THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

A health plan which provides benefits for pregnancy delivery generally may not restrict benefits for a covered pregnancy hospital stay (for delivery) for a mother and her newborn to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a Cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending provider, in consult with the mother, decides an earlier discharge is appropriate.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Covered Persons must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the WHCRA.

MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

GENETIC INFORMATION NONDISCRIMINATION ACT ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Covered Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

STATEMENT OF GRANDFATHERED STATUS

The Blue Lake Rancheria Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Contract Administrator, Humboldt Independent Practice Association at (707) 445-4563. You may also contact the U.S. Department of Health and Human Services at http://www.hhs.gov/. In addition, the following website has additional information regarding Grandfathered Health Plans: https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/.

UTILIZATION MANAGEMENT PROGRAM

The Plan includes a **Utilization Management Program** as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

PREAUTHORIZATION REQUIREMENTS

The Plan Sponsor has contracted with an independent organization to provide preauthorization services. The name and phone number of the organization is shown on the Employee's coverage identification card.

Hospital Admission - Except as noted, seven (7) to ten (10) days prior to any scheduled Hospital admission which is not a Medical Emergency, the Covered Person or his attending Physician must contact the Utilization Management Organization for authorization. For an emergency admission, the Utilization Management Organization must be contacted within 48 hours of admission or on the first business day following a weekend or holiday admission.

NOTE: Prior authorization will not be required for an Inpatient admission for Pregnancy delivery which does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, prior authorization for such extended confinement is required.

Major Diagnostic Procedures, Surgery & Rehabilitation Therapy - Prior to any non-emergency major diagnostic procedure (e.g., CT, MRI, PET or CAT scan), surgery or rehabilitation therapy, the Covered Person or his attending Physician should contact the Utilization Management Organization for authorization.

MORE INFORMATION ABOUT PREAUTHORIZATION

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Prior authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service which is not Medically Necessary or which is otherwise not covered under the Plan.

CATASTROPHIC CASE MANAGEMENT SERVICES

The **Utilization Management Program** also includes services for the management of large or potentially large claims. On a case-by-case basis as selected by the Plan Sponsor, the Utilization Management Organization will provide an initial assessment of the patient, summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Sponsor.

In conjunction with these services, the Plan Sponsor reserves the right to monitor health care and modify Plan benefits to assure that high-quality medical care is provided in the most cost-effective settings.

GENERAL PLAN INFORMATION

Name of Plan:	**Blue Lake Rancheria Health Plan** (Legal name) Blue Lake Rancheria Employee Benefits Trust
Plan Sponsor:	**Blue Lake Rancheria**
Address:	428 Chartin Road P.O. Box 1128 Blue Lake, CA 95525
Business Phone Number:	(707) 688-5101 Ext. 1042
Participating Employer(s):	**Blue Lake Rancheria, Gaming Commission, Blue Lake Hotel LLC, and Blue Lake Casino**
Plan Sponsor ID No. (EIN):	**80-0928592**
Source of Funding:	**Self-Funded**
Plan Year:	**January 1 through December 31**
Applicable Law:	**ERISA**
Plan Number:	**501**
Plan Status:	**Grandfathered**
Plan Benefits:	**Medical, Prescription, and Dental Benefits**
Named Fiduciary:	**Blue Lake Rancheria**
Address:	428 Chartin Road P.O. Box 1128 Blue Lake, CA 95525
(See also definition of "Fiduciary")	
Designated Legal Agent:	**Jason Ramos, Tribal Administrator**
Address:	Blue Lake Rancheria 428 Chartin Road P.O. Box 428 Blue Lake, CA 95525
(Legal process may be served upon the Plan Sponsor or a Fiduciary)	
Privacy Officer & Benefits Coordinator Contact:	**Shayna McCullough, Benefits Coordinator**
Phone Number:	(707) 668-5101 x. 1042
Health Insurance Issuer:	**Pan-American Life Insurance Company**
Applicable Collective Bargaining Agreement(s):	**None**
Contract Administrator:	**Humboldt Independent Practice Association**
Address:	2662 Harris St. Eureka, CA 95503
Phone:	(707) 443-4563

FUNDING - SOURCES AND USES

Employee & Employer Obligations
An Employer is responsible for at least a portion of the cost of an Employee's health care coverage. If an Employee elects to enroll Dependent(s), he may be responsible for a portion of that cost. The Employer pays costs in excess of the Employee obligations.

COBRA costs are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the costs for active (Non-COBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See the **COBRA Continuation Coverage** section for more information.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer.

Plan Funded Benefits
The contributions will be applied to provide the benefits under the Plan.

Insurance Policy(ies)
Contributions may be used to purchase insurance coverage(s) to ensure that the Plan will meet its self-funded obligations. The policy(ies) may be reviewed upon request submitted to the Plan Sponsor. The Plan Sponsor is also available to answer any questions about the coverages. The provisions of the Plan Document in no way modify those of any insurance policy.

If an insurance company is providing excess loss ("stop loss") protection for the Plan and the Plan is the "named insured" on that contract, the name of the insurer is provided at the front of this **General Plan Information** section - see "Health Insurance Issuer." The administrative services provided by that insurer may include underwriting services and payment of claims (i.e., reimbursement to the Plan for claims dollars paid in excess of the stop loss limit of the contract).

Administration Expenses
Contributions may also be used to pay: (1) administrative expenses of the Plan in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and Contract Administrator(s) and (2) other reasonable operating expenses of the Plan.

ADMINISTRATIVE PROVISIONS

Administration (type of)
Certain benefits of the Plan are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such

election be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with the provisions of the Plan Document.

Amendment or Termination of the Plan
The Plan Sponsor expects the Plan to be permanent, but since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

determine eligibility for benefits or to construe the terms of the Plan;

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and

terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTES: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment which is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), any amendment limiting benefits under a Plan shall be universally applicable to all individuals in the same eligible class, shall be based on bona fide employment classifications consistent with the Employer's usual business practices, and shall not be directed at individual participants or beneficiaries based on any health factor of such individual(s). However, a Plan amendment applicable to all individuals in one or more groups of similarly situated individuals and made effective no earlier than the first day of the first Plan Year after the amendment is adopted is not considered to be directed at individual participants and beneficiaries.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Entire Contract
The Plan Document, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of

executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband, wife, domestic partner, or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciaries
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation, but they will be entitled to reimbursement of their expenses properly and actually Incurred in an official capacity. The Plan Sponsor may at any time and from time to time remove any Fiduciary or appoint new Fiduciaries. Any Fiduciary may resign at any time upon 30 days' notice in writing delivered to the Plan Sponsor. Fiduciaries may act at a meeting or without a meeting, by a majority of the Fiduciaries at the time in office. The Fiduciaries may appoint a member as its secretary who will have such powers and responsibilities relating to the administration of benefits under the Plan as the Fiduciaries may delegate.

The Plan Administrator may delegate to the Contract Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Contract Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, the Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision
The illegality of any particular provision of the Plan Document will not affect the other provisions, but the Plan Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Covered Person or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

an employee's cessation of active service for the employer;

a Covered Person's failure to pay his share of the cost of coverage, if any, in a timely manner;

a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);

a Covered Person is injured and expenses for treatment may be paid by or recovered from a third party;

a claim for benefits is not filed within the time limits of the Plan.

Material Modification
A Summary of Material Modifications (SMM) reports changes in the information provided within the Summary Plan Description. Examples include a change to deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: The Patient Protection and Affordable Care Act (PPACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least 60 days before the effective date of the Material Modification.

Material Reduction
A Summary of Material Reduction (SMR) is a type of SMM. In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Covered Persons and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days. "Material reductions" are those that would be construed by the average Covered Person as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated in accordance with the Plan's provisions.

Non-Discrimination Due to Health Status
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
claims experience
receipt of health care
medical history
evidence of insurability
disability
genetic information

Physical Examination
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion & Authority
The Plan Administrator has the exclusive authority, it its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator or the delegated Contract Administrator shall make determinations regarding Plan Benefits.

Privacy Rules & Intent to Comply
The Plan Sponsor certifies that the Plan is amended (by separate addendum) to comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA). See the section entitled **Privacy Rules** for more information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements
Plan's Right to Reimburse Another Party - Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Clerical Error - When, as a result of clerical error, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer
Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Substitution
The Plan Sponsor will be substituted for all rights of an Employee to recover attorney fees against any adverse party. Employees will do nothing to prejudice such rights of the Plan Sponsor and further they agree to do all acts necessary to preserve and take advantage of such rights. If payment has been made by the Plan in such instances and if the adverse party reimburses the Employee directly, the Plan will have the right to recover such payment from an Employee.

Titles or Headings
Where titles or headings precede explanatory text throughout the Plan Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Plan Document and will not affect the validity, construction or effect of the Plan Document provisions.

Termination for Fraud
An individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

a civil or criminal case finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

an individual has submitted a claim which, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

Termination for fraud will be made in writing and with 30-day notice to the individual.

Tribal Health Program Status and Rights

(a) Self-Insurance/Tribal Health Program: All program benefits are "self-insured", which means benefits are paid from general assets rather than through a policy or policies of insurance. Plan benefits are intended to qualify as self-insured tribal health program benefits under 25 U.S.C. Sections 1621e(f), 1623(b), 1603(12) and 1603(25). The Plan Sponsor also reserves the right to receive federal funding for benefits provided herein in accordance with 25 U.S.C. Section 1642. Stop loss insurance if carried by the Plan Sponsor does not pay individual; claims and does not convert this Plan to an insured program.

(b) Payer of Last Resort/Coordination with Indian Health Service (IHS) and Other Coverage: This program is entitled to payer of last resort rights under 25 U.S.C. Section 1623(b). Coverage under this program shall be coordinated as one component of an integrated tribal health program consisting of care provided through the Plan Sponsor using one or more mechanisms, including self-insurance, direct care, sponsorship, and patient referred care (PRC) services. The Claims Administrator shall serve as a fiscal intermediary when necessary to coordinate coverage through or on behalf of each component and applicable PRC services. This program is not treated as an alternate resource for purposes of PRC and the catastrophic health emergency fund (CHEF). Benefits provided hereunder are intended in part to serve as supplemental funding for benefits otherwise available to IHS Beneficiaries through other federal, tribal, and third party programs or payers. This program shall not pay in front of available federal, tribal, and other third party programs or payers, except to the extent agreed to by the Plan Sponsor in accordance with 25 U.S.C. Section 1621e(f).

(c) Medicare-Like Rate Discounts/CHEF: This Plan is entitled to Medicare-Like Rates ("MLR") pricing under Section 506 of the Medicare Modernization Act of 2003 and the final regulations issued thereunder at 42 CFR 136.30 through 136.32, and 42 CFR 489.29. Pursuant to 42 CFR 136.30(b), MLR shall apply "to all levels of care furnished by a Medicare-participating hospital, whether provided as inpatient, outpatient, skilled nursing facility care, as other services of a department, subunit, distinct part, or other component of a hospital (including services furnished directly by the hospital or under arrangements) that is…authorized by a Tribe or Tribal organization carrying out a CHS [now referred to as PRC] program of the IHS under the Indian Self-Determination and Education Assistance Act [the "ISDEAA"], as amended." The Plan Sponsor reserves the right to authorize MLR eligible care through its PRC program and to coordinate payment through the Claims Administrator herein, to assert Professional Services and Non-Hospital-Based Discounting to the extent permitted under 42 CFR 136.201 through 136.204, and to coordinate benefits and PRC services to maximize CHEF reimbursements under 25 U.S.C. Section 1621a.

(d) Member-Based Benefits: This Plan shall be construed as a member-based tribal health program to the fullest extent permitted at law, including without limitation, 25 U.S.C. Sections 1621e, 1623, and 1642. In the event that an enrolled tribal member qualifies for both employment-based and member-based benefits, the benefits paid hereunder shall be presumed to be paid as member-based benefits, unless designated otherwise by the Plan Sponsor, to the extent necessary to preserve member rights provided at law. This provision shall be construed to ensure that the Plan Sponsor's establishment of self-insurance or employment-based benefits will not waive any member-based rights and preferences available at law.

Type of Plan

The Plan is a group health plan that is governed by the Employee Retirement Income Security Act (ERISA) and subject to the Health Insurance Portability and Accountability Act (HIPAA). The Employer-funded ("self-funded") benefits of the Plan are not guaranteed under a contract or policy of insurance.

Further, this Plan is a tribal self-funded program within the meaning of 25 U.S.C. Sections 1621e, 1623, 1603(12) and 1603(25). The Plan provides non-taxable benefits for eligible non-member and member employees in accordance with Sections 105(b), 105(h), 106, and/or 139D of the Internal Revenue Code, as applicable.

This Plan is "self-insured" which means benefits are paid from the Plan Sponsor's general assets. The Plan Sponsor has contracted with the Claims Administrator to perform certain consultative and management services related to this Plan and to serve as a fiscal intermediary for coordination of member based benefits. The Blue Lake Rancheria is the Plan Administrator and Named Fiduciary of this Plan and thereby retains ultimate authority for this Plan.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

MEDICAL BENEFIT SUMMARY

CHOICE OF NETWORK OR NON-NETWORK PROVIDERS

The Plan Sponsor has contracted with one or more organizations or "Network" of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in that Network or any other Covered Providers of his choice (Non-Network providers).

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of the Maximum Allowable Charge. The Plan may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible - see the Schedule of Medical Benefits, below.

Complete listings of Network providers are automatically given to Covered Persons without charge. The lists may be provided in one or more separate documents. For these purposes, a "Covered Person" is each Employee, each former Employee on COBRA, and each alternative recipient under a Qualified Medical Child Support Order (QMCSO). Since certain covered services and supplies may not be available through the Network, a Covered person should refer to the Network list or directory to determine if any particular specialty is included.

Although there may be circumstances when a Network provider cannot be used, Non-Network providers will be paid at the Non-Network benefit levels EXCEPT as follows:

Emergency Care - If a Covered Person requires care for a Medical Emergency and must use the services of a Non-Network provider, any such expenses will be paid at Network benefit levels until the patient's condition has been stabilized to the point that he could be transferred to Network provider care. Thereafter, the Covered Person must be transferred to Network-provider care or Non-Network benefit levels will apply.

No Choice of Provider - If, while receiving treatment in covered Network facility, a Covered Person receives ancillary services from a Non-Network provider in a situation in which he has no control over provider selection (such as in the selection of an emergency room Physician, an anesthesiologist or a provider for diagnostic services), such Non-Network services will be covered at the Network benefit levels.

Unavailable Services - If a Network provider refers a Covered Person to a Non-Network provider specialist because the necessary specialty is not represented in the Network or is not reasonably accessible to the patient due to geographic constraints, such Non-Network specialist care will be covered at the Network benefit levels.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Maximum Allowable Charge, in accord with the terms of this Plan Document.

SCHEDULE OF MEDICAL BENEFITS

ANNUAL BENEFIT MAXIMUMS	
Individual Maximum Benefit	Unlimited
Family Maximum Benefit	Unlimited
Maximum Individual Out-of-Pocket Expense	$40,000
ANNUAL DEDUCTIBLES	Network / Non-Network Combined
Individual Deductible	$500
Family Maximum Deductible	$1,000

Individual Deductible - The Individual Deductible is an amount which a Covered Person must contribute toward payment of eligible medical expenses. The Deductible usually applies before the Plan begins to provide benefits. The "Annual Deductible" applies each Plan Year.

Family Maximum Deductible - If eligible medical expenses equal to the Family Maximum Deductible are Incurred collectively by family members during a Plan Year and are applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.

ELIGIBLE MEDICAL EXPENSES	**Network**	**Non-Network**
Chiropractic Care and Acupuncture, per visit	$30 Co-Pay	60%
COVID-19 Diagnostic Testing and Immunizations (vaccines)	100%†	100%†
Diagnostic Lab & X-ray, Outpatient Hospital and Mental Health (Physician's office, independent diagnostic facility, Outpatient Hospital)	$30 Co-Pay	Not Covered
Hospitalization (except "Newborn Care (well-baby)")	Lesser of 80% of contracted amount or Mad River Hospital Fee Schedule (if available)	60%
Inpatient Care		
Outpatient Services and Supplies	80%	60%
Emergency Room & Ambulance	80%	80%
Urgent Care	$40 Co-pay	80%
Newborn Care (well baby)		
Hospital Nursery Services	80%	60%
Inpatient Pediatric Exam	80%†	60%†
Occupational & Physical Therapy, per visit	$30 Co-Pay	60%
Physician Services		
Inpatient Visits (except newborn pediatric exam)	80%	60%
Office Visits (visit charge only):		
non-specialist visit	$30 Co-Pay	60%
specialist visit – see NOTE	$40 Co-Pay	60%
Other Physician Services (surgery, etc.)	80%	60%

NOTE: A "specialist" is as defined in the directory of Network providers. Also includes those that provide hearing tests.

Mental Health Care / Substance Use Disorder Care	(covered same as Sickness – see NOTE)	
NOTE: "Covered same as Sickness" means that the Plan's treatment limitations and financial requirements that apply to mental health or substance use disorders may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided under the Plan. "Treatment limitations" include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. "Financial requirements" includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses.		
Hospice Services Hospitalization Hospice Agency A Home Health Care Agency	 80% 80% 80%	 60% 60% 60%
Prescription Drugs, Outpatient Retail Generic Drug, per purchase Preferred Brand-Name Drug, per purchase Non-Preferred Brand-Name Drug, per purchase Mail-Order Option Generic Drug, per purchase Preferred Brand-Name Drug, per purchase Non-Preferred Brand-Name Drug, per purchase	 $10 Co-Pay† $40 Co-Pay† $70 Co-Pay† $20 Co-Pay† $80 Co-Pay† $140 Co-Pay†	
Prescription drug coverage involves a program through an independent vendor. To use the program, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A prescription can be purchased in up to a 30-day supply or 100 unit doses, whichever is greater, for the Co-Pays shown. The program also includes a "mail-order" option for maintenance (longer-term) drugs. **Mail-order drugs are available in up to a 90-day supply for the Co-Pays shown.** The Brand Co-Pay will apply to any purchase of a brand-name drug, whether or not the Physician indicates that a brand name is required and whether or not a generic form of the drug is available. However, if an individual prefers a brand-name drug and there is no medical necessity for its use over a generic drug, the Covered Person will be required to pay the brand-name Co-Pay plus the difference in price between the brand-name drug and its generic equivalent. A list of covered and excluded drugs is included elsewhere in this document. NOTE: The full terms and conditions of the prescription drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s). Further information should be obtained from the Employer's personnel office or the office of the Plan Sponsor.		
Preventive Care	100%†	100%†
Preventive Care includes routine health care check-ups and related routine lab work and X-rays, which are not related to Sickness or Accidental Injury. Such routine care may include but is not limited to: physical examinations, routine Pap smears, routine mammograms, sigmoidoscopy, vaccinations, immunizations and inoculations.		

All Other Eligible Medical Expenses	80%	60%

† Annual Deductible does not apply.

INTERNATIONAL MEDICAL CARE	
Optional Medical Care Benefit	100% of Covered Expenses**,** see description.

In alignment with guidelines published by the U.S. Centers for Disease Control and Prevention, including the American Medical Association, all medical institutions that are affiliated with this "International & Domestic Medical Care Benefit" shall either be directly or indirectly accredited by recognized international accrediting bodies (e.g., Joint Commission International (JCI) or the International Society for Quality in Health Care (ISQua)) or any recognized US-based healthcare accreditation organization (e.g. The Joint Commission, Healthcare Facilities Accreditation Program, or Accreditation Association for Ambulatory Health Care, Inc.). In some countries such as South Korea and France, their national healthcare accrediting body has had its own standards accredited by ISQua. Thus, in those countries in which the healthcare providers whom have been accredited by the national accrediting body meet international accrediting standards, Covered Persons have access to medical services rendered at overseas hospitals at a significant savings (up to 85%) compared to the cost of the same procedures in the United States. Common procedures that Covered Persons obtain overseas include:

Heart Bypass
Hysterectomy
Total Knee Replacement
Total Hip Replacement
Spinal Fusion

To access a Blue Sky Medical Travel, LLC, network facility and to make travel arrangements contact the Benefits Coordinator for other world-class medical provider options. Case management includes coordination of case services between providers, assistance with travel arrangements, providing a central point of contact, and monitoring the Covered Person upon return.

Provided cost savings, visa-vis local or regional health care providers, the Plan will cover the 100% of the cost of obtaining a passport and visa for you and a companion, excluding any rush charges; and, 100% of the medical travel facilitator case management and travel service fees; and, 100% of the total cost of direct medical care including procedure, hospitalization, lab work, x-rays, consultations, physical therapy, prescriptions; and, 100% of the cost for coach airfare, travel meal allowance, airport taxes/fees (excluding parking), lodging and meal allowance, and transportation to/from airport/medical facility(ies)/recovery resort for the Covered Person and companion. Other expenses may be covered, if approved in advance. The Plan will also provide a 10% cost savings stipend to the patient equal to the difference between pre-authorized domestic and foreign medical services subject to the annual medical expenditure maximum.

The uncovered expenses for an international medical service include, but are not limited to, any rush charges in obtaining passports/visas; the difference in airfare cost between First Class and Coach, if flying First Class; and 100% of resort upgrades, tips, concierge services, food costs beyond daily allowance, extra transportation beyond necessities, leisure travel (if any), cell phone/internet charges, and petsitter/housesitter.

ABOUT THE SUMMARY…

The percentages shown in the summary reflect the amounts the Plan pays of Covered Expenses after any required Deductible or Co-Pay has been deducted. The percentages apply to the "Maximum Allowable Charge". For Network providers, this means that the percentages apply to the negotiated rates and not necessarily to the provider's actual charges or the usual charges of similar providers. See "Maximum Allowable Charge" in the **Definitions** section for more information.

A "Co-Pay" is an amount the Covered Person must pay and the balance of the Covered Expenses will be paid by the Plan unless a lesser percentage (%) is shown. Co-Pays are usually paid to the provider at the time of service.

BALANCE BILLING

In the event that a claim submitted by a Network or non-Network provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Covered Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network provider.

The Covered Person is responsible for payment of co-insurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Nothing herein shall be construed to permit balance billing by a provider for treatment qualifying for and paid at Medicare-Like Rates.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions which are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (application of deductible requirements and benefit sharing percentages, etc.). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Maximum Allowable Charge for the items listed below and which are Incurred by a Covered Person – subject to the **Definitions**, **Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes medical expenses will be deemed to be Incurred on:
The actual date a service is rendered.

Acupuncture - Acupuncture services by a Doctor of Medicine (MD) or a certified acupuncturist (CA).

Alcoholism – Treatment of alcoholism or alcohol abuse.

Ambulance - Professional ambulance service, ground or air, when used to transport the Covered Person from the place where the Covered Person is injured or stricken by a Sickness to the nearest Hospital where treatment can be given. Ground surface transportation is also covered if required after admission to transfer a Covered Person from a Non-Network Hospital to a Network Hospital.

Ambulatory Surgical Center - Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient surgery.

Anesthesia - Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Birthing Center - Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

Blood - Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Chemotherapy - The use of chemical agents in the treatment or control of disease.

Chiropractic Care - Musculoskeletal manipulation and modalities (hot & cold packs, etc.) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

Contraceptives - Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. In addition, the Plan also covers abortifacient drugs (e.g., mifepristone (RU-486) and misoprostol). Most workers in employer-sponsored plans are currently covered for contraceptives. Contraception has additional health benefits like reduced risk of cancer and protection against osteoporosis.

NOTE: Oral contraceptives (birth control pills) and contraceptive patches can be obtained through the prescription drug program – see "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**.

COVID-19 (2019 Novel-Coronavirus)

Covered Expenses associated with testing for and treatment of COVID-19 include the following:

- *Diagnostic Tests.* The following items are covered at 100%, deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require preauthorization. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the Covered Provider's website, or such other amount as may be negotiated by the Covered Provider and Plan.
    - In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy one of the following conditions:
        - That are approved, cleared, or authorized by the FDA;
        - For which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
        - That are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
        - That are deemed appropriate by the Secretary of Health and Human Services.
    - Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.
- *Qualifying Coronavirus Preventive Services.* The following items are covered at 100%, deductible waived, and do not require preauthorization.
    - An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and
    - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- *In-Patient Hospital Quarantines.* There may be times when Members with the virus need to be quarantined in a Hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the Hospital for public health reasons. Such charges will not be denied solely because otherwise-applicable Medically Necessary requirements would not indicate a need for a private room.
- *Telehealth and Other Communication-Based Technology Services*. Members can communicate with their doctors or certain other practitioners without going to the doctor's office in person. This is recommended if a Member believes he or she has COVID-19 symptoms.
- *Requests for Prescription Refills*. When considering whether to cover a greater-than-30-day-supply of drugs, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request and make decisions based on the circumstances of the patient.

The above benefits are specific to diagnosis and treatment of COVID-19. Covered Persons who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

Diagnostic Lab & X-ray, Outpatient - Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis Services - Dialysis services, including training, when provided and billed for by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

Domestic Medical Travel - Hospital Services and Physician Services performed outside of the California north coast region at a hospital that participates in the Blue Sky Medical Travel, LLC or Health Flight Solutions networks. The regional medical care region includes facilities as far south, and in between, as Stanford Hospital & Clinics; and southeast as UC Davis Medical Center; and, as far east as Shasta Regional Medical Center.

Durable Medical Equipment - Rental of durable medical equipment (but not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury. Excess charges for deluxe equipment or devices will not be covered.

"Durable medical equipment" includes such items as non-dental braces, hearing aids, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc., which: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

Drug Abuse – Treatment of addiction to or abuse of legal and/or illegal substances.

Genetic Testing or Counseling – Genetic testing or counseling services when ordered by a Physician and deemed Medically Necessary through the utilization review process.

Genomic Testing – Genomic testing services, when ordered by a Physician as a part of the treatment planning process for a confirmed diagnosis of any/all types of cancer and deemed Medically Necessary through the utilization review process.

Hearing Aids, Exams, Etc. - Hearing exams, hearing aids, cochlear implants and all related services or supplies, or other internal or external devices for the purpose of improving, restoring or stimulating hearing.

Hospice - a public agency or private organization which provides or arranges for provision of Hospice Care to Terminally Ill Covered Persons under a written plan which is established and submitted to the Foundation every 30 days for review. A Hospice program shall include, but is not limited to the following:

a) it provides Hospice Care and makes such care available (as needed) on a 24-hour basis;
b) it provides bereavement counseling for the immediate family of Terminally Ill Covered Persons;
c) it has an interdisciplinary team which establishes its policies governing the provision of Hospice Care and which includes at least one Physician, one registered professional nurse, one social worker and one pastoral or other counselor;
d) it maintains central clinical records on all patients;
e) it utilizes volunteers in the provision of Hospice Care and maintains records regarding the use of such volunteers; and
f) if it is located in a state or locality which provides for the licensing of Hospice programs, it is licensed pursuant to such law.

Covered Expenses include services for:

- Daily Room and Board, if inpatient.
- Miscellaneous Hospice service expenses or fees for Hospice Care and Physician's services.
- Services of a licensed therapist for Physical Therapy, occupational therapy, speech therapy and respiratory therapy.
- Medical social services.
- Services of a home health aide.
- Dietary and nutritional guidance. Nutritional support, such as intravenous feeding or hyper alimentation.

- Drugs and medicines approved for general use by the FDA that are available only if prescribed by a Physician.
- Medical supplies, oxygen and related respiratory therapy supplies.
- Palliative care which controls pain but does not cure symptoms, which is appropriate for the illness.
- Professional nursing services charged by a Registered Nurse (R.N.) or Licensed Vocational Nurse (L.V.N.).

Hospital Services - Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies. Coverage for room and board is limited to the Semi-Private Room Charge or the Maximum Allowable Charge for necessary confinement to an Intensive Care Unit. Additional limitation of Network hospitals is that the benefit will not exceed the lesser of 80% of contracted amount or 80% of the negotiated Mad River Community Hospital fee schedule, excluding maternity services, if available.

International Medical Care - Hospital Services and Physician Services performed outside the United States at a hospital that participates in the Blue Lake Medical Travel, LLC or Health Flight Solutions, Inc. networks. All healthcare facilities or the respective national accreditation agency must be accredited by a recognized international healthcare accreditation organizations such as International Society for Quality in Healthcare (ISQua), Joint Accreditation International (JCI).

Medical Supplies - Disposable medical supplies such as casts, splints, trusses, surgical dressings, catheters, colostomy bags and related supplies.

Medicines - Medicines which are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit. See "Prescription Drugs, Outpatient" in the **Medical Benefit Summary** for Outpatient prescription coverage information.

Mental Health Care – Inpatient or Outpatient treatment of any type of mental health condition, behavioral or personality disorder.

Midwife - Services of a registered nurse midwife when provided in conjunction with a covered Pregnancy – see "Pregnancy" below.

Newborn Care - Hospital services provided during the birth confinement to a covered well newborn child and an initial Physician’s pediatric exam. If the newborn is not a covered child, then certain Hospital expenses will be covered as part of the mother's Pregnancy claim for delivery, if Plan benefits are payable for such Pregnancy delivery - see "Pregnancy" for more information.

A covered newborn who is sick or injured is eligible for benefits to the same extent as any other Covered Person.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Hospital stay for a newborn (birth confinement) to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean delivery. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

Nicotine Addiction - Nicotine withdrawal programs, facilities, drugs or supplies.

Oxygen - see "Durable Medical Equipment"

Physical or Occupational Therapy - Outpatient physical or occupational therapy services rendered by a Doctor of Medicine (MD), registered physical therapist, or certified occupational therapist.
Physician Services - Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations.

Pregnancy - Eligible Pregnancy-related expenses are covered to the same extent as any other Sickness. Pregnancy related expenses include the following, but may include other services, which are deemed to be Medically Necessary by the patient's attending Physician:

Pre-natal visits and routine pre-natal and post-partum care;

Expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;

Genetic testing or counseling when deemed Medically Necessary by a Physician, and alpha-fetoprotein (AFP) testing; newborn Hospital expenses Incurred during the mother's confinement for delivery, limited to the minimum requirements of the Newborns' and Mothers' Health Protection Act (see below). This will not apply, however, if the newborn is a Covered Person and the charges are covered as the newborns own claim.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, or (3) expenses of a surrogate mother (unless the surrogate is a Covered Person, in which case the pregnancy expenses will be covered in accordance with the Plan provisions).

Prescription Drugs - Drugs and medicines, which are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit.

Coverage for other Outpatient drugs (i.e., pharmacy purchases) is provided through a separate program. See the **Medical Benefit Summary** for additional information.

Preventive Care - Certain preventive services, which are provided in the absence of sickness or injury. Some of these preventive health serves are intended for women, such as the following:

- **Well-woman visits:** This would include an annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their health care providers determine they are necessary. These visits will help women and their health care providers determine what preventive services are appropriate, and set up a plan to help women get the care they need to be healthy.
- **Gestational diabetes screening:** This screening is for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes. It will help improve the health of mothers and babies because women who have gestational diabetes have an increased risk of developing type 2 diabetes in the future. In addition, the children of women with gestational diabetes are at significantly increased risk of being overweight and insulin-resistant throughout childhood.
- **HPV DNA testing:** Women who are 30 or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of Pap smear results. Early screening, detection, and treatment have been shown to help reduce the prevalence of cervical cancer.
- **STI counseling:** Sexually-active women will have access to annual counseling on sexually transmitted infections (STIs). These sessions have been shown to reduce risky behavior in patients, yet only 28 percent of women aged 18-44 years reported that they had discussed STIs with a doctor or nurse.
- **HIV screening and counseling:** Sexually-active women will have access to annual counseling on HIV. Women are at increased risk of contracting HIV/AIDS. From 1999 to 2003, the Centers for Disease Control and Prevention reported a 15% increase in AIDS cases among women, and a 1% increase among men.
- **Contraception and contraceptive counseling:** Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and

counseling. In addition, the Plan also covers abortifacient drugs (e.g., mifepristone (RU-486) and misoprostol). Most workers in employer-sponsored plans are currently covered for contraceptives. Contraception has additional health benefits like reduced risk of cancer and protection against osteoporosis. NOTE: Oral contraceptives (birth control pills) and contraceptive patches can be obtained through the prescription drug program – see "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**.

- **Breastfeeding support, supplies, and counseling:** Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment. Breastfeeding is one of the most effective preventive measures mothers can take to protect their health and that of their children. One of the barriers for breastfeeding is the cost of purchasing or renting breast pumps and nursing related supplies.
- **Interpersonal and domestic violence screening and counseling:** Screening and counseling for interpersonal and domestic violence should be provided for all adolescent and adult women. An estimated 25% of women in the United States report being targets of intimate partner violence during their lifetimes. Screening is effective in the early detection and effectiveness of interventions to increase the safety of abused women.

Prosthetics - An artificial limb, eye or other prosthetic appliance required to replace or perform the function of a natural limb, eye or other body part. A prosthetic will be covered whether the loss of such body part or function is due to Accidental Injury, Sickness, surgery or a functional birth defect in a Dependent child. Also, to comply with the Women's Health and Cancer Rights Act, coverage expressly includes post-mastectomy breast prostheses.

NOTE: Prosthetics coverage does not include:

Dental prosthetics, except as expressly included under "Dental Care" in the **Medical Limitations and Exclusions** section;

Repair or replacement of a prosthetic device except when replacement is Medically Necessary, such as when necessitated by the normal growth processes of a child or due to a change in the Covered Person's physical condition which makes the original device no longer functional.

Radiation Therapy - Radium and radioactive isotope therapy.

Respiratory Therapy - Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

Speech Therapy - Treatment under the direction of a Physician (MD), provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient’s vocal skills which have been impaired by a accident/illness.

Spinal Manipulation - see “Chiropractic Care”

Sterilization Procedures - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

Transplant-Related Expenses (Human Tissue) – Covered Expenses Incurred by a Covered Person who is the recipient of a human organ or tissue transplant which is not experimental or investigational in nature.
Expenses for services incident to obtaining the transplanted material from a living donor or an organ transplant “bank” will be covered and treated as though they were expenses of the Covered Person-recipient.

Urgent Care Facility - see Definitions

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

Abortion - Elective abortion, unless the mother's life would be endangered if the Pregnancy were allowed to continue to term.

NOTE: Complications arising out of an abortion are covered as any other Sickness.

Air Purification Units, Etc. - Air conditioners, air-purification units, humidifiers and electric heating units.

Biofeedback - Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Complications of Non-Covered Treatment - Care, services or treatment which are required to treat complications resulting from a treatment or surgery which is not or would not be covered under the terms of the Plan, unless expressly stated otherwise. For example, if breast implants were placed for cosmetic reasons, the subsequent removal of such implants would not be covered, even if such removal is considered to be Medically Necessary.

Cosmetic & Reconstructive Surgery, Etc. - Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except for:

> services necessitated by an Accidental Injury or Sickness and which are provided while the patient is covered by the Plan and then limited to Covered Expenses Incurred within twelve (12) months from the date of the accident or within twelve (12) months of the date treatment was first medically appropriate, whichever occurs last;
>
> services provided to comply with the requirements of the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient.

Custodial Care - Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient's condition.

Dental Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion. See the **Dental Benefit Summary** and related sections for coverage information.

Diagnostic Hospital Admissions - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Ecological or Environmental Medicine - Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training - Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

Exercise Equipment / Health Clubs - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs, except for membership and incentives at health clubs/fitness centers under contract.

Foot Care, Routine - Routine and non-surgical foot care services and supplies including, but not limited to:

trimming or treatment of toenails;

foot massage;

treatment of corns, calluses, metatarsalgia or bunions;

treatment of weak, strained, flat, unstable or unbalanced feet;

orthopedic shoes (except when permanently attached to braces) or other appliances for support of the feet.

NOTE: This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Hair Replacement - Replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs, services or supplies relating to baldness or hair loss.

Hazardous Hobbies - Care and treatment of an injury or Sickness that results from engaging in a hazardous hobby. A hobby is hazardous if it is an unusual activity, which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies are skydiving, auto racing, hang gliding, 3-wheel ATV operating, snowmobiling or bungee jumping.

NOTE: This exclusion does not apply where any such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Holistic or Homeopathic Medicine - Services, supplies, drugs or accommodations provided in connection with holistic or homeopathic treatment.

Hospice Care – Expenses subject to the following:

a) The Covered Person is suffering from a terminal illness for which the prognosis of life expectancy is six months or less: and,
b) the services are ordered and approved by a Physician before the services begin, and
c) the services are provided in place of Hospital services or Hospital admission; and,
d) services are part of a Hospice Care program designed to meet the special physical, psychological, spiritual, and social needs of Terminally Ill Covered Persons and their families.

Services are provided by one of the following:

(1) A Hospital;
(2) A Hospice;
(3) A Home Health Care Agency

Hypnotherapy - Treatment by hypnotism.

Impregnation - Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Infertility - Fertility studies, sterility studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

International Medical Care - International Medical Care that is not pre-approved or coordinated through Blue Sky Medical Travel, LLC.

Maintenance Care - Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.

Non-Prescription Drugs - Drugs for use outside of a hospital or other Inpatient facility which can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription coverage's of the Plan.

Drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed - Any services or supplies which are: (1) not Medically Necessary, and (2) not Incurred on the advice of a Physician - unless expressly included herein.

Hospitalization, which is not Medically Necessary, such as confinement for eating disorders or for treatment of chronic pain.

Orthographic Procedures - Jaw (mandible) augmentation or reduction procedures.

Pain Control - Services or supplies for treatment of chronic, intractable pain by a pain control center or under a pain control program.

Penile Implants, Etc. - Penile implant devices and surgery or any related services or resulting complications, unless Medically Necessary.

Personal Comfort or Convenience Items - Services or supplies that are primarily and customarily used for non medical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (3) hypoallergenic mattresses, pillows, blankets or mattress covers, (4) cervical pillows, (5) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (6) home blood pressure kits, or (7) personal computers and related equipment, televisions, telephones, or other similar items or equipment.

Preventive or Routine Care - Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **Medical Benefit Summary**.

Self-Procured Services - Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, which are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Sex Assignment/Reassignment. Any charge for care, supplies, or services, which are related to a sex assignment or sex reassignment operation.

Sexual Dysfunction Therapy or Surgery. For sexual dysfunctions or inadequacies that do not have psychological or organic basis.

Sterilization Reversal Surgery - Reconstruction (reversal) of prior elective sterilization procedures.

Surrogate Mother – all expenses related to surrogate pregnancy (unless the surrogate is a Covered Person, in which case the pregnancy expenses will be covered in accordance with the Plan provisions).

TMJ / Jaw Joint Treatment - Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

Untimely Filing - Claims which are not filed within one (1) year from date of service - see **Claims** Procedures section.

Vision Care - Except as noted, eye examinations for the purpose of prescribing corrective lenses, eye glasses or contact lenses or the fitting thereof, orthoptics, vision therapy, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy.

NOTE: The Plan Sponsor has made a special arrangement with VSP for vision care. Contact the Benefits Coordinator for coverage information with VSP.

Vitamins or Dietary Supplements - Prescription or non-prescription organic substances used for nutritional purposes.

Vocational Testing or Training - Vocational testing, evaluation, counseling or training.

Weight Control - Services or supplies for obesity, weight reduction or dietary control. All pre-operative, operative, and post-operative services related to weight loss surgery and complications related to weight loss surgery are specifically excluded.

Wigs or Wig Maintenance - see "Hair Replacement"

- (See also **General Exclusions** section) -

The Plan reserves the right to waive certain exclusions based on the specific terms or conditions of an approved individual case management plan, or as required to comply with a reimbursement agreement entered into under 25 U.S.C. Section 1621e(f).

PRESCRIPTION DRUGS

PRESCRIPTION DRUG COVERAGE IS PROVIDED THROUGH SEPARATE AGREEMENT(S) BETWEENTHE PLAN SPONSOR AND PRESCRIPTION DRUG VENDOR(S). IF THERE ARE ANY CONFLICTS BETWEEN THE PRESCRIPTION INFORMATION IN THIS DOCUMENT AND THE TERMS OF SUCH AGREEMENT(S), THE AGREEMENT(S) WILL PREVAIL.

COVERED PRESCRIPTION DRUGS

Covered prescription drugs include the following:

legend drugs;

compounded medications of which at least one (1) ingredient is a prescription legend drug;

insulin on prescription only;

prescription oral and patch contraceptives;

any other drug which under the applicable state or tribal law may only be dispensed upon the written prescription of a physician or other lawful prescriber;

insulin syringes/needles ONLY when prescribed and dispensed at the same time as insulin. INSULIN SYRINGES/NEEDLES MUST BE DISPENSED IN DAYS SUPPLY CORRESPONDING TO THE AMOUNT OF INSULIN DISPENSED AND WILL BE INCLUDED UNDER THE SAME CO-PAY AMOUNT AS THE INSULIN. CLAIMS FOR INSULIN AND INSULIN SYRINGES/NEEDLES MUST BE SUBMITTED ON THE SAME CLAIM FORM.

EXPENSES NOT COVERED

Prescription drug coverage will not include any of the following:

Administration - Any charge for the administration or injection of a covered drug.

Blood, Blood Plasma and Biological Sera

Cosmetic Drugs - Drugs with cosmetic indications (e.g., Retin-A, Tretinoin).

Devices - Devices of any type, even though such devices may require a prescription. These include but are not limited to: therapeutic devices, artificial appliances, support garments and other non-medicinal substances, regardless of intended use. Insulin syringes/needles when prescribed alone and syringes/needles for other than diabetic use.

Excess Refills, Etc. - Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.

Experimental & Non-FDA Approved Drugs - Experimental drug and medicines, even though a charge is made to the Covered Person. Any drug not approved by the Food and Drug Administration.

Hair Loss Drugs - Any drug used for the treatment of hair loss (i.e., Minoxidil or "Rogaine").

Immunizations Agents

Injectables & Supplies - Injectables or any prescription directing administration by injection (other than insulin or Imitrex).

> Hypodermic syringes and/or needles for the administration of injectables, except as may be expressly included.

Investigational Drugs - A drug or medicine labeled: "Caution - limited by federal law to investigational use."

No Charge - A prescribed drug which may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any tribal law or workers' compensation or occupational disease law.

Non-Home Use - Drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.

Non-Legend drugs - Non-Legend drugs, except for insulin.

Non-Prescription Drugs - A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

Nutritional Supplements

Refills, Excess - Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one (1) year from the physician's original order.

Tretinoin (Retin-A) - see "Cosmetic Drugs"

Vitamins & Minerals - Prescription or non-prescription vitamins, except for prenatal vitamins.

DISCLAIMER: THIS ADDENDUM IS ONLY A SUMMARY OF THE PRESCRIPTION DRUG COVERAGES OFFERED BY THE PLAN. THE ACTUAL CONTROLLING PROVISIONS AND LISTS OF COVERED AND EXCLUDED DRUGS, ETC., MUST BE OBTAINED DIRECTLY FROM THE PLAN SPONSOR OR THE PRESCRIPTION PROGRAM PROVIDER.

The Plan reserves the right to waive certain exclusions based on the specific terms or conditions of an approved individual case management plan, or as required to comply with a reimbursement agreement entered into under 25 U.S.C. Section 1621e(f).

DENTAL BENEFIT SUMMARY

ANNUAL MAXIMUM	$2,000* or $2,500**	
In any Plan Year, Plan benefits for a Covered Person will not exceed the maximum shown above. (See NOTE below). *Includes Orthodontia procedures, limited to $2,000 annually. ** The annual maximum dental benefit for major services is increased to $2,500, when received within a foreign country and facilitated by Blue Sky Medical Travel, LLC. NOTE: The Annual Maximum does not apply to covered Preventive Services, Basic Services, or Major/Orthodontia Services for Covered Persons under age 19. Coverage for pediatric dental services is provided until the end of the month in which the individual turns 19.		
ANNUAL DEDUCTIBLE	$50	
The Individual Deductible is an amount which a Covered Person must contribute toward payment of eligible dental expenses in any Plan Year. Usually, the deductible applies before the Plan begins to provide benefits.		
ELIGIBLE DENTAL EXPENSES	**Covered Person Pays**	**Plan Pays**
Preventive Services (Deductible waived)	-0-	100%
Limits applicable to certain Preventive Services: - routine oral examinations and cleanings are limited to 1 exam/cleaning per 6-month period; - fluoride treatment is limited to children under age 16 and to 1 application per 12-month period; - space maintainers are limited to children under age 16; - a routine full-mouth X-ray series or a panoramic X-ray is limited to once per 3-year period; - routine bitewing X-rays are limited to 1 set per 6-month period.		
Basic Services	20%	80%
Major/Orthodontia Services	50%	50%
If an individual enrolls late under the terms of the "Open Enrollment" provision in the **Eligibility and Effective Dates** section, benefits for Major/Orthodontia Services are not available until an individual has been covered under the Plan for 12 consecutive months.		
Major/Orthodontia Services – Blue Sky Medical Travel, LLC	10%	90%
The network is comprised of three dental clinics located in San Jose, Costa Rica. Blue Sky Medical Travel, LLC (BSMT) has conducted an investigation and determined that in their opinion each offers highly trained, experienced dentists that have received training and/or continuing education in the US and provides procedures at substantially lower rates for procedures than in the US. Blue Sky Medical Travel, LLC patients (those who plan their treatment through BSMT) receive an additional discount. (It remains the responsibility of users of these services to determine whether the dentists and clinics are appropriate for their needs.) Covered Persons will be responsible for paying out of pocket at the clinic but should bring a dental claim form with them when traveling. Each clinic will sign the claim form following services and the Covered Person should mail it to the Humboldt Independent Practice Association.		

Before services are performed, Covered Persons should mail their dental x-rays and records to the following address and indicate the dental clinic that the patient wishes to go to for treatment.

Blue Sky Medical Travel, LLC
Attn: Shayna McCullough
PO Box 428
Blue Lake, CA 95525

Once the clinic receives the records, they will provide a treatment estimate, which Blue Sky Medical Travel will provide to the patient. At that point, Blue Sky Medical Travel will provide as much assistance as the patient needs including, travel arrangements, passports and even connecting patients to tourism opportunities. Covered Persons should call (707)668-5101 ext. 1042 or email azuraski@bluelakerancheria-nsn.gov.

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **ELIGIBLE DENTAL EXPENSES** AND **DENTAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed, the Plan Sponsor recommends that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental X-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X-rays or additional information during the course of its review.

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimates.

If a pre-treatment estimate is not obtained prior to the work being performed, the Plan Sponsor reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTE: A pre-treatment estimate is not a guarantee of payment. Payment of Plan benefits is subject to Plan provisions and eligibility at the time the services are actually Incurred.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Maximum Allowable Charge for the dental services and supplies listed below, which are: (1) Incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he is licensed.

For benefit purposes, dental expenses will be deemed Incurred as follows:

for an appliance or modification of an appliance, on the date the final impression is taken;

for a crown, inlay, on lay or gold restoration, on the date the tooth is prepared;

for root canal therapy, on the date the pulp chamber is opened; or

for any other service, on the date the service is rendered.

NOTE: Many dental conditions can be properly treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment which is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

PREVENTIVE SERVICES

Exams & Cleanings, Routine - Routine oral examinations and routine cleaning and polishing of the teeth.

Fluoride - Topical application of stannous or sodium fluoride.

Prophylaxis - see "Exams & Cleanings, Routine"

Sealants - Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars, which are free of decay or prior restoration.

X-rays - Dental X-rays for diagnostic purposes, as well as routine “full mouth” X-rays or a panoramic X-ray, and routine bitewing X-rays.

BASIC SERVICES

Anesthesia - General anesthesia when administered in connection with oral surgery or when deemed necessary by the dental provider for other covered dental services.

NOTE: Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation are not covered. Such services should be included in the cost of the procedure itself.

Consultation - Consultation by a dental specialist upon referral by the patient's attending dentist.

Extraction - see "Oral Surgery"

Fillings, Non-Precious - Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary; all optional materials at an additional cost to covered patient. For example if the patient's preference is an optional material, other than Amalgam, the Plan will pay up to the cost of Amalgam, after which the insured member will be responsible for all additional costs.

NOTE: For teeth posterior to (behind) the second bicuspid, only amalgam fillings will be covered. See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions**.

Injections - Injection of antibiotic drugs.

Oral Surgery - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Palliatives - Emergency treatment for the relief of dental pain.

Pathology - Laboratory services required for dental procedures.

Space Maintainers - Fixed and removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

Stainless Steel Crowns

Study Models

Visits, Non-Routine - Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structure. Professional visits after hours.

MAJOR/ORTHODONTIA SERVICES

Crowns - A gold, porcelain or composite crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

Replacement of a crown, if the existing crown is at least five (5) years old and cannot be made serviceable.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on veneer or facing (i.e., "tooth-colored") restorations. Crowns placed for periodontal splinting are not covered.

Endodontia - Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Implants - Implants (materials implanted into or on bone or soft tissue) and all related services, or the removal of implants.

Inlays, Onlays & Gold Restoration - An inlay, onlay or gold restoration when a tooth cannot be satisfactorily restored with a less costly filling (amalgam, etc.) restoration.

Replacement of an inlay, onlay or gold restoration, if the existing restoration is at least five (5) years old and cannot be made serviceable.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on "tooth-colored" restorations.

Occlusal Restoration - Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

increasing the vertical dimension;

replacing or stabilizing tooth structure lost by attrition;

realignment of teeth;

gnathological recording or bite registration or bite analysis;

occlusal equilibration.

Orthodontia, Etc. - Orthodontia procedures, subject to annual plan limit, for appliances or restorations used to increase vertical dimension or to restore occlusion.

Periodontia - Treatment of the gums and tissues of the mouth, including periodontal scaling and root planing.

Prosthetics – Initial placement of a full or partial denture or bridge. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement.

Addition of teeth to a partial denture or bridge.

Replacement of an existing full or partial denture or bridgework, but only if:

the existing denture or bridgework cannot be made serviceable and is at least five (5) years old; or

the existing denture is an immediate temporary denture to replace one (1) or more natural teeth and replacement by a permanent denture is required and takes place within twelve (12) months from the date of the initial installation of the immediate temporary denture.

Repairs & Adjustments - Repair or re-cementing of crowns, inlays, bridgework or dentures or the relining of dentures. Prosthetic adjustments, but only for services provided more than six (6) months after placement.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Appliances - Items intended for sport or home use, such as athletic mouth guards or habit-breaking appliances.

Congenital or Developmental Conditions - Treatment of congenital (hereditary) or developmental (following birth) malformations, unless expressly included.

Cosmetic Dentistry - Treatment rendered for cosmetic purposes, except when necessitated by an Accidental Injury.

NOTE: Excess charges for a veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic or a tooth colored restoration is not covered on a tooth posterior to the second bicuspid but will be considered "cosmetic". The maximum allowance will be the allowance for the least costly restoration, which will provide a functional result.

Customized Prosthetics - Precision or semi-precision attachments, overdentures, or customized prosthetics.

Discoloration Treatment - Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

Excess Care - Services, which exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) which would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

Experimental Procedures - Services which are considered experimental or which are not approved by the American Dental Association.

Grafting - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

Hospital Expenses

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.

Medical Expenses - Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits sections of this Plan.

Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits.

Non-Professional Care - Services rendered by someone other than:
a dentist (DDS or DMD); a dental hygienist, who lacks a Registered Dental Hygienist in Alternative Practice [**RDHAP**] license, X-ray technician or other qualified technician who is under the supervision of a dentist; or a Physician furnishing dental services for which he is licensed.

Oral Hygiene Instruction & Supplies, Etc. - Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, water picks, and mouthwashes.

Orthognathic Surgery - Surgery to correct a receding or protruding jaw.

Personalization or Characterization of Dentures

Prescription Drugs - see the Prescription Drug Benefits section

Prior to Effective Date / After Termination Date - Courses of treatment which were begun prior to the Covered Person's effective date, including crowns, bridges or dentures which were ordered prior to the effective date.

Expenses Incurred after termination of coverage, except that benefits will be extended for up to thirty (30) days for completion of the following when "Incurred" while an individual is covered under the Plan:

an appliance, or modification of an appliance when the impression was taken prior to the date of termination;

a crown, inlay, onlay or gold restoration when the tooth was prepared prior to the date of termination;

root canal therapy when the pulp chamber was opened prior to the date of termination.

Splinting - Appliances or restorations for splinting teeth.

Temporary Restorations & Appliances - Excess charges for temporary restorations and appliances. The Covered Expenses for the permanent restoration or appliance will be the maximum covered charge.

TMJ Treatment / Jaw Surgery - Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

- (See also **General Exclusions** section) -

The Plan reserves the right to waive certain exclusions based on the specific terms or conditions of an approved individual case management plan, or as required to comply with a reimbursement agreement entered into under 25 U.S.C. Section 1621e(f).

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

CHEF Eligible Care or Services - Subject to its right to waive or limit this provision, the Plan hereby excludes all care or services eligible for reimbursement through the Catastrophic Health Emergency Fun ("CHEF"), 25 U.S.C. Section 1621a. This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Sections 1621e and 1623.

Contract Health Service Coverage ("CHS" or "PRC") - Subject to its right to waive or limit this provision, the Plan hereby excludes all care or services eligible for coverage by a Contract Health Services program, also referred to as a Purchased Referred Care or PRC Program (referred to herein as "CHS" or "PRC") operated by, through, or in connection with the federal Indian Health Service or by an Indian tribe, tribal organization, or tribal consortium of tribes or tribal organizations pursuant to a self-determination contract or self-governance compact under Public Law 93-638, as amended (or other applicable federal law governing tribal health care and Indian Health Service programs). This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Sections 1621e and 1623. The Plan Sponsor reserves the right to waive this exclusion in full or in part for designated care pursuant to express reimbursement agreements between the Plan Sponsor and a contracting facility. The Plan Sponsor also reserves the right to pay CHS eligible care as a member-based benefit herein. In no event will the Plan be required to pay more than MLR for care that would be paid at MLR if paid directly through CHS.

Court-Ordered Care, Confinement or Treatment - Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the confinement would have been covered in the absence of the court order.

Deductible - Amounts applied toward satisfaction of deductibles and expenses that are defined as the Covered Person's responsibility in accordance with the terms of the Plan.

Drugs in Testing Phases - Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing, drugs which are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Excess Charges – Care, supplies, treatment, and/or services that are for charge(s) or portion of a charge or charges that exceed(s) Plan lHiPimits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Maximum Allowable Charge, or are for services not deemed to be Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental / Investigational Treatment - Expenses for treatments, procedures, devices, or drugs which the Plan Sponsor determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities - Services, except for contracted dental and orthodontia services, furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Illegal Acts - That are for any Accidental Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Accidental Injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Incurred by Other Persons - Are expenses actually Incurred by other persons.

Indian Health Services Facilities – Services, except for contracted dental and orthodontia services, furnished to the Covered Person in any Indian Health Service hospital, institution, or facility operated by the Indian Health Service or by an Indian tribe or tribal organization under a contract pursuant to the Indian Self-Determination Act. This exclusion shall not waive the Plan Sponsor's right to enter into reimbursement agreements per 25 U.S.C. Section 1621e(f).

NOTE: This exclusion is an exception to the Indian Health Service payor of last resort rule available to tribally funded self-insured plans. For the following reasons, the **Blue Lake Rancheria Tribally Funded Self-Insured Employee Health Plan** is eligible for this exception: (1) the Blue Lake Rancheria is a federally recognized Indian tribe, (2) the Blue Lake Rancheria assumes the risk of payment, and (3) the Blue Lake Rancheria has contracted with a third party administrator that makes payment directly from tribal funds.

Indian Health Service Coverage (direct services) - Subject to its right to waive or limit this provision, the Plan hereby excludes all direct service care or services covered by or provided through a federal Indian Health Service program or a tribal health program operating under the Indian Self-Determination and Education Assistance Act, except for programs, services or facilities for which the Plan Sponsor has elected to provide reimbursements in accordance with 25 U.S.C. Section 1621e9f). This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Sections 1621e and 1623.

Individual Policy Coverage – Subject to its right to make provisional payments pending resolution under the Coordination of Benefits section, the Plan hereby excludes all care that is covered by an Individual Policy as referred to in the Special Tribal Coordination Rules set forth below.

Late-Filed Claims - Claims, which are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Medical Necessity - Charges that are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service - Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments - Expenses Incurred for failure to keep a scheduled appointment.

Negligence – Expenses that are for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or Covered Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.
NOTE: This exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid). This provision shall not negate any reimbursement agreements per 25 U.S.C. Section 1621e(f) or coordination rights asserted by the Plan Sponsor under the Special Coordination Rules for Tribal Programs set forth below.

No Coverage – Services that are Incurred at a time when no coverage is in force for the applicable Covered Person and/or Dependent.

Not Acceptable - That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Listed Services or Supplies - Any services, care or supplies which are not specifically listed in the Plan Document as Covered Expenses may not be covered unless substantiated and determined to be Medically Necessary by the Plan.

Not Specified As Covered - That are not specified as covered under any provision of this Plan.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Pay or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States - Charges Incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services, drugs or supplies, except for those coordinated by Blue Sky Medical Travel, LLC.

Payer of Last Resort - Subject to its right to coordinate benefits, including reimbursement agreements approved by the Plan Sponsor per 25 U.S.C. Section 1621e(f), the Plan hereby excludes coverage for which the Plan is the payer of last resort under 25 U.S.C. Section 1623(b).

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the plan which this Plan replaces.

Prior to Effective Date / After Termination Date - Charges Incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

Prohibited by Law – Charges that are to the extent that payment under this Plan is prohibited by law.

Provider Error – Charges that are required as a result of unreasonable provider error.

Purchased Referred Care ("PRC") Coverage - See Contract Health Service Coverage.

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction. This exclusion will not apply where such self-inflicted injury results from a documented medical condition (physical or mental), including a medical condition resulting from being the victim of an act of domestic violence (e.g., depression). With respect to any injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the injury if the injury results from being a victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, the exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

Subrogation, Reimbursement, and/or Third Party Responsibility - Expenses that are for an illness, injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Unreasonable - Charges arising from care, supplies, treatment, and/or services that are required to treat illness or injuries arising from and due to errors caused at the time of treatment by the treating Covered Provider, including, but not limited to, a Physician or Hospital, wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Covered Provider whose error caused the loss(es).

Travel - Travel or accommodation charges, whether or not recommended by a Physician, except for pre-approved travel assistance, pre-approved international medical or dental care, ambulance charges or as otherwise expressly included in the list of **Eligible Medical Expenses**.

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications there from, or service (past or present) in the armed forces of any country.

Work-Related Conditions - Any condition for which the Covered Person has, had or could have had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. However, if the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

With respect to any Sickness or Accidental Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Sickness or Accidental Injury if the Sickness or Accidental Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

The Plan reserves the right to waive certain exclusions based on the specific terms or conditions of an approved individual case management plan, or as required to comply with a reimbursement agreement entered into under 25 U.S.C. Section 1621e(f).

COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans including Medicare are paying. When a Covered Individual is covered by this plan and another plan, or the Covered Individual's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two (2) or more plans, the plans will coordinate benefits when a Claim is received.

The plan that pays first, according to the rules set forth below, will pay as if there were no Other Plan involved. The secondary and subsequent plans may pay the balance due up to one hundred (100%) percent of the allowable expense (defined below for the purposes of this Section).

Indian Health Service (IHS) facilities, whether operated by the Federal government or by an Indian Tribe or Tribal Organization pursuant to the Indian Self-Determination Act are required under the "payer of last resort" rule, 42 CFR 136.61 (now codified as part of the Patient Protection and Affordable Care Act) to exhaust alternate resources and must generally treat insurance and benefit plan coverage as primary to IHS direct care and third-party care (known as contract health service (CHS) or patient referred care (PRC)).25 USC Section 1621e(f) provides an exception prohibiting reimbursements from tribal self-insurance plans, as is this Plan, unless agreed to by the Tribe on an annual basis, and allowing the Plan to be disregarded as an alternate resource under the payer of last resort rule, the Plan, therefore may take a secondary position to IHS direct care and/or IHS CHS/PRC, including the Catastrophic Health Emergency Fund (CHEF) located in Subpart L of 42 CFR Part 136 (42 CFR §§ 136.501-136.509). Consistent with congressional intent not to burden Tribal resources, the Agency has made a determination that tribally-funded self-insured health plans (e.g. this Plan) are not to be considered alternate resources for purposes of the IHS' Payer of Last Resort Rule.

EXCESS INSURANCE

If at the time of injury, Sickness, disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including, but not limited to, the following: crime victim restitution funds, civil restitution funds, no-fault restitution funds such as vaccine injury compensation funds, any medical, applicable disability or other benefit payments, and school insurance coverage.

VEHICLE LIMITATION

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the exclusions in this Plan up to the maximum amount available to the Covered Person under applicable state law, regardless of a Covered Person's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any of the following that provides benefits or services for health care services:

group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured). A "closed panel plan" is a plan that, except in an emergency, provides coverage only in the form of services obtained through a panel of providers that have contracted with or are employed by the plan;

medical benefits under group automobile contracts; and

auto insurance which is subject to a state "no-fault" automobile insurance law. A Covered Person will be presumed to have at least the minimum coverage requirement of the state of jurisdiction, whether or not such coverage is actually in force;

Medicare or other governmental benefits, as permitted by law.

An "Other Plan" does not include: (1) individual or family insurance, (2) closed panel or other individual coverage (except for group-type coverage), (3) school accident type coverage, (4) benefits for non medical components of group long-term care policies, (5) Medicare supplement policies, (6) Medicaid policies or coverage under other governmental plans, unless permitted by law.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits which would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan - The coverages of this Plan.

Allowable Expense - The Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

If a Claimant is confined in a private hospital room, the difference in cost between a semi-private room in the hospital and a private room will not be an Allowable Expense unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms.

If a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense.

If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee is not an Allowable Expense.

If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the negotiated fees shall be the Allowable Expense for This Plan.

Indian Health Service facilities, whether operated by the Federal government or by an Indian Tribe or Tribal Organization is empowered to authorize certain care under its CHS (also referred to as PRC) program for which Medicare-participating facilities must accept Medicare-Like Rates (MLR) as payment in full, when such care, in addition to being authorized under CHS guidelines, is consistent with Section 506 of the Medicare Modernization Act of 2003 (the MMA) and the final regulations issued thereunder at 42 CFR 136.30-136.32 and 42 FR 489.29 (the MLR Regulations). In the case of care or service that is eligible for re-pricing at Medicare-like Rates ("MLR), the Plan Sponsor may limit the "allowable charge" to MLR.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

Benefit Plan
This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- Group or group type plans, including franchise or blanket benefit plans.
- Blue Cross and Blue Shield group plans.
- Group practice and other group prepayment plans.
- Federal government plans or programs. This includes, but is not limited to, Medicare and TRICARE.
- Other plans required or provided by federal or state law. Programs purporting to limit or prohibit coordination (like Medicaid and Medicare) may not limit coordination with the Plan in violation of 25 U.S.C. Section 1623(b) and 1621e(f).
- No fault Auto Insurance, by whatever name it is called, when not prohibited by law.
- Individual insurance policies (including those arranged for or purchased in part by a tribal government for its members) as provided in the Special Tribal Coordination Rules.
- Member-based benefits herein.
- Indian Health Service, Tribal direct care, PRC Programs and other programs in accordance with the Special Coordination Rules for Tribal Programs.

Claim Determination Period - A period which commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules"

below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law.

Non-Dependent vs. Dependent - The benefits of a plan which covers the Claimant other than as a dependent (i.e., as an employee, member, subscriber or retiree) will be determined before the benefits of a plan which covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married or are not separated (whether or not they have ever been married), or (2) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

the plan of the Custodial Parent;

the plan of the spouse of the Custodial Parent;

the plan of the non-custodial parent; and then

the plan of the spouse of the non-custodial parent.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage (COBRA) Enrollee - If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person’s dependent) is primary and

This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan which has covered the Claimant for the longer period of time will be determined before those of the plan which has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information - For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment - A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Workers' Compensation – Coverage under this Plan is not in lieu of workers' compensation.

SPECIAL COORDINATION RULES FOR TRIBAL PROGRAMS

The following special coordination rules supersede the above coordination of benefits rules for IHS Beneficiaries and benefits under the member-based program:

a. PRC and IHS as Primary Payers / MLR: Purchased/Referred Care (PRC) and IHS programs shall pay as the primary plan or to the exclusion of the Plan, and the Plan reserves the right to exclude all MLR Eligible Care, except as follows:

   (1) Permitted Reimbursements (direct services) – The Plan will not reimburse the United Indian Health Services, Inc. for direct services care otherwise covered herein, except to the extent that the Plan Sponsor has agreed to such reimbursement in accordance with 25 U.S.C. Section 1621e(f).

   (2) Permitted Reimbursements (contract health services) – The Plan reserves the right to make direct payments to a provider otherwise entitled to reimbursement through the United Indian Health Services, Inc. PRC program for charges paid through that program that are otherwise covered herein. The foregoing reimbursements or payments are permitted only to the extent agreed to by the Plan Sponsor in accordance with 25 U.S.C. Section 1621e(f).

   (3) CHEF Coverage – In no event will coverage under the Plan, including without limitation under (1) or (2) above, obligate the Plan to pay for care that is eligible for reimbursement under CHEF; provided that the

Plan may pay such claims on a provisional basis pending a final determination as to whether the charges qualify for reimbursement though CHEF. Once CHEF eligibility is determined: (1) the applicable PRC Program shall reimburse any provisional payments as a Plan overpayment, (2) the Plan may reverse the payment (with PRC paying the provider direct), or (3) the Plan Sponsor and PRC Program may agree that the Plan should continue to pay such claims on a provisional basis on behalf of the PRC Program for claims efficiency and continuity of care. Upon rejection of a CHEF claim by IHS, the Plan may invoke its exclusionary clause and reverse any provisional Plan payments for direct payment through PRC.

(4) MLR Eligible Care – In no event will coverage under (1) through (3) above require the Plan to provide in excess of what would be paid by the UIHS' PRC program for such care or services. Any reimbursements or payments for MLR Eligible Care are made on a provisional basis and expressly contingent upon the provider accepting MLR from the Plan as payment in full.

(5) Supplemental Funding Arrangement – All reimbursements or payments under (1)through (4) above represent payments for and on behalf of the applicable IHS, Tribal health program, or PRC eligible care as a means to provide supplemental funding as part of the Sponsor's coordinated tribal health program.

(6) Provisional Payments – The Plan may pay any claim otherwise covered by the express terms of the Plan on a provisional basis pending a final determination under the Plan coordination of benefits rules and procedures. In the event that it is confirmed that IHS or PRC should have been primary under this coordination of benefits provision after a provisional payment has been made by the Plan, the Plan shall be entitled to reimbursement from the IHS or PRC program, as applicable. Reimbursement between this Plan and IHS or PRC programs shall be determined in accordance with 25 U.S.C. Section 1621e(f), as amended, and applicable Tribal Government Policies.

(7) Reservation of Rights – Nothing in this section requires the Tribe to adopt policies authorizing reimbursement or payment of IHS or PRC eligible care.

b. Individual Policy Rules:

In the event that a service or charge would be paid for through or by an Individual Policy in the absence of benefits hereunder, the following special coordination of benefits rules shall apply:

(1) The Plan shall pay secondary to available Individual Policy coverage in accordance with 25 U.S.C. Section 1623(b), which provides that health programs operated by Indian tribes and tribal organizations shall be the payer of last resort for services provided by such tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State or local law to the contrary.

(2) An Individual Policy that is required to pay primary to IHS or PRC program benefits shall pay primary to any benefits available hereunder to the extent that benefits herein are entitled to secondary status behind IHS or PRC, including, without limitation, any benefits subject to an exclusionary clause as referred to in 25 U.S.C. Section 1621e(f) or CHS (aka PRC) Manual Section 2-3.8(I).

(3) Regardless of 1 or 2 above, an Individual Policy that does not contain a coordination of benefits provision shall pay primary to any benefits available hereunder.

c. Medicare / Medicaid – Special Federal and State Program Rules:

(1) Medicare, Medicaid and other Federal or State programs shall pay primary to this Plan for any care or services (1) as required by 25 U.S.C. Sections 1621e(f) and 1623(b), and (2) that such State and Federal programs would otherwise pay primary to IHS or PRC. Medicare shall also pay primary to any member-based benefits. See 42 U.S.C 1395y(b)(v); 42 C.F.R. 411.20; and 26 U.S.C. 5000(b)(1)(v).

(2) The benefits provided hereunder shall not be treated as an alternate resource for purposes of eligibility under Indian Health Services, Contract Health or Purchased / Referred Care.

d. Other Programs or Policies:

The Plan Sponsor reserves the right to assert secondary payer status to any other program, plan or policy to the extent provided in 25 U.S.C. Section 1623(b).

e. Exclusionary and MLR Provisions:

This special coordination of benefits provisions shall be construed to permit the Plan Sponsor to enter into arrangements for the payment of designated IHS or PRC benefits for (1) a provider that agrees to accept MLR as payment in full, and (2) which are not covered under an Individual Policy.

f. Other Rules:

(1) Payments hereunder processed by or through the third party Claims Administrator (whether In-Network or Out-of-Network) are paid in its capacity as a contract fiscal intermediary of the tribal health program (including direct and PRC service where applicable). All payments for member care are made from the Plan Sponsor's tribal assets on behalf of the tribe and its health program(s) as a means of providing supplemental funding for care in addition to care or services otherwise available to members through IHS, direct service care, or PRC.

(2) The Plan Sponsor or Plan is entitled to a refund of any overpayments and may offset any future payments to recoup any such overpayments. In the event that payments are provided hereunder as a result of another plan, program or policy failing to pay in accordance with the coordination of benefit provision set forth herein, the payment shall be deemed a contingent, provisional or conditional payment and the Plan Sponsor or Plan shall be entitled to bring a legal action through reimbursement or subrogation to recoup all such overpayments plus a attorneys' fees and all other litigation expenses.

(3) All payments hereunder through reimbursement or otherwise, including conditional or provisional payments made as a result of another plan, program or policy's failure to comply with the coordination of benefits rules shall apply against the Plan's specific or aggregated stop loss reinsurance limits, as applicable, unless or until recovered. Nothing herein or in any other plan or SPD document or communication shall be constructed as a waiver of sovereign immunity. Acceptance of benefits or payments shall constitute an assignment of the above reimbursement and subrogation rights to the Plan Sponsor or Plan, as well as consent by the recipient to tribal court jurisdiction and to the laws of the Blue Lake Rancheria.

(4) Nothing herein shall be construed or create any private right of action against the Plan Sponsor, the Plan Sponsor's health program, or the Plan Sponsor's PRC or IHS program or any employee of thereof.

The Plan may pay any claim on a provisional basis pending a final determination under the Plan coordination of benefit rules. The Plan reserves the right to exclude any care for which a provider declines to accept MLR as payment in full or for which is eligible for CHEF.

COORDINATION WITH MEDICARE

Subject to the Special Tribal Coordination Rules set forth herein, the Plan shall coordinate with Medicare as follows:

APPLICABLE TO ACTIVE EMPLOYEES AND THEIR SPOUSES AGES 65 AND OVER

An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

APPLICABLE TO ALL OTHER COVERED PERSONS ELIGIBLE FOR MEDICARE BENEFITS

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payer (as described under the Special Tribal Coordination Rules set forth above). To the extent permitted at law, the Covered Person will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Covered Person has enrolled for the full coverage. If the Healthcare Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

APPLICABLE TO MEDICARE SERVICES FURNISHED TO END STAGE RENAL DISEASE ("ESRD") COVERED PERSONS WHO ARE COVERED UNDER THIS PLAN

If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits until the end of the Medicare secondary coordination period (not applicable for member-based benefits or other claims for which Medicare is primary under the Special Tribal Coordination Rules).

SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY

PAYMENT CONDITION

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, Sickness or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is

entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person(s) fails to file a claim or pursue damages against:

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Workers' compensation or other liability insurance company; or
    e. Any other source, including, but not limited to, the following: crime victim restitution funds, civil restitution funds, no-fault restitution funds such as vaccine injury compensation funds, any medical, applicable disability or other benefit payments, and school insurance coverage;

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the

Covered Person shall indemnify the Plan against any of the Covered Person's attorney's fees, costs, or other expenses related to the Covered Person's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, injury, or disability.

COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Covered Person understands that he or she is required to:

    a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

RELEASE OF LIABILITY

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) ("Incurred") prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior

to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

EXCESS INSURANCE

If at the time of injury, Sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including, but not limited to, the following: crime victim restitution funds, civil restitution funds, no-fault restitution funds such as vaccine injury compensation funds, any medical, applicable disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

OBLIGATIONS

1. It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the Sickness, disability, or injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
h. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
i. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
j. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
k. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Covered Person and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

MINOR STATUS

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees
To participate in the health coverages of the Plan, an Employee must be in active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) .

"Employee" shall mean a person who is employed by the Employer and regularly scheduled to work at least 30 hours per week or 130 hours per month (i.e. Non-variable Hour Employee) or a Variable Hour Employee who has averaged at least 30 hours per week or 130 hours per month for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

The following definitions are associated with the Code Section 4980H (Employer Shared Responsibility) as enacted under the Affordable Care Act:

Administrative Period shall mean a period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage.

Full-time Employee or Full-time Employment shall mean, with respect to a calendar month, an Employee who is employed an average of at least 30 hours per week or 130 hours per month with the Employer.

Hour of Service shall mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an Employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Measurement Period shall mean a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's Hours of Service are tracked to determine his or her employment status for benefit purposes.

Initial Measurement Period - for a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after six whole consecutive months of service.

Standard Measurement Period - for Ongoing Employees, each Calendar Year will have two Standard Measurement Periods. These Measurement Periods will start on December 1 and June 1 each year and will last for six consecutive months. Note the first Standard Measurement Period began on June 1, 2015.

New Employee shall mean an Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero Hours of Service.

Non-variable Hour Employee shall mean an Employee reasonably expected at the time of hire to work 30 hours per week or 130 hours per month.

Ongoing Employee shall mean an Employee who has been employed by the Employer for at least one complete Measurement Period.

Seasonal Employee shall mean an Employee who is hired into a position for which the customary annual employment is six months or less.

Stability Period shall mean a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period (and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period), and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is a 6-month period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

Variable Hour Employee shall mean an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

NOTE: An eligible Employee does not include one who is eligible for Medicare by reason of age and who has elected Medicare coverage in lieu of Plan coverage.

Effective Date - Employees
Each Non-variable Hour Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following completion of a waiting period of sixty (60) days.

Each Variable Hour Employee who has averaged the requisite Hours of Service, as defined herein, will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period, as defined herein.

Each Employee who was covered under the prior plan, if any, will be eligible on the Effective Date of this Plan. Any waiting period or portion thereof satisfied under the prior plan, if any, will be applied toward satisfaction of the waiting period of this Plan.

Eligibility Requirements - Dependents
An eligible Dependent of an Employee is:

a spouse. The marriage must meet all requirements of a valid marriage contract under applicable law. An Employee's spouse must meet the following requirements:

- Employee and spouse shall not have been engaged in a trial separation for more than 12 consecutive months upon the date a Clean Claim for Covered Service(s) provided to spouse are received by the Plan.

- Employee and spouse shall have been cohabitating at the same residence for the majority of the applicable Plan Year. When an Employee or spouse is traveling or residing elsewhere as part of their profession, to care for a family member (due, for instance, to Sickness or Accidental Injury),

and/or is residing elsewhere due to their own Sickness or Accidental Injury, for more than half of the applicable Plan Year (and thus residing with each other for less than the majority of the applicable Plan Year), but the primary residence of the Employee is also the spouse's primary residence for all legal, regulatory, and statutory purposes, this constitutes cohabitation as required by this provision.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

a domestic partner. The Employee and domestic partner must provide the Plan Sponsor with a signed, notarized affidavit that neither partner has had a different domestic partner in the six (6) months prior to signing the affidavit and, if living in a city, county or state providing for such registration, must have registered as Domestic Partners with the city, county or the state of domicile and must have provided the Plan Sponsor with a copy of the Certificate of Domestic Partnership. Also, the Employee and domestic partner must not be related to each other, must have assumed mutual obligation for the welfare and support of each other and must have been living together as a couple in the same household for at least six (6) months. A domestic partner will not include any person who is covered under the Plan as an Employee or spouse;

an unmarried child under age 26. For these purposes a "child" will include:

- a natural child;
- a stepchild or a foster child who is in the custody of the Employee;
- a child who is adopted by the Employee or placed with him for adoption up to age 26. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun;
- notwithstanding any main support and care requirements, a child who is dependent upon the Employee for medical support pursuant to a court order, including a child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (which are incorporated herein by reference and which can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609(a));

NOTE: When a dependent turns age 26, their insurance coverage will terminate at the conclusion (midnight) of the last day of the corresponding month.

An eligible Dependent does not include:

- a spouse following legal separation or a final decree of dissolution or divorce;
- a spouse who is eligible for Medicare coverage by reason of age and who has elected Medicare coverage in lieu of Plan coverage;
- any spouse or domestic partner who is on active duty in a military service;
- any spouse or child who is eligible and has enrolled as an Employee under the Plan.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

NOTE: Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents
A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date (see the "Special Enrollment Rights" provision for details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled). Otherwise, a Dependent can be added only in accordance with the "Open Enrollment" provision, below.

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Newborn Children - Limited Automatic 31-Day Benefit Period
An Employee's newborn child will be eligible for benefits for Covered Expenses which are Incurred within the first thirty-one (31) days after the child's birth. Benefits for such child will be available for the 31-day period only. After the 31-day period, coverage for the child will be available only if, within the thirty-one (31) days after the child's birth, the Employee has notified the Plan Sponsor or the Contract Administrator of the birth, has enrolled the child, and has agreed to make any required contributions for coverage from the moment of birth.

NOTE: During the limited 31-day benefit period, a newborn child is not a Covered Person. Any extended coverage periods or coverage continuation options which are available to Covered Persons WILL NOT APPLY to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within such 31-day period.

Special Enrollment Rights

Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when first eligible, will be allowed to apply for coverage under the Plan at a later date if:

> he was covered under another group health plan or other health insurance arrangement at the time coverage was initially offered;
>
> if Employer required it, the Employee stated in writing at the time initial enrollment was offered that other overage was the reason for declining enrollment in the Plan;
>
> the individual lost the other coverage as a result of a certain event, such as loss of eligibility for coverage, expiration of COBRA continuation coverage, termination of employment or reduction in the number of hours of employment, or because employer contributions towards such coverage were terminated; and
>
> the Employee requested Plan enrollment within thirty-one (31) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, domestic partnership, birth, a foster child being placed with the Employee, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTES:

> where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application;

where Employee's domestic partnership is the "triggering event" - the domestic partner's coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application;

where birth, foster child being placed with the Employee, adoption or placement for adoption is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within thirty-one (31) days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently.

If an Employee or spouse is required to provide coverage for a child under a Medical Child Support Order and such order is determined to be a Qualified Medical Child Support Order (QMCSO), the child shall be covered subject to the terms of the order. A request to enroll the child may be made by the Employee or spouse, by the child's other parent, or by a State Agency on the child's behalf.

Newborn Children - Limited Automatic 31-Day Benefit Period
An Employee's newborn child will be eligible for benefits for Covered Expenses which are Incurred within the first thirty-one (31) days after the child's birth. Benefits for such child will be available for the 31-day period only. After the 31-day period, coverage for the child will be available only if, within the thirty-one (31) days after the child's birth, the Employee has notified the Plan Sponsor or the Contract Administrator of the birth, has enrolled the child, and has agreed to make any required contributions for coverage from the moment of birth.

NOTE: During the limited 31-day benefit period, a newborn child is not a Covered Person. Any extended coverage periods or coverage continuation options which are available to Covered Persons WILL NOT APPLY to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within such 31-day period.

Open Enrollment
If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period which will be held annually, mid-November to mid-December. Plan coverage will be effective on the first of the month following the end of the Open Enrollment period.

NOTE: See "Special Enrollment Rights" for exceptions to this provision.

Reinstatement / Rehire
A covered Employee who is terminated and rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire.

A Variable Hour Employee who is terminated and rehired will be treated as a continuing Employee upon rehire only if the Employee break in service did not exceed 13 weeks and the Employee was a covered Employee immediately prior to termination.

Upon return, coverage will be reinstated immediately, so long as all other eligibility criteria are satisfied.

Transfer of Coverage
If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior

coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

TERMINATION OF COVERAGE

Employee Coverage Termination
An Employee's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan;

termination of participation in the Plan by the Employee;

the date the Employee begins active duty service in the armed services of any country or organization, except for reserve duty of less than thirty (30) days. See the "Extension of Coverage During U.S. Military Service" in the **Extension of Coverage** section for more information;

the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

at midnight on the last day of employment in which the covered Non-Variable Hour Employee leaves or is dismissed from the employment of the Employer or ceases to be eligible or engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision;

the date following the end of the Stability Period for Variable-Hour Employees, if the Employee failed to qualify during the previous Measurement Period, as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision ;

the ninety-first (91st) day that an Employee has been continuously furloughed or on a leave of absence. NOTE: This means that the maximum time that an Employee, including spouse and Dependents, could maintain coverage while on leave is ninety (90) days.

the date the Employee dies.

NOTE: Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

Dependent Coverage Termination
A Dependent's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan or discontinuance of Dependent coverage under the Plan;

termination of the coverage of the Employee;

the date the Dependent spouse or domestic partner begins active duty service in the armed services of any country or organization, except for reserve duty of less than thirty (30) days. See the "Extension of Coverage during U.S. Military Service" in the **Extensions of Coverage** section for more information;

at midnight on the last day of the month in which the Dependent child ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the terms of any **Extension of Coverage** provision. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

the date in which the Dependent, other than a Dependent child, ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the terms of any **Extension of Coverage** provision;

the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage which will take effect immediately upon termination.

- (See COBRA Continuation Coverage)

EXTENSION OF COVERAGE PROVISIONS

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children
If an already covered Dependent child attains the age which would otherwise terminate his status as a "Dependent," and:

if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan;

at the time of attainment of such age the child is incapable of self-sustaining employment by reason of intellectual disability, cerebral palsy, epilepsy, other neurological disorder, physical handicap, or disability which results from injury, accident, congenital defect or sickness;

the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit to the Contract Administrator proof of the child's incapacity within thirty-one (31) days of the child's attainment of such age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extension of Coverage for Students on Medically Necessary Leave ("Michelle's Law")
Coverage for a Dependent child who is attending a postsecondary educational institution (including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965) will be extended for up to one (1) year if the child takes a medically necessary leave of absence.

For these purposes "medically necessary leave of absence" means any change in enrollment of such child at the educational institution that:

commences while the child is suffering from a serious illness or injury;

is medically necessary; and

causes such child to lose student status for purposes of continued eligibility (see student eligibility requirements in the **Eligibility and Effective Dates** section).

A Physician's written certification by the Dependent child's treating Physician must be provided. Such statement must certify that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

The period of extended coverage begins on the first day of the medically necessary leave of absence and ends on the date that is one (1) year later or on the date coverage would otherwise terminate under the terms of this document. A dependent child whose coverage is continued under the terms of this provision shall be entitled to the same benefits as if the child continued to be a student at the institution of higher education and was not on a medically necessary

leave of absence. Should the child resume full-time attendance within the one (1) year period, eligibility will continue without interruption based upon the child's regained student status.

Extensions of Coverage During Absence From Work
If an Employee fails to continue in eligible active status but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

NOTE: This means that employee's share of bi-weekly premium must be paid and received by the employer no later than 5:00 PM each corresponding payday, otherwise coverage will be retroactively terminated corresponding to the immediate date and time when payment was not timely received.

Except as noted, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

the ninety-first (91st) day that an employee has been continuously furloughed or on a leave of absence.

NOTE: This means that the maximum time that an employee, including spouse and dependents, could maintain coverage while on leave is ninety (90) days.

the date the person becomes covered under any other group plan for benefits of a type similar to those provided by this Plan;

the end of the period for which the last contribution was paid, if such contribution is required;

the date of termination of this Plan.

NOTE: Regardless of the established leave policies mentioned above, the Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA). It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights to those so required.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Continued coverage under the FMLA is allowed during up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

the birth of an Employee's child and in order to care for the child;

the placement of a child with the Employee for adoption or foster care;

to care for a spouse, child or parent of the Employee where such relative has a serious health condition; or

Employee's own serious health condition that makes him unable to perform the functions of his or her job.

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

USERRA provides for the continuation of health benefits for Employees who are on military leave. If an Employee was covered under the Plan immediately prior to being ordered to active military duty, coverage may continue for up to 18 months, or the duration of active military service, whichever is shorter. The Employee must pay the cost of coverage if the leave duration is over 30 days. The premium may not exceed 102% of the actual cost of coverage.

Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

on the first full business day following completion of military service for military leave of 30 days or less; or

within 14 days of completion of military service for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

The Employee who is ordered to active military service (and that Employee’s eligible Dependent(s)) are considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the above stipulations.

- (See COBRA Continuation Coverage) -

CLAIMS PROCEDURES & PAYMENT OF BENEFITS

DEFINITIONS

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

"Claimant"
"Claimant" shall mean any plan Covered Person or beneficiary submitting a claim to the Plan and thereby seeking to receive Plan benefits.

APPLICATION OF BENEFITS

To entitle a Covered Person to the payment of or authorization for any benefits for which he is eligible under the Plan, a Covered Person shall comply with such rules and procedures as the Contract Administrator may prescribe with reference to the completion and filing of a written claim forms and shall furnish such other pertinent information as the Contract Administrator may require, together with documentary evidence in support of his claim. A Covered Person must also provide the Contract Administrator with written authorization to obtain information from his Physician pertaining to the diagnosis and related matters.

HEALTH CLAIMS

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Contract Administrator. The Plan Administrator may delegate to the Contract Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Contract Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Contract Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an Assignment of Benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since

payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Claimant, or to a provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, because of this Plan's design Pre-service Urgent Care claims will not be filed with the Plan; Post-service claims will instead be filed after the urgent care is provided.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim."

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

   If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

   Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

A. When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Contract Administrator within 90 days for contracted providers and within 365 days for non-contracted providers of the date charges for the service(s) and/or supplies were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is received by the Contract Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Contract Administrator, together with the industry standard claim form:

1. The date of service.
2. The name, address, telephone number and tax identification number of the provider of the services or supplies.
3. The place where the services were rendered.
4. The diagnosis and procedure codes.
5. Any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days (48 hours in the case of urgent care claims) from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

B. Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and Concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Non-urgent Care Claims:
    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than five days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).
2. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination

before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination.

b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).

3. Post-service Claims:
   a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
   b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
   c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.
      i. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
      ii. Extensions – Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

C. Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
2. Specific reason(s) for a denial.
3. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
5. A statement that the Claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).

7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, upon request).
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, upon request.
9. In a claim involving urgent care, a description of the Plan's expedited review process.

APPEAL OF ADVERSE BENEFIT DETERMINATIONS

A. Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. At least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
4. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
5. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
6. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
7. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
8. That a Claimant will be provided, upon request: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits in possession of the Plan Administrator or the Contract Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and (d) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

B. Requirements for Appeal

The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within at least 180 days following receipt of the notice of an Adverse Benefit Determination.

For urgent care claims, if the Claimant chooses to initiate an appeal orally, the Claimant may telephone:

Humboldt Independent Practice Association
2662 Harris St.
Eureka, CA 95503
Phone: (707) 443-4563
Fax: (707) 442-2047

Oral appeals should be submitted in writing as soon as possible after it has been initiated.

To file any appeal in writing, the Claimant's appeal must be addressed as follows:

1. For Pre-service Claims:
   Claimants should refer to their identification card for the name and address of the utilization review administrator. All Pre-service claims must be sent to the utilization review administrator.

2. For Post-service Claims:

   Humboldt Independent Practice Association
   2662 Harris St.
   Eureka, CA 95503
   Phone: (707) 443-4563
   Fax: (707) 442-2047

It shall be the responsibility of the Claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant.
2. The Employee/Claimant's social security number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

C. Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Non-urgent or Post-service.
3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal. **Note:** This timeframe is reduced to no later than 30 days per internal appeal should the Plan allow for two levels of internal appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

D. Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

2. Specific reason(s) for a denial.
3. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice.
4. A statement that the Claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
5. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided.
6. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
7. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, upon request.
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

E. Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

F. Decision on Review to be Final

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

PAYMENT OF BENEFITS

All Plan benefits will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

ASSIGNMENTS

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Covered Person of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less deductible, copayments and coinsurance amounts, to a medical provider. If a Covered

Provider accepts said arrangement, the Covered Provider's rights to receive Plan benefits are equal to those of the Covered Person, and are limited by the terms of this Plan Document. A Covered Provider that accepts this arrangement indicates acceptance of an AOB and deductibles, copayments, and coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Covered Person of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the Covered Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Covered Person, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Covered Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Covered Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Covered Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5%

per month. If the Plan must bring an action against a Claimant, Covered Provider or other person or entity to enforce the provisions of this section, then that Claimant, Covered Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Covered Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Covered Provider, due to a claim being made in error, a claim being fraudulent on the part of the Covered Provider, and/or the claim that is the result of the Covered Provider's misstatement, said Covered Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental Injury - Any accidental bodily injury which is caused by external forces under unexpected circumstances. Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Ambulatory Surgical Center - Any public or private establishment which:

complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and does not provide services or other accommodations for patients to stay overnight.

Birthing Center - A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility which:

is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients; has organized facilities for birth services on its premises;

provides birth services which are performed by or under the direction of a Physician specializing in obstetrics and gynecology;

has 24-hour-a-day registered nursing services;

maintains daily clinical records.

Calendar Year - The period of time commencing at 12:00 A.M. on January 1 of each year and ending at 11:59 P.M. December 31. Each succeeding like period will be considered a new Calendar Year.

CHEF – refers to the Catastrophic Health Emergency Fund in 25 U.S.C. Section 1621a.

CHIP - "CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA - "CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Claimant - Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

Clean Claim - A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity, or

fees under review for the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expense(s) in accordance with the terms of this document.

Filing a Clean Claim. A Covered Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Covered Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Contract Administrator - A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

Contract Health Service or "CHS" – See Purchased Referred Care or "PRC".

Convalescent Hospital - see "Skilled Nursing Facility"

Covered Expense(s) - A service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as set forth elsewhere in this document.

Covered Person - A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See Eligibility and Effective Dates and COBRA Continuation Coverage sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider - An individual who is:

licensed to perform certain health care services which are covered under the Plan and who is acting within the scope of his license; or

in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is an:

Acupuncturist (CA)
Audiologist
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dental technicians

Dentist (DDS or DMD)
Enterostomal therapist
Licensed Clinical Social Worker (LCSW)
Licensed Practical Nurse (LPN)
Licensed Vocational Nurse (LVN)
Optometrist (OD)
Physician - see definition of "Physician"
Podiatrist or Chiropodist (DPM, DSP, or DSC)
Registered Nurse (RN)
Respiratory Therapist
Speech Pathologist

A "Covered Provider" will also include the following when appropriately-licensed and providing services which are covered by the Plan:

facilities as are defined herein including, but not limited to,

Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.;

freestanding public health facilities;

hemodialysis and Outpatient clinics under the direction of a Physician (MD);

enuresis control centers;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities;

blood banks;

speech and hearing centers;

ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services.

Dependent - see **Eligibility and Effective Dates** section

Emergency - see "Medical Emergency"

Emergency Services – An Emergency Service is**,** with respect to a Medical Emergency, the following:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency.

2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee - see **Eligibility and Effective Dates** section

Employer(s) - The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

Essential Health Benefits - Under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational - Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or

3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

Fiduciary - A Fiduciary of the Plan has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

GINA - The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

Hospital - An institution which is a:

licensed facility which is primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis, which provides such facilities under the supervision of a staff of Physicians and 24-hour-a-day nursing service by registered nurses, and is NOT principally a rest home, nursing home or home for the aged; OR

psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

IHS Beneficiary - an individual who may also be eligible for Indian Health Service, tribal direct care, and/or Purchased Referred Care benefits.

IHS Benefits - includes any direct care services or contract health services (now referred to as "purchased referred care") available through the Indian Health Service or through a tribal health clinic or program operated under ISDEAA.

Incurred - A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Indian Health Service or "IHS" Program - a program that provides direct services to Indians and other eligible individuals, including care or services pursuant to the Indian Health Care Improvement Act and 42 CFR part 136, Subpart B, regardless of whether the IHS program is operated directly by the federal Indian Health Service or through an Indian tribe, tribal organization, or tribal consortium of tribes or tribal organizations pursuant to a self-determination contract or self-governance compact under ISDEAA, as amended.

Individual Policy - shall include any policy of insurance (including a health maintenance organization) or a policy offered through a Patient Protection and Affordable Care Act marketplace/exchange, for an enrolled member of the Blue Lake Rancheria or other individual eligible for PRC services, that is paid in part or facilitated throught the Plan Sponsor. The Plan Sponsor may, at its option, also include any policy of insurance (including a health maintenance organization) or a policy offered through a Patient Protection and Affordable Care Act marketplace/exchange for: (1) any IHS Beneficiary purchased individually or from other sources, including without limitation, 25 U.S.C. Section 1642, (2) non-IHS Beneficiaries that are paid for in part or facilitated through the Plan Sponsor, and/or (3) non-IHS Beneficiaries regardless of source.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (Hospital, etc.) which is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and which is separated from the rest of the Hospital's facilities.

ISDEAA - refers to the Indian Self Determination and Education Assistance Act, as amended.

Leave of Absence - A period of time during which Employee must be away from his/her primary job with Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her participating Employer, and as provided for in the participating Employer's rules, policies, procedures and practices where applicable.

Legal Separation and/or Legally Separated - An arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Maximum Allowable Charge - The benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Charge(s) will be a negotiated rate, if one exists.

If and only if there is no negotiated rate for a given claim, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Covered Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Covered Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Medical Emergency - An Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

Medical Record Review - The process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medically Necessary - Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;

the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;

it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license, and it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment which can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listing in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare - Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, and as amended from time to time.

Medicare-Like Rates or "MLR" - shall include the amount a provider is required to accept as payment in full under Section 506 of the Medicare Modernization Act of 2003 and the final regulations issued thereunder at 42 CFR 136.30 through 136.32 and 42 CFR 489.29. This Plan shall be construed as part of a tribal health program consisting of self-insurance, direct service care, and PRC. These benefits are authorized in part by a tribe or tribal organization carrying out a CHS program of the IHS under ISDEAA, as amended. In the event the Plan covers MLR Eligible Care, the Plan shall pay no more than MLR. Any payment made by the Plan for MLR Eligible Care in accordance with the foregoing is made under a reservation of rights for a full refund if the provider refuses to accept payment at MLR as payment in full. MLR for purposes of this Plan shall also include, where applicable, Professional Services and Non-Hospital-Based Discounting to the extent permitted in 42 CFR 136.201 through 136.204.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA - In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

Mental or Nervous Disorder - Any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

MLR Eligible Care - shall mean any care for which a provider must accept MLR as payment in full under 42 CFR 136.30 and Professional Services and Non-Hospital-Based Discounting, as applicable.

Network - The facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Covered Persons, and by whose terms they have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Covered Person's identification card.

Outpatient - Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

Physician - A Doctor of Medicine, (MD), or Doctor of Osteopathy, (DO), who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: The term "Physician" will not include the Covered Person himself, his relatives (see **General Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

Plan - The benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document which describes the plan of benefits and the provisions under which such benefits will be paid to Covered Persons, including any amendments.

Plan Sponsor - The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Pregnancy - Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising there from. See "Pregnancy" in the list of **Eligible Medical Expenses** for further information.

Prior to Effective Date or After Termination Date - Dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless Extension of Coverage provisions apply.

Professional Services and Non-Hospital-Based Discounting - means discounting asserted under 42 CFR 136, Subpart I, Limitation on Charges for Indian Care Professional Services and Non-Hospital-Based Care, Subsection 136.201 through 136.204.

Purchased Referred Care or "PRC" - the terms Purchased Referred Care or PRC are used interchangeably with "Contract Health Service" and "CHS" as used herein.

Purchased Referred Care or "PRC" Program - a contract heath service program (also referred to as "CHS", "Purchased Referred Care" or "PRC") under 42 CFR Part 136, Subpart C, regardless of whether the PRC program is operated directly by the federal IHS, a tribe, or tribal organization, including a PRC program operated by and Indian tribe, tribal organization, or tribal consortium of tribes or tribal organizations pursuant to a self-determination contract or self-governance compact under ISDEAA, as amended.

Semi-Private Room Charge - The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness - Bodily illness or disease (other than mental health conditions), congenital abnormalities, birth defects and premature birth. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility - A facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from injury or Sickness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care, educational care or care of Mental or Nervous Disorders.
7. It is approved and licensed by Medicare.

Substance Abuse and/or Substance Use Disorder - Any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

Surgery - In the Plan Administrator's discretion, the treatment of injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Covered Provider's license.

Urgent Care Facility - A facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;

X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or which is part of a regular Hospital.

STATEMENT OF RIGHTS

Adoption of the following "ERISA" Statement of Rights is not a waiver of sovereign immunity, tribal court jurisdiction, or any exemptions that the Plan Sponsor or the Plan may be entitled to at law or in equity, including under ERISA Section 3(32).

As a participant in this Plan, an individual is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies;

receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report;

continue health care coverage for himself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or his Dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights;

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan (the Fiduciaries). Fiduciaries have a duty to operate the Plan prudently and in the interest of Covered Persons and beneficiaries. No one, including the Employer, may fire a Covered Person or discriminate against him to prevent him from obtaining a welfare benefit or exercising rights under ERISA.

If an individual's claim for a welfare benefit is denied in whole or in part, he must receive a written explanation of the reason for the denial. He has the right to have the Plan review and reconsider his claim.

Under ERISA, there are steps he can take to enforce the above rights. For instance, if he requests materials from the Plan and does not receive them within 30 days, he may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him up to $110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If he has a claim for benefits which is denied or ignored, in whole or in part, he may, file suit in a state or Federal court but not before he exhausts the Plan's mandatory appeals, where applicable (see the **Claims Procedures** section). In addition, if he disagrees with the Plan Sponsor's decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if he is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he is successful, the court may order the person he has sued to pay these costs and fees. If he loses, the court may order him to pay these costs and fees, for example, if it finds his claim is frivolous.

All references herein to monetary penalties, the right to file suit in court, or the right to seek assistance from the DOL apply only if or to the extent to which the Plan is governed by ERISA. Nothing herein shall serve as a voluntary waiver of tribal court exhaustion, sovereign immunity, or governmental plan status.

If an Employee or Covered Person has any questions about the Plan, he should contact the Plan Administrator. If he has any questions about this statement or about his rights under ERISA, he should contact:

the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his telephone directory; or

the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

A Covered Person may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

> Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

> voluntary or involuntary termination of Employee's employment for any reason other than Employee’s gross misconduct;
>
> reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;
>
> for an Employee's spouse or child, Employee’s entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;
>
> for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;
>
> for an Employee's spouse or child, the death of the covered Employee;

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

Non-COBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights within 14 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Employer or Plan Administrator within 60 days of the later of: (1) the date of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse, or (2) the date the Qualified Beneficiary would lose coverage on account of such Qualifying Event. The Plan Administrator must then notify the Qualified Beneficiaries of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow Non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.
See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan’s full cost of coverage during the period for similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The “full cost” includes any part of the cost that is paid by the Employer for Non-COBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan’s 12-month determination period if:

the cost previously charged was less than the maximum permitted by law;

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

the Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

Also, COBRA coverage will run concurrently with medical continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). That is, if an Employee on military leave continues coverage for 18 months under USERRA, 18 months of COBRA entitlement will be exhausted, unless there was another Qualifying Event.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a

Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated Non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

PRIVACY RULES

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Covered Person's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling (707) 668-5101 x 1042.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Breach is an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

PHI is individually identifiable health information, as defined by HIPAA, that is created or received by the Plan that relates to the past, present or future physical or mental health or condition of of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is to carry out payment of benefits or if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.

Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

In order to comply with the Privacy Rules, the Plan Sponsor agrees to:

not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).

ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.

establish safeguards for information, including security systems for data processing and storage;

maintain the confidentially of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions such as quality assurance, claims processing, auditing, monitoring and management of carve-out plans (such as vision or dental);

not use or disclose genetic information for underwriting purposes;

report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Disclosures to Covered Person: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

The Covered Person has the following rights regarding PHI about him/her:

Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.

Right to Receive Confidential Communication: The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and include how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.

Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.

Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer.

Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Covered Person wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.

Amendment: The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.

Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Privacy Officer Contact Information:
Jack Norton III
428 Chartin Road
P.O. Box 428
Blue Lake, CA 95525
(707) 668-5101 x. 1042

SECURITY RULES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Electronic Protected Health Information (ePHI), as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
Security Incidents, as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware;

report to the Plan any security incident of which it becomes aware;

establish safeguards for information, including security systems for data processing and storage;

not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
    i. Privacy Officer.
    ii. Director of Employee Benefits.
    iii. Employee Benefits Department employees.
    iv. Information Technology Department.

b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Contract Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

mitigating any harm caused by the breach, to the extent practicable;

documentation of the incident and all actions taken to resolve the issue and mitigate any damages;

training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections;

disclosing the Covered Person's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

ADOPTION OF THE PLAN DOCUMENT

Adoption
The Plan Sponsor hereby adopts this Plan Document on the date shown below. This Plan Document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law. Changes required for compliance with applicable law shall not be considered employer voluntary changes for purposes of continued grandfather status under the ACA.

Participating Employers
Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Acceptance of the Plan Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2024.

Blue Lake Rancheria

By:_____
Jason Ramos

Title: Tribal Administrator