
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**NASOMAH HEALTH GROUP
CITCHC EPO HEALTH CARE PLAN**

Effective May 1, 2011

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NASOMAH HEALTH GROUP

Background

The Coquille Indian Tribe created the Nasomah Health Group as a means to provide Tribal members living outside of the five county service area (Coos, Curry, Douglas, Lane and Jackson) with low-cost, high quality group health care coverage.

Origination

The word “Nasomah” comes from the Miluk language of the Lower Coquille Band of Tribal Indians and according to some interpretations means “People of the Great Water”. Jennifer Mecum, a Tribal member, designed the Nasomah Logo, which incorporates four animals (a salmon, eagle, whale, and a wolf).

Established

Nasomah was established on May 1, 1998 for the benefit of Tribal members, employees of the Tribe and its enterprises, and eligible dependents.

Tribal Commitment

Since Nasomah’s inception, the Coquille Indian Tribe has contributed over \$40 million in premiums to the Nasomah Health Group program on behalf of Tribal members and Tribal employees.

INTRODUCTION

This document is a description of Nasomah Health Group (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Participant and designated Dependents when the Participant and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal and Coquille Indian Tribe laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

SCHEDULE OF BENEFITS

Verification of Eligibility (800) 442-7247, HealthComp Administrators

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are percentages paid by the Plan and are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are based on the Recognized Charge; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

Inpatient Hospitalizations

Diagnostic Imaging over \$1,250 including, but not limited to, MRI/CAT scans

Diagnostic Procedures over \$1,250 including, but not limited to, Thallium treadmills, EGD, Sleep Studies, Colonoscopy and Mammography (other than routine screenings)

Inpatient Substance Abuse/Mental Disorder treatments

Skilled Nursing Facility stays

Home Health Care or Home Infusion Therapy

Hospice Care

Durable Medical Equipment over \$1,250 including, but not limited to, respiratory products, orthotics/prosthetics, diabetic supplies and insulin pumps

Injectables and Specialty Pharmacy Program

Cardiac rehabilitation therapy

Outpatient surgical procedures over \$1,250 performed in a facility

Residential Day Treatment programs

Please see the Cost Management section in this booklet for details.

Please read the sections Alternate Treatment and Predetermination of Benefits in the Dental Plan. You will need to follow these sections or reimbursement from the Plan may be reduced.

The Plan is a plan which contains an Exclusive Provider Organization.

The Exclusive Provider for the Plan is the **Coquille Indian Tribe Community Health Clinic (CITCHC)**. **All participants who elect to have the CITCHC as their Primary Care Provider will be subject to the Exclusive Provider Schedule of Benefits.** In addition, participant contributions will be at the Exclusive Provider levels if the CITCHC is chosen.

If enrollment in the CITCHC is elected **ALL services**, except for those benefits listed in the CITCHC **Schedule of benefits** as "Referral Not Required", must be provided or referred to another provider by the CITCHC in order to be considered as Covered services under this Plan. Services not obtained from the CITCHC that do not have a CITCHC referral to another provider will not be covered under this Plan.

EPO Referral Procedures: During business hours of the CITCHC, the Plan participant must be seen at the CITCHC, or acquire a referral from the CITCHC to see any Non-CITCHC provider.

If a **Participant and/or Dependent** covered under this EPO Plan requires emergency services, no referral is required, and benefits for covered services will be reimbursed subject to the Referral Provider Copayments as listed in the Schedule of Medical Benefits. In addition, no referral is required for services as shown in the Schedule of Benefits.

Deductibles/Copayments/Coinsurance payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each May 1st, a new deductible amount is required. Deductibles do not accrue toward the 100% maximum out-of-pocket payment.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Coinsurance is the amount of money the Participant pays after the Plan pays the percentages shown in the Schedule of Benefits.

OVERVIEW OF MEDICARE-LIKE RATE PRICING-APPLICABLE TO ELIGIBLE PARTICIPANTS ONLY

Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Generally, provided authorization for Contract Health Services (CHS) and urban Indian programs to pay no more than "Medicare-like" rates for referred services furnished by Medicare-participating hospitals upon the effective date of enacting regulations.

These regulations were published in a final run in the Federal Register on June 4, 2007, with an effective date of July 5, 2007. The regulations describe the payment methodologies and other requirements covered providers must adhere to when processing claims for services authorized for purchase by a CHS or urban Indian program. This applies to programs operated by the HIS, Tribes or Tribal organizations, and urban Indian programs.

Employees who are eligible for Contract Health Services benefits are eligible to access Medicare-like rates under their employee health plan for certain hospital services. Claims paid using Medicare-like rates, will be processed at the Network benefit level described in the Schedule of Benefits.

MEDICAL BENEFITS SCHEDULE

	CITCHC PROVIDERS	REFERRAL PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER PLAN YEAR - The Plan Year Deductible is combined for CITCHC Providers and Referral Providers.		
Per Covered Person	\$500	
Per Family Unit	\$1,000	
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - The Plan Year Out-of-Pocket Amount is combined for CITCHC Providers and Referral Providers.		
Per Covered Person	\$3,000	
Per Family Unit	\$6,000	
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Deductible(s) Cost containment penalties Any charge excluded in the Plan Exclusions		
COVERED CHARGES		
Note: The maximums listed below are the total for CITCHC and Referral Providers expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total which may be split between CITCHC and Referral providers.		
All Reimbursement Percentages – unless otherwise specified in this document	N/A	75% after deductible
Hospital Services		
Room and Board	N/A the semiprivate room rate	75% after deductible and \$250 copayment per day the semiprivate room rate
Preadmission testing	75% after deductible	75% after deductible
Emergency Room Visit - including professional services.		
Medical Emergency - Includes emergency medical care outside of the United States	N/A	75% after deductible and \$200 copayment Copayment waived if admitted Referral not required
Ambulatory Surgery Center, Outpatient Surgery	N/A	75% after deductible and \$100 copayment per surgery
Urgent Care Center	N/A	75% after deductible and \$10 copayment Referral not required
Skilled Nursing Facility	N/A	75% after deductible the facility's semiprivate room rate 60 days Plan Year maximum
Physician Services		
Inpatient visits	N/A	75% after deductible
Office visits - includes all procedures done in the office except as specified elsewhere in this document	75% after deductible	75% after deductible and \$10 copayment

	CITCHC PROVIDERS	REFERRAL PROVIDERS
Surgery - Inpatient/outpatient	N/A	75% after deductible and \$125 copayment
Inpatient Anesthesiologist	N/A	75% after deductible Referral not required
Outpatient Anesthesiologist	N/A	75% after deductible and \$25 copayment Referral not required
Allergy testing	75% after deductible	75% after deductible
Allergy serum and injections	75% after deductible	75% after deductible and \$3 copayment
Second Surgical Opinion	75% after deductible	75% after deductible and \$10 copayment Referral not required
Abortion	75% after deductible	75% after deductible and \$10 copayment per procedure
Diabetes Education	75% after deductible	75% after deductible and \$10 copayment
Diagnostic Testing, X-ray & Lab - performed outside of the physician's office	N/A	75% after deductible and \$10 copayment per visit
MRI, CTs, EEGs, Echocardiography, Holter Monitor, Treadmill Stress Tests	N/A	75% after deductible and \$100 copayment per procedure
Neurodevelopmental Therapy	N/A	75% after deductible and \$10 copayment
Hearing Exam	75% after deductible	75% after deductible and \$10 copayment
Hearing Aids	50% deductible waived Limited to one device per ear every 60 months Referral not required if related to hearing aid exam or audiologist	
Home Health Care	N/A	75% after deductible 100 visits Plan Year maximum
Home Oxygen & Related Supplies	N/A	75% after deductible
NOTE: Maintenance and repairs are limited to \$500 Plan Year maximum.		
Hospice Care	N/A	75% after deductible
Bereavement Counseling	N/A	75% after deductible Referral not required
Specialty Pharmacy Program	75% after deductible	75% after deductible
Ambulance Service	N/A	75% after deductible Referral not required
Jaw Joint/TMJ	75% after deductible \$500 Plan Year maximum	75% after deductible \$500 Plan Year maximum
Radiation Therapy & Chemotherapy	N/A	75% after deductible and \$10 copayment per visit Referral not required if ordered by oncologist
Wig After Chemotherapy	N/A	75% after deductible \$250 Lifetime maximum Referral not required if ordered by oncologist
Occupational Therapy	75% after deductible	75% after deductible and \$10 copayment
Speech Therapy	75% after deductible	75% after deductible and \$10 copayment

	CITCHC PROVIDERS	REFERRAL PROVIDERS
Physical Therapy - includes MIRE treatment	75% after deductible	75% after deductible and \$10 copayment
Durable Medical Equipment - includes diabetic supplies, insulin pumps & orthotics	N/A	75% after deductible Referral not required
EKG and Ultrasounds	N/A	75% after deductible and \$20 copayment per procedure
Family Planning Services – for services rendered in the physician’s office or clinic	75% after deductible	75% after deductible and \$10 copayment
Prosthetics	N/A	75% after deductible and \$10 copayment
Spinal Manipulation Chiropractic/Massage Therapy/Acupuncture – combined	N/A	75% after deductible and \$10 copayment \$1,000 Plan Year maximum Referral not required
Mental Disorders		
Inpatient	N/A	75% after deductible and \$250 copayment per day
Outpatient	75% after deductible	75% after deductible and \$10 copayment
NOTE: No referral required for counseling services.		
Substance Abuse		
Inpatient	N/A	75% after deductible and \$250 copayment per day
Outpatient and Residential Facility & Day Program	75% after deductible	75% after deductible and \$10 copayment
NOTE: No referral required for counseling services.		
Preventive Care		
Routine Well Care - all ages	100% deductible waived	100% deductible waived
Includes services in accordance with the Patient Protection and Affordable Care Act (PPACA).		
Tobacco Cessation Counseling/Programs	100% deductible waived	100% deductible waived Referral not required
Weight Loss Program	100% deductible waived \$300 Plan Year maximum limited to Weight Watchers Program Referral not required	
Organ Transplants	N/A	SAME AS ANY ILLNESS
Donor – when recipient is a Covered Person	N/A	75% after deductible \$10,000 maximum per transplant
Pregnancy - Prenatal & Postnatal Care	75% after deductible	75% after deductible and \$10 copayment
Birthing Center	N/A	75% after deductible and \$200 copayment
NOTE: No referral required for infant care to age 6 months.		

PRESCRIPTION DRUG BENEFITS

Pharmacy Option

Generic drugs

Copayment..... \$8 copayment

Formulary Brand Name drugs

Copayment..... \$25 copayment

Non-Formulary Brand Name drugs

Copayment..... 50% copayment

Pharmacy Advantage 90 Option

Generic drugs

Copayment..... \$16 copayment

Formulary Brand Name drugs

Copayment..... \$50 copayment

Non-Formulary Brand Name drugs

Copayment..... 50% copayment

Mail Order Prescription Drug Option

Generic drugs

Copayment..... \$16 copayment

Formulary Brand Name drugs

Copayment..... \$50 copayment

Non-Formulary Brand Name drugs

Copayment..... 50% copayment

Generic drugs will be dispensed whenever possible. If you choose the name brand drug when a generic derivative is available, you will be responsible for paying the Brand Name Copayment plus the difference in cost between the generic and the brand name drug.

Prescription Drug Copayments **DO NOT** apply to the Plan Year Out-of-Pocket Maximum in the Medical Plan.

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate deferral regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

See page 45 for more detailed information regarding Prescription Benefits.

VISION CARE BENEFITS

Plan Year maximum..... \$300

The Plan Year maximum includes charges for eye exams, eyeglass lenses and frames, prescription sunglasses, contact lenses, and laser eye surgery to correct vision.

Prescriptions for eyeglasses and/or sunglasses must be to correct vision and must be for corrections of .50 or greater.

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

See page 47 for more detailed information regarding Vision Benefits.

DENTAL BENEFITS

Plan Year deductible,
per person..... \$50

per Family Unit..... \$100

The deductible applies to these Classes of Service:

Class B Services - Basic

Class C Services - Major

Dental Percentage Payable

Class A Services -
Preventive 100%

Class B Services -
Basic 80%

Class C Services -
Major 50%

Note: No benefits are payable under Class C Services for dentures, partial dentures and bridges in the first 12 months of the Covered Person's coverage under the Plan for newly eligible Plan Participants that do not have immediate prior coverage. The 12 month waiting period begins on the date the participant is eligible for benefits. Proof of 12 months of continuous prior coverage will be required to waive the waiting period.

Maximum Benefit Amount

Per person per
Plan Year \$1,500

See page 48 for more detailed information regarding Dental Benefits.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Participants. All regular Full-time Participants of ORCA Communications, Coquille Economic Development Corporation (CEDCO), The Mill Casino Hotel, The Mill Casino RV Park, Native American Cranberries, Coquille Indian Tribal Administration Office, Community Center, Community Health Center, Gaming Commission, and Nasomah Administration.

Employees of the Tribe's enterprises, agencies, corporations and departments are also eligible for coverage.

Eligibility Requirements for all Participants and Dependents – Not Prohibited from using Health Center Services. To be eligible for this plan, Participants and Dependents must not be prohibited from entering the Coquille Indian Community Health Center, or from using the services there. If a Participant or Dependent fails to meet the requirements of this section, the Plan Administrator will offer the Participant and Dependents, collectively, the options of either continuing under the EPO Plan without the prohibited person, or converting to the Nasomah Health Group PPO Plan.

It is also possible for the prohibited member to stay on the EPO Plan; but, they would be limited to those EPO services that do not require a referral.

Eligibility Requirements for Plan Participant Coverage. A person is eligible for coverage from the first day that he or she:

- (1) is a regular Full-Time, Active Participant of the Employer. A Participant is considered to be Full-Time if he or she normally works at least 20 hours per week for Coquille Indian Tribe, or 30 hours per week for all other entities, and is on the regular payroll of the Employer for that work.
- (2) is in a class eligible for coverage.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Participant's Spouse and children from birth to the limiting age of 26 years. When a child reaches the limiting age, coverage will end on the last day of the child's birthday month.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Nasomah Health Group. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to May 1, 2011. For more information contact the plan administrator at Nasomah Health Group, P. O. Box 921, North Bend, Oregon, 97459, 541-751-0940.

- (a) The term "Spouse" shall mean a person who is legally married to the eligible Participant in their state of primary residency. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Spouse" shall also mean the person who is currently registered with the Employer as the legal domestic partner of the Participant, this includes opposite sex and same sex couples, and is a member of a registered domestic partnership or civil union formed under the laws of a recognized jurisdiction.

To obtain more detailed information or to apply for this benefit, the Participant must contact the Plan Administrator, Nasomah Health Group, P. O. Box 921, North Bend, Oregon, 97459, 541-751-0940.

In the event the marriage or domestic partnership is terminated, either partner is required to inform Nasomah Health Group of the termination of the partnership.

The Plan Administrator will require documentation proving a legal marital and/or domestic partner relationship.

- (b)** The term "children" shall include natural children of the Participant or domestic partner, adopted children, Foster Children or children placed with a covered Participant (or domestic partner) in anticipation of adoption. Step-children may also be included as long as a natural parent remains married to the Participant and resides in the Participant's household. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Participant or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

If a covered Participant or domestic partner is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Participant or domestic partner in anticipation of adoption" refers to a child whom the Participant or domestic partner intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Participant or domestic partner 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 commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

- (2)** A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Participant for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Participant's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Participant; any person who is on active duty in any military service of any country, unless the covered Participant is the spouse; any former domestic partner of the Participant; or any person who is covered under the Plan as a Participant.

If a person covered under this Plan changes status from Participant to Dependent or Dependent to Participant, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both husband and wife or domestic partner are covered under this Plan as Participants, their children will be covered as Dependents of the husband or wife or domestic partner. If both husband and wife elect to cover the Dependent children, covered expenses for the Dependent children will be reimbursed according to the Coordination of Benefits provision of this Plan.

If both husband and wife are covered under this Plan as Participants, they may both cover each other as dependents. In the case of Dual Coverage, this Plan will reimburse covered expenses according to the Coordination of Benefits provision of this Plan.

Eligibility Requirements for Dependent Coverage. A family member of a Participant will become eligible for Dependent coverage on the first day that the Participant is eligible for coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, domestic partner, or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Contributions (payments) must be made on a timely basis as follows:

The Health Care Coverage(s) afforded to a Participant by this Plan may require Participant contribution but shall be at least partially funded by the Employer. If a Participant elects to enroll Dependent(s) under the Plan, the Participant may be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment. For active Participant, the Employer shall deduct such costs on a regular basis from the Participant's wages or salary. Participants enrolled in the Plan will be advised of any required contributions at the time they apply for enrollment. Participants will be notified by the Nasomah Health Group prior to any increase change in the required contributions.

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan even if that coverage is still in effect. The Plan will reduce the length of the Pre-Existing Condition Limitation period by each day of Creditable Coverage under this or a prior plan; however, if there was a significant break in the Creditable Coverage of 63 days or more, then only the coverage in effect after the break will be counted.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage from this Plan if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

All questions about the Pre-Existing Condition Limitation and Creditable Coverage should be directed to the Plan Administrator, Nasomah Health Group, P. O. Box 921, North Bend, Oregon, 97459, 541-751-0940.

Covered Charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months after the person's Enrollment Date. This time, known as the Pre-Existing Conditions Limitation period, may be offset if the person has Creditable Coverage from his or her previous plan.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not, by itself, a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy or to any dependent child under the age of 19 who is otherwise eligible and enrolled for coverage under this Plan.

ENROLLMENT

Enrollment Requirements. A Participant must enroll for coverage by filling out and signing an enrollment application and remitting the required contribution. The covered Participant is required to enroll for Dependent coverage also. Enrollment forms for Dependent coverage must be completed by the Participant.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Participant who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 31 days of birth, the child will not be eligible for benefits as an eligible Dependent.

TIMELY ENROLLMENT

Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Participants (husband and wife or domestic partners) are covered under the Plan and the Participant who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Participant with no Waiting Period as long as coverage has been continuous.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If a Participant is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Nasomah Health Group, P. O. Box 921, North Bend, Oregon, 97459, 541-751-0940.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. This means that any Pre-Existing Condition will be determined on the basis of the look back period prior to the Enrollment Date, and the period of the Pre-Existing Conditions Limitation will start on the Enrollment Date.

(1) Individuals losing other coverage creating a Special Enrollment right. A Participant or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

- (a)** The Participant or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- (b)** If required by the Plan Administrator, the Participant stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
- (c)** The coverage of the Participant or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

The Participant or Dependent requests enrollment in this Plan not later than 31 days after the date of conditions described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

- (a)** The Participant or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
- (b)** The Participant or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time participants).
- (c)** The Participant or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
- (d)** The Participant or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
- (e)** The Participant or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Participant or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Dependent beneficiaries. If:

- (a)** The Participant is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b)** A person becomes a Dependent of the Participant through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Participant) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse or domestic partner of the covered Participant may be enrolled as a Dependent of the covered Participant if the Spouse or domestic partner is otherwise eligible for coverage. If the Participant is not

enrolled at the time of the event, the Participant must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Participant must request enrollment during this 31-day period.

The coverage of the Dependent and/or Participant enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, as of the date of marriage , or in the case of domestic partner relationship, on the date of registration of the domestic partner relationship; or
 - (b) in the case of a Dependent's birth, as of the date of birth; or
 - (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
- (4) **Medicaid and State Child Health Insurance Programs.** A Participant or Dependent who is eligible, but not enrolled in this Plan, may enroll if:
- (a) The Participant or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Participant or Dependent is terminated due to loss of eligibility for such coverage, and the Participant or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
 - (b) The Participant or Dependent becomes eligible for assistance with payment of Participant contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Participant or Dependent requests enrollment in this Plan within 60 days after the date the Participant or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Participant is not then enrolled, the Participant must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

REDUCTION OF COVERAGE ELECTIONS DURING PLAN YEAR

Generally, coverage elections cannot be changed after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You may change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Under Federal law, the following events are considered to be a change in status:

- Marriage, divorce, death of a spouse, legal separation, or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for a Plan Participant: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- A dependent ceases to satisfy the requirements for coverage due to change in age, student status; and
- A change in the place of residence of a Plan Participant that would lead to a change in status, such as moving out of a coverage area for insurance.

If any of these conditions apply to you, you should contact the Plan Administrator.

HEALTH TIP # 1

- ▶ **Be healthy.** Prevention is the best medicine. Practice healthy choices like eating more fruits and vegetables, walking 20 minutes a day, getting 7-8 hours of sleep a night, living without tobacco use, avoiding or limiting alcoholic beverages to 1-2 drinks per day and maintaining a healthy weight.

EFFECTIVE DATE

Effective Date of Participant Coverage. A Participant will be covered under this Plan as of the first day of the calendar month following the date that the Participant satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Enrollment Requirements of the Plan.
- (3) The employment Waiting Period as stated below:

For CEDCO, The Mill Casino Hotel, The Mill Casino RV Park, Native American Cranberries and ORCA Communications:

- (a) All regular full-time Participants - the first of the month following 180 consecutive days as an Active Participant.

For all Coquille Indian Tribe Administration Office, Community Center, Community Health Center, Gaming Commission, and Nasomah Administration:

- (a) Executive Management Participants - the waiting period is waived. The effective date of eligibility will be from the date of hire.
- (b) All other regular full-time Participants - the waiting period will be as defined in the Participant's "Participant Personnel Manual".

Active Participant Requirement.

A Participant must be an Active Participant (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Participant is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Participant and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Participant and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Participant's and/or Dependent's paid contributions.

When Participant Coverage Terminates. Participant coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Participant may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month in which the covered Participant ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Participant. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes a Participant on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (3) The last day of the month in which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) The earliest date the Participant has a claim that is denied in whole or in part because the Participant has met or exceeded a lifetime limit on all benefits.
- (5) If a Participant commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Participant and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Participant. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Participant had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Participant and his or her covered Dependents if the Participant returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Participant and/or his or her Dependents when Plan coverage terminated.

Rehiring a Laid Off Participant. A Participant who is laid off and subsequently rehired within 30 days of the date of layoff will be eligible to re-enroll in this Plan immediately upon rehire. Coverage in this case will become effective on the date of rehire. Coverage will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other waiting periods will not be imposed unless they were in effect for the Participant and/or his or her Dependents when Plan coverage terminated due to the lay off. The Participant must request re-enrollment by completing an enrollment form.

Rehiring a Terminated Participant. An Participant who is terminated and subsequently rehired within 30 days of the date of termination will be eligible to re-enroll in this Plan immediately upon rehire. Coverage in this case

will become effective on the date of rehire. Coverage will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other waiting periods will not be imposed unless they were in effect for the Participant and/or his or her Dependents when Plan coverage terminated.

A terminated Participant who is rehired more than 30 days after the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of a Participant returning to work directly from COBRA coverage. This Participant does not have to satisfy the employment waiting period or Pre-Existing Conditions provision.

Furlough Positions. These participants do not work all year round. These participants are laid off up to 90 days, generally in the summer time and return to work in the fall. Nasomah Health Group will maintain health insurance benefits for furlough participants at the same level and under the same conditions that would have been provided if the participant had not been on furlough leave.

Participant Status Change. A Participant who is covered under this Plan and who changes employment status from Full Time to Part Time status and is then reinstated as a Full Time Participant within 30 days will be reinstated with no lapse in coverage.

Participants on Military Leave. Participants going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Participants and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Participant's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Participant wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Nasomah Health Group, P. O. Box 921, North Bend, Oregon, 97459, 541-751-0940. The Participant may also have continuation rights under USERRA. In general, the Participant must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Participant may elect USERRA continuation coverage for the Participant and their Dependents. Only the Participant has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The last day of the month in which the Participant's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

- (3) The last day of the month in which a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) The last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) The last day of the month in which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a lifetime limit on all benefits.
- (7) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

OPEN ENROLLMENT

OPEN ENROLLMENT

Every April, the annual open enrollment period, Participants and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective May 1.

An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

HEALTH TIP # 2



Be more safety conscious. Use proper lifting techniques. Wear your car's safety belt and use child restraint seats for children. Keep all medications, cleaners and insecticides out of children's reach to avoid accidental poisoning. Wear a helmet when riding bicycles, go-carts, ATVs, motorcycles, scooters, and skateboards.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will not accrue toward the 100% maximum out-of-pocket payment.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Plan Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Plan Year. The out-of-pocket limit consists of copayments and coinsurance paid by the Covered Participant.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Plan Year.

HEALTH TIP # 3

→ **Don't substitute an emergency room for your doctor.** Never go to an emergency room (except in absolute emergencies) before contacting your health care provider first.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person. The Maximum Benefit applies to all plans and benefit options offered under the Nasomah Health Group, including the ones described in this document.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for an Intensive Care Unit stay are payable.

- (2) **Coverage of Pregnancy.** The charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

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

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (a) the patient is confined as a bed patient in the facility; and
- (b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- (b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Charge for that procedure; and
- (c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's allowance.

- (5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
- (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

HEALTH TIP # 4

- ▶ **Ask for generic prescriptions when available.** Generic drugs are fully regulated by the U.S. Food and Drug Administration and by law the only difference between a generic and a brand name drug is its color and the binder which holds it together. Generic drugs are less costly because they are offered to the public after the brand-name patent has expired. This means the manufacturer of the generic drug can sell it at a much lower price because they have not incurred the expense of research and development. Generic drugs have lower copays versus copays for brand-name drugs for our group. If you elect to purchase a brand-name drug when a generic is available, the copay is higher and you pay the difference in the drug cost between the brand and the generic.

- (6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

- (8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- (a) Surgical methods of terminating a pregnancy also called elective **abortion**.
- (b) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (c) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions, blood transfusion services, including the cost of blood, blood plasma and other blood products not donated or replaced by voluntary donors. Administration of these items is included.
- (d) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (e) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

- (f) **Circumcision** within six months of birth, or when deemed medically necessary by the physician.
- (g) Initial **contact lenses** or glasses required following cataract surgery.
- (h) **Dental Care.** Medical facility, anesthesia charges or any fees associated with treatment that is determined to be medically necessary will be covered under the medical plan. Following are some examples of medical necessity:
 - (i) The patient is a child (up to 6 years old) with a dental condition that requires repairs of significant complexity (e.g., multiple restorations, pulpal therapy, extractions);
 - (ii) Patients with certain physical, intellectual or medically compromising conditions (e.g., mental retardation, cerebral palsy, epilepsy, cardiac problems, hyperactivity verified by appropriate medical documentation);
 - (iii) Extremely uncooperative, fearful, unmanageable, anxious or uncommunicative patients with substantial dental needs and no expectation that behavior will improve soon;
 - (iv) Patients with dental restorative or surgical needs for whom local anesthesia is ineffective (such as due to acute infection, anatomic variations or allergy);
 - (v) Patients who have sustained extensive orofacial or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.
- (i) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Repair or replacement will be covered only when required due to growth or development of a dependent child, or deterioration from normal wear and tear if recommended by the attending physician.
- (j) **Electrocardiograms and Electroencephalograms.** Magnetic resonance imaging (MRI), basal metabolism tests, or similar well established diagnostic tests generally approved by physicians throughout the United States.
- (k) **Family Planning services,** including voluntary sterilization and birth control. Benefits are based on level of care. Refer to the schedule of benefits.
- (l) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.
- (m) **Home Oxygen.** Includes rental, but not to exceed purchase price (or if less costly to buy, initial purchase) of medically necessary Home Oxygen and equipment for its administration and related consumable and/or disposable supplies, as shown in the Schedule of Benefits. Benefits are not to be provided for Home Oxygen or related equipment that is customized or more elaborate than the cost of the least expensive adequate equipment.

Purchase of Home Oxygen equipment and related supplies will be applicable only to those patients who have a written prescription from their medical provider and have a qualifying medical diagnosis that requires the continuous use of oxygen for longer than 6 months. The request for purchase must be reviewed for medical necessity and precertified by the Utilization Review Department.

Charges for repair or maintenance are covered, if the cost to repair or maintain an item is more cost efficient to the patient and the Plan. Cost for a maintenance agreement cannot exceed the Plan Year Maximum shown in the Schedule of Benefits and should include related supplies and services, such as, but not limited to, tubing and filters as needed, plus delivery, education, equipment set up, applicable repairs, and home visits by qualified personnel to check the equipment per maintenance standards established by the manufacturer for that particular item.

Replacement of equipment due to normal use is covered.

Charges for Oxygen cylinders and contents will continue to be billed separately from the equipment and supplies.

(n) Injectables (Outpatient). Outpatient Injectables that are FDA approved and are prescribed by a licensed medical provider for a medically necessary treatment of an illness or injury can be obtained through a discounted Injectables and Specialty Pharmacy Program. To qualify for this program you must first call your Utilization Management Company for precertification and determination of benefits.

(o) Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome (TMJ).

Charges for TMJ are subject to the limits as described in the Schedule of Benefits.

(p) Laboratory studies. Covered Charges for diagnostic and preventive lab testing and services.

(q) Lap band surgery is covered and subject to the following pre-certification provisions:

(i) Five years of documented non-surgical weight loss attempts.

(ii) A psychological evaluation by a licensed psychologist.

(iii) A nutritional evaluation by a licensed dietician or registered nurse.

(iv) Documentation of two or more of the following co-morbid diagnosis with clinical data such as lab work, diagnostic testing, and physician assessment.

(a) Hypertension

(b) Hyperlipidemia

(c) Diabetes

(d) Coronary Artery Disease

(e) Sleep Apnea

(f) Body Mass Index (BMI) of 34 or greater with co-morbidities and/or BMI of 40 or greater with no co-morbidities

(v) Current Body Mass Index calculation supporting diagnosis of Morbidly Obese.

(vi) A list of current medications, the diagnosis or reason the medication has been prescribed, and how long the patient has taken the medication.

(vii) A medical evaluation by a Bariatric Surgeon or General Surgeon who will be performing the Gastric Bypass Surgery.

(viii) Evidence that the patient is at least 18 years of age.

- (ix) A Pre-op examination and medical clearance by an Internist or Cardiologist.
 - (x) Evidence that the patient has no endocrinology disorder that would interfere with weight loss.
 - (xi) Evidence that the patient has no chemical/alcohol abuse problems.
- (r) Treatment of **Mental Disorders and Substance Abuse** are payable as shown in the Schedule of Benefits.
- (s) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - Emergency repair due to Injury to sound natural teeth.
 - Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
 - Excision of benign bony growths of the jaw and hard palate.
 - External incision and drainage of cellulitis.
 - Incision of sensory sinuses, salivary glands or ducts.
 - Removal of impacted teeth.
 - Reduction of dislocations and excision of temporomandibular joints (TMJs).
- No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.
- (t) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
- (u) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:
- The transplant must be performed to replace an organ or tissue.
 - Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
 - evaluating the organ or tissue;
 - removing the organ or tissue from the donor; and
 - transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.
- Benefit payments for donor charges are subject to the separate donor maximum benefit limit as show in the Schedule of Benefits.

- (v) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (w) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.
- (x) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. MIRE therapy is also included.
- (y) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

- (z) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.
- (aa) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

- (bb) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.
- (cc) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. and including related X-rays performed and billed by the chiropractor. Massage Therapy by a licensed massage therapist and acupuncture are also covered up to the combined maximum specified in the Schedule of Benefits.
- (dd) **Sterilization** procedures.
- (ee) **Surgical dressings,** splints, casts and other devices used in the reduction of fractures and dislocations.
- (ff) **Tobacco cessation counseling/programs.** Care and treatment for tobacco cessation programs, including telephone and online counseling.

Smoking cessation products, including over-the-counter products, are covered in the Prescription Drug Program.
- (gg) **Weight loss program.** Charges for weight loss membership fees are limited to Weight Watchers Program.

This benefit does not include meals or other miscellaneous items.

(hh) Coverage of Well Newborn Nursery/Physician Care.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

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

Charges for Routine Physician Care. The benefit is limited to the charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

If the baby is ill, suffers an injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided coverage is in effect.

(ii) Charges associated with the purchase of wigs or artificial hair pieces for hair loss due to injury, disease or treatment for a disease, to the maximum stated in the schedule of benefits.

Charges for wig after chemotherapy are subject to the limits as described in the Schedule of Benefits.

(jj) Diagnostic x-rays.

HEALTHY TRADITIONS: WELLNESS SERVICES

The Wellness Program, sponsored by Nasomah Health Group, is a comprehensive approach to improving the health and well-being of Nasomah health plan members and their families. It includes: group and one-on-one educational sessions, team-based fitness and weight management challenges, wellness screenings, health newsletters and health fairs.

The mission of the Wellness Program is to improve the health and well-being of tribal members and its extended family, which includes participants and families of the business enterprises.

You will find tips to save your health care dollars throughout this Plan Document

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

HealthComp Administrators
800-755-7247

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least five days in advance of services being rendered or within 48 hours after an emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
 - Inpatient Hospitalizations
 - Diagnostic Imaging over \$1,250 including, but not limited to, MRI/CAT scans
 - Diagnostic Procedures over \$1,250 including, but not limited to, Thallium treadmills, EGD, Sleep Studies, Colonoscopy and Mammography (other than routine screenings)
 - Inpatient Substance Abuse/Mental Disorder treatments
 - Skilled Nursing Facility stays
 - Home Health Care or Home Infusion Therapy
 - Hospice Care
 - Durable Medical Equipment over \$1,250 including, but not limited to, respiratory products, orthotics/prosthetics, diabetic supplies and insulin pumps
 - Injectables and Specialty Pharmacy Program
 - Physical, speech and occupational therapy
 - Cardiac rehabilitation therapy
 - Outpatient surgical procedures over \$1,250 performed in a facility
 - Residential Day Treatment Programs
 - Referrals to Out-of-Network Providers
- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be medically necessary. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care. Precertification does not confirm or verify eligibility for coverage, nor is it a guarantee of payment. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator **at least five days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Participant
- The name, participant identification number and address of the covered Participant
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will precertify the number of days of Medical Care Facility confinement or use of other listed medical services as determined by medical necessity. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive precertification as explained in this section, the benefit payment may be reduced by \$500.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

NASOMAH REFERRALS

CITCHC Providers - order diagnostic tests or Physical Therapy
no referral needed

no precertification needed

CITCHC Providers - refer to an outside provider
referral needed

no precertification needed

Outside Provider - orders diagnostic tests or Physical Therapy
no additional referral,
original referral covers diagnostics & Physical
Therapy

no precertification needed

Outside Provider - sends client to another provider or orders surgery
new referral needed

precertification needed

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as shown in the Schedule of Benefits.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

- (1) performed on an outpatient basis within seven days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable as shown in the Schedule of Benefits even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

HEALTH TIP # 5



Talk to your health care provider about all tests being recommended so that you can approve before it is ordered. Ask why you need the test. Ask how reliable the test is, what the chance of false result is, and how the risk can be minimized. Find out what alternatives you have if you refuse the test. Ask how much the test will cost. Make sure you get all of the referrals, and precertifications done in advance of any procedure costing more than \$1,250; or, you will be faced with penalty charges.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

“MOMMIES 2-B” PROGRAM

The primary objective of the “Mommies 2-B” Program is to provide a strong foundation of support for you and your baby. Through complimentary educational materials provided, you and your family can gain an understanding of pregnancy, thus increasing participation in all aspects of your care. The program is also a screening tool to identify the possibility of a high or moderate risk pregnancy and coordinate effective medical care.

It is highly recommended that the expectant mother call Utilization Management's toll-free number: 1-800-442-7247, extension 2392 and ask for the “Mommies 2-B” Nurse during the first trimester of pregnancy or upon confirmation of pregnancy. The “Mommies 2-B” Registered Nurse (RN) may also generate calls to the expectant

mother. During the call, the RN will ask her questions about her general health and medical history in order to determine any risk factors for the pregnancy.

If the pregnancy is classified as low risk, the expectant mother will have satisfied the "Mommies 2-B" Program initial screening requirements, and may only wish to call again when nearing the due date to inquire about any anticipated delivery needs. If the pregnancy is classified as moderate to high risk, HealthComp's Utilization Management will follow the case, recommending specialists and/or facilities when applicable, and coordinate communication among Physicians, the patient, and others.

SPECIALTY PHARMACY

Self-Injectable & Specialty Pharmacy Programs are available for members who are receiving outpatient medical treatment by means of self-injectables or specialty pharmacy (high cost medications). Some of the conditions being treated by these types of medications are Multiple Sclerosis, Rheumatoid Arthritis, Cancer, Hepatitis-C, RSV, and Psoriasis. HealthComp utilizes BioScrip as its preferred vendor because they provide **excellent customer service** to you and your medical providers. Enrollment into this voluntary program is beneficial because you will receive your medications and supplies delivered to your home at a substantial savings. BioScrip will bill the member their applicable copayment as determined by the Plan parameters. **Precertification is mandatory** in order to receive this benefit. Contact 1-800-755-7247 to learn more about this excellent program and for assistance with enrollment.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Participant is a Participant who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowable charge is a charge which is either the network Provider's reduced fee or the Recognized Charge for a service or supply.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is a Participant or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employer is ORCA Communications, Coquille Economic Development Corporation (CEDCO), The Mill Casino Hotel, The Mill Casino RV Park, Native American Cranberries, Coquille Indian Tribal Administration Office, Community Center, Community Health Center, Gaming Commission, and Nasomah Administration.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (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; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Participant and the family members who are covered as Dependents under the Plan.

Five County Service Area includes the counties of Coos, Curry, Douglas, Lane, and Jackson.

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Participant has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Participant's; the child depends on the covered Participant for primary support; the child lives in the home of the covered Participant; and the covered Participant may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Participant's home; one placed in the covered Participant's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and substance abuse and licensed as such by the state in which the facility operates.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Occupational Disease or Injury: a disease, injury or condition which is either peculiar to an occupation, arises out of the individual's employment, or arises out of the individual's self-employment.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Participant is a person who is directly employed and compensated for services by the Coquille Indian Tribe, or any participating employer as listed under General Plan Information, and all enrolled Coquille Indian Tribal Members who reside outside the five county service areas who meet the eligibility requirements and are properly enrolled in the plan.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

HEALTH TIP # 6

- **Ask for itemized bills.** Sometimes errors are made at the hospital, doctors office, pharmacy, or at the Third Party Administrator (HealthComp). Review your bill and the explanation notice that you should receive from HealthComp for each of your bills for errors or miscalculations. Question your doctor or the Third Party Administrator if you disagree with a service or charge. If you can not resolve the difference to your satisfaction, call the Nasomah Program Manager.

Plan means Nasomah Health Group, which is a benefits plan for Participants of the Coquille Indian Tribe or any of its subsidiaries and Tribal Members of the Coquille Indian Tribe who reside outside of the Five County Service Area.

Plan Participant is any Participant or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prosthetic Devices are appliances that replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The design, construction and attachment of artificial limbs or other systems are to assume the function of a missing body part.

Recognized Charge is the lower of:

- (1) The provider's usual charge to provide a service or supply, or
- (2) The charge the Claims Administrator determines to be the recognized charge percentage for the service or supply, or

- (3) The charge the Claims Administrator determines to be appropriate, based on factors such as:
 - (a) The cost of supplying the same or similar service or supply, and
 - (b) The manner in which the charges for the service or supply are made.

The Claims Administrator also may take into consideration:

- (1) The complexity of the service or supply,
- (2) The degree of skill needed to provide the service,
- (3) The provider's specialty, and
- (4) The recognized charge in other areas.

Residential Treatment Facility is a psychiatric facility that can be part of or affiliated with a contracting hospital. It must be licensed according to state and local laws to provide care, treatment of mental and nervous disorders, or substance abuse; under the supervision of physicians and follow a comprehensive medical treatment regimen for rehabilitation.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (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 or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Tribal Member is an enrolled member of the Coquille Indian Tribe.

PLAN EXCLUSIONS

Note: Exclusions related to Prescription Drugs are shown in the Prescription Drug Plan. Contact your Prescription Drug vendor for additional information.

Note: All exclusions related to Vision are shown in the Vision Plan.

Note: All exclusions related to Dental are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The responding officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (2) **Amniocentesis** charges, except when done in the last trimester for the purpose of determining fetal lung maturity or in the **first 20 weeks** for genetic testing for the purpose of determining the need for fetal therapy or to determine a medically necessary intervention for the mother.
- (3) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (4) **Counseling.** Legal and financial Counseling services. Charges for counseling, education or training services, except for the support services if stated in the Substance Abuse Treatment Benefit and the Mental and Nervous Conditions benefits plan. This includes vocational assistance and outreach and family, marital, social, sexual, lifestyle, nutritional and fitness counseling.
- (5) **Court-Ordered Confinement** any confinement for a Covered Person in a public or private institution as the result of a court order.
- (6) **Court Mandated.** Treatment and services ordered or mandated by a court for psychiatric or substance abuse treatment.
- (7) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (8) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (9) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Recognized Charge.
- (10) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (11) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (12) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. However, refer to the Schedule of Benefits for Vision Benefits and coverage under the Vision Plan. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (13) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

- (14) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.
- (15) **Genetic (DNA) Testing.**
- (16) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (17) **Habilitative,** education or training services or supplies for dyslexia, for attention deficit disorders (except as provided under the Mental Health Care Benefit) and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations therefore. However, this exclusion does not apply to treatment of neurodevelopment disabilities in children under age seven.
- (18) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.

HEALTH TIP # 7

▶ **Ask for a predetermination.** If you want to know ahead of time what the Third Party Administrator will cover and how much they will pay for a particular service then ask your doctor (or dentist) to send a predetermination request to the Third Party Administrator. A predetermination is nothing more than a pretend bill that the dentist or doctor sends to the Third Party Administrator. The Third Party Administrator in turn processes that bill as if it were a real bill. The charges do not actually apply (as they would with a real bill) but the assessment of that bill by the Third Party Administrator is an accurate accounting of how they would process that bill if it were sent in – as a real bill. In this way you will know how much you will be responsible for paying, before you incur the service.

- (19) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (20) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Covered Person's commission of or attempt to commit a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (21) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (22) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.
- (23) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.
- (24) **Injectables.** A charge for hypodermic syringes and /or needles, injectables or any prescription directing administration by injection (other than insulin or the Injectables and Specialty Pharmacy Program).

- (25) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.
- (26) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (27) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
- (28) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (29) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (30) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (31) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (32) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment or claims for injuries or illness incurred while engaging in compensated activities of an inherently hazardous nature are not covered under this Plan. This exclusion may apply even if the expenses for the illness or injury are not paid by Worker's Compensation or similar employer's liability insurance.
- (33) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (34) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (35) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (36) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (37) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (38) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (39) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (40) **Surrogacy.** All charges associated with surrogacy, a method of reproduction whereby a woman agrees to become pregnant and deliver a child for a contracted party.
- (41) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
- (42) **War.** Any loss that is due to a declared or undeclared act of war.

PREScription DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

This Plan participates in a special retail pharmacy program which allows the Covered participant to purchase maintenance medications at participating pharmacies. Your doctor must authorize a 90-day supply of medication. Some medication may not be available in 90-day supplies under applicable law.

If a drug is purchased from a non-participating pharmacy or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

Prescription Drugs filled under this Plan will apply towards the Lifetime Maximum Benefit per covered Person under the Medical Benefits of this Plan.

Please contact the Nasomah Program Manager for additional information regarding covered prescriptions and exclusions under the Prescription Drug program.

HEALTH TIP # 8



Become a knowledgeable health care consumer. Reading about your condition will enable you to make more informed decisions about your treatment. Go into your doctor's visit with specific questions to ask him or her. Make informed decisions. Remember, it's your health and you should be in control of it.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (3) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (4) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, when used as an anti-wrinkle medication, pigmenting/de-pigmenting medications or medications for hair growth or removal.
- (5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (6) **FDA.** Any drug not approved by the Food and Drug Administration, including a charge for FDA-approved drugs that are prescribed for non-FDA approved uses.
- (7) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.
- (8) **Immunization.** Immunization agents or biological sera.
- (9) **Infertility.** A charge for infertility medication.
- (10) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
- (11) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (15) **Non-legend drugs.** Any drug for which no prescription is required by federal or state law.
- (16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision care charges are charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits.

LIMITS

No benefits will be payable for the following:

- (1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
- (2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.
- (3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.
- (4) **No prescription.** Charges for non-corrective lenses and/or sunglasses with or without a prescription.
- (5) **Not listed.** Services or products not specifically listed as covered benefits.
- (6) **Orthoptics.** Charges for orthoptics (eye muscle exercises).
- (7) **Sunglasses.** Charges for safety goggles or non-corrective sunglasses and or lenses.
- (8) **Training.** Charges for vision training or subnormal vision aids.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Plan Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Allowable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services: Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two per Covered Person each Plan Year.
- (2) One bitewing x-ray series every two Plan Years.
- (3) One full mouth x-ray every two Plan Years.
- (4) Fluoride treatment for covered Dependent children under age 19 each Plan Year. Limited to two treatments each Plan Year.
- (5) Space maintainers, but not their replacement, for covered Dependent children under age 19 to replace primary teeth.
- (6) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children to age 19, once per tooth in any 36 consecutive months.

**Class B Services:
Basic Dental Procedures**

- (1) Dental x-rays not included in Class A.
- (2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
- (3) Periodontics (gum treatments).
- (4) Endodontics (root canals).
- (5) Extractions. This service includes local anesthesia and routine post-operative care.
- (6) Stainless Steel Crowns (Temporary Crowns).
- (7) Fillings, other than gold.
- (8) General anesthetics, upon demonstration of Medical Necessity.
- (9) Apicoectomy (surgical removal of the tip of the root of a tooth).
- (10) Emergency palliative treatment for pain.

**Class C Services:
Major Dental Procedures**

A twelve (12) month waiting period will be applied for Major Services (Class C) for newly eligible plan participants that do not have immediate prior coverage. The 12 month waiting period begins on the date the participant is eligible for benefits. Proof of 12 months of continuous prior coverage will be required to waive the waiting period.

- (1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- (2) Installation of crowns, including crowns for the purpose of periodontal splinting.
- (3) Installing precision attachments for removable dentures.
- (4) Installing partial, full or removable dentures to replace one or more natural teeth that were extracted. This service also includes all adjustments made during six months following the installation.
- (5) Addition of clasp or rest to existing partial removable dentures.
- (6) Bruxism splints/night-guards & periodontal splints.
- (7) Initial installation of fixed bridgework to replace one or more natural teeth.
- (8) Repair of crowns, bridgework and removable dentures.
- (9) Rebasing or relining of removable dentures.
- (10) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
 - (a) The replacement or addition of teeth is required because of one or more natural teeth being extracted.

- (b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
 - (c) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.
- (11) Appliances for restoration necessary to increase vertical dimensions or restore occlusion.
 - (12) Orthodontic appliances, services and/or treatment.
 - (13) Appliances for the correction of harmful habits, such as thumb sucking.
 - (14) Temporomandibular Joint Dysfunction Syndrome (TMJ). Treatment, by any means, (including specialized appliances) of jaw joint problems including temporomandibular joint dysfunction syndrome (TMJ) and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint..
 - (15) Charges for root canal therapy for which the pulp chamber was opened before the effective date of coverage under this Plan.
 - (16) Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be \$500 or more, a predetermination of benefits form must be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Participant fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

HealthComp Administrators
P. O. Box 45018
Fresno, California 93718-5018
(800) 442-7247

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Allowable Charge for an amalgam filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Broken appointments.** Charges for broken or missed dental appointments.
- (3) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
- (4) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (5) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
- (6) **No listing.** Services which are not included in the list of covered dental services.
- (7) **Personalization.** Personalization of dentures.
- (8) **Replacement.** Replacement of lost or stolen appliances.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

- (1) Obtain a Claim form from the Plan Administrator.
- (2) Complete the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Participant's name
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (4) Send the above to the Claims Administrator at this address:

HealthComp Administrators
P. O. Box 45018
Fresno, California 93718-5018
(800) 442-7247

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits or pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days

Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	60 days

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was

relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

- (7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, 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 free of charge, upon request.

Appeals

In cases where a claim for benefits payment is denied in whole or in part, and the mandatory appeal process has been exhausted, the Plan Participant may appeal the denial to Nasomah Health Group Plan Administrator. To appeal further, a Plan Participant or the Participant's duly authorized representative must:

- (1) Request from the Plan Administrator a review of any claim for benefits. Such request must be in writing and must include: the name of the Participant, the name of the patient and the Group Name; and
- (2) File the written request for review, stating in clear and concise terms the reason or reasons for this disagreement with the decision to deny benefits payment and any other relevant comments.

The request for review must be directed to the Plan Administrator within 60 days after the Participant receives the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall include specific reasons for the decision and shall cite the specific Plan provision(s) upon which the response is based.

A Plan Participant must exhaust the claims appeal procedure before pursuing any other legal remedies for the denial of claims.

If the Plan Administrator upholds a denial of benefits, that decision must be appealed as follows:

Any person affected by a decision of the Plan Administrator may appeal that decision to the Nasomah Health Group Board within 60 days of such decision. If the request is filed less than 31 days before the next regularly scheduled meeting of the Nasomah Health Group Board, the Board shall make a decision no later than the second regular meeting after receipt of the request for review. Otherwise the Board shall make a decision regarding the review at the next scheduled regular meeting of the Nasomah Health Group Board. In the case of special circumstances, the Nasomah Health Group Board may extend the time periods described in this paragraph. In any case, the Board shall render any decision no later than the third regularly scheduled meeting after receipt of the request for review.

If the Nasomah Health Group Board does not respond to any request for review of a Plan Administrator's decision, that person may deem the request denied.

In addition, it is the Plan Administrator's intent to comply with federal law regarding internal and external appeals procedures under the Patient Protection and Affordable Care Act. The Plan Administrator will comply with those internal and external appeals procedures, as defined by the appropriate federal regulatory agencies, to the extent such procedures are mandatory and in effect. The Plan Administrator will issue amendments to this Plan when such procedures are finalized by the respective federal regulatory-agencies.

COORDINATION OF BENEFITS

Coordination of the benefit plans. 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 Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

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

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Negotiated or Recognized Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan shall always be considered the secondary carrier regardless of the individual's election to file a claim under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as a participant, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as a Participant who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Participant. The benefits of a benefit plan which covers a person as a Dependent of a Participant who is neither laid off nor retired are determined before those of

a benefit plan which covers a person as a Dependent of a laid off or Retired Participant. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- (c) The benefits of a benefit plan which covers a person as a Participant who is neither laid off nor retired or a Dependent of a Participant who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
- (e) When a child's parents are divorced or legally separated, these rules will apply:

 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Participant is Medicare entitled this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A, B and D, regardless of whether or not the person was enrolled under any of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party. In such circumstances, the Covered Person may have a claim for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or any other insurer or source, including but not limited to, "first party" underinsured or uninsured motorist coverage, worker's compensation, crime victim restitution funds, medical or disability payments, homeowner's plan, renter's plan, medical malpractice plan, or any other liability plan or any other source of coverage.

This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan Administrator retains sole, full and final discretionary authority to construe, apply, 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 also retains the right to delegate this discretionary authority to the Claims Administrator without notice.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and Refund. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party or insurer to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses, even if the Covered Person's Recovery is less than the amount claimed, and, as a result, the Covered Person is not made whole. The Covered Person further specifically agrees and acknowledges that the "made whole doctrine" and "common fund" doctrine are completely abrogated under this Plan, and will not affect the Plan's right to 100% Subrogation or Refund for any and all benefits paid. 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 interfere with or compromise in any way the Plan's equitable subrogation lien. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party or insurer. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims and/or the Covered Person's claims under any other policy of insurance or other coverage.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the

right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Failure by the Covered Person(s) and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Participants and their families covered under Nasomah Health Group (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Nasomah Health Group, P. O. Box 921, North Bend, Oregon, 97459, 541-751-0940. COBRA continuation coverage for the Plan is administered by HealthComp Administrators, P. O. Box 45018, Fresno, California 93718-5018, (800) 442-7247. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active participants who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Participant, the Spouse of a covered Participant, or a Dependent child of a covered Participant. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Participant during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Participant" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law participants (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Participant is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Participant during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Participant.
- (2) The termination (other than by reason of the Participant's gross misconduct), or reduction of hours, of a covered Participant's employment.
- (3) The divorce or legal separation of a covered Participant from the Participant's Spouse. If the Participant reduces or eliminates the Participant's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Participant's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Participant, or the covered Spouse or a Dependent child of the covered Participant, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Participant, or the Spouse, or a Dependent child of the covered Participant, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a Participant does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Participant and family members will be entitled to COBRA continuation coverage even if they failed to pay the participant portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered participant who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the participant and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired participants who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Participant or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the participant,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) enrollment of the participant in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Mail to:
HealthComp Administrators
P.O. Box 45018
Fresno, CA 93718

Fax to:
559-499-2464

Hand-deliver to:
HealthComp Administrators
621 Santa Fe
Fresno CA 93721

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the participant** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later 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 made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any participant.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) 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
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Participant's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Participant ends on the later of:
 - (a) 36 months after the date the covered Participant becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Participant's termination of employment or reduction of hours of employment.

- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Participant during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Participant) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Participant's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered participants or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum

coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Nasomah Health Group is the benefit plan of Nasomah Health Group, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Nasomah Health Group to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Nasomah Health Group shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
- (10) Any duties delegated to the Plan Administrator by the NASOMAH HEALTH GROUP.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Participants and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

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.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these participants from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these participants are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Participants.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all participants and other persons under the control of the Employer.
 - (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

- (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
- (c) **Resolution of Issues of Noncompliance.** In the event that any member 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 official. The privacy official shall take appropriate action, including:
 - (i) 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;
 - (ii) 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;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
 - (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or participant benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
 - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
 - (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
 - (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
 - (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of 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 information unfeasible; and

- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Nasomah Health Group's workforce are designated as authorized to receive Protected Health Information from Nasomah Health Group ("the Plan") in order to perform their duties with respect to the Plan: Privacy Officer and other individuals trained and authorized by the Privacy Officer to receive Protected Health Information.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Participants and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Participant and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Participants.

The level of any Participant contributions will be set by the Plan Administrator. These Participant contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Participant or withheld from the Participant's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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 copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Participants or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if a Participant or dependent has Creditable Coverage from another plan. The Participant or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan

Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Participants. The Plan is not insured.

PLAN NAME

Nasomah Health Group
TAX ID NUMBER: 93-1250047

PLAN EFFECTIVE DATE: May 1, 1998

PLAN YEAR ENDS: April 30

PLAN SPONSOR: Coquille Indian Tribe
TAX ID NUMBER: 93-1073003

EMPLOYER INFORMATION

The Mill Casino & Hotel
3201 Tremont Street
North Bend, OR 97459

The Mill Casino RV Park
3201 Tremont Street
North Bend, OR 97459

Coquille Indian Tribe
3050 Tremont Street
North Bend, OR 97459

Coquille Economic Development Corporation
3201 Tremont Street
North Bend, OR 97459

Native American Cranberries
3201 Tremont Street
North Bend, OR 97459

ORCA
3201 Tremont Street
North Bend, OR 97459

Nasomah Health Group
P.O. Box 921
North Bend, OR 97459

PLAN ADMINISTRATOR

Nasomah Health Group
P. O. Box 921
North Bend, Oregon 97459
541-751-0940

NAMED FIDUCIARY

Nasomah Health Group
P. O. Box 921
North Bend, Oregon 97459

AGENT FOR SERVICE OF LEGAL PROCESS

Coquille Indian Tribe
3050 Tremont Street
North Bend, OR 97459

CLAIMS ADMINISTRATOR

HealthComp Administrators
P. O. Box 45018
Fresno, California 93718-5018
(800) 442-7247

BY THIS AGREEMENT, Nasomah Health Group is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Nasomah Health Group on or as of the day and year first below written.

Booklet effective date: May 1, 2011.

By _____
Nasomah Health Group – EPO Plan

Date _____

Witness _____

Date _____

ACCEPTANCE OF RESPONSIBILITY & CONFIRMATION OF ACCURACY

Pursuant to the terms of your agreement with HealthComp Administrators, Inc. ("HealthComp") we have assisted in the preparation of the enclosed **Nasomah Health Group EPO Plan Document**. Our assistance has been based upon our understanding of what you, the Plan Sponsor, wish to have incorporated into this document. While we have undertaken to prepare this document to the best of our abilities, responsibility for the accuracy of this document remains that of the Plan Sponsor.

It is imperative that you immediately review this document in detail. You may wish to have legal counsel review this document to ensure that it reflects your plan's objectives in terms of the types and amounts of coverage afforded, exclusions, rights, and other substantive material provisions, and that it meets with all applicable regulatory requirements.

By signing below, you acknowledge your acceptance of responsibility for the contents and accuracy of this document. Please sign and return this form. If you have any questions regarding this document, please immediately contact our office.

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the **Nasomah Health Group EPO Plan Document** effective May 1, 2011 and that while HealthComp, its employees, agents, and/or sub-contractors may have assisted in the preparation of this 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.

Dated: _____

By: _____

Authorized Representative of
Nasomah Health Group

Print Name: _____

Title: _____