PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

The Mashantucket Pequot Tribal Family Health Plan

January 1, 2026

This SPD supersedes prior summaries, plan documents and addenda. Provisions described in this SPD are effective on or after January 1, 2026.

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ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **Mashantucket Pequot Tribal Nation** (the "Plan Sponsor" or "MPTN") as of January 1, 2026, hereby sets forth the provisions of the Mashantucket Pequot Tribal Family Health Plan (the "Plan" or "TFHP"). Any wording which may be contrary to applicable federal or tribal laws or regulations will be interpreted to meet the standards set forth in such laws or regulations. Also, any changes in federal or tribal laws or regulations which could affect the Plan are also automatically a part of the Plan, to the extent required.

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Mashantucket Pequot Tribal Nation

By: _____

Name: _____

Title: _____

Date: _____

SECTION 1: GENERAL PLAN INFORMATION ❖❖❖❖

PLAN NAME:

Mashantucket Pequot Tribal Family Health Plan

PLAN FIDUCIARY AND PLAN SPONSOR:

Tribal Council
Mashantucket Pequot Tribal Nation
2 Matt's Path
P.O. Box 3060
Mashantucket, CT 06338

PLAN ADMINISTRATOR:

c/o Pequot Health Care
Pequot Plus Health Benefit Services
One Annie George Drive
P.O. Box 3620
Mashantucket, CT 06338

CLAIMS ADMINISTRATOR:

Pequot Health Care
Pequot Plus Health Benefit Services
One Annie George Drive
P.O. Box 3620
Mashantucket, CT 06338

MISCELLANEOUS:

The tax identification number of the Plan Administrator is 06-0995554

AGENT FOR SERVICE OF LEGAL PROCESS RELATING TO THE PLAN:

Office of Legal Counsel
Mashantucket Pequot Tribal Nation
2 Matt's Path
P.O. Box 3060
Mashantucket, CT 06338

PLAN TYPE:

Self-funded community-based health plan consisting of Medical, Vision, Dental and Pharmaceutical coverage. The Tribal Family Health Plan is designed to provide an optimal level of care to the members of the Mashantucket Pequot Tribal Nation and their eligible Dependents. The Mashantucket Pequot Tribal Nation, as the governing body of its land and people, provides the funding for this benefit. The Tribal Family Health Plan is a community plan—it is <u>not</u> a "group health plan" as defined by the Tribal Employee Retirement Income Security Act (Title 15 of the Mashantucket Pequot Tribal Laws). The Tribal Family Health Plan is also tribal health program under the Indian Health Care Improvement Act.

PLAN EFFECTIVE DATE:

This Plan's was amended and restated effective as of January 1, 2026, and may be revised from time to time. The financial records of the Plan are kept on a Plan Year basis, ending on each December 31st, thereafter at 11:59 pm Eastern Standard Time.

PLAN FUNDING:

Funding for the Plan's claims and administrative expenses is provided totally from Tribal funds and from Plan member contributions.

PLAN INTERPRETATION

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan participant's rights; and to determine all questions of fact and law arising under the Plan.

LEGAL ENTITY; SERVICE OF PROCESS

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

NOT A CONTRACT

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Plan Sponsor and any Tribal Member or any other person covered under the Plan.

APPLICABLE LAW

This Plan is a tribal government-sponsored plan and is not conditioned on employment, and as such it does not qualify as an employee benefit plan under Title 15 of the Mashantucket Pequot Tribal Laws (also known as "TERISA"). The participants' rights in the Plan are governed by this Plan Document and applicable tribal law and regulations.

SECTION 2: INTRODUCTION ❖❖❖❖

The Tribal Family Health Plan (TFHP) is a comprehensive “COMMUNITY” benefit designed to provide an optimal level of health care to the members of the Mashantucket Pequot Tribe, their families and eligible Dependents “from cradle to grave”. The overall health and wellness of Tribal Members and their families is very important to the growth, security and preservation of the Tribe. That is why the Tribe is committed to ensuring you and your families have access to high quality health care services and financial protection from unforeseen catastrophic illnesses.

IT IS VERY IMPORTANT THAT YOU READ THIS PLAN DOCUMENT CAREFULLY AND BECOME FAMILIAR WITH YOUR HEALTH BENEFITS AND OTHER HEALTH RELATED RESOURCES AND SERVICES AVAILABLE TO COMPLEMENT THE TFHP. Understanding how they work will enable you to take full advantage of your health care coverage and avoid unnecessary expenses.

This Plan Document describes the benefits and services available to you as a Tribal Member or Dependent, defines eligibility for the Plan, and provides guidelines to be used by the Plan Administrator in making decisions regarding the Plan. Each Tribal Member and Dependent enrolled in the Plan is referred to in the Plan Document as a “Participant.”

Shortly after you enroll in the TFHP, you will receive a health plan identification card(s) issued in your name for use by you and your Dependents. Be sure to show your health care provider your card whenever medical services are necessary for you or a covered Dependent. Carry your card at all times. In case of loss, you may still use your coverage. You can replace your card(s) by contacting Pequot Plus Health Benefit Services at 888-779-6872.

Legal requirements govern the use of your card. Therefore, you should not let anyone who is not named in your coverage use your card to obtain benefits or receive payment for them. **Improper use of the card or benefits is considered fraud and may lead to legal action, termination of benefits, non-payment of claims and other penalties.**

If you have questions regarding the SPD or your benefits, please contact Pequot Plus Health Benefit Services at **888-779-6872.**

SECTION 3: PEQUOT HEALTH CARE ❖❖❖❖
(PRxN and Pequot Plus Health Benefit Services)

Pequot Health Care (PHC) is designated by the MPTN Tribal Council as the Claims Administrator for all the Tribe's health benefit plans, including the Tribal Family Health Plan. PHC, a managed care company, offers third party claims administration and pharmacy dispensing, including pharmacy benefit management services to the MPTN community of Tribal Members, employees and their dependents, as well as other Native American Tribes and commercial business groups.

The mission of PHC is to improve the health of all MPTN Tribal Members and employees, as well as the employees of external clients, by providing superior managed care and benefit administration services. The company achieves its mission by providing affordable, safe, convenient, and culturally-sensitive services utilizing state-of-the-art technology and advanced business practices in the health benefit administration and pharmacy services industry. Founded in 1991 by MPTN, PHC consist of two distinct lines of business branded as: Pequot Pharmaceutical Network (PRxN) and Pequot Plus Health Benefit Services (Pequot Plus).

PRxN offers an array of pharmacy services to meet Participants' retail and mail order pharmacy needs. Prescriptions can be filled on a walk-in basis by accessing the on-reservation pharmacy or by visiting the satellite pharmacy located "back of house" at Foxwoods Resort Casino. Participants can also conveniently order prescriptions online by using PRxN's mail order service. This service is especially ideal for refilling maintenance medications. Delivery is made to Participants' homes through the U.S. Postal Service and, when required, via Federal Express. In addition to ordering prescriptions by facsimile or telephone, Providers can also place orders using PRxN's electronic Provider prescribing (e-Rx) system. All medication is dispensed by licensed pharmacists and certified pharmacy technicians.

A Pharmacy Benefit Manager, or PBM, is an organization that provides programs and services designed to help maximize drug effectiveness and contain drug expenditures by appropriately influencing the behaviors of prescribing physicians, pharmacists and members. PRxN provides PBM services to its clients, giving patients access to an integrated network of over 65,000 chain and independent retail pharmacies across the United States. This service is especially important for Participants needing access to pharmacy services after hours or when off-reservation. Ensuring that Participants benefit from the use of cost effective and the most beneficial medication is another important role of the PBM. This is accomplished by employing the best blend of clinical, educational and financial programs such as drug utilization review, Prior Authorization, formulary management and step therapy. PRxN closely interacts with Tribal Health Services to help monitor and safeguard patient health and progress in connection with their medication use.

Pequot Plus is the designated third party administrator (TPA) for the Tribe's health plans. Claims incurred by Participants for medical, dental and vision care are processed by Pequot Plus. Besides processing claims, Pequot Plus also manages the relationship with regional and national provider networks, such as UnitedHealthcare. This affords Participants freedom of choice and access to a wide range of hospitals, physicians and behavioral/mental health professionals based on quality, cost of care and outcomes. Coordination for utilization review, case management services, and disease and wellness programs are also managed by Pequot Plus. Beneficial to Participants is immediate and on-site access to Pequot Plus Customer Service staff for the resolution of health benefit concerns and plan coverage inquiries.

PHC is committed to helping MPTN optimize healthcare savings by improving the health status of Tribal Members and their Dependents.

SECTION 4: ELIGIBILITY, PARTICIPATION AND ENROLLMENT
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Eligibility

WHO IS ELIGIBLE FOR COVERAGE?

To be eligible for benefits under the Tribal Family Health Plan (TFHP or the Plan), a person must be an enrolled member of the Mashantucket Pequot Tribal Nation (MPTN) or an eligible Dependent of the enrolled Tribal Member. Individuals eligible to receive health benefits under the TFHP are:

- **Tribal Member** – A person (an adult or a child) who is enrolled in the Mashantucket Pequot Tribal Nation.
- **Tribal Spouse** – A person who is the legal spouse of an enrolled MPTN Tribal Member joined in lawful marriage with documentation of an original marriage certificate; however, legally separated spouses shall be treated as divorcees.
- **Widow or Widower**– A spouse of a Tribal Member who has died.
    - If age 18 through 64, the Widow or Widower may continue to receive coverage for a period of two (2) years from the passing of the Tribal Member. However, if a Widow or Widower is or will be eligible for Medicare within that period, the Widow/Widower must apply for Medicare when eligible, and coverage under the Plan continues until such time as Medicare is obtained.
    - If over the age of 64, the Widow/Widower must apply when eligible for Medicare, but coverage under the Plan continues until such time as Medicare is obtained.
- **Tribal Child** – a dependent child who is a lineal descendent of an enrolled Tribal Member
    - Under 18 – the child is covered under the Tribal Member's family coverage
    - 18 – 26 – if the child is an enrolled Tribal Member, he/she/they may remain on his/her/their parent's family enrollment until the age of 26.
    - If a Tribal Child is adopted by a non-Tribal Member, the Tribal Child, within ninety (90) days of turning 18, must complete an enrollment application to the Tribal Clerk for consideration by Elders Council to become a member of the Tribe, in order to continue to receive the TFHP benefit.
    - If the child of a Tribal Member is subject of a Qualified Medical Child Support Order, other than an ex-stepchild, the Plan will provide coverage to such child as an alternate recipient pursuant to the order and subject to all limitations and conditions on any other Participant.
    - A Legally-Adopted Child and a Tribal Member Dependent Child may be covered under the Plan up to the age of 18; provided that if the child turns 18 and is still enrolled in High School, the child may remain covered until the last day of the sixth month after the child graduates from or leaves High School, whichever occurs sooner. If the child is an enrolled Tribal Member, he/she/they may remain on his/her/their parent's family enrollment until the age of 26.

- **Permanent Dependent** – Permanent Dependents older than 26 years of age may remain in the Plan or enroll in the Plan through their parent's enrollment, or the enrollment of a sibling, grandparent, or legal guardian who is eligible for and enrolled in the Plan.

REGISTRATION WITH TRIBAL HEALTH SERVICES

The Plan and the Tribal Health Service (THS) have implemented a "single sign-on" process. When you register for the Plan, the information you provide will be submitted to THS. THS will use this information to register you within its system so that you are eligible for services through THS.

WHO IS NOT ELIGIBLE FOR COVERAGE?

Individuals not eligible to receive health benefits under the TFHP are:

- Significant others/domestic partners – a person not lawfully married to an enrolled Tribal Member.
- Divorcees – a person who is legally divorced or legally separated from an enrolled Tribal Member, or who does not cohabitate at the same residence as the Tribal Member for the majority of the applicable Plan Year (unless due to work or family care obligations).
- Dependent(s) not eligible for enrollment in the Mashantucket Pequot Tribe (i.e. stepchild, foster child, except when one is a Legal Dependent.)
- "Banished" or "Excluded" Tribal Members, by Order of the Mashantucket Pequot Elders Council, and their Spouses and Legal Dependents, unless otherwise noted in the banishment or exclusion order. These individuals must meet with the Elders Council for reinstatement of coverage under the Plan.

Participation

A Tribal Member who has satisfied the eligibility requirements described above will become covered along with any eligible Dependents as of the date the Tribal Member completes the enrollment process (called his/her/their "Participation Date").

Enrollment

When Coverage Begins – Initial Enrollment

All Tribal Members enrolled and listed on the Membership Roll maintained by the Office of Tribal Clerk are automatically eligible for immediate benefits upon proper enrollment into the Plan. Tribal Members enrolled in the Plan will continue to be eligible for benefits as long as they are listed on the Membership Roll and remain in good standing with the Tribe, including staying current on all payments due under the Plan.

The Tribal Clerk is responsible for enrolling Tribal Members and their Dependents in the Plan. Eligible Tribal Members must sign up for coverage for themselves and any Dependents by completing the enrollment process as defined by the Tribal Clerk. Tribal Members who wish to sign up for health coverage or have questions about the enrollment process should contact the

Tribal Clerk's office at (860) 396-6618.

Tribal Members and their Dependents may enroll at any time during the year. There is no annual or late enrollment period for eligible Tribal Members. However, it is advisable that Tribal Members review their enrollment elections at least once every year, preferably in the last two months of every calendar year. Benefit elections made during this period generally become effective January 1st and will remain in effect through the next December 31st, unless there is a Qualifying Life Event.

For an eligible newborn Tribal Child, coverage is effective for the first thirty-one (31) days following birth, for an accidental injury or sickness, or for routine nursery charges as listed in the Schedule of Benefits (See p. 43). Coverage will continue beyond the initial thirty-one (31) days provided a Plan enrollment form is completed, signed and submitted to the Tribal Clerk within thirty-one (31) days from the date of birth.

Coverage is provided for newborn Hospitalization routine care while the newborn is Hospital-confined after birth and includes room, board and other Medically Necessary care for which a Hospital makes a charge. Charges will be covered under the "Tribal Member Primary Plan Enrollee" if the "Tribal Member Primary Plan Enrollee" is covered under the Plan at the time of the child's birth.

Permanent Dependent – A Permanent Dependent may be kept on the Plan or enroll in the Plan through their family's or legal guardian's enrollment by providing written notice to the Tribal Clerk and the Plan Administrator. Any such notice shall be provided at least sixty (60) days prior to the Permanent Dependent's 26th birthday, or within thirty (30) days of the initial diagnosis of the condition qualifying that person as a Permanent Dependent. The Tribal Clerk or Plan Administrator may request reasonable supporting documentation, including medical files, to confirm the enrollee's status as a Permanent Dependent.

As a condition to enrollment as a Permanent Dependent, the Permanent Dependent's family or legal guardian must use reasonable efforts to utilize alternate healthcare resources for the Permanent Dependent (e.g., Medicaid, Medicare). If you need assistance, please contact Pequot Plus at (888) 779-6872 or PequotPlus@prxn.com. Failure to utilize available alternate resources may result in loss of coverage under the Plan as a Permanent Dependent. No premium contribution will be owed for any Permanent Dependent enrolled in Medicaid, Medicare, or other comprehensive alternate health plan.

Qualifying Life Event and Enrollment Changes

A qualifying life event occurs when a specific circumstance has altered your life in a way that affects eligibility for coverage under the Plan. For example, if you were recently married, divorced, became a parent or experienced a Dependent's death, you are eligible to make additions or deletions in your health elections. Again, any changes you wish to make in your coverage (i.e. adding or removing an individual) require that you make those changes through the Office of the Tribal Clerk. You must provide to the Tribal Clerk notice of a divorce or loss of Dependent status within thirty-one (31) days after such event.

No other individual can make changes in enrollment status other than the Primary Plan Enrollee, and, in most cases, that is the enrolled Tribal Member.

Notification of Ineligibility

The Tribal Clerk will notify you if it is determined that you and/or your Dependents are no longer eligible to receive coverage. Notice of this determination will be provided to you in writing at the address on file with the Tribal Clerk's Office, and will include the date on which coverage will terminate. You will have thirty (30) days to provide any certified official documents or other information as requested by the Tribal Clerk for reconsideration of eligibility status. The Tribal Clerk will make one (1) written attempt after sending the initial notification to obtain such documentation or information. If such documentation or information is not provided, your health coverage will be terminated for you and/or your Dependents on the date in the initial notice, after which the Plan will not pay for or reimburse any claims. If such documentation or information is provided, the Tribal Clerk will review the documents and information submitted and notify you of its determination. If you and/or your Dependents are still determined to be ineligible, coverage will end thirty (30) days from the date the notice is sent. In either case, the Tribal Clerk shall send written notice when coverage has been terminated (the "Notice of Denial of Eligibility").

Failure to notify the Tribal Clerk of a change in a Dependent status could result in the Plan pursuing reimbursement for benefits paid on behalf of an ineligible Dependent. See Section 23, Right of Reimbursement, for additional information.

If the Tribal Clerk receives a copy of a divorce decree issued by a court of competent jurisdiction, the Tribal Clerk will notify the Claims Administrator who will notify the non-eligible divorcee that he/she/they is no longer eligible to receive health benefits under the Plan and that coverage shall cease sixty (60) days following the mailing of the notification.

Should a court of competent jurisdiction issue an Order demanding that a Tribal Member continue to provide health coverage to an **"unenrolled"** Tribal Child over the age of 18 or a former Tribal Spouse, it is the responsibility of the Tribal Member to purchase health coverage outside of the Plan.

Notification For Tribal Children/Legal Dependents:

Upon turning 18, a Tribal Child or Legal Dependent is no longer eligible for coverage through the TFHP. If the Tribal Child or Legal Dependent is eligible for enrollment in the Tribe, they must enroll by the age of 18 to continue to receive health benefits under their parent's coverage.

The Tribal Clerk shall provide notice to the parent or guardian of Tribal Children enrolled in the Plan (i) six (6) months prior to the Tribal Child's 18th birthday; and (ii) six (6) months prior to the Tribal Child's 26th birthday, if on his/her/their parent's family enrollment. This notice shall include information on what the Tribal Child must do to remain enrolled in the Plan. The Tribal Clerk's failure to provide notice shall not excuse the Tribal Child from taking any actions necessary to remain eligible for enrollment on the Plan.

Fraud

Under this Plan, coverage may be retroactively canceled, terminated, or rescinded if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

It will be deemed fraud if a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud may result in immediate termination of all coverage under this Plan for the Participant and their entire family unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. Claims incurred after the retroactive date of

termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Termination of Coverage

All health benefits for a Participant will automatically terminate if:

- The Plan is discontinued (coverage is cancelled for all Plan Participants);
- There is sufficient evidence, as determined by the Plan, of an effort to defraud the Plan or waste or abuse Plan assets; or
- The Tribal Member is banished, excluded, or Tribal Membership terminates, unless otherwise noted in the banishment or exclusion order.

Termination of Dependent Coverage

The coverage for any Dependents of any Tribal Member who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Tribal Member's coverage for himself/herself/themself under the Plan.
4. The date of the expiration of the last period for which the Tribal Member has made a contribution, in the event of his/her/their failure to make, when due, any contribution for coverage for Dependents to which he/she/they has agreed in writing.
5. The day immediately preceding the date such person is no longer a Dependent.
6. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of a Tribal Member or his/her/their Dependent, or upon the Tribal Member or his/her/their Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Waiving Health Coverage under the Plan

For medical expenses to be covered by the Tribe, an eligible Tribal Member must enroll himself or herself and any Dependents in the Plan. A Tribal Member may waive medical coverage under the Plan, but the Tribe will NOT cover any medical expenses for the Tribal Member or his/her/their Dependents.

A Tribal Spouse may waive his/her/their Mashantucket Pequot Employee Health Benefit Plan coverage to join the TFHP if he/she/they meets the eligibility criteria and the subscribing Tribal Member enrolls him/her/them into the TFHP. Dependents covered under another plan may waive medical coverage under this Plan, and cannot be covered by more than one Tribal Nation health plan. The TFHP shall be the payor of last resort for all Tribal Members or Dependents covered under the TFHP and another health care plan.

Appeals Process for Eligibility Determination

A Tribal Member, who is denied enrollment in the Plan, may file an appeal within thirty (30) days of the Notice of Denial of Eligibility with the Office of the Tribal Clerk. The Tribal Member may also appeal a decision to deny coverage to any of the Tribal Member's Dependents on behalf of the Dependent. In appealing the denial, the Tribal Member must provide a written statement that must include an explanation explaining the reasons and basis for the individual's disagreement with the ineligibility determination. In addition, the individual must also provide supporting documentation certifying their eligibility. The Tribal Clerk is required to give a written decision within thirty (30) days of receipt of the appeal.

Should the Tribal Clerk uphold the original determination to deny enrollment in the Plan, the Tribal Member may appeal the decision, in writing, to the Health and Human Services (HHS) Committee Review Panel. The HHS Committee Review Panel is required to make a determination and notify you in writing of their decision on your eligibility for coverage within thirty (30) days of receipt of your appeal. The decision of HHS Committee Review Panel shall be considered a final decision of an agency for purposes of the Mashantucket Pequot Administrative Procedures Act (the "APA"), Title 40 of the M.P.T.L., and may be appealed to the Mashantucket Pequot Tribal Court as provided under the APA.

SECTION 5: HEALTH CARE COVERAGE ❖❖❖❖

Participating Provider Organization (PPO)

The Plan provides coverage for a broad range of services, including hospitalization, surgery, doctor visits, prescription drugs, and behavioral and mental health treatment in a Participating Provider Organization ("PPO") arrangement. The PPO for the Plan is UnitedHealthcare.

Under the PPO arrangement, Plan Participants may choose to obtain medical services from providers who are classified as "in-network," meaning a preferred provider, or "out-of-network" meaning a provider that is not part of the network. Your benefits are higher when you go in-network; meaning the Plan generally reimburses a higher percentage of fees and you pay less out-of-pocket. If you use an out-of-network provider, you are responsible for paying a larger share of the cost of health care services.

Again, the best choice and savings to you, is to choose an "IN-NETWORK" Provider whenever it is conveniently possible. WHY? You save and you help the Tribe save on health care costs!

Pequot Health Care can help you find in-network providers, where your costs will be lower:

CALL: 1-800-219-1226
EMAIL: PequotPlus@prxn.com
VISIT US: https://www.pequothealthcare.com

Out-of-Network Exceptions

There are times when the Plan will pay the higher in-network reimbursement for Covered Services received from an out-of-network provider.

- If the Utilization Review Company approves such service because a required specialty or procedure is not available within the network area.
- If a Participant has an emergency requiring immediate care.
- Expenses incurred from out-of-network physicians who are covering for in-network physicians (due to vacation, etc.) are paid at in-network benefits. The covering physician must note on the claim form that he is covering for an in-network physician.
- Charges by out-of-network providers at an in-network facility for ancillary services are covered as in-network expenses. A few examples are pathologists, radiologists, anesthesiologists, and emergency room physicians.

Special Note about Referrals

- Referrals by in-network providers to out-of-network providers will be considered as *out-of-network* services and supplies. In order to receive the higher in-network benefits, ask your provider to refer you to a participating network provider.

How a PPO Plan Works

With a PPO, there is no requirement to see a "primary care physician" or obtain a referral before seeing a specialist—**HOWEVER**, certain services require you to obtain Prior Authorization from the Plan, or else you will not receive coverage from the Plan. See Section 6, Prior Authorization, for more details.

Where Prior Authorization is not required, you simply select a network provider and receive the care you need. However, In-Network providers will cost you less than Out-of-Network providers. *Always ask your health care provider whether he/she/they participates in the Plan's network(s).*

The PPO network may change from time to time. Be sure to contact your provider before treatment to determine whether he/she/they is still part of the network. A change in the membership of the provider network is not considered a qualifying event for change in coverage status.

How PPO Benefits Are Paid

For In-Network and Out-of-Network coverage, you pay a certain amount in the form of a copay, deductible or co-insurance; then the Plan pays a percentage of eligible charges for covered expenses. Anything not paid by the Plan will be your responsibility. Amounts are based on services according to the Schedule of Medical Benefits, which could include copays, deductibles, or co-insurance. You may also be charged penalties if you do not first obtain Prior Authorization, when required, such as for hospital stays and outpatient services and diagnostic procedures. See the Prior Authorization Schedule (p. 19) and Schedule of Medical Benefits (p. 43) for additional information.

Balance Billing

Sometimes a claim submitted by a Physician is subject to medical bill review or medical chart audit, which may result in some or all of the charges in being repriced. This may occur due to billing errors and/or overcharges. The Plan believes Participants should not be responsible for payment of any charges denied as a result of the review or audit, and should not be balance billed (i.e., required to pay the difference between the billed charges and the amount determined to be payable by the Claims Administrator after review or audit). **However, the Plan generally cannot control a Physician's decision to engage in balance billing.**

In-Network Physicians are less likely to engage in balance billing due to their contract with the network. Therefore, you are far less likely to experience balance billing if you visit In-Network Providers.

Claims Audit

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

Plan Administrator or its agent (including the Claims Administrator) has the sole discretionary authority for selection of claims subject to review or audit.

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

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

Despite the existence of any agreement to the contrary, the Plan Administrator or its agent (including the Claims Administrator) has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accordance with the terms of this Plan Document.

SECTION 6: PRIOR AUTHORIZATION ❖❖❖❖

The services listed in the Type I Prior Authorization Schedule and the Type II Prior Authorization Schedule require Prior Authorization **before** you receive such service. Prior Authorization can apply to both in-network and out-of-network providers.

WHAT IS PRIOR AUTHORIZATION?

Prior Authorization is a review program to ensure you are receiving the appropriate level of care *before* you are treated. The medical appropriateness standards are derived by combining scientific research data and the expert clinical experience of a multispecialty physician panel.

Prior Authorization is not intended to replace clinical judgment but rather to enhance it with the combined wisdom of research and expert consensus. Initial screening is done by UnitedHealthcare's Medical Care Coordinators, who are experienced registered nurses. Cases with questionable indications are referred to Physician Advisors. Both the nurses and the Physicians are specially trained in medical appropriateness review.

Depending on the specific procedures, the Medical Care Coordinators will pose questions to the physician's office staff (or physician), the patient or both. The Medical Care Coordinators will enter the responses to these questions into the clinical standards database.

If the responses indicate the proposed procedure is appropriate, the procedure may be certified after two or three questions. The place of service will also be certified during this discussion, thus eliminating the need for duplicate phone calls.

If the responses do not indicate the proposed procedure is appropriate, the case will be referred to a Physician Advisor. The Physician Advisor will call the Physician's office within two business days and discuss the case with the attending Physician to determine whether any extenuating circumstances make the procedure appropriate. The outcome of this peer discussion will determine whether reimbursement for the procedure by the Plan should be approved.

You must obtain Prior Authorization for certain kinds of health procedures and services. Prior Authorization may sometimes be called pre-authorization, pre-certification or pre-approval. **This Prior Authorization is designed to help protect you from the cost and inconvenience of unnecessary treatment or extended inpatient stays.** By calling for Prior Authorization, you learn, before you incur an expense, whether your treatment is Medically Necessary. If treatment is not Medically Necessary, the Plan will not pay any benefits for that treatment.

WHY IS PRIOR AUTHORIZATION NECESSARY?

Most problems have more than one solution. When it comes to medical care, these solutions range from the management of your condition with medication or physical therapy on the one hand to surgical intervention on the other. Our goal is to support your provider by finding the course of treatment that offers you the best possible results with the least amount of risk in

accordance with your health coverage. Like your Provider, we want to ensure you get the best treatment for your health problem by helping you make the right decision about medical care.

There are two types of Prior Authorizations. These are referred to as Type I and Type II, and they have different requirements. Each type of Prior Authorization is described below in detail.

Type I Prior Authorization: It is important to note that if you do not obtain Prior Authorization for services that fall under Type I there are significant penalties.

It is important to obtain Prior Authorization when the Plan requires it. If the Plan requires Prior Authorization for a service and you fail to get Prior Authorization for that service, the Plan may not pay for the services or supplies provided.[1] **You will also incur an out-of-pocket penalty of 20% of billed charges or $5,000, whichever is less, for each failure to obtain Prior Authorization.**

Network providers are primarily responsible for obtaining Prior Authorization for all applicable covered health care services. **When a provider is out-of-network, YOU are responsible for confirming that your provider has obtained Prior Authorization for services or supplies. If not, you must call for Prior Authorization.**

Type I Prior Authorization Schedule

Type I Prior Authorization is required for the following services. See Type I General Prior Authorization Requirements for more details (list subject to change by Plan Administrator)

- All inpatient services (except pregnancy admissions that do not exceed 48 hours for a vaginal delivery or 96 hours following a cesarean delivery)
- All outpatient surgeries
- All MRI/MRA, CT scans, bone scans (including bone density), PET scans, abdominal ultrasounds, and other non-emergency imaging
- Autism Spectrum Disorder
- Cardiac rehabilitation
- Chemotherapy and radiation therapy
- Dialysis treatment
- Durable medical equipment costing more than $1,000 to purchase or where total anticipated rental fees will exceed $1,000
- Home health care, including home infusion care
- Medical alert systems and remote patient monitoring devices
- Physical therapy or occupational therapy beyond thirty (30) treatments annually
- Prosthetic devices and appliances
- Speech therapy
- Transplants

[1] The Plan will pay for services or supplies if such services or supplies were found to be Medically Necessary and otherwise would have been approved if submitted for Prior Authorization; however, you will still incur a penalty for failure to obtain Prior Authorization. If the services or supplies were not Medically Necessary or otherwise would not have been approved if submitted for Prior Authorization, the Plan will not pay for such services or supplies.

Type I General Prior Authorization Requirements

All inpatient admissions, all outpatient surgeries, including certain hospital-provided diagnostic testing and medical services from the Type I Prior Authorization Schedule must receive Prior Authorization.

DEADLINES AND PROCEDURES

You and or your provider can request Prior Authorization by telephoning the Prior Authorization line: (877) 883-5980. The prior authorization number also appears on the back of your ID card.

Non-Emergency Services: For non-emergency supplies or services you or your medical provider must request Prior Authorization from UnitedHealthcare before services are provided. It is best to do this as early as possible and as soon after you learn of the need for a procedure, supplies or services. Delay by UnitedHealthcare will not excuse you from the requirement to get Prior Authorization.

Emergency Services: An emergency service is one where immediate medical care is required for a condition that could seriously jeopardize the Participant's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without emergency services. For these services, there is no need to contact the Plan for Prior Authorization. The Covered Person should obtain such care without delay. Call 911 if necessary. However, either the Covered Person, an authorized representative, the medical care facility or the attending Physician must contact UnitedHealthcare within three (3) business days of an emergency Hospital admission or medical services.

Extended Stay/Additional Services: If a provider determines that you or a Participant must receive additional services or stay in a medical care facility for longer time than previously authorized by the Utilization Review Company, the provider must obtain Prior Authorization for the additional service or days.

Maternity: Prior Authorization is not required for maternity stays that are within the authorized time: forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a Cesarean delivery. If additional time in the Hospital is required for mother, baby or both, these additional days MUST BE CERTIFIED. For patients discharged in less than the authorized time, one follow-up home care visit will be considered medically appropriate and will NOT require Prior Authorization. ALL other admissions for complications arising from pregnancy must have Prior Authorization.

Questions & Answers about the Type I Prior Authorization Process

Q: How does Type I Prior Authorization work?

A: *A UnitedHealthcare Medical Care Coordinator will interview you about your condition and verify with your Physician the proposed place of service and the length of stay. Based on nationally-recognized standards, the services are authorized if Medically Necessary and appropriate.*

Q: When do I call UnitedHealthcare to obtain Prior Authorization?

A: *It is important that UnitedHealthcare is contacted before you begin any treatment or services for which Prior Authorization is necessary. Prior Authorization should be obtained as early as possible in advance of any procedure and within three (3) business days of an emergency.*

Q: Is it absolutely necessary to obtain Prior Authorization before planned hospitalizations or scheduled surgeries?

A: *YES. In the Hospital, the Physician obtains certification for you. If you choose to use a Physician or Hospital outside the* ***UnitedHealthcare network*** *and you do not obtain Prior Authorization, your benefits will be reduced. All inpatient hospitalizations and selected outpatient procedures require approval. Outpatient surgeries, certain Hospital-provided diagnostic testing and medical services, such as dialysis treatment require Prior Authorization. All calls must be made at least three (3) business days for Emergencies.*

Even if not required, we urge you to confirm with the Claims Administrator that services you intend to receive are covered health services. That's because in some instances, certain procedures may not be covered by the Plan, or may exceed the allowable benefits amount, and therefore are excluded. In other instances, the same procedure may be covered. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

Q: What about an emergency situation, when there may not be enough time to contact UnitedHealthcare before hospitalization or surgery?

A: *If emergency treatment is necessary, go straight to the emergency room or call 911. You, or your provider, an authorized representative, or a family member should contact* ***UnitedHealthcare*** *for Prior Authorization within three (3) business days after an emergency admission.*

Q: Does UnitedHealthcare ever tell my provider or me what medical services are needed?

A: *No. The Prior Authorization process does not direct care. You and your provider always make the final decision on any treatment plan. Prior Authorization determinations simply indicate whether or not the proposed treatment meets the medical necessity criteria and if reimbursement for this procedure by the Plan is approved.*

Q. What happens when I need to stay longer in the Hospital or have different covered services? Is another Prior Authorization required?

A. *Yes. If in the opinion of your provider or Hospital facility, it is necessary for you to receive Covered Health Services for a longer period of time than has already been pre-certified, or to receive different Covered Health Services than those that have already been pre-certified, you must obtain Prior Authorization for the longer period for the different Covered Health Services.*

Q: What if my network physician disagrees with a determination made by United-Healthcare?

A: *If your network physician disagrees with the initial determination, the medical utilization company (currently Optum Inc.) offers a multi-level appeals process. You or your provider must initiate an appeal within 180 days. You and your provider are able to participate in this process in an attempt to reach resolution. If your treatment is denied during the Prior Authorization process, you should encourage your provider to become involved and to request an appeal. Please contact the Claims Administrator for further information on the appeals process.*

Q: What if I disagree with an authorization decision when utilizing a network or out-of-network physician?

A: *If your request for Prior Authorization is denied, you may appeal. If you disagree with the initial determination, contact UnitedHealthcare at the Prior Authorization phone number on the back of your ID card. If UnitedHealthcare denies your appeal, you may appeal to the Plan (see Section 22, Claims Determination).*

Type II Prior Authorization Requirements

Type II Prior Authorization requires a Service Reference Number (SRN), which can be obtained by either the healthcare provider or the Plan Participants.

WHY IS IT NECESSARY FOR PLAN PARTICIPANTS TO COMPLY?

Compliance is extremely important to the Tribe and to Plan Participants because it lowers the cost of the Plan to the Tribe, which allows the Plan to provide better and cheaper coverage.

Unlike Type I Prior Authorization, which is concerned with medical appropriateness, Type II Prior Authorization purely addresses the cost of care paid by the Tribe. It is a payment schedule allowed by the federal government to assist Native American tribes afford healthcare for their family members. Similar to FSS pricing for pharmacy costs, with proper Prior Authorization, the Plan is allowed to pay Medicare Like Rates (MLR) for certain healthcare services received by Plan Participants.

IS THERE A PENALTY FOR NON-COMPLAINCE WITH TYPE II PRIOR AUTHORIZATIONS?

No, there is no penalty to the Tribal Member. However, there is a significant increased cost to the Plan, which is paid by the Tribe.

Accordingly, Plan Participants must receive Prior Authorization by calling the phone number on the back of their Identification Card (800) 595-6241 when they expect to receive the following services:

- All services provided by and billed by a Medicare-participating Hospital (which most are) for inpatient admissions or outpatient surgeries.
- All services provided by and billed by an outpatient facility that is part of a Hospital facility, for example, diagnostic testing, mammograms, and blood tests.
- All services in a Medicare-participating outpatient surgical center.
- All Medicare-participating dialysis centers.

Prior Authorizations must be obtained at least twenty-four (24) hours in advance of a scheduled admission, surgery, or diagnostic testing. In emergency situations, notice must be given within three (3) business days following admission.

It is important to know that only ONE Prior Authorization is necessary for the same service. For example, if you will be admitted to a Hospital, Type I Prior Authorization applies and it also satisfies the requirement for Type II.

Similarly, if you need an MRI that will be done at a Hospital, approval for Prior Authorization under Type I satisfy the Type II requirement.

In summary, Type II Prior Authorizations are required for any and all services that will be provided by and billed by a Hospital and its affiliated outpatient centers.

SECTION 7: CASE MANAGEMENT❖❖❖❖

Case Management is a utilization management technique that focuses on coordinating a number of health care and disability services needed by the patient. It includes a standardized, objective assessment of patient needs and the development of an individualized care plan. Often used for patients who need extensive medical services, the care plan is usually overseen by an individual or team of medical practitioners. Case management services are provided by UnitedHealthcare as part of the Plan's PPO arrangement.

In addition to the Prior Authorization program for inpatient and outpatient services, there may be a need for a Case Manager to become involved in your ongoing care. A Case Manager will work with you, your family and your doctor to assist in making arrangements on your behalf. These nurses are specialists in their field and are able to obtain high quality care and services at the most cost-efficient means possible. They should be utilized as a valuable resource for your health care needs.

The Plan may elect to offer benefits for services not usually covered by the Plan, but that are furnished under an alternative treatment plan. The Plan may authorize such alternative benefits under the review and determination of the Case Manager and for so long as it is determined that alternative service is Medically Necessary, cost effective and that the total benefits paid for such services do not exceed the total of benefits to which the patient would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

SECTION 8: TELEMEDICINE SERVICES ❖❖❖❖

The Plan offers various telehealth services, which allow you to instantly connect with a Physician without leaving your home.

Within minutes you are connected via phone or video chat with a board-certified Physician who can help you with your healthcare question by listening to your symptoms and asking follow-up questions. Often, via video chat on your phone, the provider can actually see your concern (e.g., a burn, rash, wound or sore throat). The provider can then effectively provide advice about what to do next. More often than not, treatment for the problem can be administered over the phone (including prescribing medicine), or can wait until you can see your primary care Physician in person. Other times, the telemedicine provider will suggest that you should seek in-person care. Regardless, telemedicine provides quick and convenient treatment option and ensures you avoid unnecessary trips to your primary care Physician, emergency room or urgent care, saving you time and money.

Keep in mind that with telemedicine you will often get a Physician who is a specialist for the symptoms you have. In an emergency room, the doctor you see is often not the kind of specialist you need for the illness or injury you have. Emergencies rooms also have high cost and may have longer wait times.

Telepharmacy services are also available under the Plan. By phone call or video chat, you can receive standard pharmacy services such as drug utilization counseling, drug therapy monitoring, remote dispensing, Prior Authorization and refill authorization.

You may also receive behavioral health services through telemedicine, such as therapy, psychiatric evaluation, and medication management.

Telemedicine doctors are usually available twenty-four (24) hours a day, seven (7) days a week.

When you use the telemedicine provider associated with this Plan, there is **no copay or coinsurance** for the call.

Telemedicine providers are also an option for you when you are traveling. For example, if you lose or forget your medication, you can call a telemedicine provider and have a new prescription available to continue your medication uninterrupted.

For more information on the Telemedicine Program available to you please call 888-779-6872.

SECTION 9: DISEASE MANAGEMENT AND WELLNESS SERVICES

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The Plan includes wellness and disease management services. Additional wellness program services are directly available to eligible Plan Participants through the Tribal Health Service Clinic (THS) and the Pequot Pharmaceutical Network (PRxN) located on the Mashantucket Pequot Reservation. These programs include, but are not limited to: health coaching, diabetes education, nutrition management, medication adherence and smoking cessation. Plan Participants can contact THS at (860) 312-8000 or PRxN at (860) 396-6355 for more information about these specific services.

Disease Management Services: Provides assistance to Participants with certain chronic diseases so they can better manage their conditions. Participants who are eligible for this service are identified through claims information and will be contacted by the Plan's disease management vendor to offer services including education, coordination and progress monitoring.

Wellness Program

The Plan sponsors a wellness program that is based on providing Plan Participants with opportunities to learn new life skills, and build awareness of and make conscious choices toward a more balanced and healthy lifestyle. Health Risk Assessments, telephone-based and face-to-face coaching and written materials are available and address certain health goals, risks and preferences in areas of:

Blood Pressure	Cholesterol
Weight Management	Stress Management
Exercise	Smoking Cessation

SECTION 10: TRIBAL HEALTH SERVICES ❖❖❖❖

The Indian Health Services (IHS) is the principle federal health care provider and health advocate for Native Americans and Alaskan Natives. The IHS carries out its responsibilities through developing and operating a health services delivery system designed to provide a broad spectrum of preventive and rehabilitative services. The mission is to provide a comprehensive health services delivery system for American Indians and Alaska Natives with opportunity for maximum Tribal involvement in developing and managing programs to meet their needs.

The Tribe, through its contract with IHS, operates the Tribal Health Services (THS) program to deliver direct health care services to the eligible Native American / Alaskan Native population. THS services include, but are not limited to:

- Holistic, primary care services that include comprehensive physicals, diagnostic laboratory services, immunizations and ambulatory care services by appointment or on a walk-in basis;
- Identification and coordination of care for specialty needs;
- Community health nurse outreach, including home visits, transportation and health education;
- Health promotion/disease prevention, including activities for addressing special health concerns aimed at youth, adults and elders;
- Social services and Tribal disability administration;
- Behavioral health, alcohol/substance abuse comprehensive assessment and screening, counseling, outreach and crisis management; and
- Chronic disease education and management.

Medical care that THS is unable to provide onsite at its facility may be available through the Purchased Referred Care (PRC) program (formerly Contract Health Services). The PRC program is not an entitlement program and qualified members seeking to use PRC funds must meet the PRC eligibility criteria. In particular, the patient must (1) reside on the MPTN Reservation or within the Purchased Referred Care Delivery Area (currently New London County); and (2) have close social or economic ties to the Tribe. Also, the requested services must be “medically necessary” and fall within established medical priorities for its PRC program. The medical priorities are:

- Level 1: Emergent or Acutely Urgent Care services (necessary to prevent immediate death or serious impairment of health) (e.g., gunshot wound, heart failure)
- Level 2: Preventive Care Services (primary health care aimed at prevention of disease or disability) (e.g., diabetes management, HIV testing)
- Level 3: Primary and Secondary Care Services (treatment of illnesses or conditions that have a significant impact on morbidity and mortality; treatment for conditions that may be delayed without progressive loss of function or risk of life, limb or senses) (e.g., chemotherapy, dermatology)
- Level 4: Chronic Tertiary and Extended Care Services (services that are: (a) not essential for initial/emergent diagnosis or therapy, (b) have less impact on mortality than morbidity, or (c) are high cost, elective, and require a specialty care facility) (e.g., gastric bypass surgery, joint replacement)

- Level 5: Excluded Services (services that are purely cosmetic, experimental, investigational, or have no proven medical benefit) (e.g., non-reconstructive plastic surgery, acupuncture)

Typically the Tribe sets its priority at Level 3, meaning PRC claims for Level 4 and Level 5 services will not be covered. However, the priority level can change year to year, or even during the year, based on available funds.

The Tribe receives an annual allotment of PRC funds through its contract with IHS. The Tribe may also supplement its PRC funds with Tribal resources. In some cases, PRC will pay the residual balance of a claim for service, after insurance has paid or assist with the reimbursement of copays. The Tribe will not be able to pay for any PRC services once the year's PRC funds have been exhausted.

Patient eligibility must be determined prior to receiving any service. To utilize PRC services an eligible Plan Participant must register with THS by calling **1-800-312-8000.**

SECTION 11: MEDICAL PLAN COVERED SERVICES ❖❖❖❖

The following is a list of services that are covered by this Plan. The list of Covered Services should be read in conjunction with the Schedule of Medical Benefits . This list is adetailed **summary** and is subject to change.

Note that many services will only be covered if you or your Dependents receive Prior Authorization to confirm the service(s) are Medically Necessary. See Section 6, Prior Authorization on p. 18 for more details.

Further, the Plan will only cover the Maximum Allowable Charge (MAC) for covered services. The MAC is determined by the Medicare-like rate for comparable services or the negotiated rate, if one exists.

Services are considered to have been incurred on the date the service is rendered. Supplies are considered to have been incurred on the date the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. In other words, covered expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Summary of Services

Acupuncture: The practice of inserting needles into specific exterior body locations to relieve pain, to induce surgical anesthesia or for therapeutic purposes. Charges will only be considered when submitted by a specialist who is licensed and certified to provide acupuncture services within the scope of their license.

Allergy: Testing and treatment, including allergy injections.

Ambulance Service / Medical Transport: Professional ambulance service when Medically Necessary in an emergency and used to transport the Participant from the place where injured or stricken by an illness to the nearest appropriate hospital where treatment can be provided. The Plan also covers charges for professional medical transport as ordered by a Physician and deemed Medically Necessary by the Plan. This includes charges made by a city or county rescue squad, paramedic or other fire department assistance for responding to an Emergency call necessitated by an injury or illness of a Participant, whether or not such services include transport of the Participant to any type of Hospital.

Ambulatory Surgical Center Services: In connection with covered licensed outpatient surgery, a licensed Surgical Center that is used mainly for performing outpatient surgery has a staff of Physicians and registered nurses providing continuous care, but does not provide for overnight stays.

Anesthesia or Anesthetics: Provided by a Physician or certified registered nurse anesthetist for the administration of anesthesia.

Autism Spectrum Disorder: The Plan covers services for substantial and severe autism spectrum disorder. This includes diagnostic evaluation, as well as applied behavior analysis (ABA) with discharge from care criteria that is necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of the individual. ABA is an evidence-based behavioral intervention that is used to diminish substantial deficits in a child's adaptive functioning or significant behavioral challenges due to autism spectrum disorder. Interventions address three areas of behavioral functioning: deficits in developmentally appropriate skills and behaviors, impairments in social communicative adaptive skills, and prevention of harm to self or others. Coverage is subject to:

- Prior Authorization, which may include proof of an Individualized Education Program (IEP) or other documentation required by the Claims Administrator
- Ongoing Medical Necessity and utilization review
- Participation in an approved case management or concierge program
- Applying for and using all available alternative resources (e.g., CHIP, Medicaid, Tribal and state disability, public school resources)

Coverage for Autism Spectrum Disorder is not a substitute for services required to be provided by the public school system in order to ensure the Participant receives a free appropriate public education. The Plan's coverage will be secondary to any services required to be provided by the Participant's school. The Plan's coverage will also be secondary to any disability services available to the Participant. The Plan will not pay for services, supplies, or equipment for which the Participant has no legal obligation to pay in the absence of the Plan's coverage, which is provided to the Participant by a publicly funded program, which is performed by a relative of the Participant, or for services provided by persons who are not licensed as required by law. Coverage is capped at $20,000 per year for children at least one year old and not of school age, and $10,000 per year for school-age children up to the age of 18.

Birthing Center Services: Any freestanding health facility, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. The facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery, provide care under the full-time supervision of a Physician and either a registered nurse or a licensed nurse-midwife, and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Blood and Blood plasma: Administration of blood processing, blood transfusions and blood not donated or replaced.

Cancer Clinical Trials: Phase I, II and Ill of cancer clinical trials performed at, or in conjunction with, an in-network facility. Out-of-network facilities may be covered only at out-of-network benefit levels which may leave you with significant out of pocket expense. Prior Authorization is required and you must be eligible for the clinical trial; you must be accepted for an Approved Clinical Trial. The Plan will not cover services not normally covered by the

Plan, such as experimental tests, extra blood tests, scans or any other service not normally covered for an admission for non-trial treatment.

Cardiac Rehabilitation: Phase I or Phase II cardiac rehabilitation services that are rendered under the supervision of a Physician and are (i) provided in connection with myocardial infarction, coronary occlusion or coronary bypass surgery and/or (ii) initiated within twelve (12) weeks after other treatment for the medical condition ends.

Chemotherapy: Use of chemical agents in the treatment or control of disease. “Off Label” or experimental agents are not covered.

Chiropractic Care: Non-surgical treatment of a condition of the vertebral column by a Physician or licensed chiropractor, by manual or mechanical means, including distortion, misalignment or subluxation, to relieve the effects of nerve interference which results from or is related to such condition.

Circumcision: Covered for a child less than two (2) years of age.

Contraceptive Management Services: The charges for all Food & Drug Administration approved contraceptive methods, except oral contraceptives, in accordance with Health Resources & Services Administration guidelines. Note that oral contraceptives may be covered under the Prescription Drug Benefits section. See Schedule of Pharmacy Benefits.

Cosmetic Surgery: Covered when cosmetic surgery is Medically Necessary: as a result of an accidental injury; to repair a birth defect of a child that has resulted in a functional defect; or for reconstructive surgery due to mastectomy, tumors or chemotherapy.

Dental Anesthesia: When rendered in a Hospital, Ambulatory Surgical Center or other licensed facility to an enrolled Tribal Child or Legal Dependent, when such child, in the treating dentist's opinion, and with Prior Authorization, satisfies one or more of the following criteria: (i) has a physical, mental or medically compromising condition, (ii) has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy, (iii) is extremely uncooperative, unmanageable or anxious, or (iv) has sustained extensive oro-facial and dental trauma to a degree that would require unconscious sedation.

Diabetic Self-Management Programs: For self-management and treatment of diabetes after initial diagnosis, subsequent diagnosis indicating a significant change in the Participant 's symptoms or condition or when new techniques and treatment for diabetes are developed.

Diagnostic Services: Laboratory and x-ray services including EKGs, ultrasounds, mammograms, CT scans, MRIs, etc. or similar diagnostic tests approved by Physicians throughout the United States. Prior Authorization, either Type I or Type II, is required for all Hospital-billed diagnostic services.

Dialysis Services: The Plan has established a specialized procedure for dialysis. See subsection “Dialysis” on p. 41 for more details.

Durable Medical Equipment (DME): Rental of durable basic (i.e., non-luxury) medical equipment, not exceeding the purchase price, or purchase of such equipment, but only when

purchase is permitted or more cost-effective due to a long-term need for the equipment. Equipment must be prescribed by a Physician and required for therapeutic use in treatment of an illness or injury. Evaluations may be required prior to rental or purchase and periodically after initial rental to ascertain need. DME includes items such as braces, crutches, wheelchairs, Hospital beds, traction apparatus, head\halters, oxygen, dialysis equipment, etc. Prior Authorization may be required depending on the cost of the DME.

Enteral Formulas: When used as a primary source of nutrition and not as a supplement, special food products, for the home use treatment of an inherited metabolic disease that is characterized by a deficient metabolism, or malabsorption or deficient amino acids, organic acids, carbohydrates, or fat originating from congenital defects or defects arising shortly after birth. Prior Authorization is required for enteral formulas.

Extended Care/Skilled Nursing/Rehabilitation Facility: The Plan covers stays of a Participant in facilities other than a general Hospital, up to certain limits when Medically Necessary. For stays in an Extended Care/Skilled Nursing/rehabilitation facility, this benefit covers the average semi-private room and board costs for the facility and covered services for a maximum period of ninety (90) days (in-network and out-of-network combined) per plan year. Confinement must begin within fourteen (14) days of discharge from a Hospital confinement of at least three (3) days on account of the same or related conditions, provided a daily qualified Physician is supervising such care and certifies in writing that the patient continues to need skilled nursing care or supportive therapeutic services as part of a regimen of medical care.

Gamma Knife Procedures: Gamma radiation as treatment for brain tumors and arteriovenous malformations. Treatment must have Prior Authorization by the Utilization Review Company and must be performed at a facility designated by the Plan.

Gender Dysphoria: Medically Necessary treatment for gender dysphoria, including:

- Behavioral health services (e.g., counseling for gender dysphoria, anxiety, depression), subject to Section 12;
- Hormonal therapy, including androgens, anti-androgens, GnRH analogues, estrogens, and progestins (Prior Authorization required);
- Laboratory testing to monitor prescribed hormonal therapy;
- Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individual's biological anatomy (e.g., cancer screening);
- Gender reassignment and related surgery if:
    - Medically Necessary – cosmetic surgery is not covered
    - The Participant is at least 18 years old; the Plan Administrator may consider requests for surgery for Participants under 18 in its discretion
    - For reconstructive chest surgery (i.e., initial mastectomy, breast augmentation) -- one letter of support from a qualified mental health professional
    - For hysterectomy, salpingo-oophorectomy, orchiectomy -- documentation of at least 12 months of continuous hormonal sex reassignment therapy and recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the Physician performing the genital surgery. If the first referral is from the

individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual.
- For reconstructive genital surgery -- documentation of at least 12 months of continuous hormonal sex reassignment therapy and recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the Physician performing the genital surgery, and documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity.

Home Health Care Services: Covers certain services or supplies furnished in a Participant's home, in connection with an accidental injury or acute sickness, by a Home Health Care Agency that is federally certified as a "home health care agency," and is licensed by the state in which it is located, and whose main function is to provide home health care services and supplies. Participant must have in place in writing a "home health care program" that is approved in writing by the Participant's attending Physician and that states that continued Hospital or Skilled Nursing Facility Confinement would be required in the absence of home health care.

The services and supplies to which this benefit applies are:

1. Part-time, or intermittent, nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse if the services of a registered nurse are not available.
2. Part-time, or intermittent, home health aide services which consist primarily of patient care of a medical or therapeutic nature by other than a Registered or Licensed Practical Nurse.
3. Physical therapy, occupational therapy, and speech therapy provided by the home health agency.

In determining the limit of benefits for Home Health Care Services, each visit by a member of a home health care team shall be considered as one home health care visit and four hours of home health aide services shall be considered as one home health care visit. Charges for home health care services incurred with respect to the Covered Person in excess of 120 visits (in-network and out-of-network combined) per plan year are not included as covered home health care expenses.

Benefits covered:

1. Medical supplies, drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of a Hospital, to the extent such items would have been covered under the Hospital Benefit if the Participant had remained in the Hospital.
2. Medical social services provided to or for the benefit of an individual who has been diagnosed as terminally ill.

Physician house calls related to home health care are not covered.

Custodial care is not covered. Custodial care refers to care that is primarily for the purpose of assisting in the activities of daily living or in meeting personal, rather than medical, needs, and is not specific therapy for an illness or injury (e.g., meal preparation, personal grooming).

Non-skilled in-home services include assistance with daily living tasks and activities, with services provided in the Participant's home. Typical services include tending to personal care needs such as bathing, dressing, eating and cleaning, as well as medication management and transportation to medical appointments. Non-skilled in-home services may be covered if necessary to compensate for physical impairments, to diminish the impact of injuries or health conditions, or to reduce avoidable emergency room utilization. Services must be medically appropriate and recommended by a Physician, and are subject to Prior Authorization. The Plan may also cover basic training for family members or friends to provide appropriate medical home care (e.g., administering medicine, changing bandages).

Hospice Care Program: A coordinated, interdisciplinary program designed to meet the physical, psychological, and social needs of the terminally ill persons and their families by providing palliative and supportive medical, nursing, and other health services through home or inpatient care. An organization must be licensed by the state in which it is located, if licensing is required. The Plan covers charges for hospice care services provided by a hospice program, hospice care team, home health care agency or Skilled Nursing Facility for:

- Any sick or injured individual (you or your Dependent) who, in the opinion of the attending Physician, has no reasonable prospect of cure and is expected to live no longer than six months; and
- The family (you or your Dependents) of such individual, but only to the extent that such hospice care services are provided under the terms of a Hospice Care Program and are billed through the hospice that manages that program.

Hospice care services consist of:

1. Inpatient and outpatient care, home care;
2. Nursing care;
3. Counseling and other supportive services and supplies provided to meet the physical, psychological, spiritual and social needs of the dying individual;
4. Drugs and medicines (requiring a Physician's prescription) and other supplies prescribed for the dying individual by any Physician who is part of the hospice care team; and
5. Instructions for care of the patient, counseling and other supportive services for the family of the dying individual.

Hospice care services do not include charges for:

1. Hospice care services not approved by the attending Physician and the Claims Administrator;
2. Transportation services;
3. Custodial care; or,
4. Hospice care services provided outside of a Hospice Care Program.

Hospital Expense Benefits (Inpatient Care): This benefit is payable if a Participant becomes a registered bed patient in a general Hospital as a result of an accidental injury or sickness. A general Hospital is one which is not used principally as a rest facility, nursing facility, a facility

for the aged or for the treatment of drug addicts and alcoholics, or a place for convalescent,custodial, educative or rehabilitative care.

The amount payable is the daily room and board charge for a semi-private room. This benefitalso covers the room and board charge in an Intensive Care Unit when Medically Necessary,and the full allowance (for example, network fee allowances or reasonable and customary fees for out of network services) for the cost of miscellaneous services and supplies such as operating rooms fees, laboratory procedures, drugs, dressings and the like.

An Intensive Care Unit is a separate, clearly designated service area that is maintained withina Hospital solely for the care and treatment of patients who are critically ill, has facilities for special nursing care not available in regular rooms and wards of the Hospital, special life- saving equipment which is immediately available at all times, at least two beds for the accommodation of the critically ill and at least one registered nurse in continuous attendance 24 hours a day.

Non-emergency inpatient admissions must have a Type I Prior Authorization to receivefull benefits.

Hospital Services (Outpatient Care): The Plan covers many diagnostic and treatment services in participating Hospital outpatient departments. **Outpatient services provided by aHospital, any of its departments, or offsite (satellite) facilities require Type I Prior Authorization.**

Infertility: See “Maternity and Obstetrics.”

Maternity and Obstetrics: Subject to the provisions set forth in the Schedule of Benefits, maternity and obstetrical benefits are payable as any other illness for a Pregnant Tribal Spouse or a Pregnant Tribal Member. See “Dependent Maternity Care” under Limitations/Exclusions for Medical Services, p. 48. Preventive care charges for other pregnantParticipants may be covered as a Preventive Care benefit.

Benefits will not be restricted for a pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a Cesarean section. The attending Provider, after consulting with the mother, may discharge themother or her newborn earlier than earlier than 48 hours (or 96 hours as applicable), if the mother agrees to be discharged earlier than the 48/96 hour minimum.

Where a Participant’s child is delivered through surrogacy, the Plan will cover up to $15,000 for the pregnancy covered expenses listed above and the costs of labor and delivery for the surrogate mother. Plan coverage will be secondary to insurance maintained by the surrogate mother. The Plan will not cover post-natal care (including any health issues of the surrogate mother resulting from the pregnancy). At least forty-five (45) days prior to the expected due date, the Participant must provide to the Tribal Clerk and the Claims Administrator in writing the name of the surrogate mother, her insurance information, documentation sufficient for the Tribal Clerk and Claims Administrator to confirm that the child is the biological child of the Tribal Member, and

any other information reasonably requested by the Plan. The Claims Administrator may require documentation showing the prenatal costs incurred as a condition of payment. Coverage is only for health care costs relating to the surrogate pregnancy; this does not include any payment made to the surrogate mother for her services acting as the surrogate. For clarity, the coverage provided under this paragraph: (i) applies only to a surrogate pregnancy where the child is the biological child of a Tribal Member and would be eligible for enrollment in the Tribe, and (ii) does not apply to a surrogate pregnancy where the surrogate mother has an agreement or other arrangement whereby the child will be adopted by, or parental rights will be surrendered to, non-Tribal Member parents after birth.

No authorization is required if the Provider prescribes a Hospital stay within the 48/96hour minimum.

Pregnancy Covered Expenses may include (i) prenatal visits and routine prenatal care, (ii) expenses associated with normal or Cesarean delivery, (iii) one (1) routine ultrasound (and additional ultrasounds if Medically Necessary) and (iv) genetic testing (but only after impregnation) or amniocentesis on a Participant over the age of 35 or when deemed MedicallyNecessary by a Physician.

Where a Participant's child is delivered through surrogacy, the Plan will cover up to $15,000 forthe pregnancy covered expenses listed above and the costs of labor and delivery for the

surrogate mother. Plan coverage will be secondary to insurance maintained by the surrogate mother. The Plan will not cover post-natal care (including any health issues of the surrogate mother resulting from the pregnancy). At least forty-five (45) days prior to the expected due date, the Participant must provide to the Tribal Clerk and the Claims Administrator in writing the name of the surrogate mother, her insurance information, documentation sufficient for the Tribal Clerk and Claims Administrator to confirm that the child is the biological child of the Tribal Member, and any other information reasonably requested by the Plan. The Claims Administrator may require documentation showing the prenatal costs incurred as a condition of payment. Coverage is only for health care costs relating to the surrogate pregnancy; this does not include any payment made to the surrogate mother for her services acting as the surrogate.

The Plan will cover fertility counseling and related services provided by an approved fertility benefit management company. Contact the Claims Administrator for a list of approved providers.

In-vitro fertilization ("IVF") will be covered if the Participant is diagnosed with infertility. The Plan will cover three cycles of IVF, including preparatory procedures. Medications relating to IVF may be covered as provided in the Schedule of Pharmacy Benefits. Other Assisted Reproductive Technology (ART) services (including artificial insemination, zygote intra-fallopian transfer, and embryo transfer) may also be covered. All infertility coverage provided by the Plan must be Medically Necessary and requires prior consultation with and recommendation by an approved fertility benefits manager.

Fertility preservation services are also covered by the Plan when a Medically Necessary treatment will directly or indirectly result in iatrogenic infertility (i.e., infertility caused by medical treatment such as surgery, radiation, or chemotherapy). Treatment may include preventative treatment that is based on family history, is recommended by a Physician, and carries a strong likelihood of resulting in infertility. Services must be provided by an approved fertility preservation facility.

Mammography: See "Preventative Care."

Medical Alert/Information Systems and Remote Patient Monitoring: Devices that provide real-time monitoring of a patient's health, including fall detection and chronic disease indication, or devices used to collect patient data outside of a traditional healthcare setting for analysis and monitoring by a Physician. The device must be prescribed by a Physician with an existing provider-patient relationship with the Participant, must be approved by the U.S. Food & Drug Administration, and Prior Authorization is required. The device must be reasonable and necessary for the monitoring, diagnosis or treatment of the illness or injury, and must electronically collect and transmit data. For devices with a subscription, the Plan will pay a monthly subscription up to $30 per month.

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

Medications (Inpatient): Medicines which are dispensed and administered to a Participant during an Inpatient confinement.

Medications: (Outpatient) See "Prescription Drugs."

Mental Health Care: Coverage is provided for both inpatient and outpatient treatment of mental health conditions, including mental disorders. "Mental health conditions" do not include: (i) conduct disturbances unless related to a co-existing condition or diagnosis otherwise covered, (ii) educational, vocational and/or recreational services provided on an outpatient basis, (iii) treatment for learning disabilities, (iv) treatment which is determined to be for the Participant's personal growth or enrichment, (v) court-ordered placement for mental health care when such orders are inconsistent with the recommendations of the Utilization Review Company, (vi) services for mental retardation, or (vii) any other treatment which is expressly excluded in the Plan.

Newborn Infant Health Care Benefits: For an eligible newborn dependent child, coverage is effective for the first thirty-one (31) days following birth for an accidental injury or sickness, or for routine nursery charges as listed in the Schedule of Benefits. Coverage will continue beyond the initial thirty-one (31) days provided a Plan enrollment form is completed, signed and submitted to the Tribal Clerk within thirty-one (31) days from the date of birth.

Coverage is provided for newborn hospitalization routine care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge. Charges will be covered under the “Tribal Member Primary Plan Enrollee” if the “Tribal Member Primary Plan Enrollee” is covered under the Plan at the time of the child’s birth.

Occupational Therapy: See “Rehabilitation Therapy (Outpatient).”

Obesity: Screening and counseling weight reduction, or weight control in connection with a diagnosis of obesity, hypertension, high cholesterol or diabetes, including medically-supervised dietary or nutritional therapy program lasting not longer than one year. Medical supervision must be provided by a Provider or registered dietician with a National Provider Identifier number. The Plan will pay a maximum of $5,000 per year. Please contact the Claims Administrator for additional information on centers of excellence for obesity services.

Certain forms of bariatric surgery (gastric bypass, lap band, duodenal switch, and sleeve gastrectomy, and reversal of these surgeries) may be covered when the following conditions have been met:

- BMI of 35 or greater
- At least one co-morbidity (e.g., sleep apnea, high blood pressure, diabetes)
- Over the age of 18
- Evidence of obesity for the last five (5) years
- Documented participation in at least two (2) medically-supervised weight loss programs, lasting at least six months each, without success; at least one (1) of these programs must have happened within the twelve (12) months prior to surgery
- A determination by your Physician that surgery is Medically Necessary and all other potential medical diseases have been ruled out as a cause of obesity
- A psychological evaluation

- The surgery is performed at an American Society for Metabolic and Bariatric Surgery (ASMBS) center of excellence

Oral Surgery: Charges for injury to or care of the mouth, teeth, gums and alveolar processes will only be considered if that care is for the following oral surgical procedures: (i) excision of tumors and cysts of jaws, cheeks, lips, tongue, roof and floor of mouth, (ii) emergency repair due to injury to sound natural teeth, (iii) surgery needed to correct injuries to jaws, cheeks, lips, tongue, floor and roof of mouth, (iv) excision of benign bony growths of the jaw and hard palate, (v) external incision and drainage of cellulites, (vi) incision of sensory sinuses, salivary glands or ducts, (vii) removal of teeth which is necessary in order to perform radiation therapy, or (viii) reduction of dislocations and excision of lesions.

Orthotic Appliances: Orthotic shoes without braces are allowed for diabetic patients, subject to Prior Authorization. Inserts to be placed into shoes are not covered except when necessary to reduce foot damage related to a diabetic condition and after Prior Authorization is obtained.

Partial Hospitalization: A structured outpatient program specifically designed for the diagnosis or active treatment of a mental disorder or substance abuse when there is a reasonable expectation of improvement or when it is necessary to maintain a patient's functional level and prevent relapse. This program must be administered in a psychiatric facility that is accredited by the Joint Commission on Accreditation of Health Care Organizations and must be licensed to provide partial hospitalization services if required by the state in which the facility is providing these services. Such facility must be of the type in which treatment lasts less than twenty-four (24) hours, but more than four (4) hours a day, and the patient returns home at the end of each day. Coverage does not include meals, transportation, social support groups (group psychotherapy is covered), or testing or training for job skills.

Pre-Admission Testing: Subject to the provision set forth in the Schedule of Benefits, benefits will be provided for tests given on an outpatient basis before admission to the Hospital when ordered by the attending Physician and when scheduled so that results will be medically valid when the inpatient stay begins.

Pregnancy: See “Maternity and Obstetrics”.

Preventative Care: Routine health care to prevent illness or detect illness at an early stage, when treatment is likely to work best, such as yearly wellness visits, bone density measurement, screenings (such as for colorectal, prostrate, breast, cervical, and vaginal cancer), HIV, diabetes, obesity, glaucoma, tobacco and alcohol misuse, flu shots, vaccinations/immunizations, and other services that are listed as recommended by the United States Preventive Services Task Force, the Health Resources and Services Administration, and the Federal Centers for Disease Control. These services may be provided based on recommendation of the Physician. The Plan Administrator has discretion to determine which services will be covered.

Physical Exams: See "Preventative Care.”

Prosthetics: Externally applied prostheses to restore or replace mobility or function of natural limbs and eyes, including replacement when there is significant change in the Participant's physical condition to make the original device no longer functional while covered under the health benefit portion of the Plan. Post-mastectomy prostheses are included; however, dental prosthetics are not unless Medically Necessary. Repair or replacement of a prosthetic device is not covered any sooner than five (5) years from previous placement except when medically necessary, such as when necessitated by the normal growth processes of a child.

Radiation: Therapy Radium and radioactive isotope therapy.

Reconstructive Mammoplasty (Post-Mastectomy): Charges for expenses incurred due to the reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance if the Member is receiving benefits in connection with a mastectomy, and charges for prosthesis and physical complications of all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Reconstructive Surgery: Reconstructive surgery is surgery that is (i) necessary for the prompt repair of an injury occurring while covered under the Plan, (ii) incidental to, or follows, surgery resulting from trauma, infection or other disease of the involved part, or (iii) due to congenital disease, defect or anomaly of a Tribal Child or Legal Dependent, covered under the Plan from birth, which has resulted in a functional defect.

Rehabilitation Therapy (Outpatient): Short-term rehabilitation services performed by a licensed therapist which consists mainly of cardiac, pulmonary, occupational and/or physical therapy, and speech therapy for a medically stable patient following an injury. There must be an expectation that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

Skilled Nursing Facility: See section for “Extended Care/Skilled Nursing/Rehabilitation Facility.”

Speech Therapy Services: Covered when provided by a qualified speech therapist to restore speech loss or correct impairment due to: (i) a congenital defect for which corrective surgery has been performed; or (ii) an accidental injury or sickness such as a stroke.

Coverage is also provided for idiopathic delays in speech development when the Participant: (a) is 18 months of age or older; and (b) has been evaluated by a qualified speech-language therapist who has determined that a treatable communication problem exists. Prior Authorization is required. Coverage may be limited to a designated Center of Excellence.

Coverage does not include a mental, psychoneurotic, or personality disorder.

Sterilization: Surgical procedures for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female). An initial voluntary sterilization procedure will be covered under this Plan, but in no event will the reversal of that procedure be covered, whether or not the original sterilization was performed while covered under this Plan.

Substance Abuse Treatment: Inpatient care is covered if confined to a Hospital or Skilled Nursing Facility accredited by the Joint Commission for Accreditation of Healthcare Organizations JCAHO or other federal accreditation approved by the Claims Administrator. Partial hospitalization, intensive Outpatient treatment and Outpatient treatment for substance abuse is covered as indicated in the Schedule of Health Care Benefits, but Type I Prior Authorization is required.

Surgical Procedures: Covers the allowable cost of Medically Necessary surgical procedures undergone by Participants as a result of an accidental injury or sickness. Charges for an assistant surgeon must be deemed Medically Necessary to be considered for payment.

Surgical Dental Procedures are not covered, except for the treatment of a fractured jaw, treatment of accidental injuries or medical illness to sound natural teeth. If any of the above dental procedures requires Hospital confinement, allowable charges by the Hospital, the anesthesiologist, and the dentist shall be covered expenses. If the anesthesia is administered by the surgeon or dentist who performed the dental procedure, this separate charge shall be a covered expense only if the procedure is performed on an outpatient basis.

Surgical dental procedures may be covered as dental benefits. See Section 14, Dental Benefits, and the Schedule of Dental Benefits (p. 45).

Surrogacy: See Maternity and Obstetrics.

Transplants (Human Tissue): Covered Expenses may include those incurred by a Participant who is the recipient of a human organ or tissue transplant which is not Experimental or Investigative in nature, subject to the following conditions: (i) coverage is only available when a facility designated by the Plan is used, (ii) transplants of only the following body organs will be covered: kidney, kidney/ pancreas, heart, heart/lung, lung, liver, pancreas (when the condition is not treatable by use of insulin therapy), bone marrow, stem cell, and cornea, (iii) not more than two (2) transplants for each body organ will be covered. Donor or organ acquisition costs may be Covered Expenses of the Participant who is the transplant recipient.

Wigs or hairpieces: When prescribed by a physician as a prosthetic for hair loss due to: Chemotherapy or Radiation therapy. A $500 calendar year maximum benefit applies.

Dialysis

Outpatient Dialysis Treatment: When used in this document, the term "Outpatient Dialysis Treatment" shall mean any and all products, services, and/or supplies provided to Participants for purposes of, or related to, outpatient dialysis.

a. The Plan has established a specialized procedure for determining the amount of Plan benefits to be provided for Outpatient Dialysis Treatment, regardless of the condition causing the need for such treatment; this procedure is called the "Dialysis Program". The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan Participants and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

b. The Dialysis Program shall consist of the following components:

i. Application. All claims filed by, or on behalf of, Participants for coverage of Outpatient Dialysis Treatment ("Dialysis Claims") shall be subject to the provisions of this section, regardless of the treating Provider's participation in the PPO.

ii. Mandated Cost Review. All claims for Outpatient Dialysis Treatment shall be subject to cost containment review, negotiation and settlement, application of the maximum benefit payable analysis (as set forth below), and/or other related administrative services, which the Plan Administrator or its designee may elect to apply in the exercise of its discretion. The Plan Administrator or its designee reserves the right, in the exercise of its discretion, to engage relevant and qualified third-party entities such as Zelis Claims Integrity, LLC, for the purpose of determining the maximum benefit payable.

iii. Maximum Benefit. The maximum benefit payable for any and all Dialysis Claims shall be 100% of the lesser of (x) the Usual, Customary, and Reasonable Outpatient Dialysis Charge (as defined below), (y) the Maximum Allowable Charge after all applicable deductibles and cost-sharing, and (z) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.

A. Usual, Customary, and Reasonable Outpatient Dialysis Charge. For the purposes of Outpatient Dialysis Treatment and the Dialysis Program, "Usual, Customary, and Reasonable Outpatient Dialysis Charge" means that portion of a claim for Outpatient Dialysis Treatment that is, as determined by Zelis Claims Integrity, LLC or other third-party engaged by the Plan (i) consistent with the common level of charges made by other medical professionals with similar credentials, or other medical facilities, pharmacies, or equipment suppliers of similar standing, in the geographic region in which the charge was incurred; (ii) based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation; (iii) for reasonably comparable

services performed or provided in accordance with generally accepted standards of medical practice applicable to a similarly-situated individual receiving similar services in the same geographic region; (iv) otherwise in compliance with generally accepted billing practices for unbundling and/or multiple procedures; and (v) necessary and appropriate for the care and treatment of illness or injury presented, taking into consideration relevant data, including, without limitation, industry practices and standards as they apply to similar scenarios, and various forms of normative data and price indexes. The Usual, Customary, and Reasonable Outpatient Dialysis Charge does not necessarily mean the actual charge made, submitted, or accepted. The Plan Administrator reserves the right, in the exercise of its discretion, to engage relevant and qualified third-party entities, such as Zelis Claims Integrity, LLC, for the purpose of determining the Usual, Customary, and Reasonable Outpatient Dialysis Charge.

iv. Secondary Coverage. Plan Participants/participants/beneficiaries eligible for other health coverage under any other health plan are strongly encouraged to enroll in such coverage. Plan Participants who do not enroll in other coverage for which they are eligible may incur costs not covered by the Plan that would have been covered by the other coverage. The Plan will only pay for costs payable pursuant to the terms of the Plan, which may not include any costs that would have been payable by such other coverage.

Type I Prior Authorization is required for all dialysis treatment

Schedule of Medical Benefits

The following Schedule of Medical Benefits shows Covered Services and the amount of the Covered Expenses that are eligible for payment under the Plan. The Plan will pay the percentage of Covered Expenses designated on the Health Care Schedule of Benefits for each Covered Service, minus any applicable co-pays or penalties.

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
Deductibles	None	None
Annual Out of Pocket Maximum for OON only (includes medical copays, but excludes Rx copays)	None	$1,000/$2,500 Eligible charges paid at 100% of MAC after out of pocket has been met
AUTISM SPECTRUM DISORDER (Maximum $20,000 per Plan Year for children under school age; $10,000 per Plan Year for school-age children up to age 18)	No cost to you below cap You are responsible for costs above cap	Not Covered

OBESITY Screening and counseling weight reduction, or weight control in connection with a diagnosis of obesity, hypertension, high cholesterol or diabetes, including medically-supervised dietary or nutritional therapy program lasting not longer than one year. Medical supervision must be provided by a Provider or registered dietician with a National Provider Identifier number. The Plan will pay a maximum of $5,000 per year for this medically-supervised nutrition therapy program." Please contact the Claims Administrator for additional information on centers of excellence for obesity services. The Plan is offering a pilot program called MPTN Healthy Weight Program for plan participants who meet the following criteria. (Individual program eligibility required): a. Body Mass Index ("BMI") of 35 or greater b. At least one obesity-lined co-morbidity (e.g., sleep apnea, high blood pressure, diabetes, fatty liver) c. Over the age of 18 years d. Evidence of obesity for the last five (5) years For participants meeting the above criteria the Plan will pay for anti-obesity medications, prescribed specifically for the treatment of obesity only for the one-year pilot program period and only for prescriptions sent to PRxN by licensed providers under a contractual arrangement with the Plan for the MPTN Healthy Weight program. Anti-obesity medications are not covered when prescribed outside of the MPTN Healthy Weight program by other general practitioners and prescribers. In order for the Plan to pay for these medications, they must be filled exclusively by PRxN and are subject to clinical pharmacy management, utilization review, step therapy, and class substitution, generic requirements as clinically necessary. Continuation of coverage of anti-obesity medications beyond the one-year pilot of the MPTN Healthy Weight Program is not guaranteed and is subject to review and determination at the end of the one-year period. Bariatric surgery (Subject to meeting pre-conditions)	No cost to you below cap You are responsible for costs above cap (Subject to cap)	30% of MAC
PRIOR AUTHORIZATION (TYPE I) PENALTY For failure to prior authorize medically necessary procedures. Penalty does not apply to OON out-of-pocket maximum.	20% of allowable expenses up to $5,000	20% of allowable expenses up to $5,000

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
PREVENTATIVE CARE ❖ Routine Physicals (1 per year) ❖ Well Woman's Exam • 13 years and older, Pelvic Exam and PAP Smear (1 per year) ❖ Routine Mammogram • Ages 40 and older: Annually • Ages 35 – 39: 1 baseline mammogram ❖ Well Man's Exam Prostate cancer screening • Age 40 and over: 1 annual exam ❖ Colorectal cancer screening • Age 40-50 ○ 1 blood test every year • 45 and Over ○ 1 blood test every year ○ 1 sigmoidoscopy every three years ○ 1 colonoscopy every year ❖ Routine Immunizations (up to age 18) • Cervical Cancer Vaccine (Up to age 26) • Pneumococcal Vaccine (Age 65 and Older, 19-64 with certain medical conditions) • Other Vaccines in accordance with AMA guidelines ❖ Routine Pediatric Care (Birth through age 18)	No cost to you	30% of MAC
OUTPATIENT CARE An * means Type I Prior Authorization is Required ❖ Primary Care Office Visits ❖ Urgent Care-Hospital Based* ❖ Walk-In Center (Non-Hospital associated) ❖ X-rays, Ultrasounds, CT, PET Scans, MRIs, and SPECTS; Laboratory Tests and EKGs* ❖ Restorative Physical and Occupational Therapy* (30 visits each, per Plan year additional visits require approval for Medical Necessity) ❖ Chiropractic Care, when deemed Medically Necessary.* (Maximum 20 visits per Plan year) ❖ Cardiac Rehabilitation* (up to 60 visits per Plan year)	No cost to you	30% of MAC

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
❖ Acupuncture; see definitions, when deemed medically necessary. (Maximum $600 per Plan year) ❖ Hypnosis/Hypnotherapy Services, when deemed medically appropriate. Must be provided by a licensed hypnotist. (Maximum $500 per Plan year) ❖ Speech Therapy* must be physician approved and related to a sickness or injury occurring while covered under this Plan ❖ Allergy Testing and Injections ❖ All outpatient surgery*		
OUTPATIENT OR OFFICE SURGERY (Hospital-based services require Type I Prior Authorization)	No cost to you	30% of MAC
CHEMOTHERAPY Type I Prior Authorization required	No cost to you	30% of MAC
CONTRACEPTIVE MANAGEMENT- BIRTH CONTROL	Covered under Pharmacy Benefit Plan. See Schedule of Pharmacy Benefits (p. 68).	
DIAGNOSTIC PROCEDURES (PERFORMED IN HOSPITAL) NOTE: Services provided in a Hospital based setting require Prior Authorization	No cost to you	30% of MAC
DIABETIC NUTRITIONAL COUNSELING	No cost to you	30% of MAC
DURABLE MEDICAL EQUIPMENT NOTE: Some DME expenses may require Prior Authorization	No cost to you	30% of MAC
HEARING AIDS $2000 Maximum every 36 months combined In and Out of Network	No cost to you	30% of MAC
ORTHOTICS ❖ Diabetics only	No cost to you	30% of MAC
PRE-ADMISSION TESTING	No cost to you	30% of MAC
SPECIALITY AND SECOND SURGICAL OPINION	No cost to you	30% of MAC
EMERGENCY ROOM ❖ Co-pay waived if admitted to the Hospital ❖ NOTE: Hospital-based services require Prior Authorization within 72 hours or 3 business days	No cost to you after $75 co-pay	$75 co-pay plus 30% of MAC
AMBULANCE SERVICE/ MEDICAL TRANSPORT	No cost to you after $50 co-pay	No cost to you after $50 co-pay

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
PREGNANCY AND MATERNITY CARE ❖ Hospital Services ❖ Pre-Natal and Post-Natal Care ❖ Birthing Facility Fee ❖ Surrogacy ❖ Infertility Services Prior Authorization is **NOT** Required for maternity stays that are 48 hours or less for a vaginal delivery or 96 hours or less for a Cesarean delivery. If additional time in the Hospital is required for mother, baby, or both, these additional days MUST BE CERTIFIED. For patients discharged in less than the authorized time, one follow-up home care visit will be considered medically appropriate and will NOT require Prior Authorization. Type I Prior Authorization required for all other admissions for complications arising from pregnancy.	No cost to you ($15,000 cap for Surrogate Mother)	30% of MAC ($15,000 cap for Surrogate Mother)
INPATIENT CARE Room and Board limited to 120 Days per cause (semi-private room) ❖ Inpatient physician services ❖ Miscellaneous inpatient services and supplies Type I Prior Authorization Type I Required	No cost to you	30% of MAC
EXTENDED CARE FACILITIES ❖ Skilled Nursing, Convalescent or Sub Acute Facility ❖ Medical care only; no custodial care ❖ Limited to 365 days maximum per confinement Type I Prior Authorization Required	No cost to you	30% of MAC
ORGAN AND TISSUE TRANSPLANT Type I Prior Authorization Required	No cost to you	30% of MAC
HOME HEALTHCARE ❖ Limited to 120 days per calendar year Type I Prior Authorization Required	No cost to you	30% of MAC
HOSPICE CARE Type I Prior Authorization Required	No cost to you	No cost to you
Remote Patient Monitoring Type I Prior Authorization Required	No cost to you for device; You are responsible for subscriptions to the extent	30% of MAC

Tribal Family Health Plan Calendar Year Covered Services (January 1 – December 31)	In-Network (Amounts listed below are what you pay)	Out-of-Network (Amounts listed below are what you pay)
	exceeding $30 per month	
SMOKING CESSATION ❖ Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; the American Cancer Society (800-227-2345) can provide assistance in locating counseling services in your area. All Food and Drug Administration (FDA)-approved tobacco cessation medications are covered under Pharmacy Benefit.	No cost to you	No cost to you
WIGS ❖ *When prescribed by a Physician as a prosthetic for hair loss due to permanent burn Alopecia, Chemotherapy, or Radiation therapy*	No cost to you The Plan will pay for one wig per year up to a $500 maximum	30% of MAC The Plan will pay for one wig per year up to a $500 maximum

Limitations/Exclusions for Medical Services

What's Not Covered?

Some medical services and supplies are not covered under the Plan. If you have a question about whether a service or supply is covered, call Pequot Plus Health Benefit Services at 888-779-6872 to check. The Plan Administrator or its designee makes the final determination as to which services and supplies are covered or excluded.

If your request for benefits is denied, you may appeal. For more information on appealing a claim, see Section 22, Claims Determination.

NO BENEFITS WILL BE PROVIDED UNDER THE PLAN FOR ANY EXPENSE INCURRED FOR OR RELATING TO THE FOLLOWING:

Abortion: Charges due to abortion, except for charges incurred when: (i) the mother's life would be endangered if the fetus is carried to term; (ii) medical complications have arisen from an abortion; or (iii) arising from incest or rape.

After the Termination Date: Any charges for services that are incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol. Involving a Participant who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for substance abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Alternative/Complementary Treatment: Hypnosis, holistic, homeopathic or naturopathic medicine, or other treatment that is not accepted medical practice as determined by the plan.

Coordination of Benefits: Benefits of this Plan will be determined in consideration of charges for which payment is made by any other plan(s) as defined by and in connection with the Coordination of Benefits provision of this Plan.

Cosmetic or Reconstructive Procedure: Any related services or supplies which alter appearance but do not restore or improve impaired physical function and are not Medically Necessary, except when performed for: (i) repair within one year of an accident which occurred while covered under the Plan, (ii) replacement of tissue or diseased tissue surgically removed or altered while covered under the Plan, or (iii) treatment (that is simply cosmetic in nature) of a birth defect in a child who has been continuously covered under the Plan since the date of birth (e.g., cleft palate).

Court-Ordered Services: Services required by a third party, government agency or authority or court judgment, whether or not medically necessary, including but not limited to, physicals for immigration exams, court ordered detoxification or counseling of any type, except when such treatment is pre-certified by the medical Utilization Review Company or is authorized by Tribal Elders Council.

Custodial care: Care that is primarily for the purpose of assisting in the activities of daily living or in meeting personal, rather than medical, needs, and is not specific therapy for an illness or injury, such as help in walking, getting out of bed, meal preparation, grooming, or any service that could be performed by a non-professional person, including rest care or nursing home care and personal comfort items.

Dental: Services, supplies, and charges for dental care and dental procedures, surgical or otherwise, which are specifically listed by the American Medical Association, the American Dental Association, or any other such professional body as having no medical value. Dental care may be covered as specified under Surgical Procedures (p. 40) or coverage for oral surgery under Dental Benefits (Section 14) (p. 61).

Dependent Maternity Care: Charges related to pregnancy, childbirth or related medical conditions for Dependents who are not enrolled Tribal Members, other than the primary enrollee or the covered spouse. **NOTE:** Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.

Developmental Delays: Services pertaining to, including, but not limited to: Occupational Therapy and Physical Therapy.

Durable Medical Equipment (DME): Sales or other tax, shipping and handling of DME products.

Educational Therapy: For non-medical self-care or self-help education and/or training and any related diagnostic testing or for medical social services.

Educational or Vocational Testing, or Treatment: Educational or vocational testing or training which is principally intended to overcome or compensate for any learning impairment or learning disability.

Exercise Programs: Exercise programs for treatment of any condition, except for Physician-supervised Cardiac Rehabilitation, Occupational Therapy or Physical Therapy covered hereunder.

Exercise Equipment/Health Clubs: Physical fitness equipment or supplies made or used for physical fitness, athletic training or general health upkeep.

Experimental or Investigative: Services, supplies or treatments not recognized by the Plan as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active illness or accidental injury.

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

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

All phases of clinical trials shall be considered Experimental; and are only eligible for coverage as specified in the Plan.

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

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    - maximum tolerated dose;
    - toxicity;
    - safety;
    - efficacy; and
    - efficacy as compared with the standard means of treatment or diagnosis;
- If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    - maximum tolerated dose;
    - toxicity;
    - safety;
    - efficacy; and
    - efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

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

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

Extended Care: Services or supplies incurred after a concurrent review determines the services and supplies are no longer Medically Necessary.

Exceeding Maximum Allowable Charges: Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the MAC, or are for services not deemed to be reasonable or Medically Necessary, based upon the Claims Administrator's determination as set forth by and within the terms of this document.

Foot Orthotics and shoe inserts: Not covered. See eligible coverage for Diabetics, p. 45.

Formula and Nutritional Supplements: Enteral tube feedings are not covered for individuals who are capable of adequate oral intake. Food supplements, specialized infant formulas, vitamins and/or minerals taken orally are not covered even if they are required to maintain weight or strength, except as specified under Preventive Care. Diet supplements are not covered.

Fraudulent, wasteful, or abusive claims: Charges that arise in connection with a fraudulent, materially false, or misleading statement of claim submitted by any person who knowingly intends to defraud or deceive the Plan's authorized representatives; charges that overutilize services in a manner that directly or indirectly result in unnecessary costs to the Plan; and charges for items or services where there is no legal entitlement for such charges.

Genetic counseling: Counseling or testing when performed for investigational purposes *except* when medically necessary for the following conditions: For the purpose of identifying and treating a specific hereditary disease or prenatal testing when the family history has established the child is at-risk for a genetic disease.

Home or Automobile Modifications: Modifications to a home, automobile or other property such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, or tanning equipment, lifts or ramps.

Hospital admissions: When care can be safely done on an outpatient basis.

Illegal Acts: Any charge for care, supplies, treatment, and/or services for any injury or sickness which is incurred while taking part or attempting to take part in a criminal activity. This does not include minor traffic violations or citations.

Immediate family provider: Services that are performed by a person who is related to the Participant as a spouse, parent, child, brother or sister, whether the relationship exists by virtue of "blood" or "in-law."

Impotence: Surgical procedures in connection with treatment for impotence or sexual function.

Incurred by Other Persons: Any charges for services that are expenses actually incurred by other persons.

Learning Disability: Services pertaining to diagnosis and treatment.

Legal Obligations: The Plan does not pay for services the patient is legally obligated to pay, or for services for which the Provider does not and/or would not customarily render a direct

charge, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, or charges for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Marriage Counseling: Counseling services provided by a licensed marriage counselor, or other counselor/therapist.

Negligence: Any charges for services that are for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Hospital, or Provider, as determined by the Claims Administrator, in its discretion, in light of applicable laws and evidence available to the Claims Administrator.

No Coverage: Any charges for services that are incurred at a time when no coverage is in force for the applicable Participant.

Non Pre-Certified Services or Supplies: Services and/or supplies which are not Medically Necessary.

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

Not Specified As Covered: Any charges for services that are not specified as covered under any provision of this Plan.

Nutritional Counseling: Except for diabetic counseling or counseling for obesity.

Orthopedic Shoes: Not covered. See eligible coverage for “Diabetics” on p. 45.

Other than Attending Physician: Any charges for services that are other than those certified by a Physician who is attending the Participant as being required for the treatment of injury or illness.

Over the Counter (OTC) items: Services, supplies, medications, or first aid items not prescribed or performed by a Physician or another professional health care provider.

Personal Comfort Items: Services that are provided for housing, hotel or motel expenses, or reconstruction arising out of special medical needs in the place where the patient resides.

Personal Hygiene and Convenience Items: For example, air conditioners or humidifiers.

Prohibited by Law: Any charges, payments, services or supplies to the extent prohibited by applicable laws or regulations.

Provider Error: Any charges for services that are required as a result of unreasonable Provider error.

Prior to Coverage Services: Services provided before the Participant’s coverage begins.

Rehab/Respite care: Charge for hospitalization when such confinement occurs primarily for physical therapy, hydrotherapy, convalescent, or rest care.

Routine non-surgical foot care for non-diabetics: The treatment of flat or pronated feet, calluses, toe nails (unless ingrown), weak or fallen arches, weak feet metatarsalgia, or chronic foot strain.

Self-inflicted injuries or illness: Any charge for care, supplies, treatment, and/or services that are the result of intentionally self-inflicted injuries or illnesses. This exclusion does not apply if the injury resulted from a medical condition (including both physical and mental health conditions).

Subrogation/reimbursement: Any charge for care, supplies, treatment, and/or services of an injury or sickness not payable by virtue of the Participant's ability to seek reimbursement from a third party and reimbursable to the Plan. See Section 23, Right of Reimbursement and Subrogation.

Surgical Sterilization Reversal: Services or supplies for the reversal of sterilization, both male and female.

Telephone Consultations: Consultations with a provider not conducted in person, such as by telephone, unless specifically conducted as part of the Plan's telemedicine benefit program; charges because a person fails to keep a scheduled appointment; or charges to complete a claim form.

Temporomandibular Joint Syndrome (TMJ): Diagnosis and treatment of any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint) including temporomandibular joint dysfunction, arthritis, other craniomandibular joint disorders, and myofacial or facial pain syndrome.

Tobacco Addiction Services: Except for smoking cessation medications as described in the Schedule of Benefits.

Transplants: Artificial heart, lung, liver or pancreas or any other artificial organ or any associated expenses, except as related to transplants of human organs noted under Medical Plan Covered Services. See "Transplants (Human Tissue)" on p. 40.

War Related: Illness or injury resulting from participation in war (whether declared or not declared), act of war, riot or general uprising and occurring after this coverage begins, to the extent not covered by the U.S. Veterans Health Administration or similar program for veterans.

Worker's Compensation: Any services covered by Workers' Compensation or employer's liability laws. Any charge for care, supplies, treatment, and/or services for any condition, illness, accidental injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit: If you are covered as a Dependent under this Plan and you are self-employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases, workers' compensation insurance

will cover your costs, but if you do not have such coverage you may end up with no coverage at all.

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

SECTION 12: BEHAVIORAL HEALTH, MENTAL HEALTH, AND ALCOHOL/SUBSTANCE ABUSE COVERAGE ❖❖❖❖

Eligibility, participation and enrollment requirements for the Plan's Behavioral Health, Mental Health and Alcohol/Substance Abuse coverage are the same as for the Plan's health care coverage.

When it comes to you and your family's well-being, mental health is just as important as physical health. This is why the Plan provides you and your Dependents coverage of services for mental health, behavioral health and alcohol/substance-use disorders that is comparable to the Plan's medical coverage.

Plan Participants can obtain coverage for inpatient and outpatient treatment of mental health conditions, mental disorders, behavioral health, and alcohol/substance abuse treatment. In general, benefits are higher when services and treatment are received from an in-network provider. Out-of-network benefits will be priced using alternative payment methodologies as outlined below. Participants who are employed by the Tribe also have access to the Employee Assistance Program (EAP) – a free, confidential counseling and referral service that is available to all MPTN employees.

How Behavioral Health, Mental Health, and Alcohol/Substance Abuse Benefits Work

The Plan makes a distinction between inpatient and outpatient care and provides a different level of benefits for each type of care.

In general, limits on your behavioral health, mental health and alcohol/substance abuse benefits will apply when you receive care from a behavioral health, mental health or alcohol/substance abuse provider. Medical benefit limitations apply when you receive care from other providers.

Covered expenses must be for evidence-based care that is Medically Necessary and contributes to the progress and cure of an illness or injury. For inpatient care, coverage will also require a structured, ongoing review of the treatment by the Utilization Review Company or an accredited case manager (e.g., Optimum Behavioral Health) to ensure the Participant is receiving quality care. This requirement may be waived if inpatient treatment is received at a designated center of excellence.
The quality of behavioral health, mental health, and alcohol/substance abuse treatment facilities, providers, and suppliers varies greatly. Accordingly, in addition to any prior authorization requirements, you are **strongly encouraged** to reach out to Tribal Health Services, Pequot Health Care, or the Chief Medical Officer to discuss options prior to beginning treatment. Tribal Health Services, Pequot Health Care, or the Chief Medical Officer are also available to assist you in transitioning to a lower level of care.

MPTN Behavioral Health/Mental Health/Alcohol and Substance Abuse Programs

Tribal Health Services offers a variety of Behavioral Health, Mental Health and Alochol/Substance Abuse programs. Services include:

- Individual, Couple, & Family Counseling
- Addictions Recovery Counseling
- Child Therapy
- Medication Management (including MAT maintenance)
- Healthy Lifestyle Changes
- Self-Help Education
- Group Counseling
- Integrative Medical/ Behavioral Health

You are encouraged to reach out to Tribal Health Services prior to seeking care from an outside provider. Tribal Health Services can provide you with care free of charge and can help you identify the appropriate outside provider.

Contact Tribal Health Services at (860) 312-8031 for more information.

Schedule of Mental Health/Alcohol/Substance Abuse Benefits

Tribal Family Health Plan Calendar Year Covered Services (January 1 – December 31)	In-Network (Amounts listed below are what you pay)	Out-of-Network (Amounts listed below are what you pay)
MENTAL HEALTH BENEFIT		
OUTPATIENT TREATMENT	**No cost to you**	**30% of MAC**
INPATIENT TREATMENT Limited to semi-private room rate	**No cost to you**	**30% of MAC**
PARTIAL HOSPITAL AND INTENSIVE OUTPATIENT	**No cost to you**	**30% of MAC**
ALCOHOL / SUBSTANCE ABUSE BENEFIT		
OUTPATIENT TREATMENT	**No cost to you**	**30% of MAC**
INPATIENT TREATMENT Limited to semi-private room rate	**No cost to you**	**30% of MAC**
PARTIAL HOSPITAL AND INTENSIVE OUTPATIENT	**No cost to you**	**30% of MAC**

NOTE: ALL BEHAVIORAL HEALTH, MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE TREATMENT THAT IS INPATIENT TREATMENT, PARTIAL HOSPITALIZATION OR INTENSIVE OUTPATIENT MUSTHAVE PRIOR AUTHORIZATION.

NOTE: ALL OUT-OF-NETWORK BEHAVIORAL HEALTH, MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE TREATMENT IS SUBJECT TO ALTERNATIVE PAYMENT METHODOLOGIES AS DETAILED BELOW. THE PLAN STRONGLY ENCOURAGES YOU TO DISCUSS OPTIONS FOR TREATMENT WITH THE PLAN ADMINISTRATOR PRIOR TO ENTERING INTO TREATMENT.

Limitations/Exclusions for Mental Health and Alcohol/ Substance Abuse Treatment

Some Mental Health/Alcohol/Substance Abuse treatment is not covered under the Plan. If you have a question about whether a Mental Health/Alcohol/Substance Abuse service is covered, call Pequot Plus Health Benefit Services at 888-779-6872 to check. The Plan Administrator makes the final determination as whether the service in question is covered or are excluded under the Plan.

Services or treatments for the following are not covered by the Plan:

- Treatment for learning disabilities
- Educational, vocational and/or recreational services provided on an outpatient basis
- Treatment which is determined to be for the Plan Participant's personal growth or enrichment
- Autism, other than as provided in Section 11, Medical Plan Covered Services

- Court-ordered placement for mental health care or substance abuse
- Services for intellectual disability
- Any other treatment which is expressly excluded from the Plan

Outpatient Substance Abuse Treatment Centers are facilities that are primarily engaged in providing detoxification and rehabilitation treatment for alcoholism and/or drug abuse where there is no facility confinement. Inpatient stays at these facilities are not covered by the Plan.

Substance Abuse Treatment Facilities are facilities providing continuous structured twenty-four (24) hour per day programs of inpatient treatment and rehabilitation for drug dependency or alcoholism. A Substance Abuse Treatment Facility must be licensed to provide this type of care by the state in which it operates and be approved by the Plan. The facility must be JCAHO accredited.

All out-of-network behavioral health, mental health, and alcohol/substance abuse coverage under this Section 12 is subject to alternative payment methodologies pursuant to Subpart I of Title 42, Part 136 of the Code of Federal Regulations. Specifically, this means that all out-of-network providers, centers, non-hospital-based intensive outpatient, partial hospitalization, residential services, and other similar facilities, providers, or suppliers will be paid:

1. The rate negotiated by the Plan and the provider or supplier;
2. If no negotiated rate exists, the lowest of: (i) the Medicare-like rate; (ii) the rate negotiated by a repricing agent; and (iii) the provider or supplier's Most Favored Customer rate; or
3. If no payment rate is available under #1 or #2, then 65% of the MAC.

This section is intended to incorporate 42 C.F.R. § 136.203 without alteration.

SECTION 13: VISION BENEFITS ❖❖❖❖

Eligibility, participation and enrollment requirements for the Plan's vision coverage are the same as for the Plan's health care coverage.

You and your Dependents can obtain eye care and vision services from any eye care provider. However, it is important for the Participant to ask the provider whether they accept health insurance coverage. If you choose to receive vision care from a Provider that does not accept insurance you must pay that Provider directly for all charges and then submit a claim for reimbursement to Pequot Plus Health Benefit Services. You will be reimbursed up to the maximum allowable amount authorized by the Plan.

Schedule of Vision Benefits

The following Schedule of Vision Benefits shows Covered Services and the amount of the Covered Expenses that are eligible for payment under the Plan.

Tribal Family Health Plan Calendar Year Covered Services (January 1 – December 31)	**Maximum Benefit**	**Maximum Frequency**
Eye Examination	$300 per exam	1 Exam per 12-month period
Eyeglass Lenses	$400 per set	1 set per 12-month period
Eyeglass Frames	$200 per set	1 set per 24-month period
Contact Lenses	$400	1 set per 12-month period
LASIK	$2000 per eye (lifetime maximum)	
This benefit allows for either one (1) set of eyeglass lenses or one (1) set of contact lenses – but not both – in a 12 month period.		

Filing a Claim for Vision Benefits

Filing a claim for Vision Benefits:

1. See your doctor or other vision care provider. Generally, your doctor, if they accept insurance, will submit your claim to the Plan.
2. If your Provider does not accept insurance, you must pay in full for all services received and file a claim with Pequot Plus Health Benefit Services. Your claim must include an itemized bill showing the name and address of the patient, the name of the Provider, the services rendered, and the amount paid.
3. The Plan will reimburse up to the maximum amount allowed for each Plan Year.

LASIK

Refractive/laser eye surgery (LASIK) will be covered, for any reason, up to the maximum lifetime benefit of $2,000.00 per eye.

SECTION 14: DENTAL BENEFITS ❖❖❖❖

Eligibility, participation and enrollment requirements for the Plan's dental care coverage are the same as for the Plan's health care coverage.

You and your Dependents may obtain services from dentists who are participating dentists in the Plan's dental PPO network or those who are not. In-network dentists' rates for covered dental services are negotiated rates. The Plan will only pay an out-of-network dentists for covered dental services up to the negotiated rate paid to an in-network dentist. The balance, or the difference between the two rates, is the responsibility of the patient.

Dental services may be covered by Tribal Health Services under their PRC program. Plan Participants should contact Tribal Health Services for more information prior to receiving care.

To be covered under the Plan, all covered services must be provided by a dentist who is properly trained and licensed to practice dentistry and who is practicing within the scope of their license.

For assistance in locating an in-network dental provider or to obtain a copy of the Dental Provider Directory, Participants can call: (888) 779-6872. The Provider Directory may change at any time without notice.

In-Network Dental Providers

Due to the network plan allowances, utilization of in-network providers will greatly expand the total benefit available to the you and your Dependents. The benefits of using an in-network dentist are:

1. No out-of-pocket costs (up to the annual maximum benefit of $10,000.00);
2. No deductible paid for any covered category of care delivered; and,
3. Plan makes payments directly to network providers at 100% of negotiated fee schedule.

Out-Of-Network Dental Providers

Dental providers that are not part of the dental network are considered out-of-network dental providers. The Plan will make payment to the out-of-network provider at the negotiated fee rate for that particular service. Because out-of-network providers do not agree to accept this network rate as payment in full, you will be responsible for payments in excess of the network rate. In other words, you become responsible for reimbursing your dentist the difference between the in-network rate and the provider's charge.

Pre-Determination of Benefit

A dentist providing treatment to a covered Participant that is expected to exceed $1,200 must submit a dental treatment plan to the Claims Administrator before starting treatment. The treatment plan must be a written report that contains the results of the Participant's dental exam, the suggested treatment, an estimate of the charges for such treatment, and such other information as the Claims Administrator may require.

Dental Quality Review System

Your dental coverage is designed to insure the benefits provided are for quality and cost appropriate dental services. It also includes a continuous review for:

a. Appropriate levels of care, and
b. Reasonable and customary charges, not to exceed the Maximum Allowable Charge, for dental services.

All claims filed for dental services are subject to a claims auditing review process. If irregularities are found, the claim may be subject to further review by an independent dental consultant or claims review analyst. Dental consultants are practicing dentists representing both general and other dental specialties. In addition to cases questioned during claim audits, questions received from patients or from a second treating dentist are reviewed by the dental consultants.

The system described above may seem extensive, but it is effective. It works to assure quality and cost-effective care.

Preventive Care/Annual Examination

You and your dependents are encouraged to have regular examinations (including cleanings and x-rays), either semiannually or annually as recommended by your dentist. Regular treatment promotes better oral and physical health, and may help you avoid larger dental problems in the future.

Schedule of Dental Benefits

The following Schedule of Dental Benefits shows Covered Services and the amount of the covered expenses eligible for payment under the Plan. The percentages of covered expenses designated on the Schedule of Dental Benefits for listed Covered Services will be paid under the Plan minus any applicable co-pays or penalties.

Tribal Family Health Plan Calendar Year Covered Services (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
Deductibles	None	None
Annual Benefit Limitation	$10,000 per individual	
Preventive and Diagnostic • Routine Oral Exams - once every 6 months • Cleanings – once every 6 months • Fluoride – one treatment every 6 months • Bitewing X-rays – one set of 2 or 4 films every 12 months • Panorex - once every 3 years • Full mouth series of x-rays – once every 3 years • Periapical X-rays • Space Maintainers – one per space to age 16 • Emergency Exam	No cost to you, subject to annual maximum	100% of Dental Fee Schedule Participant pays amount over Fee Schedule
Restorative Benefits: (subject to frequency limits) • Fillings • Root Canals (Endodontic) • Oral Surgery • Periodontal Surgery/treatment • Denture Relines and Repairs • Anesthesia **Multiple extractions at the same visit (7 or more) and removal of impacted teeth are **NOT** subject to annual maximum.	No cost to you, subject to annual maximum	100% of Dental Fee Schedule Participant pays amount over Fee Schedule
Major Services:(once every 5 years) • Inlays • Onlays • Crowns • Post and Core • Repair crowns, bridgework and dentures • Full and Partial Removable Dentures • Implants	No cost to you, subject to annual maximum	100% of Dental Fee Schedule Participant pays amount over Fee Schedule
*Orthodontic Treatment and Appliances	Subject to Plan Year Maximum. ($10,000.00 lifetime maximum, per individual).	
*IHS PRC supplement may be available on a per case basis for this benefit.		

Alternate Benefit Rule: If more than one type of dental service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice. For example: In the case of bilateral, multiple, adjacent missing teeth, the benefit will be based on a removable partial denture rather than multiple dental implants.

Limitations/Exclusions for Dental Coverage

Some dental services and supplies are not covered under the Plan. If you have a question about whether a dental service or supply is covered, call Pequot Plus Health Benefit Services at 888-779-6872 to check. The Plan Administrator makes the final determination as to which dental services are excluded.

What is Not Covered?

1. Precision attachments
2. Cosmetic procedures
3. Services for congenital malformations
4. Replacement of lost or stolen or missing appliances or devices
5. Missed appointments
6. Devices to increase/change vertical dimension
7. Oral hygiene instruction
8. Charges related to TMJ
9. Provisional splinting
10. Restorative, endodontic, or prosthetic services performed on teeth that are periodontal compromised
11. Dental services for which you incur no charge
12. Temporary services
13. Dental Services for which coverage is available in whole or in part, under any Workers' Compensation Law or similar legislation, whether or not you claim compensation or receive benefits hereunder and whether or not any recovery is had by you against a third party for damages resulting from a condition, disease, ailment or accidental injury necessitating dental services
14. Dental services received from a dental or medical department on behalf of an employer (other than the Tribe), mutual benefit association, labor union, trustee or similar person or group
15. Dental services to replace tooth structure lost due to abrasion or attrition
16. Services rendered by a dentist that are beyond the scope of his/her/their license
17. Services not Medically Necessary or not at the most appropriate level of care
18. Dental treatment or care not specifically listed as a covered dental expense.

SECTION 15: PRESCRIPTION DRUG COVERAGE ❖❖❖❖

Eligibility, participation and enrollment requirements for the Plan's prescription drug coverage are the same as for the Plan's health care coverage.

The Prescription Medication Benefit Plan provides Participants the opportunity to purchase prescription drugs in three categories:

- Generic Drugs – These are the most cost-effective for you and the Plan. They can be purchased at PRxN with no co-pay. The first three (3) fills of any generic drug can also be purchased at other pharmacies with no co-pay.
- Preferred Brand Drugs – The Plan designates certain name-brand drugs as "preferred" because they are more cost-effective than other, similar "non-preferred" name-brand drugs. They can be purchased at PRxN with no co-pay. The first three (3) fills of any preferred brand drug can also be purchased at other pharmacies with no co-pay.
- Non-Preferred Brand Drugs – These drugs work similarly to generic and preferred brand drugs, but are more expensive. The Plan will cover non-preferred brand drugs; however, **you will be charged a co-pay for every fill**. The Plan encourages you to consult with your Provider and pharmacist before selecting a non-preferred brand drug—there is usually a generic or preferred brand drug that is equally effective and will save both you and the Plan money.

See the Schedule of Pharmacy Benefits on p. 68. Please visit https://www.pequothealthcare.com/globalassets/prxn/docs/pdl.pdf to download a current copy of the PRxN formulary list. Contact PRxN at 888-779-6638 or pharmacy@prxn.com if you have any questions.

Your prescription drug benefits depend on the pharmacy you select:

Reservation Pharmacies: PRxN is located at One Annie George Drive on the Mashantucket Pequot Reservation. Prescriptions may be brought into PRxN in person or faxed/telephoned/electronically sent by the Provider to PRxN. They may be picked up at PRxN, PRxN's Foxwoods satellite pharmacy (for Foxwoods employees), or delivered to a place of your choosing by mail.

There is **NO** cost to the Tribal Member/Dependent for generic or preferred brand prescription medications received through PRxN.

Requests for early refill or replacement for medications that have been lost, stolen, damaged or spilled are subject to review and physician/pharmacist approval.

Maintenance Medication - Mandatory Mail Service

Maintenance medication refers to prescriptions that will be used on a long-term basis. Medication for chronic conditions such as high blood pressure, high cholesterol, or diabetes are often maintenance medication.

The Plan will pay for the first three (3) fills of a particular maintenance medication at any pharmacy. This allows you to determine whether you can tolerate the medication and that you do not experience any side effects that would cause you to stop taking the medication. This retail benefit ensures that you are having a positive therapeutic response/outcome to the particular medication prior to obtaining a larger ("maintenance") supply.

Once you are "stable" on the medication, all future prescription refills for that medication ***must be obtained*** **through PRxN mail-service or retail pharmacy**. All future refills at a retail pharmacy other than PRxN will be denied, and you will need to obtain your medication through PRxN's mail-service or retail pharmacy.

You may receive up to a 90-day supply for most medications. The medications will be delivered directly to your home or office, or will be available at PRxN's retail pharmacy locations. To be sure you have an adequate supply of medications, prescriptions should be ordered ahead to plan for a seven-day delivery cycle.

Pharmacy Network: PRxN has established a nationwide network of almost 69,000 participating pharmacies for use by you and your Dependent . All major chain pharmacies and most independent pharmacies are in the national network available to Participants. The network is particularly convenient when you are out of town, or when PRxN is closed and a prescription must be filled immediately.

Please remember that after a medication has been filled three (3) times, the Plan will no longer cover that medication through a retail pharmacy. Over-the-counter products from the Network Pharmacies are not covered under the Plan.

Non-Network: Use of ***non-network*** pharmacies will require a pre-payment by the Participant to the pharmacy. You may submit these claims to PRxN network for reimbursement. Non-Network claims will be reimbursed at the rate of 50% of medication cost.

Pharmacy Benefit Management Programs:

Managed Drug Limitations (MDL)

The MDL monitoring process is a mechanism used to limit quantities of medication over a defined time period. The limitation is necessary to manage drug utilization. This process is important to help contain cost, promote safe use and encourage clinically appropriate drug use.

Prior Authorizations (PA)

The PA review process is a mechanism used to ensure that medications are prescribed in the safest and most economical manner possible. Medications that require a PA often have a history of improper use, significant safety concerns and/or a high cost with lower cost options available.

Specialty Medications

Specialty medication is a broad term that is often associated with very expensive medications costing over $5,000 per month. Often specialty medications are prescribed for rare, chronic and debilitating disease. Specialty medications often require extended counseling and monitoring for safety reasons. They also require special storage and shipping.

Step Therapy

A process whereby prescriptions are filled, with an effective, but more affordable medication (Step1). When appropriate, a more costly (Step 2) medication can be authorized if Step 1 prescription is not effective in treating the condition. In other words, Step 2 prescription drugs will not be covered until Step 1 prescription drugs are first tried. Step Therapy is used to help control plan costs without jeopardizing the health of plan participants.

340B Drug Pricing Program ("340B Program")

The Tribe has enrolled in the 340B Program, which allows the Tribe to receive drugs on the 340B formulary at significantly discounted prices. This results in a significant savings to the Plan, especially on specialty and brand-name drugs. Accordingly, specialty drugs and select brand-name drugs (as determined by the Plan Administrator in their reasonable discretion, factoring in cost and effectiveness of alternative options) must be filled through the 340B Program via Pequot Pharmaceutical Network whenever clinically appropriate, consistent with 340B regulations.

In order to be eligible to receive drugs under the 340B program, patients must have a current clinical relationship with the provider, i.e., the Tribe. Accordingly, all Participants receiving specialty or select brand-name drugs must complete both an **initial visit** and an **annual visit** with the Tribal Health Services and Pequot Health Care to establish and maintain a patient-provider relationship. These visits can be completed in person or virtually. THS and PHC will also coordinate referrals and follow-up visits (as necessary). THS or PHC may reach out to you to schedule your initial and annual visits, or you may reach out to THS or PHC directly. The Plan Administrator may offer participation incentives to Participants who complete the required initial and annual visits.

Schedule of Pharmacy Benefits

The following Schedule of Pharmacy Benefits shows Covered Services and the amount of the Covered Expenses eligible for payment under the Plan. The percentages of Covered Expenses designated on the Schedule of Pharmacy Benefits for listed Covered Services will be paid under the Plan minus any applicable co-pays or penalties.

Prescription Drugs	**Retail Pharmacy**	**PRxN Pharmacy and Mail Service**	
	Up to 30-day Supply	Up to 30-day Supply	Up to 90-day Supply
Generic	First Three (3) Fills Free (All subsequent fills must be through PRxN – see Mandatory Mail policy on p. 66)	Free	Free
Preferred Brand	First Three (3) Fills Free (All subsequent fills must be through PRxN—see Mandatory Mail policy on p. 66)	Free	Free
Non-Preferred Brand	$75 co-pay	$25 Co-pay	$50 Co-pay
PRxN Compliance Rx: Covered under your Plan at no charge regardless of their placement on the PRxN formulary. Medications in this class include prescriptions for: Blood Pressure, Cholesterol, Heart Disease, COPD/Asthma, Diabetes and Anti-psychotics		Free	Free
Oral Contraceptives (If prescribed by a Physician)	Free	Free	Free
Blood Pressure Cuffs/Monitors	Covered only under prescription drug coverage. Restricted to Plan Participants age 55 years and older; one (1) device every three (3) years. With valid prescription and filled at PRxN only.		
SMOKING CESSATION Includes both prescription and over-the-counter medications), when prescribed by a health care provider without prior authorization, for a maximum		Free	Free

of a 160 day supply per calendar year.			
Prior Authorization required for Specialty/Biotech Product coverage **Providers and Participants call 888-779-6638 for Prior Authorization**			
Annual Maximum	Not Applicable	Not Applicable	Not Applicable

Limitations/Exclusions for Pharmacy

Some medications are not covered under the Plan. If you have a question about whether a medication is covered, please call PRxN Customer Service at 888-779-6638. The following prescription drugs or other medications or treatments cannot be purchased under the Plan.

A. Over-the-counter medications.

B. Experimental or ***off-label*** non-Food and Drug Administration approved use.

C. Medications related to a non-covered medical//visual/dental condition are excluded under the Plan.

D. Drugs used to enhance physical growth or athletic performance or appearance.

E. Drugs or medications that are prescribed for treatment of an injury or illness that is covered under a Worker's Compensation Program.

F. Medications classified under the Drug Efficiency Study Implementation Program by the FDA as medications that are possibly ineffective.

G. Products ordered by persons not lawfully empowered to prescribe medication.

H. Contraceptive medications such as implants, IUDs are covered under the medical plan . See Contraceptive Management Services, Section 11.

I. Anti-obesity medications not prescribed as part of the pilot MPTN Healthy Weight program or not through PRxN.

SECTION 16: TRANSPLANT RESOURCE SERVICES ❖❖❖❖

Because medical centers can vary considerably in experience and quality of care, choosing the right health care provider to treat your complex medical condition can make an enormous difference in the outcome of your treatment.

Special Transplant Network Requirements

Transplant services require Type I Prior Authorization. Contact an Optum Transplant Coordinator at 1-800-595-6241 as soon as either you or your dependent is identified as a transplant candidate. Transplant benefits are subject to all other Plan exclusions, limitations, and other Plan provisions.

Transplant coverage is offered under this Plan through a Participating Provider Organization of specialist professionals and facilities. The Plan arranges access to a national network of transplant facilities (centers of excellence) carefully selected for the specialized expertise in transplant. The facilities are chosen for their extensive experience with transplants and their high survival rates along with experienced surgical teams with transplant surgeon certification. The transplant centers have Medicare approval and membership in a national organ-sharing network.

Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered, subject to referral to and Prior Authorization by the Plan Administrator's authorized medical review specialist (currently UnitedHealthcare).

A comprehensive treatment plan must be developed for the Plan's medical review, and must include at minimum the following information:

- Diagnosis
- The nature of the transplant
- The setting of the procedure, (i.e. name and address of the Hospital)
- Any secondary medical complications
- A five-year prognosis
- Two (2) qualified Physician opinions confirming the need for the procedure, as well as a description and estimated cost of the proposed treatment (one or both confirming second opinions may be waived by the Plan's medical review specialist). Additional attending Physician's statements may also be required.

The Participant may provide a comprehensive treatment plan independent of the participating provider network, but this will be subject to medical necessity review and may result in out-of-network benefit coverage.

All potential transplant cases will be assessed for their appropriateness for transplant resource services.

Organ Transplant Network

There is no obligation for the patient to use a participating transplant network facility. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the transplant network.

Covered Transplant Expenses

The term “covered expenses” with respect to transplants includes the reasonable and customary expenses, up to the Maximum Allowable Charge, for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are Medically Necessary and appropriate to the transplant, including:

- Hospital services
- Physicians services
- Immunosuppressive drugs
- Donor search services
- Donor charges related to the actual transplant
- Organ procurement or acquisition charges

Specifically, the Plan covers the following transplant services:

1. Charges incurred in the evaluation, screening, and candidacy determination process.

2. When both the recipient and donor are covered by this Plan, services will be covered for each patient.

3. When only the recipient is covered by this Plan, benefits will be provided for services for both the recipient and donor, provided benefits to the donor are not available under any other form of healthcare coverage. When the recipient is **not** covered by this Plan but the donor is covered, expenses for services will **not** be covered for either the recipient or the donor.

4. Charges incurred for organ procurement from a non-living donor, including costs involved in removing, preserving and transporting the organ.

5. Charges for organ procurement from a living donor including the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ, the medical services provided to the donor in the interim, and for follow up care.

6. The transplant if it is Medically Necessary and is recognized by federal agencies as appropriate treatment for the active illness and injury.

7. Charges incurred for follow-up care, including immune-suppressant therapy.

8. Re-transplantation will be covered, for a total of two (2) transplants per person, per lifetime. Each transplant will be subject to the Type I Prior Authorization Requirement for organ transplant.

9. The transplant is not for cosmetic purposes unless the following apply:

    a. Repair within one (1) year of an accident which occurred while covered under the Plan,
    b. Replacement of tissue or diseased tissue surgically removed or altered while covered under the Plan, or
    c. Treatment of a birth defect in a child who has been continuously covered under the Plan since the date of birth.

Accumulation of Expenses

Expenses incurred during any transplant period for the recipient and for the donor will accumulate towards the recipient's lifetime benefit.

Limitations/Exclusions for Transplant

Travel Expenses: To be eligible for travel and lodging benefits, the patient must be receiving services at the Plan's designated center of excellence which is greater than 50 miles from the patient's home. The maximum benefit for all travel expenses is $5,000 per transplant. No deductible or coinsurance will be applied.

The following allowances and limitations will apply:

Transportation: Expenses will be reimbursed for airfare (or train) in coach class for the patient and one companion. Travel by automobile will be covered at the applicable IRS allowance as of the date of travel. Taxi or ground transportation is allowed.

Lodging: Hotel or similar lodging expenses will be covered for up to $150 per day for the patient if not hospitalized as an inpatient and up to another $150 per day for the companion. No allowance is provided for stays with friends or relatives in their homes.

Meals: Allowances of up to $50 per day per person (patient and one companion)

Receipts: All expenses must be submitted with receipts showing payment was made in order to receive reimbursement.

Remember, the total benefit reimbursement for all expenses is $5,000 per transplant and the services must be provided at a designated center of excellence.

SECTION 17: MEDICARE ❖❖❖❖

Medicare Coverage and how it works with your Health Plan

Medicare is a federal health insurance program consisting of Part A (Hospital Insurance) and Part B (Medical Insurance). Medicare enrollees may also participate in Part C (Medicare Advantage Plans – offering additional coverage) and Part D (prescription drug coverage). Generally anyone age 65 of older is eligible to enroll in Medicare. For Elders and Tribal Spouses over the age of 65 who enroll in Medicare, their healthcare/medical bills are paid first by Medicare and second by the Plan. This results in a healthcare cost savings to the Tribe and Plan.

All Tribal Elders and their spouses, age 65 and over, must enroll in Parts A and B of the Medicare Program in order to continue to receive coverage under the Plan. Any Medicare-eligible Tribal Elder and their eligible Tribal Spouse who does not enroll in Medicare Part A and B when eligible will have their coverage under the Tribal Family Health Plan terminated and, thereafter, must utilize the services of Tribal Health Services clinic if eligible or some other alternative health insurance.

IMPORTANT THINGS FOR YOU TO KNOW

- Medicare Enrollment is not optional. All Tribal Elders and their spouses, age 65 or over, must sign up for Medicare both Part A and B.

- If you and your spouse do not sign up for Medicare Part A and B, when eligible, you will lose coverage under the Plan and have to rely on the Tribal Health Services clinic or other places for health care which may be at your own expense.

- You will not have to pay for the cost of the premium contribution for health coverage under the Plan if you **OR** your spouse have Medicare Part A and Part B coverage.

- All Tribal Elders and their spouses will be required to pay their own individual Medicare Part B premium. You may find the applicable premium at https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance, or contact the Claims Administrator.

- MPTN will reimburse (if deducted directly from Social Security or paid by the individual) or pay directly Medicare Part A premiums to the Social Security Administration (if permitted) for Tribal Elders and their Spouses who do not qualify for “free” coverage. If this applies to you please contact MPTN Government Finance for further assistance.

Medicare for Tribal Plan Participants Under 65

If younger than 65, you may still be eligible for Medicare if you:

- Have been receiving Social Security disability benefits for at least 24 months (that need not be consecutive)
- You receive a disability pension from the Railroad Retirement Board
- You have amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's Disease)
- You have end stage renal disease and require permanent kidney failure requiring regular dialysis or a transplant.

To reduce the cost of this Plan, if you are eligible for Medicare, you MUST apply for Medicare when first eligible.

Medicare will become the primary payer as soon as Medicare coverage starts. This Plan will pay benefits as the secondary payer in accordance with Section 18, Coordination of Benefits.

IMPORTANT: Plan Participants **must enroll for Medicare as soon as they are eligible**. If a person is eligible for either Part A or B, he/she/they will be deemed to have full Medicare coverage, even if he/she/they does not enroll for it. This means this Plan will pay as the second benefit plan and coordinate with what Medicare would have paid. Therefore, the Participant will incur a significant out–of-pocket expense.

Medicare Secondary Payer Reporting Requirements

The Plan will comply with mandatory reporting requirements, in accordance with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. Section 111 authorizes the Centers for Medicare and Medicaid Services ("CMS") and a Group Health Plan's responsible reporting entities ("RRE's") to electronically exchange health insurance benefit entitlement information. This will enable CMS to correctly pay for health insurance benefits of Medicare beneficiaries, by determining primary versus secondary payer responsibility.

SECTION 18: COORDINATION OF BENEFITS ❖❖❖❖

Coordination of benefits sets out rules for the order of payment of covered charges when two or more payers — including Medicare—are paying. When a Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

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

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

- ❖ Private or Employer-provided insurance, including: group or group-type plans, (e.g., franchise or blanket benefit plans); insurance company (e.g., Blue Cross/Blue Shield) group plans; group practice and other group prepayment plans.
- ❖ Federal government plans or programs (e.g., Medicare).
- ❖ Health insurance plans purchased on the Affordable Care Act marketplace.
- ❖ Other plans required or provided by law, including workers compensation and employer's liability insurance. For a tribal community plan like the TFHP, this also includes Medicaid, or any benefit plan like it which, by its terms, usually does not allow coordination.
- ❖ No Fault Auto Insurance, by whatever names it is called, when not prohibited by law.

PAYER OF LAST RESORT

As provided by the Indian Health Care Improvement Act, the Plan is a "tribal health program" and serves as the "payer of last resort" with respect to all benefit plans or other sources of payment. That means that *any* alternate resources must be used before the Plan will pay for covered charges. Alternate resources include health care providers and institutions, and health care programs for the payment of health services, including but not limited to: Medicare and Medicaid; state or local health care programs (not including the Plan); private insurance (such as group, blanket, or franchise insurance, no fault automobile insurance coverage, union welfare plans, labor management plans).

The Plan is also a "tribal self-insurance plan," and pursuant to Section 206(f) of the Indian Health Care Improvement Act and Part 2, Chapter 3.8(H) of the Indian Health Service Manual, the Plan shall not be an "alternate resource" for purposes of the IHS's Payor of Last Resort Rule. The Plan shall be residual to the Indian Health Service, and there shall be no right of recovery against the Plan.

Excess Insurance

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

The Plan's benefits shall be excess to any of the following:

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

Vehicle Limitation

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

Right to Receive and Release Necessary Information

The Claims Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Claims Administrator, in its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any other plan or source of payment. Any Participant claiming benefits under this Plan shall furnish to the Claims Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment

A payment made under any other plan or source of payment may include an amount that should have been paid under this Plan. The Plan Administrator or Claims Administrator may, in their sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator and/or Claims Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such allowable expenses, and any future benefits payable to the Member or his/her/their Dependents.

SECTION 19: TYPES OF HEALTH CLAIMS ❖❖❖❖

The Plan has a specific amount of time, by Tribal law, to evaluate and respond to claims for benefits. The period of time the Plan has to evaluate and respond to a claim begins on the date the claim is first filed. Any questions you have regarding how to file or appeal a claim, contact Pequot Plus Health Benefit Service at 888-779-6872.

Generally, there are four (4) categories of claims:

Pre-Service Care Claims

A “Pre-Service Care Claim” is a claim where a request for Type I or II Prior Authorization is made prior to obtaining medical care, and that request is denied. A Pre-Service Care Claim can be for non-urgent or urgent care.

Urgent Care Claims

An “ Urgent Care Claim” is any claim for medical care for which the normal approval time periods could seriously jeopardize the Participant’s life, health, or ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the Participant to severe pain. Urgent Care Claims are filed by Physicians to allow the Plan to review a claim more quickly than the normal time permitted, because the patient's life or wellbeing could be in danger if the claim isn't decided quickly.

IMPORTANT - Remember if a Participant needs medical care for a life-threatening condition or injury, SEEK CARE WITHOUT DELAY. A Participant and/or their Physician have at least seventy (72) hours or within three (3) working business days to request Prior Authorization in the event of an Urgent Care Claim.

Concurrent Care Claims

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Participant and/or Physician requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Utilization Review Company and/or the Claims Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice, which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

Post-Service Claims

A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

SECTION 20: FILING CLAIMS FOR BENEFITS/PAYMENT ❖❖❖❖

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

How to File Claims

All claims for payment must be submitted to the Claims Administrator. **Claims must be submitted to the Claims Administrator within 365 days after the date the charges were incurred or the date of discharge, whichever is later.** This includes both Hospital and Physician claims. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim, and if not, will request additional information. The Plan reserves the right to have a Participant seek a second medical opinion before approving a claim.

You or your health care provider should file claims as you receive care. If your care is continuous, your claims should be submitted at least every thirty (30) days.

Specific instructions for filing network claims are found on your I.D. card. Claim forms or claim information can be obtained by contacting Pequot Plus Health Benefit Services at 1 Annie George Drive, Mashantucket, CT 06338 or at (888) 779-6872.

Hospital Claims

Whenever you receive care in a Hospital facility, be sure to get a Type I and II Prior Authorization and present your benefit identification card at the time of your admission. The Hospital will handle the claim directly with the Claims Administrators and the Plan will make payments directly to the Hospital. **If you have other coverage such as from a Spouse's employer, Medicare or Medicaid, show all of your ID cards in order to maximize your benefits through Coordination of Benefits.** (See Section18, Coordination of Benefits)

If a Hospital should request that you make arrangements to pay the bill, ask the Hospital to provide you with a Health Care Finance Administration UB04 claim form, or an itemized statement listing the services received, the charge for each service and the diagnosis. Then submit this claim to the Pequot Plus Health Benefit Services Administrators. Payment will be made accordingly.

Physician Claims

Be sure to get a Type I or (if needed) Type II Prior Authorization. You should present your benefit identification card and all other health plan/insurance cards you might have when you receive services. Other coverage includes Medicare, Medicaid and other health plans you or your spouse may have through an employer. The overwhelming majority of providers submit claims electronically. Many physicians will accept the assignment of benefits so that payment will be made directly to them. If they are participating providers in a network, they are required to file claims through their network, which then forwards the claims on your behalf to the Claims Administrator (Pequot Plus) for processing and payment.

However, bills you receive directly from a provider for any medical expenses covered under the plan should be submitted to the Claims Administrator as soon as possible and within the 365-day time frame for claim submissions.

Assignments of Benefits

Some Hospitals or Physicians may ask you to sign an Assignment of Benefits. This will allow the Hospital or Physician to exercise certain rights that normally belong to the patient.

For purposes of the Plan, an "Assignment of Benefits" or "AOB" is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less any deductibles, copayments, or coinsurance amounts, to a Hospital or Physician. If a Hospital or Physician accepts said arrangement, the Hospital's or Physician's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Hospital or Physician that accepts this arrangement indicates acceptance of an AOB and deductibles, copayments, and coinsurance amounts, as consideration in full for treatment rendered.

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

No Participant shall at any time, either during the time in which he/she/they is a Participant in the Plan, or following his/her/their termination as a Participant, in any manner, have any right to assign his/her/their right to sue to recover benefits under the Plan, to assert or enforce rights due under the Plan or to any other causes of action which he/she/they may have against the Plan or its fiduciaries, whether such cause of action arises under federal, state, or tribal law, including any rights under TERISA (Title 15 of the Mashantucket Pequot Tribal Law).

A Hospital or Physician which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits

payable under the terms of the Plan, the Claims Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made. This may include recovery from the payee's beneficiaries, estate, heirs, guardian, personal representative, or assigns.

By accepting the benefits provided hereunder, the Participant agrees to furnish information or proof necessary to determine the Participant's right to a Plan benefit, including eligibility to enroll or remain enrolled in the Plan. Failure to submit the requested information or proof, making a false statement, or providing fraudulent or incorrect information will be grounds for the Plan to deny the Participant benefits and/or suspend or discontinue, at any time and for any length of time (including permanently), the Participant's receipt of benefits from the Plan.

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with applicable health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Participant, Provider or other person or entity to enforce the provisions of this section, then that Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs.

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

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

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with Section 23, Third Party Recovery, Subrogation and Reimbursement.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

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

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

Foreign Claims

In the event a Participant incurs a covered Medical, or Healthcare expense in a foreign country, the Participant shall be responsible for providing the following to the Claims Administrator before payment of any benefits due are payable:

1. The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language;

2. The charges for services must be converted into U.S. dollars; and

3. A current conversion chart validating the conversion from the foreign country's currency into dollars. The currency conversion amount in effect on the date of service shall determine the date on which the currency amount is applied.

Attach receipts, statements or bills to your claim and mail to:

Pequot Plus Health Benefit Services
P.O. Box 3620
Mashantucket, CT 06338
Telephone: 888-779-6872

SECTION 21: EXPLANATION OF BENEFITS (EOB) ❖❖❖❖

Each time a claim submitted by you or your healthcare provider is processed, the Claims Administrator will explain how it processed the claim in the form of an Explanation of Benefits (EOB). The EOB is not a bill. Your EOB simply explains how a claim from a health provider (such as a Physician or Hospital) was paid on your behalf. It includes:

- date you received the service,
- the Hospital or Physician's name,
- amount billed by the Hospital or Physician,
- amount eligible for coverage,
- any network discount amount,
- any amount denied or pended along with a reason why,
- amount paid by the Plan to the Hospital or Physician,
- any balance owed by you to the Hospital or Physician, and
- the amount, if required, of any copay or credited toward any required deductible.

Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider. It is very important that you keep all records of the eligible medical expenses for yourself and each of your eligible Dependents. It is recommended that you keep all EOBs for at least two years.

SECTION 22: CLAIMS DETERMINATION ❖❖❖❖

Adverse Benefit Determinations (Applicable to All Claims)

An “adverse benefit determination” is:

- a denial, reduction or termination of a benefit or failure to provide or pay for (in whole or in part) a benefit;
- a rescission of coverage, even if the rescission does not impact a current claim for benefits;
- a denial of eligibility to participate in the Plan; or
- for health coverage, a claim denial on the grounds of any utilization review or that the treatment is Experimental or Investigative or not Medically Necessary. This also includes concurrent case determinations, for example, those reviews that are conducted while you are confined in a Hospital.

In the event of an adverse benefit determination, the Claims Administrator shall provide a claimant with a notice, either in writing or electronically. In the case of claim presented due to a denial of Pre-Service Care Claims or Urgent Care Claims, the Utilization Review Company will contact you by telephone, email, text message, facsimile or similar method, with written or electronic notice within 3 days.

An **Adverse Benefit Determination Notice** shall include the following information:

1. A reference to the specific portion(s) of the Summary Plan Description or other Plan documents upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information the Participant may provide for the Claims Administrator to re-evaluate the claim, and an explanation of why such information is necessary;
4. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant’s claim for benefits;
5. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
6. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
7. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary, or Experimental or Investigative), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant’s medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request;

8. Description of the appeal procedures offered by the Plan and your right to obtain additional information about these procedures;
9. Description of the Participant's right to bring a civil lawsuit under Mashantucket Pequot Tribal Law, if applicable; and
10. For Urgent Care Claims, a description of the Plan's expedited review process.

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To seek review of an adverse benefit determination for Pre-Service Care Claims, Urgent Care Claims, Concurrent Care Claims, and Post-Service Claims (if related to Medical Necessity), Participants must contact the Medical Utilization Review Company at the number on your benefit card. The Medical Utilization Review Company provides a multi-level appeals process for claims denied based on medical necessity. For Post-Service Claims not related to Medical Necessity, appeals must be directed to the Claims Administrator.

Claims Appeal Process

First Appeal Level

Eligibility

When an adverse benefit determination relates to a person's eligibility to enroll in or remain enrolled in the Plan, the appeal process in Section 4 will govern. In the event the Plan denies coverage for a surrogate mother, that adverse benefit determination will be governed by the process set forth in this Section 22.

Content of Notification of Adverse Benefit Determination on First Appeal

The Claims Administrator shall provide a claimant with notification of the Plan's decision on first appeal by telephone, email, text message, facsimile or similar method. The notification will set forth the same information as required for the original adverse benefit determination.

Second Appeal Level

Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for:

- a description of any additional information necessary for the Plan to re-evaluate the claim and an explanation of why such information is needed; and
- a description of the Plan's review procedures and the time limits applicable to the procedures.

HHS Review Panel

The Utilization Review Company will be responsible for the first appeal level. This may involve multiple layers of review and appeal—all of this will be considered first appeal level.

You or your Dependents may appeal the Utilization Review Company's final adverse benefit determination to the HHS Review Panel. The HHS Review Panel shall be an ad hoc panel consisting of: (i) the President of the Claims Administrator; (ii) the Director of Tribal Health Service; (iii) the Chief Medical Officer; (iv) the Health & Human Services Standing Committee (including the Chair of the Committee and any alternate members serving on the Committee, to the extent an appointed member cannot participate); and (v) a representative from the Health Care Advisory Board. Each of the foregoing may appoint a designee to serve in his/her/their place on the HHS Review Panel. Members of the HHS Review Panel will recuse themselves from all discussion and decision-making if there exists an actual conflict of interest or the appearance of a conflict of interest.

The HHS Review Panel's second level appeal shall be limited to the information that was provided to or considered by the Utilization Review Company in rendering its first level appeal decision, as well as any written decision(s) of the Utilization Review Company. The HHS Review Panel will review whether all relevant evidence provided to the Utilization Review Company was considered, and that the Utilization Review Company's decision was not arbitrary, capricious, or an abuse of discretion. In considering the second level appeal, the HHS Review Panel shall not substitute its medical judgment for that of the Utilization Review Company.

The HHS Review Panel may adopt by-laws to govern its appeal process.

Decision on Second Appeal to be Final

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period, the Participant may assume that the appeal has been denied. The decision by the HHS Review Panel on appeal will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

Exhausting Administrative Remedies

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. The HHS Review Panel's decision shall be considered "final agency action" for purposes of the Mashantucket Pequot Administrative Procedures Act (Title 40 of the Mashantucket Pequot Tribal Laws). Any legal action must be commenced in the Mashantucket Pequot Tribal Court within thirty (30) days after the HHS Review Panel has issued its decision.

Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his/her/their behalf with respect to a claim or appeal of an adverse benefit determination. An assignment of benefits by a Participant to a Hospital, Physician, or other provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Participant must complete a form, which can be obtained from the Claims

Administrator. However, in connection with an Urgent Care Claim, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Claims Administrator, in writing, to the contrary.

Claims Review Procedure

You or your Dependents have the right to appeal a denied claim. The chart below explains who will review the claim. The claims review procedures are explained in detail after the chart.

Type Of Health Care Claim	Request For Review (First Appeal)	Request To Reconsider (Second Appeal)
Urgent/Emergency Care	PPO-Utilization Review	HHS Review Panel
Pre-Service • Non-Urgent • Concurrent Care	PPO-Utilization Review	HHS Review Panel
Post-Service • Medical Care • Dental Care • Vision Care • Prescription Drug	Pequot Plus (Medical, Dental, Vision) PRxN (Prescription Drug)	HHS Review Panel

FOR MORE INFORMATION ABOUT THE REVIEW PROCEDURE, WRITE PEQUOT PLUS HEALTH BENEFIT SERVICES ADMINISTRATORS (PequotPlus@prxn.com), OR CALL THE CUSTOMER SERVICE DEPARTMENT AT 888-779-6872.

Claims Review Chart

Type Of Health Care Claims	Steps To Take	
URGENT CARE CLAIMS	**If your Claim is Complete**	
Urgent Care Claims are those for conditions that could jeopardize life, health or ability to regain maximum function, or (in the opinion of a Physician with knowledge of your condition) would subject you to severe pain. The reasonable layperson standard is used for these claims, except that if a Physician determines the condition is urgent, the Plan must accept the Physician's determination. **If a Prior Authorization is required, it should be obtained within three (3) business days from the first date of service.**	Step 1	The Plan has **72 hours** after receiving your initial claim to approve or deny the claim.
	Step 2	If denied, you have **180 days** after receiving the claim denial to file a first level appeal of the Plan's decision.
	Step 3	The Plan has **72 hours** after receiving your appeal to notify you of its first level appeal decision.
	Step 4	If denied on first level appeal, you have **30 days** to file a second level appeal.
	Step 5	The Plan has **60 days** to issue a decision on the second level appeal.
	Step 6	If denied on second level appeal, you have **30 days** to file an appeal under the Administrative Procedures Act.
	If your Claim is Incomplete or Improperly Filed	
	Step 1	The Plan has **24 hours** after receiving your initial claim to notify you that your claim is incomplete or that you failed to follow the Plan's procedure for filing claims.
	Step 2	You have **48 hours** after receiving notice from the Plan to provide sufficient information to complete your claim.
	Step 3	The Plan has **48 hours** to notify you if your claim is approved or denied. Plan must do so within the earlier of 48 hours of: (1) Receiving your completed claim, or (2) Your deadline to complete the claim.
	Step 4	If denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
	Step 5	The Plan has **72 hours** after receiving your appeal to notify you of its first level appeal decision.
	Step 6	If denied on first level appeal, you have **30 days** to file a second level appeal.
	Step 7	The Plan has **60 days** after receiving your second level appeal to issue a decision.
	Step 8	If denied on second level appeal, you have **30 days** to file an appeal under the Administrative Procedures Act.
PRE-SERVICE CLAIMS		
Claims where treatment **must have Type I or II Prior Authorization** before it is performed.	Step 1	The Plan has **5 days** after receiving your initial claim to notify you that your claim is incomplete or that you failed to follow the Plan's procedure for filing claims. You may either correct the deficiency or file a first level appeal. If your claim is complete and properly filed, the Plan has **15 days** after receiving your initial claim to approve or deny the claim.
	Step 2	If denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.

	Step 3	The Plan has **15 days** after receiving your first appeal to notify you of its decision.
	Step 4	If denied on first level appeal, you have **60 days** to file a second level appeal.
	Step 5	The Plan has **15 days** after receiving your second level appeal to issue a decision.
	Step 6	If denied on second level appeal, you have **30 days** to file an appeal under the Administrative Procedures Act
POST-SERVICE CLAIMS	**If your Claim is Complete**	
Claims where you request reimbursement after treatment has been performed.	Step 1	The Plan has **30 days** after receiving your initial claim to notify you if your claim is denied.
	Step 2	If denied, you have **180 days** after receiving the claim denial to file a first level appeal of the Plan's decision.
	Step 3	The Plan has **30 days** after receiving your appeal to notify you of the appeal decision.
	Step 4	If denied on the first level appeal, you have **60 days** to file a second level appeal
	Step 5	The Plan has **15 days** after receiving your second level appeal to issue a decision.
	Step 6	If denied on second level appeal, you have **30 days** to file an appeal under the Administrative Procedures Act
	If Your Claim Is Incomplete or Improperly Filed	
	Step 1	The Plan has **30 days** after receiving your initial claim to notify you if your claim is or that you failed to follow the Plan's procedure for filing claims. You may either correct the deficiency or file a first level appeal.
	Step 2	You have **45 days** after receiving notice from the Plan to provide any additional information to complete your claim.
	Step 3	If your claim is denied, you have **180 days** after receiving the claim denial to file a first level appeal of the Plan's decision.
	Step 4	The Plan has **30 days** after receiving your appeal to notify you of the appeal decision.
	Step 5	If denied on the first level appeal, you have **60 days** to file a second level appeal.
	Step 6	The Plan has **15 days** after receiving your second level appeal to issue a decision.
	Step 7	If denied on second level appeal, you have **30 days** to file an appeal under the Administrative Procedures Act

SECTION 23: THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT ❖❖❖❖

Payment Condition

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

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

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

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Conditional Payee(s) is/are only one or a few,

that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, Participants agree to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Participants are entitled, regardless of how classified or characterized, at the Plan’s discretion, if the Participants fail to so pursue said rights and/or action.

If a Participant receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant may have against any coverage and/or party causing the illness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. Such lien which shall supersede all common law or statutory rules, doctrines, and laws of any jurisdiction prohibiting assignment of rights which interferes with or compromises in any way the Plan’s equitable lien and right to reimbursement. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan’s behalf and function as a trustee as it applies to those funds until the Plan’s rights described herein are honored and the Plan is reimbursed.

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

If the Participant(s) fails to file a claim or pursue damages against:

- The responsible party, its insurer, or any other source on behalf of that party.
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
- Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer’s policy.
- Workers’ compensation or other liability insurance company.
- Any other source of Coverage, including, but not limited to, the following:
  - Crime victim restitution funds
  - Civil restitution funds
  - No-fault restitution funds such as vaccine injury compensation funds
  - Any medical, applicable disability or other benefit payments
  - School insurance coverage

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

Right of Reimbursement

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

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

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

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant.

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

Participant is a Trustee Over Plan Assets

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

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

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

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

Release of Liability

The Plan's right to reimbursement extends to any incident-related care that is received by the Participant prior to the liable party being released from liability. The Participant's obligation to reimburse the Plan is therefore tethered to the date upon which the claims were incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident-related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

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

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Medicare and Medicaid
6. Any other source of Coverage, including, but not limited to, the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Separation of Funds

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

Wrongful Death

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

Obligations

It is the Participant's obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the illness, injury, or disability, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights, including signing reimbursement and/or subrogation agreements as the Plan may request.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his/her/their attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To notify any third party who may be responsible for payment of the Plan's reimbursement and subrogation rights hereunder.
12. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

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

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

The Plan will have no obligation to a Participant if the Participant does not comply with the requisite terms and conditions of the Plan relating to its reimbursement and subrogation rights.

Offset

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

Minor Status

In the event the Participant is a minor, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his/her/their estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs

or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Severability

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

SECTION 24: HIPAA PRIVACY / SECURITY RULE ❖❖❖❖

Commitment to Protecting Health Information

The Tribe has enacted the Tribally Sponsored Employee Benefit Plans (TERISA) law under Title 15 of the MPTL. TERISA adopts the Employee Retirement Income Security Act of 1974 (ERISA) as tribal law, to the extent its provisions do not contradict tribal law.

Pursuant to Title 15, the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") under HIPAA will be followed by the Plan. Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Plan and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her/them about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his/her/their PHI.
3. The Plan's duties with respect to his/her/their PHI.
4. The Participant's right to file a complaint.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of PHI that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

The Plan is required to disclose to a Participant most of the PHI in a designated record set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his/her/their representative. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his/her/their personal representative, or treating such person as his/her/their personal representative could endanger the Participant.

The Plan is also required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her/them:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her/them who are involved in his/her/their care or payment for his/her/their care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he/she/they receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his/her/their PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his/her/their request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the

disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.

5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her/them in certain records maintained by the Plan. If the Participant requests copies, he/she/they may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his/her/their PHI transmitted directly to another designated person, he/she/they should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his/her/their PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he/she/they does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her/their privacy rights, please contact the Plan. The Plan will not retaliate against the Participant for filing a complaint.

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

TERISA and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of PHI that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted or maintained in any electronic media.

- Security Incidents means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

If the Plan Sponsor will receive and use ePHI for plan administration functions, the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides ePHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the ePHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. “Summary health information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all

identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or Claims Administrator to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that PHI is used or disclosed other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant’s PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan’s compliance with the HIPAA Privacy Rule.

SECTION 25: PLAN ADMINISTRATION ❖❖❖❖

The Plan Sponsor has designated a three-person panel to serve as the Plan Administrator. The panel will be composed of the MPTN Chief Medical Officer, the Pequot Health Care President, and the Tribal Health Services Director. Composition of this panel may be changed from time to time by the Plan Sponsor. The Plan Administrator may adopt internal by-laws to govern its operations.

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator may retain the services of a claims administrator and/or Utilization Review Company to provide certain claims processing and other technical services. However, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator in accordance with these provisions. The Plan Administrator and serve at the convenience of the Plan Sponsor.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, including to the Claims Administrator, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of Tribal Members and their Dependents, with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall be made by a separate, written amendment enacted by resolution of the Plan Sponsor, in accordance with applicable law.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration.

SECTION 26: GLOSSARY OF IMPORTANT TERMS ❖❖❖❖

Accident – Any unforeseen or unexplained sudden bodily injury occurring by chance without intent or volition.

Adverse Benefit Determination – Any of the following:

- a denial, reduction or termination of a benefit or failure to provide or pay for (in whole or in part) a benefit;
- a rescission of coverage, even if the rescission does not impact a current claim for benefits;
- a denial of eligibility to participate in the Plan; or
- for health coverage, a claim denial on the grounds of any utilization review or that the treatment is Experimental or Investigative or not Medically Necessary.

Allowable Expense(s) – The Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses.

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

Birthing Center – A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy.

Center of Excellence – A health care facility or program with a high degree of expertise in a specific area, which is identified by the Plan Administrator or Claims Administrator as providing high levels of care in a cost-effective manner.

Chiropractic – Treatment that includes manipulation, modalities, supplies, heat treatment, cold treatment and massages. It does not include x-rays, office visits, consultations or exams, which would be covered under Physician services as shown in the Schedule of Benefits.

Copay – An amount you may be required to pay as your share of the cost for services or supply, like a doctor's visit, emergency room visit or prescription drug. A Copay is usually a set amount, rather than a percentage.

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

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

Covered Services – Any health care services, drugs, supplies, and equipment for which coverage benefits are available under the Plan pursuant to this SPD.

Custodial Care – Services for personal care such as help in walking and getting out of bed, assistance in bathing, dressing, feeding, and using the toilet, supervision over medication which can usually be self-administered and services which do not entail or require the continuing attention of trained medical or paramedical personnel.

Deductible – The specific dollar amount stated in the Schedule of Benefits that each covered Participant must pay for covered services in a Plan Year before the Plan will pay benefits.

Dependent – A Tribal Spouse, Tribal Member Dependent Child, Legally Adopted Child, and/or Legal Dependent.

Emergency – The sudden onset of a medical condition of sufficient severity that, in the absence of immediate medical attention, could:

1. Permanently place a Participant's life or health in serious jeopardy;
2. Cause serious impairments of body functions;
3. Seriously jeopardize a Participant's ability to regain maximum function of a body part or organ; or
4. In the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without emergency services.

Experimental/Investigative – The use of treatment, drugs or supplies not yet recognized by the Plan as acceptable medical practice. Any item, which requires, but has not received, approval by a federal or other governmental agency is also considered experimental.

Formulary – A list of prescription drugs covered by a prescription drug plan.

Home Health Care Agency – A public agency or private organization that provides services in a Participant's home. All providers must be certified as such by the state in which they operate or deliver services.

Hospital – A hospital must be licensed in the state in which it is located and:

1. Be primarily engaged in providing diagnostic, medical and surgical facilities for the care and treatment of sick persons;
2. Have a staff of licensed physicians and/or surgeons regularly in attendance;
3. Have twenty-four (24) hour a day nursing service by Registered Licensed Nurses (RNs);
4. Maintain inpatient facilities for the bed care of its patients;
5. Not be primarily operated as a rest home, convalescent home, or home for the aged;
6. Not be a hospital or facility operated by the federal government; and

7. Not be a hospital that also provides educational facilities for its patients. However, a psychiatric hospital will not be required to have surgical facilities.

Illness - Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness.

In-Network – A Provider who has contracted with the PPO network as a preferred provider.

Inpatient – An individual who is treated as a registered bed patient in a Hospital or Skilled Nursing Facility and for whom a room and board charge is made.

Intensive Care (ICU) or Coronary Care Units (CCU) – Those areas of a Hospital where necessary supplies, medications, equipment and a skilled staff are available to provide care to critically or seriously ill patients who require constant observation.

Legal Dependent – A person for whom another person is required by law to provide support.

Legally Adopted Child - Any non-Tribal Member person(s) legally adopted by a Tribal Member on or before the age of eighteen (18).

Legally Separated – An arrangement under applicable laws to remain married but maintain separate lives, pursuant to a court order.

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

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

Medically Necessary – As defined by Plan Administrator, to be medically necessary, your tests, treatments, services and supplies must:

1. Be consistent with the diagnosis of your illness or accidental injury;
2. Comply with the standards of good medical practice;
3. Be given to you as an inpatient only when the services cannot be safely provided as an outpatient;

4. Not be provided solely for the convenience of your Physician, Hospital, other provider, or you;
5. Be the most appropriate level of service which can be safely provided;
6. Be recognized as accepted medical practice; and,
7. Have received required federal approval or, for off-label uses: (i) have been recommended by the treating provider, (ii) there is sufficient evidence supporting the test's, treatment's, service's, or supply's efficacy and safety for the specific condition (e.g., such use is supported by drug compendia or peer-reviewed medical studies), and (iii) the test treatment, service, or supply has received prior authorization.

The Plan Administrator reserves the right to determine whether, in its judgment, a service is Medically Necessary and appropriate. The fact that a Physician has prescribed, performed, ordered, recommended or approved a service does not, in itself, make it Medically Necessary and appropriate.

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

Out-of-Network or OON – A Provider who has not contracted with the network and is not a preferred provider.

Out-of-Pocket Maximum – The dollar amount stated in the Schedule of Benefits for which a Participant is responsible to pay for covered services during a Plan Year. This maximum can be satisfied by a combination of eligible charges as stated in the Schedule of Benefits. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% for other covered services received during the remainder of the Plan Year.

Outpatient – An individual who received services or supplies while not an Inpatient.

Outpatient Surgery – Services performed in an outpatient department of a Hospital, in a doctor's office, or in a surgical center.

Partial Hospitalization – Continuous treatment consisting of not less than four (4) hours and not more than twelve (12) hours in any twenty-four (24) hour period under a program based in a Hospital, whether or not operated by the state.

Participant – An individual enrolled in the Plan, including Tribal Members, Tribal Spouses, widows/widowers, Tribal Children, and Legal Dependents.

Participating Provider - Physicians, Hospitals, clinics, and other healthcare providers and facilities that participate in a PPO network of providers. Participating Providers have agreed to provide health care services and treatment to Plan Members at contracted rates with no balance billing allowed for amounts in excess of their contracted rates.

Participating Provider Organization (PPO) –a network of independent Hospitals and Health Care Providers.

Permanent Dependent – An enrolled Tribal Member who, due to a chronic or perpetual medical condition, is unable to work or care for himself/herself/themselves.

Primary Care Doctor – A doctor whose primary specialty is in family medicine, internal medicine, geriatric medicine, pediatric medicine or a nurse practitioner.

Provider or Physician – A legally licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy, except interns and residents, who are legally qualified and licensed without limitation to practice and perform surgery at the time and place a service is rendered. Doctors of Dental Surgery, Doctors of Dental Medicine, Doctors of Optometry, Doctors of Podiatry Medicine, and Doctors of Chiropractic will be considered Physicians when performing covered services that are within the scope of their licenses.

Plan Document – This document, which outlines the terms and conditions of coverage under the Plan.

Plan Year – A period of twelve (12) consecutive months commencing on January 1 and ending on December 31st.

Pre-Admission Testing – X-rays, electrocardiograms and laboratory tests made on an outpatient basis within seven (7) days before admission to the Hospital.

Premium Contribution – The amount you pay weekly for healthcare.

Prior Authorization Type I – The requirement that patient obtain third-party approval, via the Utilization Management Company, to ensure that requested procedure is Medically Necessary and delivered in clinically appropriate setting.

Prior Authorization Type II - The requirement that a patient obtain third-party approval, via the Utilization Management Company, for any and all services (inpatient and outpatient) that will be provided by and billed by a Hospital, outpatient surgical center, or by a dialysis center.

Skilled Nursing Facility – An institution or distinct part of an institution that provides skilled nursing services to its patients. It must provide more than custodial care and be licensed by the state.

Specialist – A licensed physician who provides medical care in any generally accepted medical or surgical specialty or subspecialty. A specialist does not include family practitioners, general practitioners, internists, pediatricians, obstetricians and gynecologists.

Substance Abuse - Any disease or condition that is classified as a substance use disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, or as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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

Summary Plan Description or SPD – This document, which outlines the terms and conditions of coverage under the Plan.

Treatment Plan – a program for continued care and treatment established in writing by the patient's attending Physician.

Tribal Child – A dependent child who is a lineal descendent of an enrolled Tribal Member.

Tribal Family Health Plan (TFHP or the Plan) – The community health plan for enrolled members of the Mashantucket Pequot Tribal Nation and their eligible Dependents. This Plan is not tied to employment and all enrolled Tribal members in "good standing" are eligible for coverage from "cradle to grave". Primary enrollees are required to pay premium contributions for coverage.

Tribal Member Dependent Child - Any non-Tribal Member person(s) who was in the custody and care of a Tribal Member and resided in the household of the Tribal Member for at least seven (7) years on or before reaching the age of eighteen (18) years as a member of the Tribal family.

Usual, Customary and Reasonable (UCR) – The fees normally charged by health care providers in the same geographical area for medical treatment and services to patients with similar illnesses or injuries.

Utilization Review Company – A third party contracted by the Plan to provide Prior Authorization, concurrent care review, retrospective review of claims to ensure the care is Medically Necessary, and review of care for appropriate treatment setting and level of care.