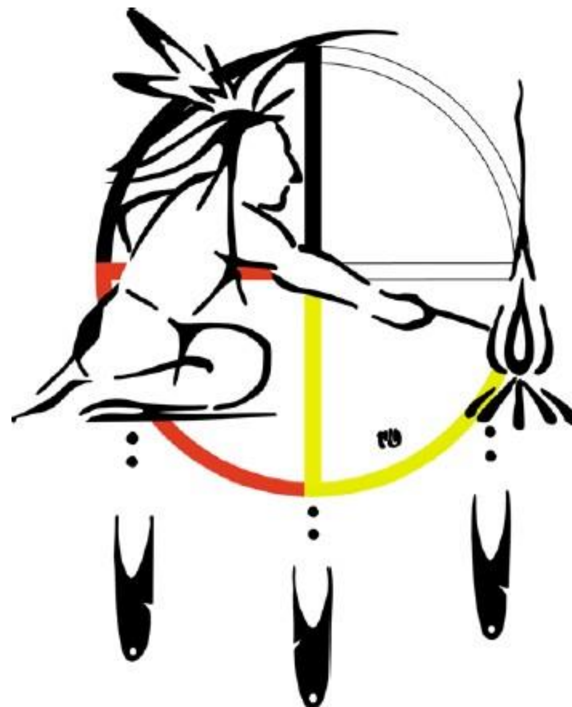
Forest County Potawatomi Community

NON-TRIBAL SPOUSE AND DEPENDENT(S)



Potawatomi
"Keeper of the Fire"

Health, Dental and Vision Plan

Revised and adopted January 1, 2014

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FOREST COUNTY POTAWATOMI
GROUP HEALTH, DENTAL AND VISION PLAN
NON-TRIBAL SPOUSE AND DEPENDENT(S)

INTRODUCTION

Forest County Potawatomi, the Plan Administrator, has made the Non-Tribal Spouse and Dependent Plan available to the Tribal Member's Non-Tribal Family. The Plan Administrator has assumed full administrative service to process claims for this self-funded Plan.

The Plan Administrator assumes the sole responsibility for funding the Plan's benefits out of general assets. State law governing guarantee funds may not cover benefits payable under This Plan if the Plan Administrator is unable to pay benefits.

This booklet is a Summary Plan Description (SPD) and is a summary of benefits under This Plan. The SPD, together with any amendments, constitute the Plan Document for the Plan. You are entitled to this coverage if the provisions in the Plan Document have been satisfied. This SPD is void if you have ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force.

The requirements for being covered under This Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including any limitations and exclusions), and the procedures to be followed in presenting claims for benefits and remedies available for redress of claims denied are outlined in the following pages of this booklet.

The Plan Administrator fully intends to maintain This Plan indefinitely. However, the Plan Administrator reserves the right, through a procedure described in the General Provisions section under the heading Plan Modification/Amendments/Termination, to terminate, suspend, discontinue, or amend This Plan. No person or entity has any authority to make any oral change or amendments to This Plan. No person will become entitled to any vested rights under This Plan.

The named Fiduciary is Forest County Potawatomi Community, who will have the authority to control and manage the operation and administration of This Plan. The Fiduciary **Forest County Potawatomi Community** may delegate responsibilities for the operation and administration of This Plan and will have the authority to amend This Plan, to determine its policies, to appoint and remove other supervisors, fix their compensation (if any), and exercise general administrative authority over them. The Fiduciary Forest County Potawatomi Community has the sole authority and responsibility to review and make final decisions on all claims to benefit hereunder.

Health Care Fraud

What is health care fraud?

Health care fraud is when a provider, employer, or Covered Person intentionally deceives or misrepresents health care for the sake of receiving an unauthorized benefit or financial gain. Each year health care fraud costs Americans billions of dollars. Individuals can be convicted of a crime and/or face imprisonment and substantial fines for committing health care fraud.

Most Common Types of Fraud:

Provider Fraud:

- Billing for services, procedures and/or supplies that were not provided
- Billing that is a deliberate application for duplicate payments of services
- Billing for non-covered services as covered items
- Performing medically unnecessary services to obtain insurance reimbursement

- Incorrect reporting of diagnoses or procedures to maximize insurance reimbursement
- Misrepresentations of dates, descriptions of services or subscribers/providers
- Providing false employer group and/or group membership information

Covered Person Fraud:

- Using someone else's coverage or insurance card
- Filing claims for services or medications not received
- Forging or altering bills or receipts

How to report health care fraud:

Call or text us at: 1-715-478-7448
Write to us at:
Forest County Potawatomi Insurance Department
5409 Everybody's Road
Crandon, WI 54520
Or email us at FCPInsurance@fcp-nsn.gov

How can Covered Persons avoid and prevent health care fraud?

- Ask your health care provider questions about your treatment plan, diagnosis and services received.
- Fill out, sign and date one claim form at a time.
- Question advertisements or promotions that offer free tests, treatments, or services.
- Safeguard your health plan ID card and be careful about disclosing your health plan information.
- Be sure your Explanation of Benefits (EOB) and medical bills are consistent with services received.

PREFERRED PROVIDER INFORMATION

A Preferred Provider Organization (PPO) is a group of Physicians and Hospitals that have agreed to discount their prices for service, while at the same time offering the same quality of service that any other patient would receive. This organization is referred to in This Plan as the **Network**.

If a Covered Person chooses to go to a provider who is part of the Preferred Provider Organization, charges billed by the PPO Provider are paid as shown in the Schedule of Medical Benefits under the heading Network Providers.

To determine whether your provider is a Network Provider, you can call the number or visit the website link listed on the back of your ID card. You should verify with the provider before each service that the provider is still a Network Provider. Please note that a provider may be considered a Network Provider at one location, but a Non-Network Provider at another.

THE NETWORK LEVEL OF BENEFITS IS ALSO PROVIDED FOR:

- SERVICES OBTAINED THROUGH NETWORK FACILITIES (I.E., SERVICES AT A PARTICIPATING PROVIDER MAY INCLUDE BILLED CHARGES BY A NON-NETWORK PROVIDER, SUCH AS AN X-RAY TECHNICIAN OR AN EMERGENCY PHYSICIAN WHO IS NOT A PARTICIPATING PROVIDER.) SUCH SERVICES FROM THE NON-NETWORK PROVIDER WILL BE PAYABLE AT THE NETWORK LEVEL, IF THE HOSPITAL OR CLINIC IS A NETWORK PROVIDER;

- EMERGENCY MEDICAL CARE RECEIVED AT A NON-NETWORK PROVIDER; OR

- SERVICES PROVIDED BY A NON-NETWORK PROVIDER WHEN A REFERRAL IS MADE FOR SUCH TREATMENT BY A NETWORK PROVIDER. THE TREATMENT PROVIDED BY THE NON-NETWORK PROVIDER MUST NOT BE AVAILABLE IN THE NETWORK.

For the purposes of This Plan, NON-NETWORK PROVIDER means a provider of service not under contract with the Preferred Provider Organization (PPO) contracting with the Company.

FOREST COUNTY POTAWATOMI HEALTH AND WELLNESS CENTER

All covered medical services under This Plan and provided by the Forest County Potawatomi Health and Wellness Center for a covered person will be paid at 100%. The Schedule of Medical Benefits and plan limitations will apply.

PLAN PAYMENT PROVISIONS

This Plan is designed to cover a wide range of services called Covered Medical Expenses. These services and supplies are covered to the extent that they:

1. Are Medically Necessary to treat Illness or Injury (unless specifically stated otherwise);
2. Are Prescribed by or given by a Physician;
3. Do not exceed the Usual and Customary charge for the service or supply; and
4. Are not specifically excluded in the General Limitations section of This Plan; and
5. Are approved by the Plan Administrator.

Claim payments are made directly to the provider of service. Payment may be made directly to the Member if a receipt showing that payment has been made is sent with the claim.

Payment for Covered Medical Expenses is made as shown in the Schedule of Medical Benefits.

THE DEDUCTIBLE: This means the amount shown in the Schedule of Medical Benefits which is applied to each Covered Person in each Calendar Year for Covered Medical Expenses incurred by that person. After the Deductible is satisfied, benefits are paid as shown in the Schedule of Medical Benefits. A separate Deductible applies to each Covered Person.

FAMILY DEDUCTIBLE: This is the amount stated in the Schedule of Medical Benefits which is the most Deductible which may be applied to both you and the Covered members of your Family. When you and the Covered members of your Family meet the Family Deductible amount, This Plan considers all Deductibles met for the entire Family for the remainder of that Calendar Year.

COMMON ACCIDENT PROVISION: If two or more members of the same Family are injured in a common accident, only one Deductible amount shall be applied to all Covered Medical Expenses incurred because of the accident.

FOREIGN CARE: If you or another Covered Person are traveling outside the United States and you or that Covered Person need non-emergency care for an Illness or Injury, that care will be treated as non-Network care under the Plan. The applicable services will be subject to all Plan exclusions and limitations.

PRE-NOTIFICATION REQUIREMENTS

The Plan Requires Pre-Certification or Pre-Notification As Outlined Below:

HOSPITAL CONFINEMENT

The Review Organization listed on the I.D. card must be called before a Covered Person is admitted as a Hospital Inpatient. If a Covered Person is admitted because of an emergency, the call must be made within the time limits shown below.

- **If the Review Organization is not called, the service will be denied for lack of Pre-Certification.**
- **If the Review Organization is not called within the time limits shown below, a 20% penalty is taken from the Covered Medical Expenses for the confinement, unless it is a maternity confinement.**
- **Maternity admissions should be called in only if the anticipated stay is more than forty-eight hours (48 hours) for a vaginal birth, ninety-six hours (96 hours) for a Caesarean section. However, please call the Notification number as soon as possible when pregnancy is confirmed. The Plan Administrator will determine whether any case management should be done.**
- **No penalty will be assessed for failure to pre-notify of a maternity admission or for a confinement that occurs outside the United States and Canada.**

To avoid a penalty and obtain maximum benefits, the Review Organization must be called within the following time limits:

- Scheduled Admissions, including admissions for Mental and Nervous Disorders or Substance Abuse, must be notified at least forty-eight (48) hours prior to Hospital admission.
- Emergency or urgent inpatient admissions must be notified by the end of the second working day following the admission. A Hospital stay following an emergency or urgent admission undergoes continued stay review just like a scheduled admission.

<u>Please remember that pre-notification approval does not verify eligibility for benefits nor guarantee benefit payment. You must request a separate verification of benefits and eligibility from the Plan Administrator.</u>

COST CONTAINMENT SERVICES

CONTINUED STAY REVIEW

The organization that reviews In-Hospital confinements may decide that it is not Medically Necessary for the Covered Person to remain an Inpatient. If this happens, the Review Organization will notify the Participant or Covered Person, the attending Physician, and the Hospital of the determination. Benefits for the Hospital confinement will stop twenty-four (24) hours after the day the Review Organization determines the confinement is no longer Medically Necessary.

COMPLEX CASE MANAGEMENT

Because This Plan wants you to have access to the Complex Case Management services provided by the Review Organization, This Plan pays 100% of the Review Organization's charges for such services. If the Plan Administrator sees that this program could be useful to your case, you will be given the option of participating. No Covered Person is required to participate in this program. There is no penalty for failure to participate.

ALTERNATIVE CARE

In addition to the Covered Medical Expenses specified, the Plan Supervisor (on behalf of and in conjunction with the Plan Administrator) may determine and pre-authorize other services to be covered hereunder which normally are excluded services or have limited coverage under This Plan. The attending Physician must submit an Alternative Care plan to the Plan Supervisor which indicates the diagnosis and Medical Necessity of the proposed medical services to be provided to the Covered Person.

Based on this information, the Plan Supervisor and/or its Medical Consultant(s) will determine and approve the period of time for which such medical service(s) will be covered under This Plan. Further, the Plan Supervisor will make such a determination based on each circumstance and stipulate that its approval does not obligate This Plan to provide coverage for the same or similar services for other Covered Persons nor be construed as a waiver of its right to administer This Plan in accordance with its established provisions.

COVERED MEDICAL EXPENSES

Covered Medical Expenses are the services and supplies listed below. These are subject to the Definitions, General Limitations and other Plan Provisions. **Covered Medical Expenses are subject to the provisions and limitations shown in the Schedule of Medical Benefits.**

1. HOSPITAL EXPENSES

Hospital expenses are the charges made by a Hospital on its own behalf. Such charges include:

a) Semi-private room and board. If a Hospital has only private rooms, the Covered Medical Expense is the actual charge for the room.
b) Miscellaneous Hospital Services, other than room and board as furnished by the Hospital, including, but not limited to, general nursing services.
c) Intensive Care Unit (ICU) room and board and special nursing services.

2. PHYSICIANS CHARGES

Fees of legally qualified Physicians for treatment of Illness or Injury are Covered Medical Expenses. This includes, but is not limited to, office visits, clinic visits, bedside visits while the patient is Hospital confined, home visits, charges for surgery and charges for additional surgical opinions.

3. PREVENTIVE CARE

Charges for services required to be covered under applicable federal law, such as

- Services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force,
- Routine immunizations for children, adolescents and adults as recommended by the Centers for Disease Control and Prevention,
- Preventive care and screenings for infants, children and adolescents under guidelines supported by the Health Resources and Services Administration (HRSA), and
- Screenings for women that are developed by the Department of Health and Human Services.

Please note: When a claim is submitted, the Physician's office must code the claim to indicate Preventive Care, or This Plan will consider the claim as treatment of Illness or Injury. Preventive Care provided in a Hospital is not a Covered Medical Expense under This Plan.

4. ALLERGY TREATMENT

Charges for allergy injections, allergens, and allergy testing.

5. AMBULANCE SERVICE

Professional ground or air ambulance service to the nearest facility where emergency care or treatment is rendered, to the nearest facility equipped to furnish necessary medical treatment if not available at a local Hospital, or between a Hospital and the Covered Person's home, when such ambulance service is the only means of transporting the Covered Person due to the medical condition.

6. AMBULATORY SURGICAL CENTER

Charges made by an Ambulatory Surgical Center.

7. ANESTHETICS

Charges for the cost and administration of anesthetics by a licensed Anesthesiologist or a Certified Registered Nurse Anesthetist (C.R.N.A.).

8. BLOOD

Charges for the processing and administration of blood, blood components, blood substitutions and blood derivatives. This Plan does not cover charges for blood which the Covered Person donated for his or her own use or blood which was donated specifically for the Covered Person.

9. CARDIAC REHABILITATION PROGRAMS

Charges for cardiac rehabilitation programs to provide supervised monitored exercise sessions following heart surgery or a heart attack.

10. CHEMOTHERAPY/RADIATION THERAPY

Charges for chemotherapy or radiation therapy or treatment.

11. CHIROPRACTIC CARE

Visits, treatments, consultations, X-rays, laboratory tests and other diagnostic studies performed in connection with Spinal Manipulation in a Physician's office setting to the limits shown in the Schedule of Medical Benefits.

12. CLINICAL TRIALS

Coverage for a qualified individual as may be delineated under the Patient Protection and Affordable Care Act and subsequent implementing regulations for clinical trials with respect to treatment of cancer or another life-threatening disease or condition. For this purpose, a "qualified individual" is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition; and either (a) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate, or (b) the Covered Person provides medical and scientific information establishing that his/her participation in such trial would be appropriate.

13. CONTRACEPTIVES

Charges for implantation and removal of contraceptive devices (e.g., IUDs and diaphragms). Oral, implantable, and injectable contraceptives, as well as patches, are covered under the Prescription Drug Card program.

14. COSMETIC AND RECONSTRUCTIVE SURGERY AND SUPPLIES

Cosmetic services, supplies or surgery to repair a defect caused by a) an accidental Injury or Illness which causes a functional disability, b) a malignant disease process or its treatment, or c) a dependent child's congenital anomaly.

15. DENTAL SERVICES

Charges for the following oral surgery whether performed by a dentist or a medical doctor:

a) Surgical extraction of impacted teeth;
b) Excision of exostosis of the jaw and hard palate;
c) External incision and drainage of cellulites;
d) Incision of accessory sinuses, salivary glands, or ducts;
e) Apicoectomy - excision of apex of tooth root;
f) Surgical reduction of dislocations of, and excision of, the temporomandibular joints;
g) Alveoloplasty - the leveling of structures supporting the teeth for the purpose of fitting dentures. Charges are not covered if the procedure is performed in conjunction with the extraction of natural teeth;
h) Frenectomy - the cutting of tissue in the midline of the tongue, usually done to prevent tongue-tie conditions;
i) Residual root removal; root amputation;
j) Surgery to correct accidental injuries of the jaw, cheeks, lips, tongue, roof, and floor of the mouth;
k) Treatment of fractured facial bones;
l) Extraction of seven (7) or more fully erupted natural teeth at the same time vestibuloplasty - the surgical modification of the gingival-mucous membrane;
n) Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examination; and
o) Treatment and initial replacement of natural teeth due to an accident, if services are started within ninety (90) days following the accident.

16. DEVELOPMENTAL DELAYS OR LEARNING DISORDERS

Diagnostic evaluations, therapies and treatment of learning disabilities or developmental delays in Dependent children.

17. DIABETIC SUPPLIES

Needles, syringes, lancets, clinitest, glucose strips and chem strips for treatment of diagnosed diabetes are covered under the prescription drug card program. (Please note, for the purposes of This Plan, insulin is considered a Prescription Drug.)

Installation and use of an insulin infusion pump, glucose monitors, other equipment or supplies in the treatment of diabetes, and diabetic self-management education programs. Coverage of an insulin infusion pump is limited to the purchase of one (1) pump.

18. DURABLE MEDICAL EQUIPMENT

Charges for the rental of a wheelchair, Hospital bed, or other Durable Medical Equipment required for temporary therapeutic use; or the purchase of this equipment if economically justified, whichever is less.

19. ENTERAL NUTRITION/HOME IV THERAPY

Charges for enteral nutrition (tube feeding) and home IV therapy.

20. EYE CARE

Charges for initial contact lenses or eyeglasses following cataract surgery. See Vision Care Benefits for additional coverage.

21. GENETIC TESTING

Charges for Genetic Testing when: a) there are signs of an inherited disease in the Covered Person, b) there have been pre-test diagnostic inquiries, and c) the determination of diagnosis in the absence of genetic testing is uncertain and would impact the treatment of such Covered Person.

22. HABILITATION SERVICES

Health care services that help a person keep, learn, or improve skills and function for daily living. Services may include but are not limited to physical therapy, occupational therapy, speech therapy and behavior modification. Pre-authorization of services will be required. -

23. HEARING AID

Charges for the purchase and repair of a hearing aid to the limits shown in the Schedule of Medical Benefits.

24. HEARING EXAM

Charges for a hearing exam is covered as shown in the Schedule of Medical Benefits.

25. HEMODIALYSIS

Charges for hemodialysis as an inpatient or at a Medicare approved outpatient dialysis center.

26. HOME HEALTH CARE EXPENSES

Charges for Home Health Care services and supplies. These services and supplies are covered when:

a) Hospital or Skilled Nursing Facility confinement would otherwise be required;
b) The diagnosis, care and treatment is certified by the attending Physician and included in a Home Health Care Plan.

A Home Health Care visit is considered a periodic visit by either a nurse or therapist or four hours of home health aide services.

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.

27. HOSPICE EXPENSES

Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal and placed the person under a Hospice Care Plan. Pre-authorization of services is required.

28. IMAGING (MRI, CT SCAN, PED SCAN)

Charges for Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, and Positron Emission Tomography (PET) scans that are related to a specific Illness or Injury. Services related to routine examinations are not covered unless they qualify as Preventive Care. If more than one MRI is performed on the same day, the Plan will pay only 50% of the otherwise covered charge for each MRI after the first.

29. INFERTILITY SERVICES

Charges for diagnostic services to determine the cause of infertility, along with the treatment of the condition causing the infertility.

Benefits are not available for donor sperm for artificial insemination or extraordinary procedures to induce fertilization with technical assistance to include surrogate motherhood, gamete intra-fallopian transfer, in-vitro fertilization, peritoneal oocyte and sperm transfer, tubal ovum transfer, artificial insemination, gestational carrier, and pre-implantation genetic diagnosis testing.

30. INFUSION THERAPY

Charges for outpatient infusion therapy.

31. JAW JOINT DISORDERS

Charges for services and supplies which treat jaw Joint Disorders. The non-surgical treatment of Jaw Joint Disorders is subject to the limit shown in the Schedule of Medical Benefits.

32. LABORATORY TESTING/X-RAYS (DIAGNOSTIC)

Charges for diagnostic X-rays, microscopic tests, and laboratory tests.

33. MASTECTOMY

Charges for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce asymmetrical appearance and prostheses (implants, special bras, etc.) and treatment of physical complications at all stages of the mastectomy, including lymph edemas for a Covered Person who is receiving benefits under This Plan in connection with a mastectomy and who elects breast reconstruction. This Plan will provide coverage in a manner determined in consultation with the Covered Person and his or her attending Physician.

34. MATERNITY CARE

Covered Medical Expenses for maternity related expenses for a Covered Person.

PLEASE NOTE: Minimum Coverage for a mother and Newborn child for a Hospital stay following childbirth is 48 hours for a normal vaginal delivery and 96 hours for a cesarean section. The law does not prohibit the mother's or Newborn's attending provider, after consultation with the mother, from discharging the mother or Newborn earlier than 48 or 96 hours as applicable. This Plan may not under the federal law require that a provider obtain authorization from This Plan for a length of stay not more than 48 (or 96) hours.

35. MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE

INPATIENT TREATMENT while the patient is in a Hospital or an Inpatient in a state licensed residential treatment facility.

OUTPATIENT TREATMENT performed by:

a) A Hospital;
b) A licensed Psychiatrist ;
c) A licensed psychologist;
d) A licensed mental health treatment facility;
e) A licensed social worker or professional counselor:
f) An Outpatient Substance Abuse Treatment Facility.

NOTE: Prescription Drugs for the treatment of Mental Health Disorders and Substance Abuse are covered as any other Prescription Drug for the treatment of Illness or Injury.

36. NEWBORN CARE

Coverage is provided for Hospital charges, Physician charges, and circumcision for the routine care of a Newborn child until the initial Hospital discharge. Coverage for the Newborn child must be in effect at the time of the infant's birth or added within the time limits shown in the section titled Eligibility, Enrollment and Effective Date. Routine Newborn care is covered under the baby's own claim and not under the mother's claim.

37. OCCUPATIONAL THERAPY

Charges for restoratory or rehabilitory occupational therapy due to an Illness or Injury, other than a functional nervous disorder, or due to surgery performed because of an Illness or Injury.

38. ORGAN TRANSPLANT EXPENSES

Organ transplant expenses are those charges; for services and supplies in connection with a transplant (or re-transplant) subject to the following criteria:

a) The recipient of the organ transplant must be a Covered Person under This Plan.
b) Pre-approval by the Plan Supervisor required.
c) Except for transplant of a cornea, the recipient must be in danger of death in the event the organ transplant is not performed.
d) The prognosis of recovery of the recipient's health or sight if the Covered Person were to receive the transplant must be favorable.
e) Charges incurred by the donor are covered if the donor has no other coverage available, i.e., group health plan, a government program, or a research program, subject to Plan provisions. Donor expenses are covered only if the recipient is covered by This Plan.
f) Organ procurement from a cadaver or tissue bank is covered; this includes the surgical procedure for organ removal, storage, and transportation costs of the organ.

g) Transportation of the Covered Person and a companion to and from the site of the transplant (if the Covered Person is a Dependent child, transportation will include 2 individuals accompanying such Dependent child), if the Covered Person's home is located 50 or more miles from the site of the transplant. This Plan will cover the cost of regularly scheduled commercial airlines, trains and/or interstate buses to a Center of Excellence or other Network transplant facility to the limit shown in the Schedule of Medical Benefits. Cab fares, local buses and car rentals are NOT Covered Expenses.
h) This Plan will also cover the cost of lodging and meals for the Covered Person and a companion to the limit shown in the Schedule of Medical Benefits when using a Center of Excellence or other Network transplant facility. (Lodging and meal charges will be covered for up to 2 individuals accompanying the Covered Person if the Covered Person is a Dependent child).

The following are not eligible for coverage under this benefit:

- Expenses associated with the purchase of any organ;
- Charges in connection with mechanical organs or a transplant involving a mechanical organ; and
- Expenses associated with a non-human organ transplant.

This Plan covers Covered Medical Expenses relating to the transplant, including but not limited to:

- Testing to determine transplant feasibility and donor compatibility;
- Donor search costs;
- Preparation and delivery of the donor organ;
- Charges related to the transplant itself, as well as follow-up care;
- Procedures to determine rejection or success of transplant; and
- Anti-rejection drugs.

39. OXYGEN

Charges for oxygen, other gases, and their administration.

40. PHYSICAL THERAPY

Treatment or services rendered by a licensed physical therapist in a home setting or at a facility or institution which has the primary purpose of providing medical care for an Illness or Injury.

41. PRE-ADMISSION TESTING

Preliminary testing services relating to an upcoming Hospital confinement which are done on an outpatient basis within seven (7) days of the Hospital confinement.

42. PRESCRIPTION DRUGS

Prescription Drugs are covered under the prescription drug card program which is not administered by the Plan Supervisor. Please see the section titled "Prescription Drug Benefits" or contact the Human Resources Department for further information. Betas Ron and Avonex used in the treatment of Multiple Sclerosis are covered under This Plan.

If a Prescription Drug is purchased at a Participating Pharmacy but the Card is not used, the pharmacy may require that the Covered Person pay the entire cost of the Prescription Drug at the time of purchase and submit the charges to the pharmacy card company selected by This Plan.

If a prescription is filled at a non-participating pharmacy, the Covered Person must pay the entire cost of the Prescription Drug at the time of purchase and submit the charges to the Prescription Card Company. The expenses will be considered as shown in the Schedule of Medical Benefits.

43. PROSTHETICS

Charges for the initial purchase of artificial limbs, eyes, or larynx. Replacement is covered only if the prosthetic is not functional.

44. REHABILITATION

Charges for rehabilitative treatment (e.g., physical, occupational, speech or oxygen therapy) to return the Covered Person to his/her physical status prior to the occurrence of accidental or medical injuries such as spinal cord injury, closed or open head injury and stroke.

45. REFRACTIVE SURGERY

Charges for outpatient eye refractive surgery when Medically Necessary. Service must not be performed on otherwise healthy eyes to replace eyeglasses or contact lenses.

46. SECOND SURGICAL OPINION

Consultation services from a Physician qualified through experience, specialist training or education regarding the medical necessity for a surgical procedure. Services must be performed by a Physician who is not located at the same clinic or in the same practice as the primary Physician.

47. SKILLED NURSING FACILITY EXPENSES

Skilled Nursing Facility Expenses are payable up to the maximum in the Schedule of Medical Benefits. With respect to charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility, only charges incurred in connection with convalescence from an Illness or Injury for which the Covered Person was Hospital confined for at least three (3) consecutive days are eligible for benefits. The confinement must commence within fourteen (14) days of discharge from the Hospital or a related confinement in a Skilled Nursing Facility. These expenses include:

a) Room and board (if private room accommodations are used, the daily room and board charges allowed will not exceed the facility’s average semi-private charges);
b) General nursing services;
c) Medical services customarily provided by the Skilled Nursing Facility except for private duty or special nursing services and Physicians’ fees; and
d) Drugs, biologicals, dressings, and casts furnished for use during the convalescent period, but no other supplies.

48. SMOKING CESSATION

Charges for smoking cessation programs to the limit shown in the Schedule of Medical Benefits. See Prescription Drug Benefits for additional coverage.

49. SPEECH THERAPY

Charges for restoratory or rehabilitory speech therapy due to an Illness or Injury or due to surgery performed because of an Illness or Injury.

50. STERILIZATION

Charges (including outpatient facility fees) for male or female elective sterilization.

51. SUPPLIES

Charges for dressings, sutures, casts, splints, trusses, crutches, braces, custom molded foot orthotics, or other necessary medical supplies; however, dental braces, corrective shoes, and arch supports are not covered.

52. URGENT CARE CLINIC

Charges made by an Urgent Care Clinic.

GENERAL LIMITATIONS

The following list includes, but is not limited to, the exclusions and limitations that apply to expenses incurred by all Covered Persons:

1. Charges incurred prior to the effective date of coverage under This Plan or after coverage is terminated unless an Extension of Benefits applies.

2. Charges incurred in connection with services and supplies which are not Medically Necessary to treat Injury or Illness.

3. Charges which are more than Usual and Customary charges.

4. Charges which are not recommended and approved by a Physician or are not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.

5. Charges incurred for Preventive Care, routine medical examinations or care, routine health checkups, or immunizations not necessary for the treatment of an Injury or Illness, *except as specifically covered elsewhere in This Plan.*

6. Charges incurred as the result of any Injury, Illness, occupational disease, or other loss which arises out of and during a covered Dependent's **employment or self-employment or for any loss due to work related injury or sickness.**

7. Charges because of **active participation in war** or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

8. Charges for which the Covered Person is **not obligated** to pay (in the absence of this coverage), or for which a charge would not ordinarily be made in the absence of this coverage.

9. Charges resulting from or occurring during the commission of a **crime** or violation of law by the Covered Person, including, without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations.

10. Charges for services rendered by a Physician, nurse, or licensed therapist if such Physician, nurse, or licensed therapist is a **Close Relative** of the Covered Person or resides in the same household as the Covered Person.

11. Charges incurred for **travel for health** or **rendered outside the United States** if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

12. Charges for services or supplies in connection with **education** or **training** *except as specifically covered elsewhere in This Plan.*

13. **Cosmetic services or reconstructive surgery** *except as specifically covered elsewhere in This Plan. Specifically excluded are procedures related to obesity treatment and follow-up, breast reduction and augmentation, and blepharoplasty.*

14. Services and supplies for or related to artificial insemination, in vitro fertilization, charges for donor ova or sperm, and other means of **assisted reproductive technologies**.

15. Charges related to or in connection with **reversal of a sterilization procedure**.

16. Charges for **cochlear implants.**

17. Charges for **orthopedic shoes**, arch supports, or exam for the prescription or fitting thereof.

18. Charges for **splints or braces for non-medical purposes** (i.e., supports worn primarily during participation in sports or similar physical activities).

19. Charges for dental services, **treatment, implants, orthodontics,** surgery, supplies or any related services and expenses *except as specifically covered elsewhere in This Plan* or for Hospital charges in relation to dental care, except those services which are certified by a medical doctor to be Medically Necessary to safeguard the life and health of the Covered Person due to the existence of a non-dental physical condition. **Pre-authorization is recommended.**

20. Charges for **elective induced abortion** unless Medically Necessary to safeguard the life of the mother.

21. Charges for Hospital Confinement when such confinement occurs primarily for physiotherapy, hydrotherapy, **convalescent or rest care**, or any routine physical examinations or tests not connected with the actual Illness or Injury.

22. Charges for **Experimental procedures**, drugs, or research studies, or for any services or supplies not considered legal in the United States or not recognized by the American Medical Association or the American College of Surgeons and/or the United States Food & Drug Administration, except as may be delineated under the Patient Protection and Affordable Care Act and subsequent implementing regulations for clinical trials.

23. Charges related to any **gender disorder** except for counseling provided by a licensed professional counselor, psychologist and/or psychiatrist.

24. Expenses for **recreational or educational** therapy or any form of non-medical self-care or self-help training, including any related diagnostic testing, training for active daily living skills or health club membership.

25. Charges for services or supplies for **religious and marital, family, or other counseling** or training service.

26. **Personal comfort items** including telephone or television, or other equipment, such as, but not limited to: air conditioners; air-purification units; humidifiers; allergy-free pillows; blanket or mattress covers; electric heating units; swimming pools; orthopedic mattresses; exercising equipment; vibratory equipment; elevators or stair lifts; blood pressure instruments; stethoscopes; clinical thermometers; scales; elastic bandages or stockings; non-hospital adjustable beds; nonprescription drugs and medicines; and first-aid supplies.

27. Care and treatment of **obesity**, weight loss or dietary control whether it is, in any case, a part of the treatment plan for another Illness except as provided under the Preventive Care benefit.

28. Charges for **development and neuroeducation testing or treatment, hearing therapy, therapy for learning disability, communication delay, perceptual disorders, sensory deficit, Developmental Disability, and related conditions,** or for other special therapy unless specifically included as a covered expense elsewhere in This Plan, whether such disorder is the result of an Illness or Injury.

29. Charges for **routine foot care**, such as removal of corns, calluses, or toenails; except the services necessary in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy.

30. **Friday, Saturday, and Sunday charges incurred for Hospital confinement** which begins on Friday, Saturday, or Sunday. This exclusion does not apply to emergency admissions or admission where surgery is performed within the 24 hour period immediately following Hospital admission. This limit applies only on the first Friday, Saturday and Sunday of the confinement.

31. Charges in relation to **chelation therapy** except in the treatment of lead or heavy metal poisoning.

32. Charges in relation to the non-surgical treatment of **Jaw Joint Disorders** more than the limit shown in the Schedule of Medical Benefits.

33. Charges for **Custodial Care**.

34. Charges for **telephone consultations**; charges for **failure to keep appointments**; charges for the **completion of a claim form, an itemized bill** or for providing necessary medical records or information to process a claim.

35. Charges for **hypnotism, acupuncture, or any type of goal oriented or behavior modification therapy, biofeedback, myo-functional therapy, or sleep therapy.**

36. Charges for **smoking cessation** programs, smoking deterrent patches and other charges for a diagnosis of nicotine addiction *except as specifically covered elsewhere in This Plan.*

37. Charges for **physical exams** for travel, employment, marriage, or exams requested by a third-party such as schools, insurance, or courts.

COVERED DENTAL EXPENSES

PREVENTIVE SERVICES

1. Oral Examinations. Limited to two (2) examinations per Calendar Year.

1. Full-mouth or panoramic x-rays. Limited to once in a thirty-six (36) month period, unless necessary due to an Injury.

2. Bitewing x-rays. Limited to two (2) sets per Calendar Year.

3. Other dental x-rays testing necessary to diagnose a dental condition.

4. Cleanings (routine prophylaxis). Limited to two (2) per Calendar Year.

5. .

BASIC SERVICES

1. Space maintainers for Dependent children under the age of 14 only. Fixed appliances to maintain a space created by the premature loss of a primary tooth or teeth.

6. Restorations. Amalgam, silicate, acrylic, synthetic porcelain, and composite fillings.

7. Endodontic. Procedures necessary for root canal treatments, root canal fillings and pulp vitality tests.

8. Emergency oral examinations and palliative treatment for relief of dental pain.

9. Local Anesthesia and Analgesia.

10. Periodontics. Procedures necessary for treatment of diseases of the tissues supporting the teeth including periodontal cleanings (prophylaxis) and periodontal exams unless covered under the Medical portion of This Plan. Periodontal splinting is not a covered expense.

11. Oral Surgery. Extractions and other oral surgery including pre- and post- operative care, unless covered under the Medical portion of This Plan. Please see Covered Medical Expenses for more specific information.

12. Stainless Steel Crowns

13. Injections of drugs by the attending Dentist.

14. General Anesthesia. When administered by a Dentist in connection with oral or dental surgery and when Dentally Necessary or necessary due to a medical condition that presents an elevated risk to the patient.

MAJOR RESTORATIVE SERVICES

1. Inlays or onlays and their maintenance.

2. Crowns and their maintenance.

Limitations for Major Restorative Services

Replacement of an inlay, onlay or crown will be a covered expense only if the existing inlay, onlay or crown was installed at least five (5) years prior to its replacement and cannot be made serviceable, or if replaced as the result of an Accidental Injury occurring while the patient is covered under this Plan or when required due to the involvement of an additional tooth surface.

Expenses incurred for Major Restorative Services performed on other than permanent teeth are not covered expenses.

PROSTHODONTIC SERVICES

1. Installation of removable or fixed bridgework.

2. Installation of partial and complete dentures, including six (6) month post- installation care.

3. Relines, rebases, and repairs.

Limitations of Prosthodontic Services

Replacement of a bridge or denture will be a covered expense only if the existing bridge or denture was installed at least five (5) years prior to its replacement and cannot be made serviceable unless:

1. Replacement is Dentally Necessary due to the placement of an initial opposing full denture or the extraction of additional natural teeth rendering the bridge or partial denture unserviceable;

2. The bridge or denture, while in the oral cavity, is damaged beyond repair because of an Injury received while the Covered Person is covered under this Plan; or

3. The existing denture is a temporary denture, placed while the Covered Person is covered under this Plan, and replacement by a permanent denture is required and performed within twelve (12) months of the date the temporary denture was placed.

Expenses incurred for Prosthodontic Services performed on other than permanent teeth are not covered expenses.

Expenses incurred for Prosthodontic Services to replace a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability are not covered expenses.

The initial installation of an appliance, bridge, or denture, replacing natural teeth which were extracted prior to the effective date of the Covered Person's coverage under This Plan, is not a covered expense. It will be covered if Dentally Necessary due to the loss or extraction of additional natural teeth after the effective date of the Covered Person's coverage under This Plan.

EXTENSION OF DENTAL BENEFITS

When coverage under This Plan terminates, all benefits stop, except benefits for operative procedures in progress on the termination date as follows:

1. Services for root canals and crowns started before the Covered Person's termination date and completed within thirty-one (31) days after his or her termination date; and

2. Prosthetic devices, dentures and bridges ordered and fitted before the Covered Person's termination date and completed within sixty (60) days after his or her termination date.

This Plan must remain in effect for Extension of Benefits to be payable.

A Covered Person has up to ninety (90) days after his or her termination date to submit claims for Extended Benefits.

DENTAL LIMITATIONS

This Plan does not cover:

1. Replacement of lost, missing, broken or stolen appliances or **duplicate appliances**.

2. Cosmetic Dentistry, including personalization or characterization of dentures and facings on crowns, abutments or pontics posterior to the second bicuspid, or labial veneer laminates.

3. **Preventive control programs** including oral hygiene instruction, plaque control, dietary planning, lab tests, anaerobic culture except in connection with periodontal disease, sensitivity testing and bite registrations.

4. Appliances or restorations for: **increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, correction of congenital or developmental malformations.**

5. Fees for **treatment other than by a Dentist,** except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the Dentist in accordance with accepted dental standards.

6. **Precision or semi-precision attachments.**

7. Dental services which do not have **uniform professional endorsement.**

8. **Any dental expense unless specifically indicated.**

9. **Dental implant logy techniques**, including prosthetic devices related to such techniques.

10. That portion of any **fee that is more than the fee for the Dentally Necessary treatment** or services needed to restore the tooth or dental arch to contour and function.

11. **Gold foil fillings** and their maintenance.

12. Expenses incurred for appliances or restorations in connection with **Jaw Joint Disorders**.

13. Expenses for **orthodontic treatment**.

14. Any expense which is covered **under the Medical portion of This Plan.**

15. Any expense which is excluded under the **GENERAL LIMITATIONS** of This Plan.

PRESCRIPTION DRUG BENEFITS

Prescription Drugs are covered under the drug card program. Under this benefit, the Covered Person is responsible for the Co-pay as specified on the Schedule of Benefits. After satisfaction of the Co-pay, eligible charges are covered at 100%.

"Formulary Prescription Drug" means the current listing of Prescription Drugs under the drug card program for dispensing when appropriate. This list is subject to periodic review and modification.

"Generic Prescription Drug" means a Prescription Drug that is produced by more than one manufacturer. It is chemically the same as and usually costs less than the Non-Formulary or Formulary Drug for which it is being substituted.

"Pharmacy" means a licensed establishment where prescriptions are dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

"Prescription Drug" means any drug or medicine whose label is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription," or any substitute required label, and injectable insulin (whether or not by prescription), as long as the drug was prescribed by a licensed Physician or provider acting within the scope of his/her license.

"Non-Formulary Prescription Drug" means a Prescription Drug that has been patented with a brand name and is produced by the original manufacturer under that brand name that is not included under the Formulary Drug listing.

Eligible Prescription Drugs are as follows:

- Federal Legend Prescription Drugs;
- Drugs requiring a prescription under the applicable law;
- Compounded medications when at least one ingredient is a Federal Legend Drug;
- Vitamin A derivatives for dermatological/cosmetic use (e.g., Retin-A, Renova);
- Diabetic supplies (OTC) including test strips and lancets;
- Insulin syringes and needles (includes OTC);
- Anti-Narcolepsy/Anti-Hyperkinesia drugs (treatment for ADD) to age 14;
- Injectable contraceptives (Depo-Provera);
- Smoking cessation products;
- Impotence treatments (limited to 6 doses per month); in any form or chemical equivalency.
- Migraine treatments (limited to 9 doses per month); in any form or chemical equivalency.
- Insulin;
- Fertility drugs relating to the diagnosis and treatment of infertility, limited to treatments for three fertility cycles per lifetime of Covered Person;
- Vitamins (includes pre-natal) and other Over-the-Counter drugs recommended under the United States Preventive Services Task Force A and B recommendations;
- AIDS treatment;
- Injectable forms of covered drugs;
- Oral contraceptives;
- Immunosuppressant;
- Fluoride products.

Cost Containment Programs

Mandatory over the counter (OTC) substitution – The Covered Person must use an OTC proton pump inhibitors and non-sedating antihistamines if a Generic, Formulary, or Non-Formulary Prescription Drug proton pump inhibitor or non-sedating antihistamine is prescribed. If an exception is needed, it will require a letter of medical necessity from your provider and the prescription will be subject to the applicable co-pays.

Mandatory Generic Substitution - The Covered Person must use Generic Prescription Drug when available; otherwise, the Covered Person must pay the difference between the Generic Prescription Drug cost and the Formulary and Non-Formulary Prescription Drug cost, in addition to the Formulary and Non-Formulary Prescription Drug (as appropriate) Copayment amount.

If an exception is needed, it will require a letter of medical necessity from the provider. The higher Copayments will apply but the Covered Person will not be responsible for the difference in cost.

Pill Splitting – Certain medications require that the tablet be split. A list of these medications is available from the Plan Administrator. The Covered Person will be responsible for one –half (½) the normal Copay for that medication.

Step Therapy requires Covered Persons to utilize Generic Prescription Drugs or lower cost products within a drug class before higher cost products can be utilized. Medications that require step therapy have shown the same effectiveness in restoring a Covered Person's health as their more expensive counter parts.

Limitations and Exclusions

The following charges are not covered, and no benefit will be paid with respect to them, except as noted:

- Non-Legend drugs other than Insulin;
- Therapeutic devices or appliances, support garments and other non-medical substances;
- Drugs intended for use in a Physician's office or another setting other than home use;
- Investigational or experimental drugs, including compounded medications for non-FDA approved use, except as may be delineated under the Patient Protection and Affordable Care Act and subsequent implementing regulations for clinical trials.
- Prescriptions which an eligible person is entitled to receive without charge under any workers' compensation law, or any municipal, state, or federal program;
- Multiple Sclerosis medications (e.g., Betas Ron, Avonex);
- Ostomy supplies;
- Glucose monitors;
- Alcohol swabs;
- Non-insulin syringes and needles;
- Cosmetic drugs (e.g., Propecia)
- Anti-obesity drugs;
- Lancet devices;
- Growth hormones;
- Schedule V (five) drugs;
- Any expense which is excluded under the GENERAL LIMITATIONS of This Plan.

ELIGIBILITY

Individuals who belong to an Eligible Class are eligible for coverage under This Plan.

ELIGIBLE CLASS: Non-Tribal Spouse and Dependent(s) of an Enrolled Tribal Member of the Forest County Potawatomi where the Tribal Member has elected coverage for his/her Non-Tribal Spouse and Dependent(s) under this Plan.

NOTE: The Eligibility as referenced in this section refers to the Non-Tribal Spouse and Dependents who are not enrolled Tribal Members of the Forest County Potawatomi. Coverage is available only by election of the Enrolled Tribal Member who desires to cover his/her family members according to the criteria set forth below.

WAITING PERIOD: A Member's Dependent is eligible on the first of the month following the date the Dependent belongs to an Eligible Class.

DEPENDENT: The following persons are eligible for coverage under This Plan:

1. LAWFUL SPOUSE - A Tribal Member's lawful spouse who is a resident of the United States, if not legally separated or divorced.

2. CHILDREN AGES 19- 25 - A Tribal Member's non-enrolled child who is 19, but under the age 26.

3. MENTALLY OR PHYSICALLY CHALLENGED CHILDREN - A Tribal Member's unmarried dependent child who is incapable of self-sustaining employment by reason of a Developmental Disability or physical handicap and is primarily dependent upon the Plan Participant for support and maintenance is covered under This Plan even after he/she has reached the limiting age. Proof of physical or mental handicap must be provided to the Plan Administrator within thirty-one (31) days of the covered dependent reaching the limiting age. Thereafter, proof may be required annually.

The term "child" or "children" as referenced in the above sections includes:

a) A Tribal Member's natural child;
b) A Tribal Member's adopted child (from the date of placement);
c) A Tribal Member's stepchild;

ENROLLMENT

The term enrollment means (a) application for coverage on a form furnished or approved by This Plan, and (b) payment of any required contribution (please contact the Insurance Department if you question whether a contribution is required). The Tribe and its Members share in the cost of This Plan. Tribal Members may enroll their Dependents for coverage under This Plan within thirty-one (31) days (sixty (60) days for adopted child) of the date they become eligible. Enrollment occurring after this date is considered Late Enrollment. The following provisions also apply.

1. LATE ENROLLMENT - If a Tribal Member or dependent is not enrolled within thirty-one (31) days (sixty (60) days for adopted child) of the date of eligibility, according to the requirements of a special enrollment date, or the earliest date on which coverage can become effective under This Plan, the Tribal Member or dependent may only apply for coverage as stated below:

For Late Enrollees coverage begins on the first of the month following the date of enrollment. Application for Late Enrollment may only be made during an open Enrollment Period held from November 1-30 of each year for coverage effective January 1 of each year. Thereafter, no Late Enrollment provisions will apply. In no event will enrollment be retroactive.

2. NEWLY ACQUIRED DEPENDENTS - If a new Dependent is acquired by reason of marriage or adoption, the Dependent is eligible for coverage from the date of the event. The newly acquired Dependent must be enrolled and the Plan Supervisor notified within thirty-one (31) days (sixty (60) days for adopted child) of the date of the event. Evidence of good health is not required. Benefits will not be paid until the dependent is enrolled.

   If enrollment of a newly acquired dependent is made more than thirty-one (31) (sixty (60) days for adopted child) after the date of acquisition it is Late Enrollment. All the Late Enrollment provisions apply.

SPECIAL CONSIDERATIONS

An eligible Tribal Member's dependent(s) already enrolled on the plan may continue coverage for a period of 18 months subject to the following provisions:

A Tribal Member's Covered Dependent(s) (i.e., surviving spouse, and or covered dependent children) may continue this coverage if current coverage ends due to the death of the Enrolled Tribal Member.

a) The covered dependent(s) must be covered by the plan before the death of the Tribal Member to continue coverage.
b) You will have 45 days from the date of choosing continuation coverage to pay the first premium. If payments of any required contributions not received within the proper period, the covered dependents will become ineligible and no longer able to choose continuation of coverage.
c) Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to the Plan Administrator or Forest Count Potawatomi Insurance Department.
d) The covered dependent(s) must choose to continue coverage in writing by notifying the Plan Administrator within thirty-one (31) days of the Member's death; failure to choose continuation within the required timeframe will make the covered dependents ineligible to choose continuation at a later date.
f) Coverage will continue from the date of the Member's death upon receipt of required contributions;
g) In all cases, continuation ends if the group plan ends, required contributions are not paid when due, the dependent child reaches he age of 26 or when the covered dependent Spouse remarries.

SPECIAL ENROLLEES

An eligible dependent who declined coverage under This Plan at the time of initial eligibility (and stated in writing at that time that coverage was declined because of alternative health coverage) will be allowed on This Plan as a Special Enrollee if:

1. He or she subsequently loses coverage under the other health plan and application for coverage under This Plan within thirty-one (31) days of the loss of coverage, **and**

2. He or she was:
    a) Under a COBRA continuation provision and the coverage under such provision was exhausted or
    b) Not under such a provision and either the coverage was terminated because of loss of eligibility for the coverage (including because of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or
    c) employer contributions toward such coverage were terminated.

Individuals who lose other coverage due to nonpayment of premium or for other suspect reasons (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder.

An eligible Tribal Member dependent who seeks to enroll in This Plan because of eligibility through marriage, adoption or placement for adoption shall be allowed to enter This Plan as a Special Enrollee if the eligible dependent is enrolled within thirty-one (31) days of the acquisition of the new dependent (legal documentation required).

A Special Enrollee shall be eligible for coverage as of the date of the marriage adoption, placement for adoption or loss of coverage.

EFFECTIVE DATE

Coverage under This Plan begins on the following dates provided the Covered Person is enrolled and any required contribution is paid:

1. For persons validly covered under a prior group plan of the Plan Administrator on the date that coverage was replaced by This Plan - the effective date of This Plan.

2. The date the Spouse or Dependent becomes eligible.

3. For new dependents acquired after the effective date by reason of marriage or legal guardianship, the date of the event (legal documentation required).

4. For an adopted child, the date the child is placed with the Tribal Member for the purpose of adoption. Coverage for an adopted child ends if the placement is disrupted prior to legal adoption or the child is removed from the home. Legal documentation is required to show adoption or placement for adoption.

5. For individuals who lose other coverage because of loss of eligibility or employer contributions toward such coverage were terminated, the date coverage is lost.

NOTE: No dependent is covered before the Tribal Member is covered.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following dates;

1. The date ending the period for which the last contribution is made if the Tribal Member fails to make any required contributions when due.

2. The date This Plan is terminated; or with respect to any benefit of This Plan, the date of termination of such benefit.

3. The date of the Member's death. See Special Considerations for coverage continuation upon Member's death.

4. For a Covered Dependent, the last day in which the Covered Dependent ceases to be eligible for dependent coverage. Please see the Eligibility and Participation section for the definition of who is eligible to be a dependent under This Plan.

COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed expenses. It applies when a Covered Person is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full, and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full, or a reduced amount which when added to the benefits payable by the other plan or plans will not exceed the amount This Plan would have paid if it had paid first. Only the amount paid by This Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether a claim is filed under the other plan or plans. If needed, authorization must be given This Plan to obtain information as to benefits or services available from the other plan or plans or to recover overpayments.

All benefits contained in This Plan are subject to this provision.

This Plan will always pay secondary when other coverage is available.

DEFINITIONS

The term "plan" as used herein will mean any plan providing benefits or services for or by reason of medical or dental treatment and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:

   a) Hospital indemnity benefits.

   b) Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims.

2. Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans.

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision.

4. A licensed Health Maintenance Organization (H.M.O.).

5. Any coverage for students which is sponsored by or provided through a school or other educational institution.

6. Any coverage under a governmental program, and any coverage required or provided by any statute.

7. Group automobile insurance.

8. Individual automobile insurance coverage on an automobile leased or owned by the Forest County Potawatomi Community.

9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage.

The term “plan” will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

The term “allowable expenses” means any necessary item of expense, the charge for which is reasonable, regular, and customary, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit.

The term “claim determination period” means a calendar or plan year or that portion of a calendar or plan year during which the Covered Person for whom claim is made has been covered under This Plan.

ORDER OF BENEFIT DETERMINATION

<u>This Plan will always be secondary to any other plan unless otherwise required by law.</u>

The Plan Supervisor has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the claimant’s consent.
2. To require that the claimant provide the Plan Supervisor with information on such other plans so that this provision may be implemented.
3. To pay the amount due under This Plan to an insurer or other organization if this is necessary, in the Forest County Potawatomi Community’s opinion, to satisfy the terms of this provision.

COORDINATION PROCEDURE

When a Covered Person is also covered by any other plan or plans, This Plan will pay a reduced amount which when added to the benefits payable by the other plan or plans will not exceed the amount This Plan would have paid if it had paid first.

SUBROGATION

If This Plan provides benefits for Injury, Illness or other loss, This Plan will be subrogated to all rights of recovery the Injured Party, his or her heirs, guardians, executors, or other representatives may have arising from the Injury regardless of how the recovery is classified. This Plan's subrogation rights include, but are not limited to, a right of recovery against any person, insurance company or other entity that is in any way responsible for providing compensation or other payment because of the Injury, Illness, or other loss. This Plan's subrogation rights include a right of recovery under no fault, personal injury protection, Medicaid Plans financial responsibility, uninsured or underinsured motorist insurance coverages or medical reimbursement insurance, specific risk insurance, "school" or "team" insurance, worker's compensation, third party liability and any other source of first party coverage.

The Injured party and any person acting on his or her behalf may be requested to provide This Plan with information This Plan believes necessary to protect its right of subrogation. If such a request is made, the Injured Party and any person acting on his or her behalf are obligated to provide This Plan with such information and to do nothing to prejudice This Plan's right of subrogation.

Notification of This Plan's right of subrogation is sufficient to protect This Plan's subrogation interest and the initiation of or intervention in any legal action shall not be required or necessary to establish This Plan's right of subrogation. This Plan shall be entitled to assert a lien against third parties, insurers, attorneys, and any other persons when and as necessary to protect the rights of the beneficiaries of This Plan or Plan assets.

The amount of This Plan's subrogation interest shall be deducted first from any recovery by or on behalf of the Injured Party or any person acting on his or her behalf. This Plan shall not be responsible for expenses or fees incurred in connection with any recovery unless This Plan shall have agreed in writing to pay a portion of those expenses or fees. This Plan reserves the right to initiate an independent action in the name of the Injured Party or his or her representative to recover its subrogation interest.

HOW SUBROGATION WORKS

When you submit an Injury claim to This Plan, the Plan Supervisor will contact you and request additional information regarding how, when, and where the Injury occurred and the names and addresses of all persons and insurers involved. **Benefits will be withheld until this information is received.** It is important that you respond to this request so that This Plan will have information necessary to process your bill and protect its right of subrogation. If the Plan Supervisor believes another party, insurer or other entity may be responsible for providing compensation or other payment regarding the Injury, it will notify the appropriate party of This Plan's subrogation interest. If there is a recovery from another party or insurer, This Plan will be reimbursed first out of such recovery. If the Covered Person has already recovered from the other party or an insurer, This Plan may require reimbursement from the Covered Person for the amount of benefits paid by This Plan for the Injury.

CLAIMS

Written notice of claim should be submitted to the party named below within ninety (90) days after the occurrence. All claims must be filed within one year of the event on which claim is based or payment may be denied.

Failure to furnish proof within the time provided by This Plan will not invalidate or reduce any claim if it can be shown not to have been possible to furnish such proof and that such proof was furnished as soon as reasonably possible. However, when a Covered Person's coverage terminates for any reason, written proof of claim must be given to the Forest County Potawatomi Community within ninety (90) days of the date of termination of coverage, provided that This Plan remains in force. However, upon termination of This Plan, final claims must be received within thirty (30) days of termination. Written notice of claim given by or on behalf of the Covered Person to the Plan Supervisor, with information sufficient to identify the Covered Person, will be considered notice.

Claims should be submitted to the office of the preferred provider network organization as listed on the back of the Covered Person's ID card.

The Plan Administrator will provide adequate notice in writing within a reasonable period of time to any Covered Person whose claim for benefits under this Plan has been partially or wholly denied. Specifically, if a claim is denied, the Covered Person will receive a written explanation of the denial:

- As soon as possible, but in any event within 72 hours for an urgent claim;
- Within 15 days for a pre-service claim (one 15-day extension is allowed for special circumstances); or
- Within 30 days for a post-service claim (one 15-day extension is allowed for special circumstances).

If more time is needed to decide the claim, the Covered Person will receive notice of any extension, including the reason for the extension and a description of any additional information needed to make a determination.

If a claim is denied, the Covered Person will receive a written or electronic notice that will include:

- The specific reason(s) for the claim denial, including a description of the Plan's standard, if any, used in denying the claim;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional materials or information necessary to perfect the claim and an explanation of why the material or information is necessary;
- A description of the Plan's internal appeal procedures, including the time limits applicable to a Covered Person's appeal rights;
- If an internal rule was relied upon in making the decision, either that internal rule will be referenced, or the Covered Person will be informed that an internal rule was relied upon and that he/she may receive a free copy of the internal rule upon request;
- If the denial is based, even in part, on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the

determination applying the terms of the Plan to the Covered Person's medical circumstances or a statement that the Covered Person may receive an explanation free of charge;

- A description of the Covered Person's right to submit any written information relating to the claim;
- Information that identifies the claim, such as the date(s) of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and/or treatment code (including their corresponding meanings);
- A description of external review procedures; and
- A description of the expedited review process for an urgent claim.

The Plan Administrator will afford a reasonable opportunity to any Covered Person, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim. As a part of this opportunity, the Covered Person will be given on request and free of charge, reasonable access to, and copies of, all materials relevant to his/her claim.

APPEAL RIGHTS

INTERNAL APPEAL

Any Covered Person has the right to appeal a denial of enrollment in the plan and/or the denial of a claim made under the Plan and/or the rescission of coverage under the Plan. The Covered Person will have one hundred eighty (180) days after receipt of the initial claim denial to file an appeal. A Covered Person may make an oral appeal of an urgent claim denial. If the Covered Person does not appeal on time, he/she will lose the right to appeal the denial and will lose the right to file suit in court because he/she will have failed to exhaust the internal administrative appeal rights.

The appeal review will afford any deference to the initial claim denial. The Plan Administrator will make its determination upon review of the appeal within the time periods set forth below based upon the type of claim involved:

- As soon as possible, but in any event within 72 hours for an urgent claim;
- Within 30 days for a pre-service claim; or
- Within 60 days for a post-service claim.

The Plan Administrator will provide the Covered Person with notice of its decision on the appeal. If the denial is upheld, the Covered Person will receive a written or electronic notice that will include:

- The specific reason(s) for the appeal denial, including a description of the Plan's standard, if any, used in denying the claim;
- Reference to the specific Plan provisions on which the determination is based;
- A statement regarding the Covered Person's right, on request, to access and receive copies of information relevant to the claim;
- If an internal rule was relied upon in making the decision, either that internal rule will be referenced, or the Covered Person will be informed that an internal rule was relied upon and that he/she may receive a free copy of the internal rule upon request;
- If the denial is based, even in part, on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Covered Person's medical circumstances or a statement that the Covered Person may receive an explanation free of charge;
- Information that identifies the appeal, such as the date(s) of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and/or treatment code (including their corresponding meanings); and
- A description of external review procedures.

EXTERNAL REVIEW

A Covered Person challenging a denial of an appeal may be entitled to an external review of the denial. Specifically, external review is available if the denial is based on one of the following:

- Clinical reasons based upon medical judgment, including medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or if a treatment is experimental or investigational; or
- Rescission (retroactive termination) of care.

Claims that have not exhausted the internal appeal procedure as outlined above will not be eligible for the external review process.

To initiate the external review process, a Covered Person must notify the Forest County Potawatomi Insurance Department within four (4) months after receipt of the final denial of the claim under the internal appeals process described above. The Plan Administrator will inform the Covered Person of the external review process, how to initiate the claim, and what the Covered Person's responsibilities under the process are.

Within five business days of receiving the request for external review, the Plan Administrator will complete a preliminary review, which is necessary to confirm whether:

- The applicant was covered under the Plan at the time of service;
- The review does not relate to the applicant's eligibility to participate in the Plan;
- The review meets the criteria for external review;
- The Covered Person completed the Plan's internal appeals process to the extent required; and
- The Covered Person has provided all necessary information and forms for processing an external review.

The Covered Person is not eligible for an external review if the Plan Administrator determines that any of the above requirements were not met. In that case, within one business day after the initial review of the request, the Plan Administrator will provide the Covered Person with a notice that includes the reasons the request does not meet the requirements for an external review. If the request was incomplete, the notice will describe the information or materials needed to complete the request. The deadline to complete the request will be the end of the four-month period described above or, if later, 48 hours after the Covered Person receives the notice that the request was not complete.

If the request qualifies for external review, it will be assigned to one of the qualified Independent Reviewer Organizations (IRO) with which the Plan Administrator has a contract. Within five business days after assigning the request to the IRO, the Plan Administrator will provide the IRO with the documents and information that were considered in the denial. If the Plan Administrator does not provide this information, the IRO may end the external review and reverse the Plan Administrator's decision. If this occurs, the IRO will notify the Covered Person and the Plan Administrator within one business day of this action.

The IRO will give the Covered Person written notice of the acceptance for external review. The notice will include a statement that the Covered Person has 10 business days to submit additional written information. The IRO will consider this information in its review. The IRO also may agree to consider additional information submitted after 10 business days. Within one business day after receiving additional information from the Covered Person, the IRO will forward the information to the Plan Administrator. The Plan Administrator may reconsider the denial on appeal based on this additional information. If the Plan Administrator decides to reverse the denial on appeal and provide payment, written notice will be provided to the Covered Person and to the IRO within one business day of the decision. The IRO's external review will end if this notice is received.

If the Plan Administrator does not provide any notice of reversal of the decision, the IRO will review all information and documents submitted by the deadline. The IRO must review each claim "de novo," which means it is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

In addition to the documents and information provided by the Covered Person, the IRO will consider other information or documents (for example, the Covered Person's medical records) if they are available and the IRO considers them appropriate.

The IRO will provide written notice of its decision to the Covered Person and the Plan Administrator within 45 days after the IRO receives the request. This notice will contain:

- A general description of the reason for the request and information that identifies the claim, such as the date(s) of service, health care provider, claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis code and/or treatment code (and their corresponding meanings) and the reason of the prior denial
- The date the IRO received the request and the date of the decision;
- References to the evidence or documents (including the specific coverage provisions and evidence-based standards) considered in reaching the decision;
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;
- A statement that the IRO's determination is binding, unless other remedies are available under federal law;
- A statement that judicial review may be available to the Covered Person; and
- The phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsmen.

If the Plan Administrator receives notice from the IRO that reverses a denial, the Plan Administrator will immediately provide or authorize coverage for or payment of the claim. The IRO will maintain records of all claims and notices associated with the external review process for six years and make these records available for examination by the Covered Person and the Plan Administrator (except where disclosure would violate applicable privacy laws).

Expedited External Review

The Covered Person may file a request for an expedited external review in certain circumstances involving emergency services or where a longer review period could put him/her in jeopardy. The applicability and standards for external review apply to expedited claims, so not all claims are subject to this type of review. For those that are, the Covered Person may file for expedited external review when:

- The timeframe for completing an expedited appeal under the Plan's internal appeal process would seriously jeopardize the Covered Person's life or health, or would jeopardize his/her ability to regain maximum function if he/she files a request for an expedited internal appeal with the Plan; or
- The timeframe for completing a standard external review would seriously jeopardize the Covered Person's life or health, or would jeopardize his/her ability to regain maximum function, or
- The Covered Person received a final internal benefit denial involving an admission, availability of care, continued stay or a health care item or service for a condition for which the Covered Person received emergency services if the Covered Person has not been discharged from the facility.

The processing of the expedited request will be the same as described above for other external review requests, except:

- The decision and notice of eligibility on the preliminary review will be made immediately upon the Plan Administrator's receipt of your request;
- If the request is eligible for external review, the Plan Administrator will send required information and documents to the IRO electronically, by telephone or facsimile, or any other fast, available method; and

The IRO will provide the Covered Person and the Plan Administrator with notice of a decision as quickly as the medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

GENERAL PROVISIONS

FACILITY OF PAYMENT

Whenever payments which should have been made under This Plan in accordance with this provision have been made under any other plan or plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under This Plan and to the extent of such payment, the Plan Administrator will be fully discharged from liability under This Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of This Plan rather than the amount payable in the absence of this provision.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this provision, or any similar provision of any other plans, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company, other organization, or person any information, with respect to any person, which the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under This Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

EFFECT OF MEDICARE

1. The Plan will always be secondary to any other benefits.
2. Any Member eligible for Medicare should contact the Insurance Department.

PROOF OF LOSS

The Plan Administrator will have the right and opportunity to have examined any individual whose Injury or Illness is the basis of a claim hereunder when and as often as it may reasonably be required during the pending of a claim and also the right and opportunity to make an autopsy in case of death (where such autopsy is not forbidden by law).

PAYMENT OF BENEFITS

All Plan benefits are payable directly to the provider of service. Payment may be made directly to the Member if a receipt showing that payment has been made is sent with the claim. All or a portion of any benefits provided by This Plan on account of Hospital, nursing, medical or surgical services may, at the Member's option and unless the Member requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the Hospital or person rendering such services. However, if any such benefit remains unpaid at the death of the Member or if the Member is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Member: wife, husband, mother, father, child(ren), brother(s) or sister(s). Any payment so made will constitute a complete discharge of the Plan Administrator's obligation to the extent of such payment, and the Plan Administrator will not be required to see the application of the money so paid.

FREE CHOICE OF PHYSICIAN

The Covered Person will have free choice of any legally qualified Physician or surgeon, and the Physician-patient relationship will be maintained. If the Plan Administrator has contracted with a Preferred Provider Organization (PPO), this Plan may provide a better benefit for utilizing a Network Provider.

ASSIGNMENT

Benefits may not be assigned except by consent of the Plan Administrator other than to providers of medical services and according to the provisions set forth in the Plan Document.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan Administrator with respect to allowable expenses more than the maximum amount of payment necessary to satisfy the intent of This Plan, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to recover such excess payments.

LEGAL PROCEEDINGS

No action at law or in equity will be brought to recover on This Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of This Plan, nor will such action be brought at all unless brought within three (3) years for disability and six (6) years for all others from the expiration of the time within which proof of loss is required by This Plan.

STATEMENTS

All statements made by the Plan Administrator or by a Covered Person are, in the absence of fraud, considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document are used in any context to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and copy of the instrument containing such representation is or has been furnished to the Covered Person.

MISCELLANEOUS

Section titles are for convenience of reference only and are not to be considered in interpreting This Plan.

No failure to enforce any provision of This Plan will affect the right thereafter to enforce such provisions, nor does failure affect its right to enforce any other provision of This Plan.

If an inadvertent error should occur due to interpretation of mandated benefits, relevant laws and regulations before the final regulations are issued, This Plan, Plan Administrator, Agent for the Service of Legal Process, Trustee, and Plan Supervisor will be held harmless for such an error; and in no way will such an error be construed as a precedent-setting event.

Payment for expenses in relation to services which are accepted as cost-containment measures in large claim management cases that are not normally covered under This Plan will be reimbursable upon recommendation of the Plan Supervisor and written approval by the Plan Administrator.

CONTRIBUTIONS TO THIS PLAN

The amount of contribution to This Plan are made on the following basis:

The Plan Administrator will from time to time evaluate the costs of This Plan and determine the amount to be contributed by the Plan Administrator and amount to be contributed (if any) by each Member.

Notwithstanding any other provision of This Plan, the Plan Administrator's obligation to pay benefits otherwise allowable under the terms of This Plan are limited to its obligation to make contributions to This Plan as set forth in the preceding paragraph. Payment of said benefits in accordance with these procedures completely discharges the Plan Administrator's obligation with respect to such payments.

If the Plan Administrator terminates This Plan, the Plan Administrator and Members have no further obligation to make additional contributions to This Plan that apply to the period after the effective date of termination. The Plan Administrator and Members will be responsible for contributions to cover Plan expenses incurred prior to the effective date of termination.

FINAL AUTHORITY

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 This Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Cover Person's rights, and to decide questions of Plan interpretations and those of fact relating to This Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

PLAN MODIFICATION/AMENDMENTS/TERMINATION

The Plan Administrator intends to provide benefits under This Plan indefinitely. However, the Plan Administrator may at any time:

1. Change the contributions you must pay for benefits; or
2. Amend or terminate the benefits provided to you in This Plan.

If the Forest County Potawatomi Community, through its acting management, decides that the Plan benefits should be amended or terminated for any reason, a designated representative of the Forest County Potawatomi Community will prepare a written notice approved and signed by the Plan Administrator or any other person to whom the Forest County Potawatomi Community gives authority in writing to amend or terminate Plan benefits. The notice will be given to you. Your Plan Administrator can tell you who is responsible for approving Plan amendments or a Plan termination and the time in which notice of amendments or termination must be provided to you.

If This Plan is amended or terminated, it will not affect the payment of any claim or expense incurred prior to the time the change is made.

In the event of termination of This Plan, all previous contributions by the Plan Administrator will continue to be issued for the purpose of paying benefits under the provisions of This Plan with respect to claims arising before such termination or will be used for the purpose of providing similar health benefits to Covered Persons, until all contributions are exhausted.

PLAN IS NOT A CONTRACT

The Plan document constitutes the entire Plan.

PROTECTION AGAINST CREDITORS

No benefit payment under This Plan is subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment, and in such case will apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his or her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, and any such application will be a complete discharge of all liability with respect to such benefit payment.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator reserves the right to allocate the Deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

INDEMNIFICATION OF MEMBERS

No director, officer, or Member of the Plan Administrator will incur any liability for any act or failure to act unless such act or failure to act constituted a lack of good faith, willful misconduct, or gross negligence with respect to This Plan. The Plan Administrator shall indemnify any director, officer or Member of the Plan Administrator against all liabilities arising by reason of any act or failure to act unless such act or failure to act is due to the person's own gross negligence or willful misconduct or lack of good faith in the performance of the duties to This Plan. Such indemnification shall include, but is not limited to, expenses incurred in the defense of any claim, including attorney and legal fees, and amounts paid in any settlement or compromise; provided, however, that indemnification shall not occur to the extent that it is not permitted by applicable law.

INDEMNIFICATION OF FOREST COUNTY POTAWATOMI

This Plan does not create any liability on the part of Forest County Potawatomi for the practice of medicine.

DEFINITIONS

ACCREDITATION means the process to ensure that education provided by institutions of higher education meets acceptable levels of quality.

ACCREDITING AGENCIES means a private educational agency of regional or national scope that develops evaluation criteria and conduct peer evaluations to assess whether those criteria are met. Institutions and/or programs that request an agency's evaluation and that meet the agency's criteria are then accredited by that agency.

ACCIDENTAL INJURY means a condition which is the result of bodily injury caused by an act of unusual circumstances likely to result in unexpected consequences. This incident must be of a sufficient departure from the Covered Person's normal and ordinary lifestyle or routine. The condition must be an instantaneous one, rather than one which continues to progress or develop.

AMBULATORY SURGERY means surgery which requires the use of conventional operating room equipment and is performed on a same-day basis without an overnight stay. This term will include surgery performed in surgical mobile units.

CALENDAR YEAR means a period beginning on January 1 and ending on December 31 of the same year.

CLOSE RELATIVE means a person whose relationship to the Covered Person is one of the following: self, spouse, child, brother, sister, or the parent of employee or employee's spouse.

COINSURANCE means money that an individual is required to pay for services after a deductible has been paid. Often specified by a percentage in a 90/10 coinsurance, you pay 10% and the insurance pays 90%.

CONVALESCENT PERIOD means a period commencing with the date of confinement by a Covered Person in a Skilled Nursing Care Facility. A Convalescent Period will terminate when the Covered Person has been free of confinement in all institutions providing Hospital or nursing care for a period of two (2) consecutive weeks. A new Convalescent Period shall not commence until a previous Convalescent Period has terminated.

CO-PAY means a flat dollar amount that the patient pays toward the cost of a healthcare service at a network provider in addition to what the insurance pays.

COSMETIC PROCEDURE means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function. It does not include restorative procedures to correct disfigurement caused by an accidental injury or birth defect which causes a functional disability.

COVERED PERSON means any non-tribal Spouse or Dependent meeting the eligibility requirements for coverage as specified in This Plan and properly enrolled in This Plan.

COVERED MEDICAL EXPENSES mean services and supplies which are not specifically excluded from coverage under This Plan and are Medically Necessary to treat Illness or Injury unless This Plan specifically states otherwise.

CUSTODIAL CARE means the medical or non-medical services (such as assistance in the activities of daily living) which:

1. Do not seek to cure;
2. Are given during periods in which the medical condition is not changing; and
3. Do not require continued administration by a licensed Health Care Provider.

DEDUCTIBLE means a specified dollar amount of Covered Medical Expenses which must be incurred before any other Covered Medical Expenses can be considered for payment according to the applicable Payment Percentage.

DENTIST means an individual who is professionally trained and licensed to practice dentistry and who is practicing within the scope of such license.

DEVELOPMENTAL DISABILITY means substantial handicap which results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder.

DURABLE MEDICAL EQUIPMENT means equipment which is:

1. Able to withstand repeated uses;
2. Primarily and customarily used to serve a medical purpose; and
3. Not useful to a person in the absence of Illness or Injury.

EDUCATIONAL INSTITUTION an accredited organization that has the primary function of developing individual knowledge or skill.

EMERGENCY MEDICAL CARE means care made necessary by the sudden and unexpected onset of severe symptoms of an Illness or an Injury, which care must be received by the Covered Person immediately or within seventy-two (72) hours after the onset of such Illness or Injury.

EXPERIMENTAL, when referring to a drug, device, procedure, or treatment, means the drug, device, procedure, or treatment is limited to research, not proven in an objective manner to have therapeutic value or benefit, restricted to use at medical facilities capable of conducting scientific studies, or is of questionable medical effectiveness. To determine whether a procedure is experimental, the Plan Supervisor will consider, among other things, commissioned studies, opinions, and references to or by the American Medical Association, the Federal Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies and any other association or federal program or agency that has the authority to approve medical testing or treatment.

FAMILY means a member and his or her covered member children.

FORMULARY means a list of medications covered by this Plan at a preferred rate.

NON-FORUMULARY means not on the formulary list.

FIDUCIARY means **FOREST COUNTY POTAWATOMI COMMUNITY**, which has the authority to control and manage the operation and administration of this plan.

GENERIC means a chemically equivalent drug whose patent has expired.

GENETIC TESTING means the analysis of nucleic acids to diagnose a genetic disease.

HOME HEALTH CARE AGENCY means a facility or program which is:

1. Engaged in providing services and supplies in the home; and
2. Licensed, certified, or otherwise authorized pursuant to the laws of jurisdiction in which treatment is received.

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 or Skilled Nursing Facility confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

HOSPICE AGENCY means an agency whose main function is to provide Hospice Care Services and Supplies, and which is licensed by the state in which it is located, if licensing is required.

HOSPICE CARE PLAN means 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: (1) inpatient care in a Hospice Unit or other licensed facility, (2) home care, (3) homemaker services, (4) physical, occupational and respiratory therapy, and (5) family counseling during the bereavement period by a licensed social worker or a licensed pastoral counselor.

HOSPICE UNIT means 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 (6) months.

HOSPITAL means an institution that meets all the following conditions:

1. It is engaged primarily in providing medical care and treatment to an ill or injured person at the patient's expense.
2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to Hospitals.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury.
4. Such treatment is provided for compensation by or under the supervision of Physicians, with continuous twenty-four (24) hour nursing services by registered graduate nurses (R.N.'s).
5. It is accredited by the Joint Commission on the Accreditation of Hospitals (JCAH).
6. It is a provider of services under Medicare.
7. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

The definition of "Hospital" will also include an institution qualified for the treatment of psychiatric problems, substance abuse, or tuberculosis that does not have surgical facilities and/or is not approved by Medicare, provided that such institution satisfies the definition of Hospital in all other respects.

ILLNESS means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person. A recurrent illness will be considered one illness. Concurrent illnesses will be considered one illness unless the concurrent illnesses are unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one illness.

INJURY means only accidental bodily injury caused by an external force, occurring while This Plan is in effect. All injuries to one person from one accident shall be considered an "injury."

INPATIENT CARE means Hospital room and board and general nursing care for a person confined in a Hospital or Skilled Nursing Facility as a bed patient.

INTENSIVE CARE UNIT (ICU) means an area within a Hospital which is reserved, equipped, and staffed by the Hospital for the treatment and care of critically ill patients who require extraordinary, continuous, and intensive nursing care for the preservation of life.

JAW JOINT DISORDERS mean the treatment of jaw joint problems including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

LATE ENROLLEE means an individual who is enrolled for coverage after the initial eligibility date described in the section titled Eligibility, Enrollment and Effective Date. Note, however, a Special Enrollee shall not be considered a Late Enrollee hereunder.

MEDICALLY NECESSARY means health care service or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered. Exception where services and treatment are specifically excluded by The Plan.

MEDICARE means the medical care benefits provided under Title XVIII of the Social Security Act of 1965, as subsequently amended.

MEMBER means a person who is enrolled for coverage and who belongs to an Eligible Class as shown in the Eligibility Provisions of this Master Plan Document.

MENTAL DISORDER means a condition which is classified as neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disorder of any kind, including pathological gambling. To be considered a Mental Disorder under This Plan the condition must be defined as such in the "International Classification of Diseases Adapted" under 9 Section V - Mental Disorders.

MORBID OBESITY means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the Covered Person.

NEWBORN means an infant from the date of his or her birth until the initial Hospital discharge.

OUT OF POCKET MAXIMUM means predetermined limited amount of money that an individual must pay out their own funds before the Plan will pay 100% for an individual's healthcare expenses.

OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY means an institution which provides a program for diagnosis, evaluation, and effective treatment of alcoholism and/or substance abuse; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services that may be required; is at all times supervised by a staff of Physicians; prepares and maintains a written plan of treatment for each patient, based on the patient's medical, psychological, and social needs and supervised by a Physician; and meets state licensing standards.

PAYMENT PERCENTAGE means that portion of Covered Medical Expenses to be paid by This Plan in accordance with the coverage provisions as stated in This Plan.

PHYSICIAN means a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is duly licensed and qualified under the law of jurisdiction in which treatment is received. **NOTE**: for purposes of This Plan, any duly licensed chiropractor (DC), podiatrist (DPM), optometrist (OD), dentist (DDS), or registered nurse (RN) certified to engage in advanced nursing practice roles such as a nurse anesthetist or nurse midwife, or licensed psychologist, acting within the scope of his or her license, will be considered on the same basis as a Physician **to the extent that services are covered under This Plan**. Physician includes a licensed Psychologist who is listed in the National Registrar of Health Service Providers in psychology. Physician also includes a Physician's Assistant, Occupational Therapist, Physical Therapist, Licensed Practical Nurse (LPN), Nurse Practitioner, Speech Therapist, Licensed Clinical Social Worker, Acupuncturist, and Alternative Medicine Practitioner operating within the scope of his or her license and providing a service which is a Covered Medical Expense under This Plan.

PLAN/THIS PLAN means, without qualification, the Plan as contained in the Summary Plan Description, and any agreements, schedules and amendments endorsed by the Forest County Potawatomi Community.

PLAN ADMINISTRATOR means the Forest County Potawatomi Community, which is responsible for the day-to-day functions and management of This Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. The Plan Administrator is the named plan administrator within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended. The Plan Administrator is **Forest County Potawatomi**.

PLAN SUPERVISOR means the person or firm employed by the Plan Administrator to provide consulting services to the Plan Administrator in connection with the operation of This Plan and any other functions, including the processing and payment of claims as may be delegated to it.

PRESCRIPTION DRUG means all drugs that are required under Federal law to bear the label, "Caution: Federal law prohibits dispensing without prescription," or any substitute required label, and inject able insulin (whether by prescription), if the drug was prescribed by a licensed Physician.

PREVENTIVE CARE means medical treatment, services or supplies rendered solely for the purpose of maintaining health and not for the treatment of Illness or Injury. When a claim is submitted, the Physician's office must code the claim to indicate Preventive Care, or This Plan will consider the claim as treatment of Illness or Injury.

PRIMARY PLAN means a plan whose allowable benefits are not reduced by those of another plan.

REGISTERED NURSE (R.N.) means an individual who has received specialized nursing training and is authorized to use the designation of "R.N." and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

REVIEW ORGANIZATION means the organization contracting with the Plan Administrator to perform cost containment services.

ROOM AND BOARD means all charges, by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care (by whatever name called).

SEMI-PRIVATE means a class of accommodations in a Hospital or Skilled Nursing Facility in which at least two patient beds are available per room.

SKILLED NURSING FACILITY means an institution, or distinct part thereof, operated pursuant to law, and one which meets all the following conditions:

1. It is licensed to provide and is engaged in providing, on an inpatient basis for persons convalescing from Injury or Illness, professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered graduate nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or registered graduate nurse.
3. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered graduate nurse.
4. Its staff 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 for the aged, drug addicts, alcoholics, mentally handicapped, custodial, or educational care, or care of mental disorders.
7. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a Skilled Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

SPINAL MANIPULATION 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.

SPOUSE means a lawful spouse who is a resident of the United States, if not legally separated or divorced, including same-sex spouses that have been legally married in a state recognizing same-sex marriage.

TRIBAL MEMBER is defined as an Enrolled Member of the Forest County Potawatomi Community.

URGENT CARE CLINIC means a free-standing facility, or a Hospital facility with a specifically designated Urgent Care Room, which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include X- ray and laboratory equipment and a life support system.

USUAL AND CUSTOMARY refers to the designation of a charge as being the usual charge made by a Physician or other provider for services, supplies, medication, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or expertise.

WOMEN'S HEALTH AND CANCER RIGHTSACT OF 1998 ANNUAL NOTICE

"Please note this plan which models the rights, but in no way waives Potawatomi's sovereign immunity, of the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Keep this notice for your records and call your Plan Administrator (715)-478-7448 for more information."

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. NOTE: THIS NOTICE ONLY APPLIES TO THE MEDICAL INFORMATION ASSOCIATED WITH FOREST COUNTY POTAWATOMI COMMUNITY.

EFFECTIVE FEBRUARY 1, 2015

OUR LEGAL DUTIES

Pursuant to federal law we maintain the privacy of Plan participants' protected health information. Additionally, pursuant to federal law, we are providing those participants with notice of our privacy practices with respect to their protected health information (hereinafter "medical information"). We must follow the privacy practices that are describes in this Notice of Privacy Practices (hereinafter "Notice") while it is in effect.

Medical Information means information about you that is created or received by us during your coverage under the Plan. It is also information which identifies you or for which there is a reasonable basis to believe that the information can be used to identify you and that relates to:

1) The past, present or future physical or mental health or condition of the individual; or
2) The provision of health care to the individual; or
3) The past, present or future payment for the provision of health care to the individual.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the updated terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a change in our privacy practices, we will change this Notice and send the new notice to you if you are then currently covered under the Plan.

You may request a copy of our Notice at any time. For additional copies of this Notice, please contact us using the information at the end of this Notice.

PERMITTED USES AND DISCLOSURES

We may use and disclose medical information about you without your permission as required by law or for treatment, payment, and healthcare operations. However, most uses, and disclosures of psychotherapy notes, uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information require an authorization from you.

Here is a non-exclusive list of examples of these uses and disclosures:

For Treatment. We may use or disclose your medical information to a physician or other health care provider to provide treatment to you.

For Payment. We may use and disclose your medical information to pay claims from physicians, hospitals and other providers for services delivered to you that are covered by the Plan or to certify that these services are covered under the Plan.

For Health Care Operations. We may use and disclose your medical information in connection with our Health Care Operations. Health Care Operations include management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling complaint handling and other functions related to the Plan. Please note that genetic information cannot be used or disclosed for underwriting purposes.

To the Individual. We may disclose your medical information to you.

To Business Associates: We may contract with entities known as "business associates" to perform various Plan functions. We may disclose your medical information to business associates (and they may use medical information they create) so that they can perform these functions, but only after they agree in writing to implement appropriate safeguards regarding your medical information.

Opportunity to Agree or Object. We may disclose your medical information, with your informal permission and in circumstances where it is impracticable to get your informal permission, to a family member or other person designated by you to the extent necessary to help with your health care or payment of your health care. We may use or disclose your name, location, and general condition or death to notify or assist in the notification of (including identifying or locating), a person involved in your care. Before we disclose your medical information to a person involved in your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Informal permission may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object.

Miscellaneous. We may disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To provide appropriate governmental authorities with information regarding abuse, neglect, or domestic violence;
- For health oversight activities;
- For certain judicial and administrative proceedings;
- To law enforcement officials for law enforcement purposes such as subpoenas and administrative requests; identification or location of persons wanted by law officials; in response to law enforcement request for information about a victim; as evidence of a crime that occurred on the health provider's premises; for a health care provider to provide evidence of a crime off site;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- For research to develop or contribute to generalizable knowledge;
- To avert serious threat to health or safety;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates;
- As authorized by the Wisconsin workers' compensation laws.

- Limited Data Set. A limited data set may be used and disclosed for research, health care operations, and public health purposes, if you enter into a data use agreement promising specified safeguards for the medical information within the limited data set.

A limited data set is medical information from which certain specified direct identifiers of individuals and their relatives and household members, and employers have been removed.

Disaster Relief. We may also disclose limited medical information to a public or private entity that is authorized to assist in disaster relief efforts for that entity to locate a family member or other persons that may be involved in caring for you.

Written Authorization for Disclosures. Except as described in the "Permitted Use and Disclosure" section of this Notice, we will not use or disclose your medical information for any purposes unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing at any time. However, any action already taken by the Plan or others in reliance on the authorization cannot be changed.

HEALTH RELATED SERVICES

We may use your medical information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your medical information to contact you in any fundraising efforts in which we may engage.

INDIVIDUAL RIGHTS

Restrictions. You have the right to request that we restrict how your medical information is used and disclosed by notifying us of your request for a restriction in writing. This request should be mailed to the address at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request. However, we are required to agree with your request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations; and (2) the medical information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

In any case we agree to your requested restriction, we will comply with the restriction. To the extent permitted, we retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for medical information we receive after we have notified you of the termination. You also have the right to terminate any agree-to restriction. This also should be done in writing. This request also should be mailed to the address at the end of this Notice.

Confidential Communications. You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. This request should be mailed to the address at the end of this Notice. You may make your request verbally, but you must follow up by sending us a written request within 14 days of your verbal request. When applicable, your request must state that the information could endanger you if it is not communicated in confidence as you request. We must accommodate your request if it is reasonable, specifies alternative means or location, and continues to permit us to collect premiums and pay claims under the Plan.

Breach. You have the right to be notified if we (or a business associate) discover a breach of unsecured medical information.

Access. You have the right to look at or get copies of your medical information, with limited exceptions. You must make a request in writing to obtain access to your medical information. This request should be mailed to the address at the end of this Notice. If you request copies, we will charge you for the photocopying costs and the postage if you want the copies mailed to you. If you request another format, we will charge a cost-based fee for providing your medical information in that format. If the information you request is maintained electronically and you request an electronic copy, we will provide a copy in the electronic format you request, if the information can be readily produced in that format; if it cannot, we will collaborate with you to come to an agreement on the format. If we cannot agree, we will provide you with a paper copy.

Amendment. You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we do not keep the information, or we did not create the information you want amended and the originator remains available or for certain other reasons. We may also deny your request if the information is already accurate and complete. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people that you name, of the amendment and to include the changes in any future disclosures of that information. This request and/or statement of disagreement should be mailed to the address at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative in certain circumstances (e.g., we think the disclosure could endanger you).

Disclosure Accounting. You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, since April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information.

Right to Receive Paper Copy of this Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in a paper form. Please contact us and we will mail it to you. This request should be mailed to the address at the end of this Notice.

Complaints. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Contact Information. If you have questions or need further assistance regarding this Notice, you may contact:

Forest County Potawatomi Insurance Department
P.O. Box 370
Crandon, Wisconsin 54520-0370
Insurance Director
715-478-7448

This notice is not and should not be construed as a waiver of the Forest County Potawatomi Community's sovereign immunity.