



THE NAVAJO NATION

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT

**MEDICAL CARE, PRESCRIPTION DRUG, DENTAL
CARE, VISION CARE AND SHORT TERM DISABILITY**

EFFECTIVE JANUARY 1, 2019

THE NAVAJO NATION



JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE PRESIDENT

Navajo Nation Employee Benefit Plan Amendment Effective January 1, 2020

DENTAL PROGRAM: The Plan Document, page 68, Dental Calendar Year Deductible will reflect the following changes:

The annual dental deductible is decreased from \$200 per covered member to \$100 per covered member, and decreased from \$600 per covered family to \$300 per covered family.

DENTAL CALENDAR YEAR DEDUCTIBLE

CLASSES II, III AND IV	
Per Covered Member	\$100
Per Covered Family	\$300

SHORT TERM DISABILITY BENEFIT PROGRAM: The Plan Document, page 71, Schedule of Short Term Disability Benefits will reflect the following changes:

The Weekly Maximum Benefit Amount is increased from \$400 per week to \$600 per week.

SHORT TERM DISABILITY BENEFITS TABLE	
Weekly Benefit Amount	Sixty (60%) percent of weekly wages Six hundred (\$600) dollars maximum per week

TABLE OF CONTENTS

INTRODUCTION.....	5
Purpose.....	5
Controlling Costs of Health Care Services and Supplies.....	5
Plan Not a Contract of Employment.....	5
PLAN INFORMATION.....	6
Name of Plan.....	6
Plan Administrator.....	6
Employer Identification Number.....	6
Type of Plan.....	6
Source of Contributions to the Plan.....	6
Initial Effective Date.....	6
Effective Date of Amendment.....	6
Plan Year.....	6
Agent for Service of Legal Process.....	6
Administration of the Plan.....	6
Third Party Administrator.....	6
Statement of ERISA Rights.....	7
No Liability for Indian Health Services or any Federally-Funded Health Care Providers...	7
DISCLOSURE NOTICES.....	8
Health Insurance Portability and Accountability Act (HIPAA) Privacy Statement	8
Separation Between Plan Administrator and Plan.....	10
Patient Protection and Affordable Care Act (PPACA).....	10
Mental Health/Substance Use Disorder Parity.....	12
Women’s Health & Cancer Rights Act of 1988.....	13
Newborns’ and Mothers’ Health Protection Act.....	13
GENERAL PLAN PROVISIONS.....	14
Plan Administrator and Fiduciary.....	14
Plan Interpretations and Determinations.....	14
Third Party Administration.....	14
Premium Contributions.....	14
Plan Amendments and Termination.....	14
Inspection of Plan Document.....	15
Provision of Records to the Third Party Administrator.....	15
Preservation of Confidentiality.....	15
Misstatement or Omission of Facts.....	15
Clerical Error.....	15
Legal Actions.....	15
Workers’ Compensation Benefits Not Replaced or Affected.....	15
Independent Contractors.....	16

Examination.....	16
Benefits Not Transferable.....	16
ELIGIBILITY AND ENROLLMENT.....	17
Enrollment for Coverage.....	17
Mistake or Misstatement of Fact or Notification of Change or Error.....	17
Election of Coverage and Annual Open Enrollment.....	17
Timely and Late Enrollment/Enrollees.....	17
Employees Eligible for Coverage.....	17
Dependents Eligible for Coverage.....	18
Dependents Not Eligible for Coverage.....	19
Employee’s Effective Date of Coverage.....	19
Reinstatement of Coverage.....	19
Change of Location Within This Plan.....	20
Other Reinstatement.....	20
Dependent’s Effective Date of Coverage.....	20
Change in Dependent Coverage Status.....	20
Removal of a Dependent for Coverage.....	21
Special Enrollment Period.....	21
Termination of Coverage for Employee Member.....	22
Extension of Coverage During Disability.....	22
Termination of Coverage for Dependents.....	22
Rescission of Coverage Due to Misrepresentation.....	23
COORDINATION OF BENEFITS.....	24
Explanation.....	24
Definitions.....	24
How Coordination of Benefits Works.....	25
Coordination Procedures.....	25
Right to Exchange of Information.....	26
Payment and Over-Payment.....	26
Coordination of Benefits with other Government Programs.....	26
SUBROGATION RIGHTS.....	27
Right to Reimbursement.....	27
GENERAL PLAN DEFINITIONS.....	28
MEDICAL PROGRAM.....	31
Definitions Applicable to Medical Benefits.....	31
Pre-certification.....	35
How Pre-certification Works.....	35
Notice to Covered Member and Health Care Service Provider.....	36
Pre-certification Second Review Procedure.....	36
Concurrent Review.....	36
Case Management and Alternate Treatment.....	37
Penalty for Failure to Obtain Pre-certification.....	37
Dialysis Treatment - Outpatient.....	37
Native Healing Benefits.....	39
Covered Medical Expenses.....	40
General Medical Benefits Exclusions and Limitations.....	47

SCHEDULE OF MEDICAL BENEFITS.....	51
Who Pays for Benefits.....	51
Preferred Provider Organization.....	51
Choice of Health Care Provider.....	51
Medical Calendar Year Deductible.....	51
Carry Over Deductible.....	52
Benefit Percentage Payable.....	52
Co-Payments.....	52
Maximum Out-of-Pocket Expenses.....	52
Schedule of Medical Benefits Table.....	53
PRESCRIPTION DRUG PROGRAM.....	58
Retail Pharmacy Option.....	58
Mail Order Option.....	58
Specialty Drug Option.....	58
Definitions Applicable to Prescription Drug Benefits.....	59
Generic Substitution.....	59
Covered Drugs and Medicines.....	59
Prescription Drug Program Exclusions and Limitations.....	60
Additional Prescription Drug Benefit Exclusions.....	61
Schedule of Prescription Drug Benefits.....	62
DENTAL PROGRAM.....	63
Pre-Treatment Review.....	63
Definitions Applicable to Dental Benefits.....	63
Class I – Preventive Services.....	65
Class II – Basic Services.....	65
Class III – Major Services.....	66
Class IV – Orthodontic Services.....	66
Dental Program Exclusions and Limitations.....	67
Dental Calendar Year Deductible.....	68
Dental Carry Over Deductible.....	68
Dental Calendar Year Maximum Benefits.....	68
Orthodontic Lifetime Maximum Benefit.....	69
Dental Percentage Payable.....	69
VISION CARE PROGRAM.....	70
Schedule of Vision Care Benefits.....	70
Vision Care Program Exclusions.....	70
Vision Care Program Limitations.....	70
SHORT TERM DISABILITY BENEFIT PROGRAM.....	71
Schedule of Short Term Disability Benefits.....	71
Short Term Disability Qualifying Provision.....	71
Waiting Period.....	71
Extension of Benefit Payments.....	72
Termination of Benefit Payments.....	72
Recurring or Successive Periods of Disability.....	72
Claim Filing for Disability Benefits.....	72
Time Limit for Filing a Claim.....	72

Continued Proof of Disability.....	73
Calculation of Benefit Payments.....	73
Disability Benefits Exclusions and Limitations.....	73
Termination of Disability Coverage.....	73
CONTINUATION OF BENEFITS FOLLOWING TERMINATION OF COVERAGE.....	74
Definitions Applicable to COBRA.....	74
Right to Elect Continuation Coverage.....	74
Notification of Qualifying Event.....	74
Length of Continuation Coverage.....	75
Total Disability.....	75
Termination of Continuation Coverage.....	75
Multiple Qualifying Events.....	76
Continuation Coverage Exclusions and Limitations.....	76
Deductibles and Plan Maximums.....	76
Premium Payment	76
Conversion Privilege.....	77
CLAIMS PROCEDURES.....	78
Time Limit for Filing a Claim.....	78
How to File a Claim.....	78
Foreign Claims (Outside the United States).....	78
Notice of Claim Denial.....	79
Explanation of Benefits.....	79
Member Portal.....	79
Assignment of Benefits.....	79
Alternate Payee Provision.....	80
Rights of Recovery.....	80
APPEALS PROCEDURES.....	81
Request for Independent External Review.....	82

INTRODUCTION

Each covered employee member of the Navajo Nation Employee Benefits Plan is encouraged to read this Plan Document (Plan) thoroughly. Becoming familiar with the terms and provisions of this Plan gives the covered member a better understanding of the procedures and benefits described for medical, prescription drug, dental, vision and short term disability programs. The benefits described herein are designed to pay the usual, customary and reasonable fees for a broad range of necessary health care services and supplies that give covered members substantial protection against the cost of serious sickness and injuries.

In addition to this Plan, a wallet-sized group health plan card is issued to the covered member that identifies the group plan name, plan number, employer number, covered employee member's name, covered employee member's identification number, and any additional covered member's names. This card includes claims filing information on the reverse side, and it is therefore important for the covered member to always have this card available when seeking health care. If the card is lost or misplaced, either the Navajo Nation Employee Benefits Program or the appropriate benefits representative should be contacted immediately for the re-issuance of a new card.

The Plan Administrator also provides life insurance benefits through a separate policy for its covered members.

PURPOSE

This Plan Document identified as the Navajo Nation Employee Benefit Plan has been in effect since January 1, 1991, with some modifications and enhancements that have occurred since then. Therefore, the purpose of this Plan revision effective January 1, 2019, is to set forth additional provisions which provide for the payment of all or a portion of covered expenses the Plan Administrator agrees to pay on behalf of all covered members. This 2019 Plan supersedes all other plans and previously issued amendments and serves as the only Plan to be used in the determination of benefits to which covered members are entitled. It is further subject to future amendments as determined by the Plan Administrator to reflect changes in benefits or eligibility requirements.

CONTROLLING COSTS OF HEALTH CARE SERVICES AND SUPPLIES

To control the costs of health care services and supplies, the covered members are encouraged to discuss charges with the health care service providers when seeking medical, prescription drug, dental, vision and other related health care services. Covered members are encouraged to comply with the pre-certification requirements which also control the costs of health care services and supplies at a reasonable level.

PLAN NOT A CONTRACT OF EMPLOYMENT

This Plan does not constitute a contract of employment or give any covered member the right to be retained in the service of the Plan Administrator or to interfere with the right of the Plan Administrator to discharge or otherwise terminate the employment of any covered employee member.

PLAN INFORMATION

1. **Name of Plan:**
The Navajo Nation Employee Benefit Plan (Master Plan Number – 710000)
2. **Plan Administrator:**
The Navajo Nation
Post Office Box 1360
Window Rock, Arizona 86515
Phone: 928/871-6300
Fax: 928/871-6408
3. **Employer Identification Number:**
86-0909270
4. **Type of Plan:**
Medical, prescription drug, dental and vision programs for employee and dependent members and short term disability benefits for employee members.
5. **Source of Contributions to the Plan:**
The Navajo Nation, its enterprises, Chapters (political sub-divisions), and employees contribute to the costs of the Plan. Employee contributions are the employee's share of costs as determined by the employer.
6. **Initial Effective Date:**
The Plan's initial effective date is January 1, 1991.
7. **Effective Date of Amendment:**
The Plan's effective date of this amendment is January 1, 2019.
8. **Plan Year:**
The Plan Year begins January 1 and ends December 31.
9. **Agent for Service of Legal Process:**
The Navajo Nation
Employee Benefits Program
Post Office Box 1360
Window Rock, Arizona 86515
Phone: 928/871-6300
Fax: 928/871-6408
10. **Administration of the Plan:**
The Plan is administered directly by the Plan Administrator. The Plan Administrator employs and utilizes the services of a Third Party Administrator to process claims.
11. **Third Party Administrator:**
Hawaii Mainland Administrators, LLC (HMA, LLC)

Post Office Box 22009
Tempe, Arizona 85285
Phone: 800/448-3585

12. **Statement of ERISA Rights:**

The Plan Administrator holds the position that ERISA does not govern the Plan, but that it is voluntarily guided by ERISA provisions as applicable to its government plans. Accordingly, interpretations of the Plan, including words and phrases, shall be guided by ERISA as applicable to government plans.

13. **No Liability for Indian Health Services or any Federally-Funded Health Care Providers:**

The Plan Administrator holds the position that neither it nor the Plan is liable for expenses or reimbursement for medical, surgical, hospital or related services to which the covered member is entitled to receive from or through the United States Public Health Service or any federally funded health care providers, or sponsored Indian Health Service programs, including referrals; nor in any event is the Plan to be considered or understood to be an “alternative source” for payment of the expense of such services.

DISCLOSURE NOTICES

This Plan Document is governed and controlled by the requirements of the Navajo Nation Privacy and Access to Information Act, 2 N.N.C. §§ 81 *et seq.*, as amended, and other applicable laws, including, but not limited to:

1. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996 PRIVACY STATEMENT, EFFECTIVE APRIL 14, 2004**

Use and Disclosure of Protected Health Information

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to a covered person to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and co-insurance amounts (for example, cost of a benefit or Plan maximums as determined for a covered person's claim);
- Coordination of Benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
- Reimbursement to the Plan.

"Health Care Operations" include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and creating, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
 - management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
 - customer service, including the provision of data analysis for policyholders, plan sponsors or other customers;
- Resolution of internal grievances.

The Plan will use and disclose PHI to the Plan Administrator and as required by law and as permitted by authorization of the covered person

With an authorization, the Plan will disclose PHI to other health benefit plans, health insurance issuers or Health Maintenance Organizations (HMOs) for purposes related to the administration of these plans.

The Plan will disclose PHI to the Plan Administrator only upon receipt of a certification from the Plan Administrator that the Plan Document has been amended to incorporate the following provisions.

With respect to PHI, the Plan Administrator agrees to certain conditions

The Plan Administrator agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan Document or as required by law;

- Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by a covered person;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Administrator unless authorized by the covered person;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to a covered person in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purpose of determining the Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

2. SEPARATION BETWEEN PLAN ADMINISTRATOR AND PLAN

The following employees or classes of employees under the control of the Plan Administrator may be given access to PHI by the Plan or a business associate servicing the Plan:

- Board of Directors
- Administration
- Human Resource/Financial Administration Support

The employees who are included in this description will have access to PHI only to perform the administration functions that the Plan Administrator provides to the Plan. Employees who violate this provision will be subject to sanction. The Plan Administrator will promptly report any violation of this provision to the Plan and will cooperate with the Plan to remedy or mitigate the effect of such violation.

3. PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

There are changes in Federal law which may impact coverage and benefits stated in this booklet and Schedule of Benefits. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-

grandfathered" plan. Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time. This Plan is considered a "non-grandfathered Plan".

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to the covered member under the terms of the plan are no longer permitted. Essential benefits include the following:
 - Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
 - Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.
 - Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's twenty-sixth (26th) birthday.
 - If the covered member does not have a grandfathered plan, in-Network benefits for preventive care services described below will be paid at one hundred (100%) percent, and not subject to any deductible, co-insurance or co-payment. If the covered member has pharmacy benefit coverage, the Plan may also be required to cover preventive care medications that are obtained at a network pharmacy at one hundred (100%) percent, and not subject to any deductible, co-insurance or co-payment, as required by applicable law under any of the following:
 - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
 - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
 - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
 - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

- Retroactive rescission of coverage under the policy is permitted, within thirty-one (31) days advance written notice, only in the following two circumstances:
 - The individual performs an act, practice or omission that constitutes fraud.
 - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the PPACA do not impact the Plan because the Plan already contains these benefits. These include:
 - Direct access to OB/GYN care without a referral or authorization requirement.
 - The ability to designate a pediatrician as a primary care physician (PCP) if the plan requires a PCP designation.
 - Prior authorization is not required before the covered members receive services in the emergency department of a hospital.
 - If the covered member seeks emergency care from non-PPO providers in the emergency department of a hospital the covered member's cost sharing obligations (co-payments/co-insurance) will be the same as would be applied to care received from PPO providers.

Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply.

Pre-Existing Conditions:

- Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

4. MENTAL HEALTH/SUBSTANCE USE DISORDER PARITY

Effective for policies that are new or renewing on or after January 1, 2014, benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are covered health services under the Policy must be treated in the same manner and provided at the same level as covered health services for the treatment of other illness or injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for co-insurance and co-payments for mental health and substance use disorder conditions must be no more restrictive than those co-insurance and co-payment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that co-insurance or co-payments that apply to mental health conditions and substance use disorder conditions in the benefit plan may be reduced.

5. WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, benefits under the policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If the covered member is receiving benefits in connection with a mastectomy, benefits are also provided for the following covered health services, as the covered member determines appropriate with the covered member's attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

The amount the covered member must pay for such covered health services (including co-payments, co-insurance and any deductible) are the same as are required for any other covered health service. Limitations on benefits are the same as for any other covered health service.

6. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g. covered member's physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce the out-of-pocket costs, the covered member may be required to obtain precertification. For information on precertification, contact the Claims Administrator at the number listed on the group health plan card.

GENERAL PLAN PROVISIONS

PLAN ADMINISTRATOR AND FIDUCIARY

The Navajo Nation is the Plan Administrator and named Fiduciary of this Plan and therefore has the authority to control and manage the operation and administration of the Plan. The Plan Administrator intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan in any way. No consent of any covered member or any other person referred to in the Plan is required to terminate, modify, amend or change the Plan. Notification shall be provided to the employer participants and covered members of any amendments to or termination of the Plan. Notice will be given to all covered members within sixty (60) days after the date of adoption of the amendment or change. No agent or Third Party Administrator is authorized to amend or terminate the Plan.

PLAN INTERPRETATIONS AND DETERMINATIONS

The Plan Administrator has full and sole discretionary authority to make all interpretive and factual determinations as to whether any covered member is entitled to receive benefits under the Plan. Any construction of the terms of this Plan and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

THIRD PARTY ADMINISTRATION

The Plan Administrator employs the services of a Third Party Administrator to process claims and other Plan related services agreed to by and between the parties in a contract. The Third Party Administrator processes claims, requests and receives funds from the Plan Administrator for the amount of the claims, and processes payments on the claims to the health care providers or covered members.

The Third Party Administrator is not an insurer, policyholder, broker of record, plan sponsor, plan administrator, employer, or a fiduciary of the Plan, nor does it insure or underwrite the liability of the Plan Administrator under this Plan.

PREMIUM CONTRIBUTIONS

The Plan Administrator, on an annual basis, evaluates the cost of the Plan and determines the amount to be contributed by the employer participants and the amount to be contributed, if any, by each covered employee member or COBRA participant. The Plan Administrator reserves the right to modify the amount of contribution for the employee member.

PLAN AMENDMENTS AND TERMINATION

The Plan Administrator intends to maintain this Plan indefinitely; however, the Plan Administrator reserves the right to amend, suspend or terminate the Plan, in whole or in part, at any time. If this Plan ends in whole or in part, a covered member's coverage under this Plan may terminate.

INSPECTION OF PLAN DOCUMENT

The Plan Administrator, upon request, will make the Plan Document available for inspection by any covered member.

PROVISION OF RECORDS TO THE THIRD PARTY ADMINISTRATOR

Each covered member authorizes his/her health care providers to provide to the Third Party Administrator, upon request, any and all information, records of attendance, examination or treatment provided.

PRESERVATION OF CONFIDENTIALITY

The Plan Administrator shall hold in strict confidence all confidential matters and exercise its best efforts to prevent any of its employees, health care providers, third party administrators, or agents from disclosing any confidential matter, except to the extent that such disclosure is necessary to enable the Plan Administrator to perform its obligation under this Plan, including but not limited to complying with the Navajo Nation Privacy and Access to Information Act, as amended, and other applicable federal laws.

MISSTATEMENT OR OMISSION OF FACTS

Statements made by a covered member, in the absence of a fraudulent or intentional misrepresentation of a material fact, are deemed to be representations and not warranties. No such representations will be used to void or reduce the Plan benefits; nor is such statement made by a covered member to be used in any contest unless it is in writing and a copy is given to the covered member or his/her beneficiary or the representative of the member's estate.

CLERICAL ERROR

A clerical error does not affect coverage to which a covered member is entitled. A delay or failure to report termination of any coverage does not continue the coverage in force beyond the date it terminates according to the Plan.

LEGAL ACTIONS

A covered member may not bring suit until sixty (60) days after a written proof of claim is furnished to the Plan Administrator. However, no suit shall be brought more than three (3) years after written proof of claim is furnished.

WORKERS' COMPENSATION BENEFITS NOT REPLACED OR AFFECTED

Coverage under this Plan does not replace or affect workers' compensation benefits provided for worked related injuries or illnesses covered by the Navajo Nation Workers' Compensation Program or other similar law.

INDEPENDENT CONTRACTORS

All health care service providers are independent contractors. The Plan is not liable for any claim or demand for damages connected with any injury or illness resulting from any treatment or lack of treatment by any health care service provider.

EXAMINATION

The Plan Administrator has the right to an examination of a covered member while a claim is pending under the Plan. The Plan Administrator will pay for the cost of these examinations, which may include physical, psychiatric or psychological examinations.

BENEFITS NOT TRANSFERABLE

Only eligible covered members are entitled to receive benefits under this Plan. The right to benefits is non-transferable.

ELIGIBILITY AND ENROLLMENT

ENROLLMENT FOR COVERAGE

An eligible employee must complete an enrollment form for coverage under the Plan by filing a completed and valid enrollment card. The employee may enroll for individual coverage (self only) or family coverage (self plus eligible dependents). Election of coverage for an employee includes medical, prescription drug, dental, vision and short term disability. Election of coverage for a dependent includes medical, prescription drug, dental and vision.

MISTAKE OR MISSTATEMENT OF FACT OR NOTIFICATION OF CHANGE OR ERROR

Any mistake of fact or misstatement of fact will be corrected with proper adjustment when it becomes known. Each employee member is responsible for providing birth, marital status, and dependent information.

It is the responsibility of the employee member to notify the employer participant of any status change, error in classification of coverage, or any other error that affects his/her coverage or contribution amount. Failure to provide notification as required will be corrected until the first of the following month, and refund of premium contributions will be limited to three (3) months retroactive from the date notice is received by the employer participant.

ELECTION OF COVERAGE AND ANNUAL OPEN ENROLLMENT PERIOD

Eligible employees may elect coverage at the time of:

1. Initial eligibility for coverage as specified in the applicable eligibility provision of this Plan;
2. Eligibility for coverage as specified under the Special Enrollment provision of the Plan; or
3. The Plan's open enrollment period in the months of October and November of each calendar year. If coverage is elected during the Plan's open enrollment period, coverage becomes effective on January 1 of the next calendar year.

TIMELY AND LATE ENROLLMENT/ENROLLEES

An enrollment is timely if the completed form is received by the Plan Administrator no later than thirty-one (31) days after the employee or dependent becomes eligible for coverage. An enrollment is late if it is not received by the Plan Administrator on a timely basis.

EMPLOYEES ELIGIBLE FOR COVERAGE

Employees eligible for coverage are persons actively working for the employer participants on a regular, part-time, or seasonal basis who are regularly scheduled to work at least twenty (20) hours or more per week. Navajo Nation Council Delegates are also eligible for coverage under this Plan, with the exception of short term disability benefits.

Employees who work less than twenty (20) hours per week, or who are classified by the Plan Administrator as temporary employees, are not eligible for coverage under this Plan.

DEPENDENTS ELIGIBLE FOR COVERAGE

1. **Spouse:** the covered member's wife or husband, including a spouse by a common-law marriage which is recognized by the Navajo Nation pursuant to 9 N.N.C. § 4(E) of the Navajo Nation Code, as amended.

For purposes of this provision, "marriage" means one man and one woman in a lawful marriage contractually recognized by the Navajo Nation or State where the marriage was performed. The Navajo Nation does not recognize a domestic same-sex partnership.

2. **Child:** the covered employee member's natural child, stepchild, legally adopted child (or child placed for adoption with the member), foster child, child for whom the member is the legal guardian, or a child for whose medical care the member or the covered spouse of the member is legally responsible through a divorce decree or other court order. An eligible dependent child may be covered until he/she reaches age twenty-six (26).

The Plan may require proof that, for purposes of coverage under this Plan, the spouse or child qualifies as a dependent under the covered employee member's coverage. It is the member's responsibility to furnish proof acceptable to the Plan to determine eligibility.

3. **Newborn Child:** a newborn child is eligible for automatic coverage from the date of birth, provided the covered member completes and submits all required forms that adds the newborn child and changes to a family coverage, if necessary, within the first thirty-one (31) days of the child's birth date. If the covered member fails to enroll the newborn within thirty-one (31) days as required, the newborn will be considered a late enrollee.
4. **Child Placed for Adoption:** coverage for a child placed for adoption before the age of eighteen (18), who are enrolled within thirty-one (31) days of the placement, begins on the date of placement. An adoptive child ceases to be a dependent under this Plan on the earliest of the date on which the petition for adoption is dismissed or denied; or the date on which the placement for adoption is disrupted prior to legal adoption and the child is removed from placement.
5. **Qualified Medical Child Support Order (QMCSO) Child:** a child covered by QMCSO is eligible for coverage under the Plan which begins on the date of the QMCSO or the covered employee member's effective date of coverage, whichever is later.
6. **Developmentally or Physically Disabled Child Dependent:** if a dependent is covered by this Plan on the day before he/she reaches age twenty-six (26), he/she will continue to be a dependent after age twenty-six (26) as long as he/she is:
 - a) mentally or physically challenged with a condition such as mental retardation, cerebral palsy, epilepsy or other neurological disorder, and such condition is diagnosed by a physician;
 - b) unmarried;
 - c) incapable of sustaining his/her own living; and
 - d) reliant on the covered employee member for support.

Within thirty-one (31) days after the covered dependent reaches age twenty-six (26), the covered employee member must submit satisfactory proof to the Plan Administrator of the dependent's incapacity and reliance on the covered employee member for support. Additional proof may be requested from time to time by the Plan Administrator. If the covered employee member fails to submit satisfactory proof when required, coverage could terminate for the dependent.

DEPENDENTS NOT ELIGIBLE FOR COVERAGE

1. A spouse who is legally separated or divorced from the covered employee member, unless the legal separation or divorce decree provides for coverage.
2. A domestic same sex partner.
3. A person who is in the military or like forces of any country.
4. If both husband and wife are eligible as covered members, only one may carry dependent coverage.
5. Any person eligible under the Plan may be covered as an employee or as a dependent, but not as both.
6. Any person living in the covered employee member's home, but not eligible as defined herein.
7. A child born to the member's dependent child, unless the member or covered spouse of the member is legally responsible through a court order.

EMPLOYEE'S EFFECTIVE DATE OF COVERAGE

An employee becomes covered for benefits under this Plan on the latest of the following dates, provided he/she meets the eligibility and waiting period requirements as listed below:

1. The first of the month following the date the employee completes a sixty (60) day waiting period for medical, prescription drug, dental and vision care. Short-term disability is effective on the date of hire;
2. The effective date of the Plan;
3. The date the employee becomes eligible as specified by this Plan; or
4. The date the Plan is amended to include the employee's employment status.

REINSTATEMENT OF COVERAGE

1. **Active Military Duty:** an employee member who receives orders to perform active military duty shall be restored to the eligibility status he/she held as of the last day he/she actively worked, provided his/her employment status is reinstated by the employer participant. The employee member will receive credit toward the waiting period for any time periods previously satisfied under this Plan prior to military service, and his/her dependents will be subject to the same Plan provisions.
2. **Family and Medical Leave Act of 1993 (FMLA):** a covered employee member who returns to work from an FMLA leave shall be restored to the eligibility status he/she held

as of the last day he/she actively worked, provided his/her employment status is reinstated by the employer participant.

3. **Extended Leave of Absence:** a covered employee member who is impacted by an extended leave of absence from employment should provide for the retention of his/her group insurance coverage by arranging to pay his/her premium contributions during the period of unpaid absence.

CHANGE OF LOCATION WITHIN THIS PLAN

When an employee member terminates employment with one covered location and accepts employment with another location and the break between the jobs is less than thirty-one (31) days, there is no waiting period to satisfy.

OTHER REINSTATEMENT

When an employee member's employment or coverage terminates for any reason, and there is a break in coverage of more than thirty-one (31) days after the termination, he/she is required to satisfy the employee eligibility requirements and waiting periods.

DEPENDENT'S EFFECTIVE DATE OF COVERAGE

Except as provided in the Special Enrollment provision of this Plan, dependent coverage is effective on the latest of the following dates:

1. The first of the month following the date the employee completes a sixty (60) day waiting period;
2. The effective date of the Plan;
3. The date the employee becomes eligible as specified by the Plan Administrator;
4. The date the Plan is amended to include the employee's employment status; or
5. If a late enrollee, on January 1 of the calendar year next following the annual open enrollment period during which enrollment is made.

CHANGE IN DEPENDENT COVERAGE STATUS

It is the covered employee member's responsibility to provide written notification to the Plan Administrator of any change in dependent status including addition of newborns, adopted children and dependent children who have reached the maximum age twenty-six (26); or marriage, divorce or legal separation. Failure to provide this notification could result in the dependent member's loss of eligibility or coverage under the Plan.

If the covered employee member and spouse are both covered under the Plan as employees, either party may change to a family coverage within thirty-one (31) days if:

1. A newborn, adopted child, child placed for adoption, or a court ordered child; or
2. The covered employee member or his/her spouse terminates employment or ceases to be in a class of employees eligible for coverage with the Plan Administrator.

If both the covered employee member and his/her spouse are covered under the Plan, and the covered employee member who is covering the dependent children terminates coverage, the dependent children's coverage may be transferred to the other employee member as long as coverage is continuous.

REMOVAL OF A DEPENDENT FOR COVERAGE

It is the employee member's responsibility to notify the employer participant if a covered dependent is to be removed from coverage within thirty-one (31) days of a change that may occur. Failure to provide notification could result in the recovery of benefit payments made on behalf of a dependent when there was no coverage at the time services were provided.

SPECIAL ENROLLMENT PERIOD

If an eligible employee or dependent declines coverage under this Plan because of other health coverage, enrollment for coverage may be made when an involuntary loss of other health coverage or a change in family status occurs.

This special enrollment applies to an employee, a dependent of an employee, or both. The enrollment must be made within thirty-one (31) days of:

1. A legal separation or divorce; loss of life; termination of employment; reduction in work hours to less than twenty (20) hours per week; termination of employer contributions for the coverage; or exhaustion of COBRA benefits offered under another health plan.

A covered member does not have to elect COBRA continuation coverage or exercise similar continuation rights in order to preserve the right to special enrollment. However, the covered member does not have a special enrollment right if he/she loses the other coverage as a result of his/her failure to pay premiums/contributions or for termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan.

2. Loss of health care coverage for an employee or dependent under a governmental plan such as Medicare, Medicaid, or CHAMPUS coverage.
3. A change in family status due to marriage; birth of a child; adoption or placement for adoption of a child; or a court order requiring coverage.

The effective date of coverage for special enrollment is:

1. The first of the month following the loss of coverage under another group health plan or a governmental plan;
2. The date of the marriage;
3. The date of birth;
4. The date of the adoption or placement; or
5. The date the court order was entered, or the first of the month following receipt of the court order by the Plan Administrator.

TERMINATION OF COVERAGE FOR EMPLOYEE MEMBER

Coverage terminates at midnight on the earliest of:

1. The last day of the calendar month in which employment ends due to a resignation, termination, retirement, layoff, or loss of life;
2. The date on which the employee member engages in fraudulent conduct, deception, or misrepresentation relating to claims, enrollment, obtaining benefits or the use of group health plan card;
3. The last day of the calendar month in which the employee member is no longer eligible for coverage;
4. The last day of the calendar month in which the required contribution for coverage is not made;
5. The date on which coverage terminates for the class of employees to which the employee member belongs;
6. The date on which the Plan terminates, or the date a specific benefit provided under the Plan terminates;
7. The date on which the employee member becomes an active full-time member of the armed forces other than for scheduled drills or other training of less than thirty-one (31) days; or
8. The last day of the calendar month in which the employee member voluntarily terminates his/her coverage.

EXTENSION OF COVERAGE DURING DISABILITY

If coverage terminates during a period of total disability, the covered member is entitled to continued coverage through COBRA.

TERMINATION OF COVERAGE FOR DEPENDENTS

Coverage terminates at midnight on the earliest of:

1. The last day of the calendar month in which the employee member's coverage terminates due to resignation, termination, retirement, layoff, or loss of life;
2. The last day of the calendar month in which the employee member ceases to be in a class eligible for dependent coverage;
3. The last day of the calendar month in which the required contribution for dependent coverage is not made;
4. The last day of the calendar month in which the Plan terminates for dependents, or the date a specific benefit provided under the Plan terminates;
5. The last day of the calendar month in which the covered dependent ceases to be a dependent of the employee member;

6. The date on which the covered dependent becomes an active full-time member of the armed forces, other than for scheduled drills or other training of less than thirty-one (31) days;
7. The last day of the calendar month in which the employee member voluntarily terminates the dependent's coverage; or
8. The last day of the calendar month in which the covered dependent becomes an employee member under the Plan.

RECISSION OF COVERAGE DUE TO MISREPRESENTATION

The Plan Administrator has discretionary authority to rescind coverage of a covered member for making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan benefits. The Plan Administrator may refund all contributions paid for any coverage rescinded; however, claims paid will be offset from the refund. The Plan Administrator also reserves the right to collect additional monies if claims are paid in excess of the employee member or his/her dependent contribution payments.

COORDINATION OF BENEFITS

If a covered member is eligible for medical, prescription drug, dental or vision benefits under any other group or student plan, the benefits provided by this Plan may be reduced so no more than one hundred (100%) percent of eligible expenses are paid by all plans combined.

EXPLANATION

Coordination of Benefits applies when a covered member participates in one or more health plans. If there is more than one plan, the total amount of benefits paid in a Plan Year under all plans cannot be more than the allowable expenses charged for that Plan Year. When an employee and spouse are both covered under the Plan, benefits will not be coordinated within the Plan.

DEFINITIONS

1. **Allowable Expense:** a medically necessary expense that is covered in whole or in part under at least one of the plans. When this Plan becomes secondary, allowable expense includes any deductible or co-insurance amounts not paid by the other plan. Deductibles or co-insurance reductions that result from non-compliance with the pre-certification requirements are excluded.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense unless the covered member's stay in a private hospital room is medically necessary.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service provided is considered both an allowable expense and a benefit paid. In the case of HMO plans, this Plan does not consider any charges in excess of what an HMO provider agrees to accept as payment in full. When an HMO pays benefits first, this Plan does not consider, as an allowable expense, any charge that would have been covered by the HMO if the covered member used the services of an HMO provider.

2. **Other Plans:** any of the following plans that provide health care benefits or services or treatment:
 - a) Group health policies or plans, whether fully or self-insured;
 - b) Group health coverage provided through an HMO and other hospital or medical services prepayment, group practice and individual practice plans;
 - c) Group-type plans obtained and maintained only because of membership with a particular organization or group, labor-management trustee, union welfare, or employer or employee organization plans;
 - d) Government or tax-supported programs. This does not include Indian Health Services or other federally funded health care providers or programs; or
 - e) No-fault motor vehicle coverage, but only where permitted by law.
3. **Primary Plan:** a plan that pays benefits first. Benefits under a primary plan cannot be reduced due to benefits payable under other plans.

4. **Secondary Plan:** a plan that pays benefits after the primary plan. Benefits under a secondary plan cannot be reduced due to benefits payable under other plans.

HOW COORDINATION OF BENEFITS WORKS

If this Plan is primary, it will pay as if there are no other plans involved.

If this Plan is secondary, it will pay the same benefits it would have paid had it paid as primary, less any payments made by the other plan. The covered member is responsible for the balance, if any.

COORDINATION PROCEDURES

When two or more plans provide benefits for the covered member, benefit payments will be determined in the following order:

1. If a plan has no coordination provision, it is automatically the primary plan.
2. If all plans have coordination provisions:
 - a) A plan is primary if it covers the person as an employee; secondary if it covers the person as a dependent;
 - b) A plan is primary if it covers the person as an active employee or dependent; the plan is secondary if it covers the person as an inactive employee or dependent or as a COBRA beneficiary;
 - c) If the covered person is also a Medicare beneficiary, Medicare is primary to the plan covering the person as a dependent; and primary to the plan covering the person other than a dependent (that is, the plan covering the person as a retired employee).
3. If this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the parent whose birthday falls earlier in the year is primary. This is called the birthday rule, (the year of birth is ignored). If both parents have the same birthday, the plan that covers the parent longer is primary. If the other plan does not have a birthday rule, the rule in the other plan determines the order of benefits.
4. If two or more plans cover a person as a dependent of divorced or separated parents, benefits for the child are determined in this order:
 - a) First, the plan of the parent who has custody of the child;
 - b) Second, the plan of the spouse of the parent who has custody of the child; and
 - c) Third, the plan of the parent who does not have custody of the child.

If the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual documentation of those terms, the benefits of that plan are determined first. The plan of the other parent becomes secondary.

If the specific terms of a court order provide for joint custody by the parents but does not state which of the parent is responsible for the health care expenses of the child, the plan

of the parent who carries the child as a federal income tax exemption is primary, and the plan of the other parent is secondary.

5. If none of the above rules determine the order of benefits, the benefits of the plan that covered the person for the longer period is primary.

RIGHT TO EXCHANGE OF INFORMATION

The Plan Administrator has the right to exchange benefit information with any other plan, insurance company or organization to determine benefits payable using this coordination of benefits provision. Any covered member who claims benefits under this Plan must provide the Plan Administrator with information required in order to apply this provision.

PAYMENT AND OVER-PAYMENT

If payments are made under another plan that should have been made under this Plan, this Plan will reimburse the other plan to the extent necessary to satisfy the intent of this coordination of benefits provision. This Plan also has the right to recover any overpayment made because of coverage under another plan. This Plan may recover this overpayment from any insurance company or organization to whom or for whom this Plan paid benefits.

COORDINATION OF BENEFITS WITH OTHER GOVERNMENT PROGRAMS

Coordination of Benefits under this Plan includes, but is not limited to government programs, such as Centers for Medicare and Medicaid Services (CMS) and Civilian Health and Medical Program of the Uniform Services (CHAMPUS). The regulations governing these programs do not take precedence over the determination of this Plan.

SUBROGATION RIGHTS

The Plan Administrator, to the extent of payment for benefits made for covered members, will be subrogated to all rights of any recovery a covered member has against any third party person or organization. The covered member may be required to execute and deliver any instruments and papers to secure those rights to the Plan Administrator.

If a covered member proceeds against any other person or business, this Plan shall have a lien on the amount actually collectable from such other person or business to the extent of such benefits paid.

Compromise of any claim by the covered member at an amount less than the benefits will be made only with written approval by the supervisor of the Navajo Nation Employee Benefits Program. The Plan Administrator has sole discretionary authority to exercise its right to reimbursement.

RIGHT TO REIMBURSEMENT

If a covered member: (a) seeks legal recourse, whether by suit, settlement, judgment or otherwise against any person, organization, other insurance company or any available uninsured or underinsured motorist coverage; and (b) recovers any payment, in whole or in part, from such person or organization for the benefits previously paid under the Plan, the covered member may be required to reimburse the Plan Administrator for all payments made under the Plan for which the covered member has received reimbursement.

The reimbursement will not exceed the amount of the benefit payments made under the Plan for which payment is recovered from any person or organization; or the amount recovered from any such person or organization as payment for the same injury or sickness.

A covered member is not eligible by this provision to seek legal action against any person or organization for which benefits have been paid under the Plan.

GENERAL PLAN DEFINITIONS

1. **Accident:** a happening by chance and without intention, a happening that is unforeseen, unexpected and unusual at the time it occurs.
2. **Active Work or Actively Working:** the employee reports for work at his/her usual place of employment and is able to perform all the duties of his/her regular occupation for his/her entire normal work day.

The employee is considered to be actively working on each day of a paid vacation or leave or on a regular non-working day if he/she actively worked on his/her last regular working day; and not totally disabled.
3. **Benefits:** the amounts paid for eligible charges to or on behalf of a covered member.
4. **Calendar Year:** the period beginning on January 1 of any year and ending on December 31 of that year.
5. **Co-Insurance:** that portion of eligible expenses paid or to be paid by the covered member as set forth in this Plan.
6. **Co-Pay or Co-Payment:** a specific dollar amount for health care services payable by the covered member at the time of the visit or purchase.
7. **Covered Employee Member/Covered Member:** an employee or a dependent for which coverage is provided under this Plan.
8. **Covered Expenses:** any medically necessary treatment, services, or supplies that are not specifically excluded from coverage elsewhere in the Plan.
9. **Deductible:** a specified dollar amount the covered member pays during a calendar year before other eligible expenses are considered for payment.
10. **Effective Date:** the date the Plan Administrator adopts the Plan; or the date coverage begins for the covered members.
11. **Eligibility Date:** the first day of coverage or, if there is a waiting period, the first day after the waiting period.
12. **Employee:** any person who is actively working for the employer participant on a regular full-time, part-time, or seasonal basis.
13. **Employer Participant:** the Navajo Nation government, its enterprises, or political subdivisions (Navajo Nation Chapters) whose employees are or may become eligible to receive health care benefits under this Plan.
14. **Exclusion:** any provision of the Plan where a specific service or condition is not covered or paid for.
15. **Family:** a covered employee member and his/her eligible dependents.
16. **Group Health Plan:** a plan, including a self-insured plan of, or contributed to by, an employer that provides health care coverage for its employees and dependents.

17. **Health Care Provider:** a person licensed to practice medicine by any state within the United States, or foreign country if the injury occurs outside of the United States, including a pharmacy dispensing prescribed medication, a hospital or other accredited medical facility, licensed or certified chiropractors and other recognized, properly licensed or certified medically related practitioners recognized by the Navajo Nation including traditional healing practitioners.
18. **Illness:** a non-occupational bodily disorder, disease, physical sickness, mental or emotional disorder, functional nervous disorder, or pregnancy complications.
19. **Incurred Expenses:** expenses incurred for health care treatments, services, and supplies for a covered member. The expenses are considered incurred on the date the treatment, service, or purchase is actually provided.
20. **Injury:** a physical harm sustained by a covered member in an accident. All injuries sustained by a covered member in a single accident are considered one injury.
21. **Late Enrollee:** an employee or dependent who is not enrolled during the initial period in which he/she is eligible to enroll, or during a special enrollment period when there is a change in family status or loss of coverage under another plan.
22. **Leave of Absence:** a period of time when the covered employee member is not working due to an illness, injury, or other circumstances, such as furloughs, military, educational or family medical leaves.
23. **Legal Guardian:** a person recognized by a court of law to take care of and manage the property and rights of another person or a minor child.
24. **Lifetime Maximum:** the total amount of benefits paid during the lifetime each covered member is covered under the Plan, whether or not coverage is continuous. Lifetime is not to be interpreted to mean the lifetime of a covered member.
25. **Limitation:** any provision other than an exclusion that restricts coverage or benefits under the Plan.
26. **Maximum Benefits:** the total amount of benefits paid, either during a calendar year or under a specific health care coverage limitation.
27. **Out-of-Pocket Maximum:** the maximum total amount the covered member or family pays during a calendar year. All eligible accumulated amounts paid by the covered members are combined to satisfy the out-of-pocket maximums under all levels of benefits provided in this Plan.
28. **Percentage Payable:** the percentage payable by the Plan for a covered expense as provided for in this Plan.
29. **Preferred Provider Organization (PPO):** a network of quality health care providers who contractually provide services and supplies on a reduced fee basis to the covered members of employer sponsored health plans.
30. **Preferred Provider Organization Provider (PPO Provider or Network Provider):** a health care service provider who provides services and supplies pursuant to a contractual agreement with the Third Party Administrator.
31. **Schedule of Benefits:** Outline of benefits described in this Plan.

32. **Subrogation/Third Party Liability:** the transfer of one's liabilities to another.
33. **Usual, Customary and Reasonable (UCR) Charge:** the base amount that is treated as the standard or most common charge for a particular health care service when rendered in a particular geographic area. The UCR charge should not exceed the amount ordinarily charged by most health care providers for comparable services and supplies in the locality where the service or supplies are received.
34. **Visits:** a personal meeting between the covered member and the health care service provider regarding the health or care of the covered member.
35. **Waiting Period:** the period of time that must pass before an employee or dependent becomes eligible for health care benefits under the terms of this Plan.

MEDICAL PROGRAM

DEFINITIONS APPLICABLE TO MEDICAL BENEFITS

1. **Anesthesia:** general anesthesia that produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness.
2. **Chemical Dependency or Substance Abuse:** physical or emotional dependency on drugs, narcotics, alcohol, inhalants, or other addictive substances.
3. **Chemical Dependency**
4. **Treatment Facility:** a facility that provides treatment for alcoholism, chemical dependency or drug addiction. The facility must be licensed by the state in which it is located or by the federal government to provide the treatment.
5. **Chemotherapy:** treatment of malignant disease by chemical or biological agents.
6. **Cosmetic Procedure:** a procedure performed solely for the improvement of a person's appearance rather than for the improvement or restoration of bodily function.
7. **Custodial Care:** care or service designed primarily to assist a person in daily living activities, bathing, getting in and out of bed, dispensing of self-administered medication, or other care not reasonably expected to contribute substantially to the improvement of a medical condition in custodial care.
8. **Dialysis Treatments:** treatment of acute or chronic kidney disease which includes the supportive use of an artificial kidney machine.
9. **Emergency Services:** treatment or services for an injury or illness that is of a serious, life threatening nature, developing suddenly and unexpectedly, and demanding immediate treatment.
10. **Genetic Information:** information about genes, gene products, and inherited characteristics that may derive from an individual or a family member, including carrier status, laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.
11. **Home Health Care Plan:** a plan established and approved in writing by a physician for care and treatment of a person at home. The health care plan must include a certification by the physician that the treatment of the illness or injury would require confinement as a resident inpatient in a hospital in the absence of the services and supplies provided as a part of the home health care plan.
12. **Home Health Care Provider:** a public or private agency or organization that specializes in providing medical care and treatment in the home. The provider must (a) be licensed if required by an appropriate licensing authority to provide skilled nursing services and other therapeutic services; (b) maintain policies established by a professional group associated with the agency or organization consisting of at least a physician and a registered nurse to supervise the services provided; (c) maintain a complete medical

record on each patient; (d) have a full-time administrator; and (e) be a health care provider under Medicare.

If there are no home health care providers that meet the above requirements, the services of visiting nurses may be substituted for the services of an agency.

13. **Hospital:** an institution constituted, licensed and operated as set forth in the laws that apply to hospitals if it: (a) maintains on its premises all the facilities necessary to provide for the diagnosis and medical treatment of an illness or an injury; (b) primarily provides care and treatment to sick or injured registered inpatients by or under supervision of a staff of one or more physicians; (c) provides treatment by or under the supervision of physicians, with continuous twenty-four (24) hour nursing services by registered nurses; (d) complies with all licensing or legal requirements to hospitals where it is located; and (e) is not primarily a nursing, convalescent or rest home, a place for the aged or custodial care, a school or a similar institution.

Hospital includes an institution specializing in the care and treatment of mental health disorders, chemical dependency (alcoholism, and drug abuse), provided the facility is duly licensed if licensing is required by law, where it is located.

14. **Inpatient:** when a person, upon the recommendation of a physician, is admitted to a hospital, hospice, or convalescent facility for treatment, and charges are made to the covered member for room and board due to the admission and treatment. Charges for any such confinement are subject to inpatient admissions requirements, including pre-certification and utilization review.
15. **Intensive Care Unit:** a section, ward, single room or coronary care unit within the hospital that is separated from other facilities and is operated exclusively for the purpose of providing professional medical treatment for critically ill patients; that it has special supplies and equipment necessary for such medical treatment available on a stand-by basis for immediate use; and that it provides constant observation and treatment by registered nurses or other highly trained hospital personnel.
16. **Medically Necessary:** health care and treatment recommended or approved by a physician consistent with a person's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of an individual or the health care service; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the covered member.
17. **Mental Health Disorders:** a diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), for which treatment is commonly sought from a psychiatrist or mental health provider.
18. **Midwife:** a person who is licensed or certified to manage the care of mothers and babies throughout the cycle.
19. **Minor Emergency Medical Clinic:** a freestanding clinic that provides minor emergency and episodic medical care. The clinic must include an x-ray and laboratory equipment and a life support system.

20. **Newborn:** refers to an infant from the date of birth until initial discharge from the hospital.
21. **Nurse:** a nurse licensed to perform nursing services by a state or regulatory agency responsible for the licensing in the state in which that individual performs health care services as a nurse.
22. **Nurse Practitioner:** a nurse who has completed a program of study affiliated with a college or university, passed a nurse practitioner certification examination given by the American Nurses Association, and who is licensed by the law of the state in which services are provided and acts within the scope of that certification and licensure in treating an injury or illness.
23. **Occupational Therapist:** a licensed practitioner who treats and educates a person on the loss of a motor function of skeletal muscles and the use of other muscles or artificial devices so that he/she may perform acceptably in any particular occupation or the ordinary tasks of daily living.
24. **Occupational Therapy:** treatment of a physically disabled person by means of constructive activities designed to promote the restoration of his/her ability to accomplish the ordinary tasks of daily living and other activities required by his/her particular occupation.
25. **Orthopedic Appliance or Device:** an external type of corrective appliance or device that is either customized or available over the counter and designed to support a weakened body part.
26. **Outpatient:** when a person receives health care, treatment, services or supplies at a health care facility that is not considered inpatient care.
27. **Outpatient Psychiatric Facility:** an administratively distinct governmental, public, private or independent facility that provides outpatient mental health services and which provides for a psychiatrist who assumes responsibility for coordinating the care of a person.
28. **Partial Hospitalization or Day Facility Treatment:** a structured program that provides less than twenty-four (24) hour health care, usually during the day, for patients in transition from a full-time inpatient care to outpatient care.
29. **Pharmacist:** a person who is licensed and trained to prepare, compound, and dispense drugs and medicines.
30. **Physical Therapist:** a person who is trained and licensed to treat patients by means of electrotherapy, hydrotherapy, mechano-therapy, massage and other therapeutic exercises. If no licensure is required, the physical therapist must be certified by the appropriate professional body.
31. **Physical Therapy:** treatment by means of electrotherapy, hydrotherapy, heat, massage, or similar modalities, physical agents, biomechanical, neuropsychological, and other therapeutic devices to relieve pain, restore maximum function so as to prevent disability following a disease, injury, or loss to a body part.
32. **Physician or Surgeon:** a licensed physician or surgeon who acts within the scope of his/her license and any other licensed practitioner required to be recognized for benefit

- payment purposes under the law of the state in which he/she lives and who is acting within the scope of his/her license.
33. **Pregnancy or Maternity:** physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.
 34. **Psychiatrist:** a trained and licensed person who provides psychotherapy and other accepted forms of evaluation, diagnosis, or treatment of mental or emotional disorders. This includes individual, group and family psychotherapy; electroshock and other convulsive therapy; psychological testing; psychiatric consultations, and any other forms of psychotherapeutic treatment as defined to be medically appropriate.
 35. **Psychologist:** a trained and licensed person who provides psychoanalytic care and treatment for a mental health disorder, chemical dependency or substance abuse. When licensure is not required, the psychologist must be certified by the appropriate professional body.
 36. **Radiation Therapy:** treatment of diseases by x-ray, radium, or radioactive isotopes.
 37. **Rehabilitation Facility:** a licensed institution or agency that provides individualized, goal-oriented, comprehensive and coordinated services designed to minimize the effects of physical, mental, social and vocational disadvantages and to effect a realization of a person's potential.
 38. **Respiration Therapy:** introduction of dry gases into the lungs for treatment purposes.
 39. **Restorative or Reconstructive Surgery:** surgery that restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal.
 40. **Room and Board:** charges made by a hospital, hospice, or convalescent nursing facility as a condition of occupancy.
 41. **Semi-Private Rooms:** rooms in a health care facility in which at least two (2) patient beds are available per room.
 42. **Speech Therapist:** a person who is skilled in the use of special techniques for the correction of speech and vocal disorders.
 43. **Speech Therapy:** treatment for the correction of speech impairment.
 44. **Surgery:** an operative or diagnostic procedure performed by an instrument or cutting procedure through an incision or any natural body opening for the treatment of an illness or injury.
 45. **Urgent Care:** the delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat persons who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.
 46. **Well-Baby and Well-Child Care:** medical treatment, services or supplies provided to a healthy newborn or child for routine and preventive health care and not for the treatment of an illness or injury.

47. **Wellness Care:** medical treatment, services, or supplies rendered for routine and preventive health care and not for the treatment of an illness or injury.

PRE-CERTIFICATION

This Plan includes a pre-certification designed to help the covered members receive necessary and appropriate health care while avoiding unnecessary expenses.

1. Pre-certification is required for medical necessity of the following non-emergency services before services are provided or performed:
 - a) Inpatient Hospitalizations
 - b) Rehabilitation Services
 - c) Inpatient Mental Disorder Treatment
 - d) Inpatient Chemical Dependency or Substance Abuse Treatment
 - e) Convalescent Nursing or Skilled Nursing Care Facility Admissions
 - f) Home Health Care
 - g) Hospice Care
 - h) Organ Transplant Services
 - i) Outpatient Occupational Therapy
 - j) Outpatient Speech Therapy
 - k) MRI, CAT Scan, MRA, or PET Scan
 - l) Durable Medical Equipment [items that exceed two hundred fifty (\$250) dollars].
2. Pre-certification may require the concurrent review of the listed services requested by the attending physician based on the diagnosis.
3. Certification for services and planning for discharge from a health care facility or cessation of medical treatment.

Pre-certification establishes medical necessity for certain care and services covered under the Plan. However, pre-certification does not guarantee the payment of benefits. Coverage and benefits are always subject to other requirements and provisions of this Plan, such as benefit limitations or exclusions, and eligibility at the time health care and services are provided.

HOW PRE-CERTIFICATION WORKS

The covered member is required to call the telephone phone number listed for pre-certification located on the reverse side of his/her member group health plan card as specified below:

1. **Elective Hospital Admissions:** If the physician recommends an elective, non-emergency hospital admission, either the physician, the covered member or his/her family member must request pre-certification prior to the admission.
2. **Maternity:** Health care plans generally do not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than forty-

eight (48) hours following a natural childbirth, or less than ninety-six (96) hours following a delivery by cesarean section.

This Plan does not require that a health care provider obtain authorization for prescribing a length of stay up to forty-eight (48) or ninety-six (96) hours. However, to use certain health care providers or facilities, or to reduce out-of-pocket expenses, pre-certification may be required.

For purposes of this Plan, any stay for a longer period of time requires pre-certification for the extended stay. Moreover, any other pregnancy-related admission that does not result in delivery must be reported prior to any scheduled non-emergency admission.

3. **Newborn:** Either the covered member, a family member or the physician must request pre-certification within five (5) working days of the baby's extended stay beyond the mother's release due to a medical diagnosis of illness.

The newborn must be promptly enrolled in this Plan in order for the baby's expenses to be considered eligible for processing.

4. **Transplant:** Either the covered member, a family member, or the physician must request pre-authorization prior to any transplant-related testing or other services.

5. **Other Listed Services:** Either the covered member, a family member or the physician must request pre-certification prior to other listed services beginning.

NOTICE TO COVERED MEMBER AND HEALTH CARE SERVICE PROVIDER

Each admission or transplant with a completed pre-certification review is assigned a certification number. An assigned length of stay, where appropriate, is also issued at the time of pre-certification review. Both the covered member and the health care service provider are provided with a letter confirming the date of admission and the length of stay authorized for the admission.

The Plan reserves the right to request a second professional opinion at the Plan's expense, when deemed necessary.

PRE-CERTIFICATION SECOND REVIEW PROCEDURE

If a hospital admission or transplant does not meet the pre-certification requirements, a second review will automatically be conducted by a Medical Director. If a difference of opinion remains after the Medical Director discusses the treatment with the physician, the covered member may appeal the decision in writing to the Plan Administrator.

CONCURRENT REVIEW

Concurrent review involves periodic assessment of a covered member's recovery progress during an inpatient stay. Prior to a covered member's release from the hospital, consultation with the attending physician will occur so that necessary follow-up care is provided, such as home visits by nurses or therapists, arrangements for transportation, or provision of medical equipment such as a wheelchair or walker.

CASE MANAGEMENT AND ALTERNATE TREATMENT

The Plan Administrator reserves the right to allow for home care or other alternative methods of treatment or health care not otherwise covered under the Plan. If a covered member's condition is determined to be of a serious nature, the Third Party Administrator may arrange for a review or case management services from a professional qualified to perform such services. The Plan Administrator may alter or waive the normal provisions of this Plan when it is reasonable to achieve a cost effective result without affecting the availability of quality health care for the covered member.

Benefits provided under this provision are subject to all other Plan provisions. Alternative care is determined on the merits of each individual case and any health care or treatment provided is not to be considered as setting precedent or creating liability with respect to the covered member.

PENALTY FOR FAILURE TO OBTAIN PRE-CERTIFICATION

Benefits are reduced by twenty-five (25%) percent for all eligible expenses if pre-certification is not obtained. If there is a medical reason for a change in the length of stay beyond what is originally authorized, either the covered member or the health care service provider is required to contact the pre-certification service before the authorized length of stay expires.

If the pre-certification service determines at any time during the inpatient stay that it is not medically necessary for the covered member to remain an inpatient, and the covered member elects to remain hospitalized, benefits are reduced by twenty-five (25%) percent for all services in connection with any day of the hospitalization following the date the pre-certification service determines the inpatient hospitalization is no longer medically necessary. Any additional expenses that become the covered member's responsibility for failure to comply with the pre-certification requirements are not considered eligible medical expenses and thus will not be applied to any deductible or out-of-pocket maximums of the Plan.

DIALYSIS TREATMENT - OUTPATIENT

When used in this document throughout this particular section, the term "Dialysis Treatment" shall mean any and all products, services, and/or supplies provided to Plan members/participants/beneficiaries for purposes of, or related to, outpatient dialysis.

1. The Plan has established a specialized procedure for determining the amount of Plan benefits to be provided for 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 members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.
2. The Dialysis Program shall consist of the following components:
 - a) Application. All claims filed by, or on behalf of, Plan members/participants/beneficiaries for coverage of Dialysis Treatment ("Dialysis Claims") shall be subject to the provisions of this section, regardless of the

treating healthcare provider's participation in the Preferred Provider Organization (PPO).

- b) **Mandated Cost Review.** All claims for 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 may elect to apply in the exercise of the Plan Administrator's discretion. The Plan Administrator reserves the right, in the exercise of its discretion, to engage relevant and qualified third-party entities for the purpose of determining the Usual, Customary, and Reasonable Outpatient Dialysis Charge.
- c) **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 Dialysis Treatment.
 - i. **Usual, Customary, and Reasonable Outpatient Dialysis Charge.** For the purposes of Dialysis Treatment and the Dialysis Program, "Usual, Customary, and Reasonable Outpatient Dialysis Charge" means that portion of a claim for Dialysis Treatment that is, (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 for the purpose of determining the Usual, Customary, and Reasonable Outpatient Dialysis Charge.

- ii. Secondary Coverage. Plan members/participants/beneficiaries eligible for other health coverage under any other health plan are strongly encouraged to enroll in such coverage. Plan members 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.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. To the extent permitted by law, the Plan Administrator shall have the discretionary authority to rely conclusively upon all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Plan Administrator.

NATIVE HEALING BENEFITS

The Plan Administrator recognizes and values the uniqueness and importance of native healing ceremonies and services. Thereby, the purpose of this Navajo Nation native healing benefit is to support its use by covered members for a culture health care that is to be given the same respect and consideration as that of western medicine. The benefit is designed as a part of the self-funded Plan administered by the Plan Administrator through its Navajo Nation Employee Benefits Program which provides and processes reimbursement claims for expenses incurred by the covered members.

1. Claim Process for Native Healing Benefits

The covered member is required to complete and submit a reimbursement claim form to the Navajo Nation Employee Benefits Program after a native healing ceremony or service is performed. After the claim form is reviewed for completeness and accuracy, authorization for payment is submitted to the Third Party Administrator with instructions to process the reimbursement payment.

- a) Other than the claim form, the covered member is not required to produce or show receipts for reimbursement, unless verification is needed.
- b) If multiple native healing ceremonies or services are claimed in the same calendar year, the covered member is required to submit a reimbursement claim form for each ceremony or service up to the maximum annual benefit of three hundred fifty (\$350) dollars per family.
- c) The covered member is encouraged to submit a reimbursement claim form within four (4) weeks after the ceremony or service is performed to ensure a timely and proper reimbursement, but in no event should a reimbursement claim form be filed no later than twelve (12) months from the date of service.
- d) The native healing benefit does not cover ceremonies or services conducted for dwellings, livestock, and other non-health related ceremony or service.

The Plan Administrator reserves the right to verify the performance of a native healing ceremony or service without infringing on the confidentiality established between the covered member and native healing practitioner (patient and health care provider) relationship.

2. **Verification Procedures**

To ensure the integrity of this native healing benefit and to assure respect for the native healing practitioner and patient relationship:

- a) The covered member is required to provide additional information that may be requested by the Navajo Nation Employee Benefits Program to satisfy verification if a claim form is incomplete or contains inaccurate information.
- b) If appropriate, the Navajo Nation Employee Benefits Program may prepare a verification form with the information provided by the covered member in the reimbursement claim form.
- c) When the requested information or verification is received, the reimbursement claim will be processed for payment.
- d) If there is a discrepancy in the claim form or the verification form results in a disputed claim, the covered member has the right to request reconsideration prior to denial of the claim by the Navajo Nation Employee Benefits Program Supervisor.
- e) If the requested information or verification is not received within thirty-one (31) days from the date of request, the claim will be denied for incompleteness, which the covered member has the right to appeal pursuant to the Appeals Procedure provided for within this Plan Document.

COVERED MEDICAL EXPENSES

Only eligible charges incurred by a covered member are considered covered medical expenses. An eligible charge is considered to be incurred on the date a health care service is performed or a purchase is made. Eligible charges are the usual, customary and reasonable charges incurred for an illness or injury for covered expenses specified in this Plan, or for one or more of the following, subject to the Schedule of Benefits and all other provisions, maximums, limitations, and exclusions of the Plan:

1. **Allergies:** charges for testing and treatment of allergies, including percutaneous, intracutaneous, and patch testing and allergy extract/injections.
2. **Alternative Care:** charges for treatment that involves manual manipulation, including treatment modalities, chiropractic care, spinal adjustments, diathermy, heat or cold therapy, massage, acupuncture, electrical stimulation or biofeedback for spinal skeletal system or surrounding tissue, hypnosis or hypnotherapy, holistic and naturopathic medicines or treatments. Charges in excess of the stated benefit maximum are not eligible for payment under any other provision of this Plan.
3. **Ambulance:** charges for professional land, air or sea ambulance service for which a designated or equipped vehicle that is licensed for transferring the sick or injured transports a covered member to the nearest medical facility qualified to treat the emergency illness or injury or when medically necessary, from one medical facility to

another. Sea or air ambulance is covered only due to inaccessibility by ground transport, or if the use of ground transport is determined to be detrimental to the health status of the patient. The ambulance service shall have customary patient care, safety, and life-saving equipment, and utilize trained personnel. Ambulance charges for convenience are not covered.

4. **Ambulatory Surgical Center:** charges made by an institution, facility, or minor emergency medical clinic, freestanding, or as part of a hospital with permanent facilities equipped and operated for the primary purpose of performing surgical procedures for which a patient is admitted and discharged.
5. **Amniocentesis Testing:** charges for amniocentesis testing, genetic testing, counseling and treatment recommended by a physician for a covered member who is over thirty-five (35) years of age or older at the time of delivery, or for a physician documented high-risk pregnancy or family history of genetic disorder. Any procedure intended solely for sex determination is not covered.
6. **Anesthetics:** charges for anesthetics procedures, including epidurals, administered by a physician or by a nurse anesthetist.
7. **Artificial Limbs:** charges for external prosthetic and orthopedic appliances such as artificial legs, arms, eyes or larynx or accessories, braces, splints, cervical collars or other orthopedic appliances, required to replace a lost natural body part, or are required for support to an injured or deformed part of the body due to a disabling congenital condition, illness or injury. These charges include the cost for fitting, adjustment, repair or maintenance of the prosthetic and orthopedic appliance. Charges incurred for replacement of a prosthetic appliance is covered only if it is deemed medically necessary due to a change in the covered member's physical condition. Only conventional, body powered and cable-operated prosthetics are eligible for loss of a limb or congenitally missing limbs. A myoelectric or utah arm may be considered only for shoulder disarticulation when a cable-operated prosthetic is totally non-functional. A charge for replacement due to a technological advancement only is not covered.
8. **Assistant Surgeon:** charges for an assistant surgeon when the procedure requires an assistant due to medical necessity. These charges are calculated at twenty (20%) percent of the usual, customary and reasonable covered surgeon's fees.
9. **Attention Deficit Disorder:** charges for initial eligible testing conducted to determine the diagnosis, medication, and medical management of medication for attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).
10. **Behavioral Problems:** charges for treatment of behavioral problems, communication delays, conduct problems, learning disabilities, developmental delays, autism, or for scholastic improvement.
11. **Birth Control:** charges for birth control injections, diaphragm, Norplant implant and removal, insertion and removal of an intra-uterine device (IUD), elective sterilization for the covered member. Charges for birth control pills are covered under the Prescription Drug Program of this Plan.

12. **Birth Center:** charges made by a licensed birthing center, which is not a hospital or in a hospital, for services or supplies that are otherwise payable if performed in a hospital.
13. **Blood:** charges for processing, administering, or storing pre-surgical autologous blood and cost of blood, blood components, or other fluids, unless it is donated or replaced.
14. **Breast Surgery:** charges for reconstruction of the breast on which a covered mastectomy has been performed; charges for surgery and reconstruction of the other breast to produce a symmetrical appearance; and charges for prosthesis and treatment of physical complications at all stages of a covered mastectomy, including lymph edemas.

At the sole discretion of the Plan Administrator, charges for breast reduction if prescribed by a physician and if the procedure is deemed medically necessary to prevent or correct a deformity or to improve a bodily function.
15. **Cardiac Rehabilitation:** charges for cardiac rehabilitation programs that provide supervised monitored exercise sessions following a heart surgery, a heart attack or when medically necessary, for a heart condition as prescribed by the physician.
16. **Chiropractic Services:** charges for chiropractic services listed and included in covered medical expenses under "Alternative Care".
17. **Circumcision:** charges for or in connection with a routine or medically necessary circumcision.
18. **Congenital Anomalies:** charges for treatment of congenital anomalies, which are defective development or formation of a part of the body that is determined by the physician to have been present at the time of birth, including cleft palate and cleft lip, up to the Plan maximums and incurred for the following services when provided by a health care provider: oral and facial surgery, surgical management and follow up care by plastic surgeons and oral surgeons; rehabilitative speech therapy; otolaryngology treatment; audio logical assessments and treatment; orthodontic treatment up to Plan limits; prosthodontics treatment; and prosthetic treatment such as obturators, speech appliances, and feeding appliances.
19. **Convalescent Nursing Facility or Skilled Nursing Care Facility:** charges for convalescent nursing home or skilled nursing care to registered patients under a twenty-four (24) hour a day supervision of a physician or registered nurse, following a hospital confinement or prior skilled nursing facility confinement, up to the limit outlined in the Schedule of Medical Benefits. The room and board and nursing care furnished are payable if (a) the covered member is confined as a bed patient in the facility; (b) the attending physician certifies the confinement is needed for non-custodial continuing care of a condition that caused hospital confinement; and (c) the attending physician completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the facility.
20. **Dental Prostheses:** charges for dental prostheses used to treat birth defects, trauma, or accidental injury; or dental prostheses used in treatment for radiation, chemotherapy or surgery for cancer.

21. **Diabetes Training and Equipment:** charges for diabetes self-management training provided after initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and diabetes supplies; additional training authorized by a health care practitioner due to a significant change in the covered member's symptoms or condition of diabetes that requires changes in the self-management regime; or periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatment for diabetes.

Diabetic equipment includes blood glucose monitors (also designed to be used by blind individuals) and podiatric appliances for the prevention of complications associated with diabetes. Diabetes supplies that include needles, syringes, lancets, dextrostix, and insulin are covered under the Prescription Drug Program of this Plan.

22. **Drugs:** charges for drugs requiring the written prescription of a licensed physician and dispensed in a physician's office, or by a hospital, ambulatory, emergency or urgent care facility.
23. **Durable Medical Equipment:** charges for rental of durable medical equipment required for temporary therapeutic use, or the purchase of the equipment if, in the opinion of the Plan Administrator, it is economically justified. The Plan reserves the right to pay a monthly rental not to exceed the purchase price. Repair, maintenance, or replacement of durable medical equipment and accessories is not covered unless the service is determined by a physician to be medically necessary to serve a medical purpose not generally useful to a person in the absence of an illness or injury. Replacement is covered only if it is needed due to a change in the covered member's physical condition; or it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

This covered expense is limited to the price of one (1) standard model of equipment. Deluxe equipment such as motor driven wheelchairs and beds are not covered except when such features are medically necessary for the effective treatment of a covered member's condition and the covered member cannot otherwise operate the equipment him/herself.

24. **Education Programs:** charges for an educational program deemed medically necessary, or for such other training needed to accommodate a change in the medical condition of a covered member or development of new treatment methods, including cardiac education and ostomy care.
25. **Elective Abortion:** charges for termination of a pregnancy voluntarily made by a covered member.
26. **Enteral or Parenteral Nutrition:** charges that are medically necessary to sustain life.
27. **Foot care:** charges for medically necessary treatment of the feet, including but not limited to weak, unstable feet, bunions, and flat feet; and the purchase of orthopedic appliances or other custom molded devices to be attached to or placed in shoes designed to relieve stresses of the foot. Orthopedic shoes are not covered unless they are part of a brace. Charges for trimming or removal of corns, calluses, or toenails, are covered only when medically necessary for the treatment of a metabolic or peripheral vascular disease.

28. **Hearing Loss:** charges for hearing examinations and tests to determine the need for hearing corrections, hearing aids, tinnitus maskers, supplies, adjustments, repairs, and cochlear implantation (a device implanted in the ear to facilitate communication for the profoundly hearing impaired).
29. **Home Health Care:** charges for services and supplies up to the limits set out in the Schedule of Medical Benefits for care and treatment of an injury or illness when hospital or skilled nursing facility confinement would otherwise be required. The care and treatment must be certified by the attending physician and be contained in a home health care plan. Periodic assessment visits by either the physician or nurse is required to continue the care.

Home health care benefits is not allowed for routine household chores not necessary to prevent or postpone hospitalization, or similar services that would materially increase the amount of time required for the visit unnecessarily; and for care provided by a person who ordinarily resides with or is a family member of the covered member.
30. **Hospice Care:** charges for hospice care services and supplies when the attending physician diagnoses the covered member's condition as being terminal, determines the member is not expected to live any longer than six (6) months, and places the person under a hospice care program. Services and treatment may be provided at home, in an outpatient setting or in an institutional setting.
31. **Hospital:** charges for hospital room, board, and general nursing care (limited to semi-private or intensive care room rate) and other hospital services and supplies necessary for treatment of illness or injury. Private room rate is covered if documented in writing by the physician as medically necessary for treatment of the condition. If the hospital only has private rooms, the maximum expense covered by this Plan is limited to eighty-five (85%) percent of the hospital's private room rate. If hospital confinement begins in one (1) calendar year and ends in another calendar year, all services are deemed incurred in the calendar year in which the hospital confinement began.
32. **Impotency:** charges for diagnoses of impotency, erectile dysfunction, sexual dysfunction, inadequacy, or frigidity are covered up to the time treatment begins; once treatment begins, diagnostic and evaluation services are not covered.
33. **Infertility:** charges for diagnosis and treatment, including medications, artificial insemination, invitro fertilization, treatment for conception and related tests or procedures, supplies, or treatment for sexual dysfunction or inadequacy.
34. **Laboratory, Pathology and Radiology (X-ray) Services:** charges for technical and professional fees associated with diagnostic laboratory services, pathology tests, x-ray services, and radiation, chemo, radium or radioactive isotope therapy treatments for the diagnosis or treatment of a health condition requiring the use of technical equipment for evaluation of body systems (e.g. MRI, CAT, PET, or MRA).
35. **Maternity:** charges for total obstetrical care, prenatal office visits, delivery, epidurals, postnatal office visits, midwife, childbirth center expenses, and fetal surgery.
36. **Native Healing Ceremonies and Services:** charges for native healing ceremonies and services when directly related to the health of a covered member; and it is performed by a native healing practitioner.

37. **Newborn Baby Care:** charges for services from birth to the time the infant is discharged from the hospital.
38. **Outside the USA:** charges for services and supplies provided by a health care provider whose principal place of business or address for payment is located outside of the United States of America (USA) while traveling outside the USA. Charges incurred outside the USA, when the primary purpose is to obtain health care services, drugs, or supplies are not covered. Benefits are not assignable to non-USA health care providers.
39. **Oxygen:** charges for oxygen and rental of equipment for its administration, and other inhalation therapy.
40. **Physician Assistant:** charges for services or procedure that requires an assistant due to medical necessity, including a nurse practitioner or nurse midwife.
41. **Physician Services:** charges for medical care and surgical treatments, including office and home visits, hospital inpatient and outpatient care, examinations, and clinical care.
42. **Pre-Admission Testing:** charges for laboratory, x-ray, and other medically necessary tests performed on an outpatient basis prior to a scheduled hospitalization. Any pre-admission testing repeated in the hospital is not covered unless it is medically necessary.
43. **Private Duty Nursing:** charges for services, if approved as medically necessary by the Plan Administrator, which require the training, judgment, and technical skills of an actively practicing registered nurse or licensed practical nurse and prescribed by a physician for continued medical treatment of a condition.
44. **Psychiatric Care:** charges for psychiatric care, including mental health disorders, eating disorders, substance abuse, chemical dependency, alcoholism or drug addiction, furnished on an inpatient or outpatient basis by a hospital, residential treatment facility, physician, therapist or counselor.

Each two (2) days of partial hospitalization counts as one (1) day of inpatient care.

If the hospitalization is for convalescent or custodial care, no benefits are available. If the type of care provided during hospitalization turns into a convalescent or custodial care, the charges for that portion of the stay is not covered. If a covered member remains in a hospital or treatment center after being advised by the appropriate authority at said hospital or center that further inpatient care is not necessary, benefits will not be furnished for the remainder of that inpatient admission.

45. **Rehabilitation Services:** charges for services provided in a hospital or rehabilitation center. The services must be of such a level of complexity or the condition of the covered member must be such that services can be safely performed only by qualified therapists or physicians, and designed to achieve objectives of improved health, welfare and the realization of a person's maximum physical, social, psychological and vocational potential for useful and productive activity.
46. **Restoration or Reconstructive Surgery:** charges for surgery performed to correct a condition caused by an illness or injury that requires restoration or reconstructive surgery that is medically necessary; or a birth defect or abnormal congenital condition that results in the malformation or absence of a body part.

47. **Second Surgical Opinion:** charges for a second opinion when surgery is recommended in a non-emergency situation. If the physician who initially recommended the surgery and the second opinion physician disagree, the Plan will pay for a third opinion.
48. **Sleep Disorders:** charges for diagnosis or treatment of sleep disorders as outlined in the Schedule of Medical Benefits.
49. **Sterilization:** charges for elective surgical procedures (vasectomy and tubal ligation or occlusion), but not the reversal of such procedures.
50. **Surgery:** charges for operative or diagnostic surgical procedures performed by a physician, nurse practitioner, or licensed midwife. Surgical benefits are payable whether the operation is performed in the hospital, surgery facility or in the doctor's office.
51. **Teeth or Supporting Tissues:** charges for treatment on or to the teeth or supporting tissues of the teeth that is medically necessary and not covered under the Dental Program, including:
 - a) removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of the mouth when the condition requires pathological examination;
 - b) treatment required because of accidental injuries to sound natural teeth (teeth that are whole or properly restored, are without impairment or periodontal disease, and are not in need of treatment for reasons other than for the dental injury), jaws, cheeks, lips, tongue, roof or floor of the mouth, provided the treatment is received within twelve (12) months from the date of the accident;
 - c) treatment of facial bone fractures;
 - d) incision and drainage of cellulitis (inflammation of soft tissue);
 - e) incision of accessory sinuses, salivary glands or ducts;
 - f) frenectomy (the cutting of the tissue in the midline of the tongue); or
 - g) dental prostheses used to treat birth defects, trauma, or accidental injury; or as used with respect to radiation, chemotherapy, or surgery for cancer.

If hospitalization is needed to safeguard the health of the covered member for a dental procedure that is not considered a medical expense benefit, the Plan will pay covered hospital, pathology, radiology, or anesthesiologist charges associated with the procedure. The Plan will not pay for the charges of the physician, dentist, or oral surgeon in non-covered dental procedures even if the hospital charges are paid.

52. **Therapy Services:** charges for a licensed therapist and associated supplies (audio diagnostic supplies needed to provide rehabilitative care for an illness or injury) used for the treatment of an illness or injury to promote the recovery of a person, if the treatment is recommended by a physician.
53. **Transplant Procedures:** charges for human organ and tissue transplant procedures that are medically necessary and not classified as investigative or experimental. Procedures considered experimental or investigational in nature require medical review to confirm coverage under the Plan.

Donor and recipient charges are covered if pre-certification is obtained; and both the donor and recipient are covered members under the Plan. If both the donor and recipient are covered under the Plan, eligible medical expenses will be treated as incurred separately for each covered member.

Charges for securing an organ from a cadaver or tissue bank, a surgeon's removal of an organ and a hospital's storage, or transportation of an organ are covered expenses.

If a covered member's transplant is not performed as scheduled, benefits will be paid for the organ or tissue as described above.

If an organ or tissue is sold rather than donated to a covered recipient, benefits are not payable for the purchase price of the organ or tissue; however, the costs related to the evaluation and procurement of the organ or tissue are covered for the recipient.

Eligible charges related to an organ or tissue transplant include, but are not limited to, hospitalizations, supplies and medications that are dispensed while either an inpatient or outpatient in a medical facility or under a physician's care. Benefits will not be duplicated if they are available from another plan, an organization, or Medicare.

54. **Urgent Care Facility:** charges incurred for treatment at an urgent care or walk-in facility.
55. **Wellness/Preventive Health Services:** Includes routine screenings and check-ups, counseling, assessments and immunizations as recommended by the national medical societies (Unites States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). The preventive health services outlined in the Schedule of Benefits are covered with no co-payment, no deductible and no co-insurance if performed as part of a preventive health visit.

GENERAL MEDICAL BENEFITS EXCLUSIONS AND LIMITATIONS

1. **Administrative or Adjunctive Charges:** charges for administrative fees; completion, filing or copying of claim forms, itemized bills or medical reports; reports or appearances in legal proceedings, mailing, postage, or shipping and handling; missed appointments; late fees; sales tax; interest or penalties; travel time or expenses; or telephone consultations.
2. **Alcohol/Controlled Substance abuse:** No compensation of any kind shall be paid for any illness, injury or death substantially related to the intentional use or abuse, by the covered member, of alcohol, controlled substances or chemicals. The use or abuse of alcohol, controlled substances or chemicals shall be deemed substantially related to illness, injury or death if objective testing of the breath, blood or urine of the covered member demonstrates the use or abuse of alcohol, controlled substances or chemicals and any competent evidence establishes that it is more probable than not that the use or abuse of alcohol, controlled substances or chemicals contributed to the occurrence of the accident that caused the illness, injury or death to the covered member.
3. **Artificial Heart:** charges related to insertion or maintenance of an artificial heart.
4. **Autopsy:** charges for an autopsy.

5. **Birthing Classes:** charges for birthing classes.
6. **Chelation Therapy:** charges for chelation or metallic ion therapy, except for treatment of acute metal poisoning.
7. **Close Relative:** charges for services rendered by a close relative of the covered member, except for native healing benefits.
8. **Cosmetic and Reconstructive:** charges for cosmetic and reconstructive procedures, except as specifically provided for in the Covered Medical Expenses provision of this Plan.
9. **Counseling:** charges for marriage, family, or group counseling, except as specifically provided for in the Covered Medical Expenses section of this Plan.
10. **Court-Ordered Treatment or Services:** charges for services, treatment or care of any kind that are provided due to a court order, or are required by a court of law or imposed as an alternative to, or in addition to, fine or imprisonment. This exclusion does not apply to expenses for an illness or injury that is covered under the Plan in the absence of a court order, and for which the covered member is legally obligated to pay.
11. **Custodial Care:** charges for services or supplies provided mainly as custodial care, to assist in the activities of daily living, or maintenance care not expected to improve the covered member's medical condition.
12. **Deluxe or Luxury Items:** charges for deluxe or luxury items, such as motorized equipment when manually operated equipment can be used or wheelchair sidecars. The Plan covers deluxe equipment only when additional features are required for effective medical treatment, or to allow the covered member to operate the equipment without assistance.
13. **Dental Care:** charges for dental services, including dental implantology, unless it is included as a covered medical expense under this Plan.
14. **Educational or Vocational Services or Supplies:** charges for educational or vocational testing or training, intelligence quotient (IQ) testing, remedial reading, recreational therapy, or vision therapy.
15. **Environmental Sensitivity:** charges for services or supplies provided primarily for environmental sensitivity; clinical ecology or any similar treatment not recognized as safe and effective; inpatient allergy testing or treatment; or for environmental change.
16. **Examinations:** charges for examinations, testing, vaccinations or other services related to employment, licensing, insurance, adoption, or marriage license, or camp applications, or travel outside the United States.
17. **Excess Charges:** charges for treatment of an injury or illness performed by a network provider that exceeds the network arrangement contract; or, for treatment performed by a non-PPO health care provider that exceeds the usual, customary and reasonable charges; and any expenses in excess of a maximum benefit limit of the Plan.
18. **Experimental or Investigational:** charges for medical services or supplies determined by the Plan Administrator to be experimental or investigational.

19. **Eye Care:** charges for reversals or revisions of surgical procedures that alter the refractive character of the eye and complications of such procedures, except when required to correct an immediately life-threatening condition. Charges for eye exercises (vision therapy) or training (orthoptics).
20. **Gender Dysphoria:** charges for non-congenital trans-sexualism, gender dysphoria, sex reassignment or transformation, and other related charges for medication, hormone therapy, implants, surgery, medical or psychiatric treatment.
21. **Hair Loss:** charges for treatment of hair loss, including medications for hair growth and hair replacement devices, wigs, hairpieces, and hair transplants, unless it is medically necessary.
22. **Health Club:** charges for health club or health spa membership, personal trainer, or aerobic and strength conditioning programs, and all related material and products for these programs.
23. **Illegal Act:** charges for medical services or supplies arising from the commission of a crime that results in a criminal conviction.
24. **Impotency:** charges for penile prosthetic implants, devices, drugs and medicines, unless it is medically necessary.
25. **Indian Health Services or Other Federally Funded Health Care Providers:** charges for medical, surgical, hospital or related services to which the covered member is entitled to receive from or through the United States Public Health Service or any federally funded health care providers, or sponsored Indian Health Service programs, including referrals.
26. **Infant formulas:** Charges for infant formulas.
27. **Marijuana:** charges for the purchase or use of marijuana for medicinal purposes.
28. **Medical Research:** charges for examinations and treatment conducted for the purpose of medical research.
29. **Not Medically Necessary:** Charges for services that are not medical necessary for the diagnosis and/or treatment of an illness or injury, unless specifically shown as a Covered Expense elsewhere in the Plan.
30. **Occupational Illness or Injury:** charges incurred for an injury, illness or occupational disease for which benefits are paid or payable under the Navajo Nation Workers' Compensation Program or other similar law.
31. **Orthognathic Surgery:** charges for mandibular or maxillofacial surgery (orthognathic surgery) for treatment to correct growth defects, jaw disproportion, or malocclusion, except if it is medically necessary.
32. **Outside the USA:** charges incurred outside the United States of America (USA) if the covered member travels to such a location for the sole purpose of obtaining medical services, drugs, or supplies.
33. **Personal Items:** charges for personal comfort items, equipment, or for services or supplies that constitute personal hygiene items or personal convenience, such as telephone, television or radio use.

34. **Public or Private School Items:** charges for examinations or consultations provided by any public or private school or halfway house, or by employees thereof, or services or items any school system requires and is provided solely to satisfy institutional requirements.
35. **Self-Inflicted Injury:** charges for injury or illness caused or contributed to by attempted suicide or intentionally self-inflicted injury.
36. **Smoking Cessation:** charges for prescription and non-prescription smoking deterrent medications, gum, patches, and aids. Charges for smoking/nicotine/tobacco deterrent programs.
37. **Special Construction:** charges for wheelchair ramps, handrails, or other specialized structural construction in or around the covered member's residence.
38. **Sterilization Reversal:** charges for care and treatment for reversal of sterilization, unless it is medically necessary.
39. **TENS Unit:** charges for a transcutaneous electrical nerve stimulator (TENS) unit for nerve stimulation.
40. **Temporomandibular Joint Dysfunction (TMJ):** charges for treatment of or prevention of, any jaw problem not caused by documented organic disease or physical trauma, including temporomandibular joint dysfunction, craniomaxillary or craniomandibular conditions of the joint linking the jaw bone to the skull, and the muscles, nerves and other tissues related to that joint, myofascial pain syndrome, and all related conditions, including orthodontic or prosthetic devices.
41. **Weight Control:** charges for supplies, instruction, or activities for weight control, weight reduction, weight loss programs, or physical fitness, vitamins, diet supplements, recreational therapy, educational therapy, non-medical self-care or self-help training, or enrollment in a health, athletic, or similar club.

SCHEDULE OF MEDICAL BENEFITS

WHO PAYS FOR BENEFITS

Each year, the Plan Administrator determines the amount of contributions to be applied toward the cost of coverage for each enrollment category. Each covered employee member will receive advance notice of any change in the payroll deduction to maintain his/her enrollment status.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Third Party Administrator contracts with Preferred Provider Organizations, also known as PPO networks, to provide hospital, physician and other health care services for the covered members. Inclusion of a health care provider in the PPO network does not bind the Plan Administrator to provide coverage for services normally not covered under the Plan.

Copies of the PPO Network Directory are available through the Third Party Administrator without charge. Because periodic changes occur with the network directory listing, verification on whether the health care provider selected is still an active PPO network provider should be made prior to receiving services. The Third Party Administrator's contact number is included on the reverse side of the covered member's group health plan card.

If the covered member receives health care services or supplies from a non-PPO network provider, he/she is responsible for charges incurred in excess of the usual, customary and reasonable fees.

CHOICE OF HEALTH CARE PROVIDER

The Plan does not provide health care services and is not responsible for the quality of health care provided to a covered member. The final choice of a health care provider is up to the covered member, and the provider-patient relationship shall be maintained. However, all health care services are subject to the Plan's conditions, limitations and exclusions.

MEDICAL CALENDAR YEAR DEDUCTIBLE

The calendar year deductible applies to all eligible charges during a calendar year for each covered member, unless otherwise provided for in the Schedule of Medical Benefits Tables.

CALENDAR YEAR DEDUCTIBLE	PPO OR NON-PPO PROVIDERS
Per Covered Member	\$400
Per Covered Family	\$800

Once a family medical deductible is satisfied, no further medical deductible applies to any covered member of the family during the remaining calendar year. Even if there is family coverage, no covered member is required to pay more than the individual calendar year deductible.

CARRY OVER DEDUCTIBLE

Eligible expenses incurred in the last three (3) months of a calendar year which are applied to that year's deductible are also applied toward the deductible for the next calendar year.

BENEFIT PERCENTAGE PAYABLE

The covered member is required to pay the remaining percentage to his/her health care service provider.

The percentages payable shown in the Schedule of Medical Benefits Tables is subject to all covered expenses unless specifically stated otherwise. Once the applicable deductible is met, the balance of the eligible charges is paid at the percentage payable until the out-of-pocket maximum is satisfied.

When an out-of-pocket maximum is satisfied, the Plan pays one hundred (100%) percent of the eligible charges for the remainder of the calendar year or to the maximums of the Plan, whichever occurs first.

CO-PAYMENTS

The covered member is required to pay a co-payment (specific dollar amount) for certain services shown in the Schedule of Medical Benefits Tables. The co-payment is not credited toward the deductible.

MAXIMUM OUT-OF-POCKET EXPENSES

The maximum out-of-pocket expenses are the maximum amount of covered expenses the covered member and his/her family pays for medical expenses during a calendar year.

The maximum out-of-pocket expenses include both the PPO network and non-PPO network providers as follows:

MAXIMUM OUT-OF-POCKET	PPO OR NON-PPO PROVIDERS
Per Covered Member	\$4,000
Per Covered Family	\$8,000

The following are not applied toward the maximum out-of-pocket expenses:

1. Charges in excess of the usual, customary and reasonable allowances.
2. Charges in excess of the maximum benefits payable under this Plan.
3. Charges covered under the dental or vision care program of this Plan.
4. Penalties assessed for non-compliance with the pre-certification process.
5. Charges not covered by this Plan.

SCHEDULE OF MEDICAL BENEFITS TABLE

The benefits included in the following Schedule of Medical Benefits Table are subject to the provisions of the Plan.

MEDICAL SERVICE	PLAN LIABILITY PPO PROVIDER	PLAN LIABILITY NON-PPO PROVIDER
ALTERNATIVE CARE	80%	60%
Alternative care benefits are limited to one thousand (\$1,000) dollars per covered member per calendar year.		
AMBULANCE TRANSPORTATION	80%	60%
Benefit applies to ambulance services by land, sea, or air, and there is no coverage for services not considered "Emergency Services."		
AMBULATORY SURGERY	80%	60%
Benefit applies to the surgical facility, physician, and anesthesiologist's charges.		
CONVALESCENT NURSING FACILITY OR SKILLED NURSING CARE FACILITY	80%	60%
Calendar year maximum is sixty (60) days. Pre-certification is required.		
COSMETIC SURGERY RELATED TO MASTECTOMY	80%	60%
DIALYSIS TREATMENT - OUTPATIENT		
	100% of the lesser of (i) the Usual, Customary, and Reasonable Dialysis Charge as defined in "Dialysis Treatment-Outpatient" Section, (ii) the PPO allowable charge after all applicable deductibles and coinsurance; and (iii) such charge as is negotiated between the Plan Administrator and the provider of Dialysis Treatment.	
Please refer to Dialysis Treatment - Outpatient description in the Medical Program section.		
DURABLE MEDICAL EQUIPMENT	80%	60%
Pre-certification is required if the amount exceeds two hundred fifty (\$250) dollars.		
EMERGENCY ROOM CARE	80% after \$350 co-payment	80% after \$350 co-payment
If the covered member is admitted to the hospital as an inpatient due to an emergency, the three hundred fifty (\$350) dollars emergency room co-payment is waived. If the covered expenses do not meet the definition of emergency services, coverage will be denied. Pre-certification is not required for emergency care or treatment. If the covered member receives emergency care from non-PPO emergency facility of a hospital, the cost sharing obligations (co-payments/co-insurance) will be the same as would be applied to care received from PPO emergency facility.		
HEARING LOSS	80%	60%
Maximum lifetime benefit for hearing loss is two thousand (\$2,000) dollars.		
HOME HEALTH CARE	80%	60%
Home health care is limited to four hundred (400) hours per covered member per calendar year. Pre-certification is required.		

HOSPICE CARE	80%	60%
Pre-certification is required.		
HOSPITAL EXPENSE Benefits for inpatient and outpatient services provided by a hospital except emergency care.	Inpatient - 80% after \$250 co-payment Outpatient – 80%	Inpatient – 60% after \$250 co-payment Outpatient – 60%
Pre-certification is required for inpatient admissions and partial hospitalization.		
INFERTILITY/STERILITY TESTING or TREATMENT	80%	60%
Maximum lifetime benefit for infertility/sterility testing or treatment is five thousand (\$5,000) dollars.		
MATERNITY	80%	60%
MENTAL HEALTH TREATMENT	Inpatient - 80% after \$250 co-payment Outpatient – 80%	Inpatient - 60% after \$250 co-payment Outpatient – 60%
Benefits for inpatient and outpatient services provided by a hospital except emergency care. Pre-certification is required for inpatient admissions and partial hospitalization.		
NATIVE HEALING CEREMONIES AND SERVICES	100% - no deductible	100% - no deductible
Maximum benefit for native healing services is three hundred fifty (\$350) dollars per family per calendar year.		
OCCUPATIONAL THERAPY	80%	60%
Pre-certification required for outpatient services.		
PHYSICAL THERAPY	80%	60%
Pre-certification required for outpatient services.		
PHYSICIAN SERVICES	80%	60%
Benefit includes Primary Care or Specialist office visit, diagnostic services, office surgery, radiology services, hospital and outpatient surgery.		
PHYSICIAN SERVICES - EMERGENCY ROOM	80%	80%
If the covered member receives emergency care from non-PPO providers in the Emergency Department of a hospital, the cost sharing obligations (co-payments/co-insurance) will be the same as would be applied to care received from PPO providers.		
SECOND AND THIRD SURGICAL OPINIONS	100% - no deductible	100% - no deductible
SLEEP DISORDERS	80%	60%
Maximum lifetime benefit for sleep disorder is one thousand five hundred (\$1,500) dollars.		
SPEECH THERAPY	80%	60%
Pre-certification is required for outpatient speech therapy services.		

SUBSTANCE ABUSE TREATMENT	Inpatient -80% after \$250 co-payment Outpatient – 80%	Inpatient - 60% after \$250 co-payment Outpatient – 60%
Benefits for inpatient and outpatient services provided by a hospital except emergency care. Pre-certification is required for inpatient admissions and partial hospitalization.		

SURGERY	80%	60%
Pre-certification is required for inpatient admissions.		

TRANSPLANTS	80%	60%
Pre-certification is required for transplants.		

URGENT CARE	80%	60%
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WELLNESS BENEFITS/PREVENTIVE HEALTH SERVICES:		
<p>ADULTS One (1) physical exam per calendar year to obtain recommended preventive and diagnostic services</p> <p>Screenings for:</p> <ul style="list-style-type: none"> ▪ Abdominal Aortic Aneurysm (one-time screening for men of specified ages who have ever smoked) ▪ Alcohol Misuse ▪ Blood Pressure ▪ Cholesterol(for adults of certain ages or at higher risk) ▪ Colorectal Cancer (adults over 50) ▪ Depression ▪ Type 2 Diabetes (for adults with high blood pressure) ▪ HIV (for all adults at higher risk) ▪ Obesity ▪ Tobacco Use ▪ Syphilis (for all adults at higher risk) <p>Counseling for:</p> <ul style="list-style-type: none"> ▪ Alcohol Misuse ▪ Aspirin (use for men and women of certain ages and cardiovascular risk factors) ▪ Diet (for adults at higher risk for chronic disease) ▪ Obesity ▪ Sexually Transmitted Infection (STI) Prevention (for adults at higher risk) ▪ Tobacco Use (including cessation interventions for tobacco users) <p>Immunizations- doses, recommended ages, and recommended populations vary:</p> <ul style="list-style-type: none"> ▪ Hepatitis A ▪ Hepatitis B ▪ Herpes Zoster ▪ Human Papillomavirus (HPV) ▪ Influenza (Flu Shot) ▪ Measles, Mumps, Rubella (MMR) ▪ Meningococcal (meningitis) ▪ Pneumococcal (pneumonia) ▪ Diphtheria, Pertussis, Tetanus (DPT) 	100% - No Deductible	100% - No Deductible

WELLNESS BENEFITS/PREVENTIVE HEALTH SERVICES:		
<ul style="list-style-type: none"> ▪ Varicella (chicken pox) 		
<p>ADDITIONAL SERVICES FOR WOMEN</p> <p>One (1) Well Woman exam per calendar year to obtain recommended preventive and diagnostic services.</p> <p>Screenings for:</p> <ul style="list-style-type: none"> ▪ Breast Cancer (mammography every 1-2 years for women over 40) ▪ Cervical Cancer (for sexually active women) ▪ Chlamydia Infection (for younger women and other women at higher risk) ▪ Domestic and interpersonal violence ▪ Gonorrhea (for all women at higher risk) ▪ Human Papillomavirus (HPV) DNA Test: (high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older) ▪ Osteoporosis (for women over age 60 depending on risk factors) <p>Counseling for:</p> <ul style="list-style-type: none"> ▪ BRCA (counseling about genetic testing for women at higher risk) ▪ Breast Cancer Chemoprevention (for women at higher risk) ▪ Contraception (education and counseling on FDA-approved contraceptive methods, sterilization procedures, not including abortifacient drugs) ▪ Folic Acid Supplements (for women of child-bearing ages) 	100% - No Deductible	100% - No Deductible
<p>SERVICES FOR PREGNANT WOMEN</p> <ul style="list-style-type: none"> ▪ Anemia Screening ▪ Bacteriuria (urinary tract or other infection screening) ▪ Gestational diabetes (for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes) ▪ Breastfeeding (comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies) ▪ Hepatitis B Screening (at the first prenatal visit) ▪ Rh Incompatibility Screening (for all pregnant women and follow-up testing for women at higher risk) ▪ Tobacco Use (expanded counseling for pregnant tobacco users) 	100% - No Deductible	100% - No Deductible
<p>SERVICES FOR CHILDREN</p> <p>Well Child exam(s) to obtain preventive services and diagnostic services</p> <p>Screenings and Assessments for:</p> <ul style="list-style-type: none"> ▪ Alcohol and Drug Use (for adolescents) ▪ Autism (for children at 18 and 24 months) ▪ Behavioral Issues (for children of all ages) ▪ Cervical Dysplasia (for sexually active females) ▪ Congenital Hypothyroidism (for newborns) ▪ Developmental screening (for children under age 3, and surveillance throughout childhood) ▪ Dyslipidemia (for children at higher risk of lipid disorders) ▪ Hearing (for all newborns) ▪ Height, Weight and Body Mass Index Measurements ▪ Hematocrit or Hemoglobin ▪ Hemoglobinopathies or sickle cell (for newborns) ▪ HIV (for adolescents at higher risk) ▪ Lead (for children at risk of exposure) ▪ Medical History 	100% - No Deductible	100% - No Deductible

WELLNESS BENEFITS/PREVENTIVE HEALTH SERVICES:		
<ul style="list-style-type: none"> ▪ Obesity ▪ Oral Health (risk assessment for young children) ▪ Phenylketonuria (PKU)(newborns) ▪ Tuberculin testing (for children at higher risk of tuberculosis) ▪ Vision(screening as part of physical exam, not a separate eye exam) <p>Medications and Supplements</p> <ul style="list-style-type: none"> ▪ Gonorrhea preventive medication for the eyes of all newborns ▪ Iron supplements (for children ages 6 to 12 months at risk for anemia) <p>Counseling for:</p> <ul style="list-style-type: none"> ▪ Fluoride Chemoprevention (supplements for children without fluoride in their water source) ▪ Obesity ▪ Sexually Transmitted Infection (STI)(for adolescents at higher risk) <p>Immunizations vaccines for children from birth to age 18 - Doses, recommended ages, and recommended populations vary:</p> <ul style="list-style-type: none"> ▪ Diphtheria, Pertussis, Tetanus(DPT) ▪ Haemophilusinfluenzae type b ▪ Hepatitis A ▪ Hepatitis B ▪ Human Papillomavirus (HPV) ▪ Inactivated Poliovirus ▪ Influenza (Flu) ▪ Measles, Mumps, Rubella (MMR) ▪ Meningococcal (meningitis) ▪ Pneumococcal(pneumonia) ▪ Rotavirus ▪ Varicella (chicken pox) 	100% - No Deductible	100% - No Deductible

UNLISTED BENEFITS	80%	60%
Benefits are provided for services listed as covered medical expenses in this Plan and not specifically outlined in this Table, provided they are not otherwise excluded or limited in the Plan.		

PRESCRIPTION DRUG PROGRAM

There are three (3) aspects of the Prescription Drug Program.

RETAIL PHARMACY OPTION

Participating pharmacies have contracted with the Plan to charge covered members reduced fees for covered prescription drugs.

The co-payment is applied to each covered pharmacy drug charge and is shown on the Schedule of Benefits. The co-payment amount is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to a thirty-one (31) day supply.

If a drug is purchased from a nonparticipating pharmacy or a participating pharmacy when the covered member's group health plan card is not used, the covered member must pay the entire cost of the prescription, including co-payment, and then submit the receipt to the prescription drug card vendor for reimbursement. If a nonparticipating pharmacy is used, the covered member will be responsible for the co-payment, plus the difference in cost between the participating pharmacy and nonparticipating pharmacy.

If the covered member purchases a brand name drug when a generic drug equivalent is available, the covered member will be required to pay the brand name co-payment, plus the difference between generic and brand name; unless the physician has issued a Dispense As Written.

MAIL ORDER PHARMACY OPTION

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

The co-payment is applied to each covered mail order prescription charge and is shown on the Schedule of Benefits. It is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to a ninety (90) day supply.

If the covered member purchases a brand name drug when a generic drug equivalent is available, the covered member will be required to pay the brand name co-payment, plus the difference between generic and brand name; unless the physician has issued a Dispense As Written.

SPECIALTY DRUG PHARMACY OPTION

The Plan also participates in a Specialty Drug Program to provide specialty medications to participants. It is required that participants use this program to obtain these specialty medications, which are most often self-injectable. All prescriptions filled through the Specialty Drug Program are limited to a 30-day supply per fill. To determine if the medication the covered member is prescribed is part of a Specialty Drug Program, or for more information, please contact the phone number on the covered member's group health plan card.

DEFINITIONS APPLICABLE TO PRESCRIPTION DRUG BENEFITS

1. **Brand Name Drug:** a prescription drug that meets the Federal Food and Drug Administration (FDA) standards.
2. **Generic Drug:** a prescription drug that is generally equivalent to a higher priced brand name drug with the same use and metabolic disintegration to brand named drug. The generic drug must meet the FDA bioavailability standards that by law requires a physician's prescription and is:
 - a) Produced and sold under the chemical name or a shortened version;
 - b) Approved by the U.S. FDA as safe and effective;
 - c) Produced after the original patent expires;
 - d) Produced by a company different from the one that first patented the chemical formulation; and
 - e) Costs less than the product produced by the company that first patented the chemical formulation.
3. **Innovative Technologically Advanced Medications:** a list of brand name drugs that are current or new products introduced to the market.
4. **Pharmacist:** a person who is licensed under the laws of the state or jurisdiction where the services are rendered, and trained to prepare, compound, and dispense drugs and medicines.
5. **Preferred Drug:** a covered prescription compiled of approved pharmaceuticals which is continually revised based on a preferred drug list that meets the FDA Standards.
6. **Prescribed Drugs or Prescription Drugs:** drugs, biological and compounded prescriptions dispensed only pursuant to written prescription given by a physician for human consumption.

GENERIC SUBSTITUTION

If the physician does not request a brand name drug (dispense as written), a generic equivalent drug will be substituted.

Covered members are encouraged to use generic drugs and the mail order service. If a covered member requests a brand name drug when a generic drug is available, he/she will be responsible for the brand name co-payment, plus the cost difference between the brand name drug and the generic drug.

COVERED DRUGS AND MEDICINES

1. **Acne** products covered through age 25, prior authorization required thereafter.
2. **AIDS** (Acquired Immune Deficiency Syndrome) treatment drugs that have been approved by the FDA.
3. **Allergy** emergency kits.

4. **Amphetamines**, central nervous system stimulants covered through age 18, prior authorization required thereafter.
5. **Compound** medications of which at least one (1) ingredient is a prescription legend drug.
6. **Contraceptive** agents.
7. **Insulin**, including disposable insulin needles/syringes, diabetic supplies, test strips, lancets and glucose monitoring machines.
8. **Immunization** agents
9. **Migraine** headache treatment drugs.
10. **Prescription legend** (brand or generic) drugs requiring the written prescription of a physician including birth control pills, prenatal legend vitamins, and vitamins to treat a covered illness or injury.
11. **Smoking deterrent medications**, nicotine gum, patches, and aids, drugs or devices to stop people from smoking, Zyban. (prescription or non-prescription).

PRESCRIPTION DRUG PROGRAM EXCLUSIONS AND LIMITATIONS

The Plan reserves the right to limit quantities dispensed of innovative technologically advanced medicines and to add medicines to the exclusion list if the U.S. FDA issues a warning or recall, voluntary or otherwise. Charges for the following drugs are not covered, unless they are specifically listed elsewhere as a covered expense:

1. Anabolic steroids, induces weight gain and increased muscle mass, Oxymetholone.
2. Biological serums (immunological vaccines), an agent that neutralizes a viral toxin, Adagen.
3. Cosmetic agents or drugs used to alter appearance.
4. Diagnostic agents, kits to detect or diagnosis a disease, Home Access.
5. Erectile dysfunction/Impotency drugs and similar “lifestyle” drugs, sexually insufficient, Viagra.
6. Experimental or investigational drug, drugs not FDA approved, or used for off label indication.
7. Fluoride products.
8. Hair growth stimulants, facilitates new hair growth (Rogaine, Minoxidil and similar drugs).
9. Medical supplies, durable medical equipment, insulin pump (including, but not limited to therapeutic devices, artificial appliance, braces, support garments, or any similar device or supply).
10. Mouthwashes (prescription antiseptic or fluoride), mouth rinses, topical oral solutions or preparations.
11. Nutritional, dietary supplements or formulas, agents that provides nutritional supplementation, Ensure.

12. Over-the-counter medications except as recommended by the USPSTF Preventive Service guidelines.
13. RU486 (Mifepristone), abortion pill, name given to the drug while it was in the FDA testing phase.
14. Research drugs, drugs that are not FDA approved, still studying effects and potency.
15. Stadol Nasal Spray, pain management, brand name of drug.
16. Vitamins (except for prenatal vitamins, folic acid, and prescription vitamins to treat a covered illness or injury), any of the organic compounds required by the body in small amounts for metabolism, or to protect health, Vitamin C.
17. Weight control, anorexics/appetite suppressants/anti-obesity drugs, Meridia.

ADDITIONAL PRESCRIPTION DRUG BENEFIT EXCLUSIONS

1. Charges for any drug prescribed as a result of, or due to complications from, any surgery, services, treatments, or supplies specifically excluded under this Plan's General Medical Benefits Exclusions and Limitations.
2. Prescriptions used or intended to be used in the treatment of a condition, illness, injury or bodily malfunction that is not covered under the Medical Expense Benefit Plan.
3. A drug or medicine that can legally be bought without a written prescription (non-legend), or drug or medicine for which there is a non-prescription equivalent available. This does not apply to injectable insulin.
4. A drug or medicine labeled: "Caution - Limited by Federal Law to Investigational Use," or a drug or medicine that have not been approved by the FDA.
5. Experimental drugs and medicines, even though a charge is made to the covered member, including medicines or drugs that are in the FDA Phases I or II testing. Phase II may be covered if there are no other alternatives available.
6. Any drug or medicine that is consumed or administered at the place where it is dispensed, such as a physician's office.
7. A drug or medicine that is to be taken by the covered member, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines, or an institution that allows a facility for the dispensing of drugs and medicines to be operated on its premises.
8. A charge for prescription drugs that may be properly received without charge, or for which the health care provider's charge is less than the required co-payment.
9. Any drug received for which there is no legal obligation to pay, or for charges that would not be made but for the availability of benefits under this Plan.
10. Any prescription refilled in excess of the number specified by the physician or any refill dispensed after one (1) year from the physician's original order.
11. Any prescription dispensed prior to the covered member's effective date or after the termination date of coverage.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

TYPE OF DRUG	PURCHASED AT RETAIL PHARMACY	PURCHASED THROUGH MAIL ORDER PHARMACY
Generic Drug	\$20 co-payment; limited to a 31-day supply	\$40 co-payment; limited to a 90-day supply
Preferred Brand Drug	\$40 co-payment; limited to a 31-day supply	\$80 co-payment; limited to a 90-day supply
Non-Preferred Brand Drug	\$70 co-payment; limited to a 31- day supply	\$120 co-payment; limited to a 90-day supply
Specialty Drug		20% up to \$200 maximum co- payment; limited to a 31-day supply

DENTAL PROGRAM

PRE-TREATMENT REVIEW

Prior to the beginning of an extensive dental treatment, the dentist generally submits a proposed course of treatment prior to the actual performance of services. The proposed course of treatment includes a completed claim form itemizing all services and procedures and the charge for each procedure. Evaluation of the treatment plan is subject to “alternate treatment plan” and does not guarantee payment of benefits when the actual services are performed.

DEFINITIONS APPLICABLE TO DENTAL BENEFITS

1. **Abutment:** a tooth or root that retains or supports a fixed bridge or a removable prosthesis.
2. **Acrylic:** plastic materials used in the fabrication of dentures and crowns and occasionally, as a restorative filling material.
3. **Alternate Treatment Plan:** a planned program or procedure of one or more services or supplies provided by one or more dentists for the treatment of a dental condition diagnosed by the attending dentist. A treatment plan or procedure begins on the date a dentist first provides a service to correct or treat the diagnosed dental condition.
4. **Amalgam:** a metal alloy consisting of silver, tin, zinc, or copper, combined with liquid pure mercury, and used as a restorative material in operative dentistry.
5. **Bridgework or Prosthetic Appliance:** fixed pontics or replacement teeth retained with crowns or inlays cemented to and used as abutments to the natural teeth. Fixed removable is one the dentist can remove but the patient cannot. Removable is partial denture retained by attachments that permit removal, normally held by clasps.
6. **Cosmetic Dentistry:** services provided by a dentist solely for the purpose of improving appearance, when form and function are satisfactory and no pathological condition exists.
7. **Covered Dental Injury:** all damages to a covered member’s mouth due to an accident caused by an external force, and all complications arising from that damage. The term does not include damage to teeth, dental appliances, or prosthetic devices that result from chewing or biting food or other substances.
8. **Crown:** the portion of a tooth covered by enamel; an artificial crown (cap) that restores the anatomy, function and esthetics of the natural crown.
9. **Dental Hygienist:** a person who is trained to clean teeth and provide additional services and information on the prevention of oral disease.
10. **Dentist:** an individual who is duly licensed to practice dentistry.
11. **Denture:** a prosthetic device that replaces missing teeth. It may be removable or fixed, and on one or both sides of the mouth.
12. **Endodontic Therapy:** treatment of diseases of the dental pulp and their canals.
13. **External Force:** any sudden, unexpected impact from outside the oral cavity.

14. **Fluoride:** a solution of fluorine applied to the teeth for prevention of teeth decay.
15. **Impression:** a form or cast of the recorded teeth or the soft tissues of the mouth.
16. **Incurred or Incurred Date for Dental:** (a) for an appliance or modification of an appliance, the date the impression is taken; (b) for a crown, bridge, or gold restoration, the date the tooth is prepared; (c) for root canal therapy, the date the pulp chamber is opened; and (d) for all other services, the date service is provided.
17. **Inlay:** a restoration, usually of cast metals, made to fit a prepared tooth cavity that is cemented into place.
18. **Occlusion:** the contact area where the upper and lower teeth come together.
19. **Onlay:** a cast restoration that covers the entire chewing surface of a tooth.
20. **Orthodontics Treatment:** corrective movement of the teeth, through the bone, by means of an active appliance used to correct a handicapping malocclusion (a microbacteriumavirus complex (MAC) interfering with a person's ability to chew food) of the mouth.
21. **Palliative:** an alleviating measure used to relieve, but not cure.
22. **Partial Denture:** a prosthesis that replaces one or more, but less than all of the natural teeth and associated structures. It may be removable or fixed, and on one or both sides of the mouth.
23. **Periodontics:** the science of examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth.
24. **Pontic:** the part of a fixed bridge which is suspended between the abutments and which replaces a missing tooth or teeth.
25. **Prophylaxis:** removal of tartar and stains from the teeth or the cleaning of the teeth.
26. **Relining:** to resurface the tissue-borne areas of a denture with new material.
27. **Restoration:** an inlay, crown, bridge, partial denture, or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue.
28. **Root Canal Therapy:** the complete removal of the pulp tissues of a tooth, sterilization of the pulp chamber and root canals and filling the spaces with sealants.
29. **Sealant:** a resin agent applied to the grooves and pits of teeth to reduce decay.
30. **Splint or Splinting:** a device used for stabilizing or immobilizing teeth to gain strength or facilitate healing.
31. **Temporomandibular Joint Dysfunction (TMJ):** is an umbrella term covering pain and dysfunction of the muscles of mastication (muscles that move the jaw) and the temporomandibular Joints (the joint which connect the mandible to the skull).
32. **Vertical Dimension:** the degree of jaw separation when the teeth are in contact.

CLASS I – PREVENTIVE SERVICES

The following services are not subject to any deductible and are paid at a benefit percentage of one hundred (100%) percent:

1. Bacteriological studies.
2. Consultation or other office visit if no other covered dental service is performed on the same date.
3. Emergency oral examination or palliative treatment.
4. Routine oral examinations, but not more than two (2) times in any one (1) calendar year.
5. Topical application of fluoride limited to two (2) times in any one (1) calendar year.
6. Histo-pathological examination.
7. Routine prophylaxis (cleaning and scaling), but not more than two (2) times in any one (1) calendar year.
8. Charges for dental x-rays, including full mouth, limited to one (1) time in any three (3) consecutive calendar years; bitewings limited to two (2) times per calendar year; and other x-rays needed to diagnose a condition.

CLASS II – BASIC SERVICES

The following services are subject to the dental calendar year deductible and are paid at benefit percentage of eighty (80%) percent.

1. Charges for general anesthesia or intravenous sedation; local anesthesia, including regional block anesthesia and injections; desensitizing medications; and nitrous oxide.
2. Charges for consultations and examinations by a dentist, other than for routine or orthodontic purposes.
3. Charges for endodontic, including pulpal and root canal therapies.
4. Charges for extraction of tooth/teeth, including those performed for orthodontic purposes.
5. Charges for amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken tooth/teeth.
6. Charges for initial placement of inlays, onlays and crowns to restore diseased or accidentally broken tooth/teeth. These procedures are covered when the tooth/teeth is damaged by dental caries or fractures that cannot be restored with a filling restoration.
7. Charges for injections of antibiotic drugs.
8. Charges for oral surgery, including surgery performed on the gums, alveolar process and removal of impacted teeth and preparation of gums for dentures, unless covered by a medical plan.
9. Charges for treatment of periodontal and other diseases of the gums and tissues of the mouth, including periodontal prophylaxis.

10. Charges for relining or repairs of prosthetic appliances and crowns.
11. Charges for replacement of inlays, onlays and crowns.
12. Charges for sealants, limited to permanent molar teeth, for children at least age six (6) but under age sixteen (16).
13. Charges for space maintainers and all adjustments within six (6) months of installation for children under age fourteen (14).
14. Charges for appliances or procedures to stabilize periodontal involved teeth, excluding periodontal splinting.

CLASS III – MAJOR SERVICES

The following services are subject to the dental calendar year deductible and are paid at a benefit percentage of eighty (80%) percent.

1. Charges for initial placement of fixed bridges, including wing attachments, inlays, onlays and crowns used as abutments to the bridge.
2. Charges for initial placement of partial or full dentures, including repairs and adjustments as follows:
 - a) If a cast chrome or acrylic denture will restore the dental arch, payment will not be made toward a more elaborate or precision appliance; or
 - b) If a personalized restoration or specialized technique is chosen, payment will not be made for more than the cost of the standard service.
 - c) Charges for precision attachments, precision partials and treatment partials.
3. Charges for replacement of an existing partial, full denture or fixed bridge, the addition of teeth to an existing partial or fixed denture, or bridgework to replace extracted teeth if:
 - a) The replacement or addition of teeth is necessary to replace teeth extracted after the existing denture or bridgework was installed;
 - b) The existing denture or bridgework cannot be made serviceable because it was installed at least five (5) years prior to the replacement date; or
 - c) The existing denture is a temporary denture that replaces one or more extracted teeth; a replacement by a permanent denture is required; and the replacement takes place within six (6) months from the placement of the temporary denture.
4. Charges for transplanting teeth or implanting fabricated teeth.
5. Charges for altering vertical dimension or restoring proper bites; restoring occlusion; replacing tooth structure lost from attrition, abrasion or erosion; correcting congenital or developmental malformations; or for aesthetic purposes.

CLASS IV – ORTHODONTIC SERVICES

Orthodontic services are subject to the dental calendar year deductible, and are paid at a benefit percentage of fifty (50%) percent. Orthodontic services are for children up to age nineteen (19).

Benefits are available for a course of treatment that begins before the covered member becomes covered under this Plan or the prior plan of the employer that this Plan replaces. The course of treatment begins on the earlier of the date of cephalometric x-rays or study models; or the date of insertion of bands or appliances.

1. Covered Orthodontic Services

- a) Charges for cephalometric x-ray; limited to one (1) in any two (2) year period.
- b) Charges for comprehensive orthodontic treatment, including initial placement of orthodontic appliances and subsequent active orthodontic treatment; limited to one (1) study model per covered member.
- c) Charges for removable, fixed, or cemented appliances for interceptive orthodontic treatment, including impressions and all adjustments made within six (6) months of installation.
- d) Charges for removable, fixed, or cemented appliances for minor treatment for tooth guidance, including impressions and all adjustments made within six (6) months of installation.
- e) Charges for non-surgical services related to an active course of orthodontic treatment, including tooth extractions, x-rays and records.

This Plan will not cover the repair or replacement of an orthodontic appliance.

2. Payment and Termination of Orthodontic Benefits

Payment for eligible charges is made when services are provided. This method of payment is applied to any portion of the treatment course that is completed while the treatment plan is in effect.

If orthodontic treatment is terminated for any reason before completion, benefits shall cease with payment to the date of termination. Benefits will resume for the remainder of the treatment plan when the orthodontic treatment is re-activated.

3. Alternate Treatment Plan

If the covered member and the dentist select a treatment plan or procedure other than what is customarily provided by the dental profession, the Plan will pay no more than the cost of the lesser of the treatment plan or procedure. If the covered member and the dentist decide upon a more costly treatment, the covered member is responsible for any additional charges beyond those for the less costly alternative treatment for which benefit is provided by the Plan.

DENTAL PROGRAM EXCLUSIONS AND LIMITATIONS

- 1. Charges for athletic mouth guards, night guards, or occlusal guards, including replacement, repair, relines or adjustment.
- 2. Charges determined to be cosmetic dentistry in nature, including the alteration or extraction and replacement of sound and natural teeth to change appearance.
- 3. Charges covered under the Medical or Prescription Drug Program of this Plan.

4. Charges for replacement of lost, missing or stolen appliances or any type and replacement or repair of orthodontic appliances, or charges for duplicate appliances.
5. Charges for periodontal splinting procedures.
6. Charges for appliances, restorations or services for the diagnosis or treatment for disturbances of the temporomandibular joint (TMJ).
7. Charges for services performed after a covered member's coverage terminates. If the Plan terminates, all coverage and benefits end immediately. However, the following services will be considered if performed within thirty-one (31) days after the coverage terminates:
 - a) Installation or adjustment of dentures or fixed bridgework if the impressions were taken prior to the date coverage ended;
 - b) Crowns, inlays or onlay restorations if the tooth/teeth were prepared prior to the date coverage ended; or
 - c) Root canal therapy if the pulp chamber was opened prior to the date coverage ended.
8. Orthodontic services for covered members over the age of nineteen (19).

DENTAL CALENDAR YEAR DEDUCTIBLE

CLASSES II, III AND IV	
Per Covered Member	\$200
Per Covered Family	\$600

This deductible does not apply to eligible preventive services (Class I).

If a family satisfies the maximum family dental deductible during the same calendar year, no further dental deductible applies to any member of the family during the remaining calendar year. However, even if the employee and dependents are covered under the family coverage rules, no one covered member is required to pay more than the individual calendar year deductible.

DENTAL CARRY OVER DEDUCTIBLE

Eligible expenses incurred in the last three (3) months of a calendar year which are applied to that year's dental deductible will also be applied toward the deductible for the next calendar year.

DENTAL CALENDAR YEAR MAXIMUM BENEFIT

PER COVERED MEMBER (CLASS I, II AND III SERVICES COMBINED).....\$1,500

The calendar year maximum applies to all eligible charges paid during each calendar year.

ORTHODONTIC LIFETIME MAXIMUM BENEFIT

PER COVERED MEMBER (CLASS IV SERVICES).....\$2,000

The “lifetime maximum” applies to all eligible charges paid during the lifetime of a covered member, whether or not coverage is continuous.

DENTAL PERCENTAGE PAYABLE

Subject to the calendar year and lifetime maximum limitations, the Plan will pay the percentages payable during a calendar year for the lesser of the usual, customary and reasonable charge for such services, or the actual charge for such services.

DENTAL SERVICE	PLAN PAYS
Class I – Preventive Services	100% - no deductible
Class II – Basic Services	80% - after calendar year deductible
Class III – Major Services	80% - after calendar year deductible
Class IV – Orthodontic Services (For children up to age nineteen (19)).	50% - after calendar year deductible

VISION CARE PROGRAM

SCHEDULE OF VISION CARE BENEFITS

VISION CARE SERVICES	
Maximum	\$200 per covered member per calendar year
Lasik Surgery	\$500 lifetime maximum per covered member

BENEFITS
Eye Examination
Lenses
Frames
Contact Lenses
Lasik Surgery

VISION CARE PROGRAM EXCLUSIONS

1. Charges covered under the Medical or Prescription Drug Program.
2. Charges for vision training or subnormal vision aids.
3. Charges for glasses or contact lenses not prescribed to correct visual acuity.

VISION CARE PROGRAM LIMITATIONS

1. One (1) set of lenses or contact lenses per covered member per calendar year.
2. One (1) eye examination per covered member per calendar year.
3. One (1) set of frames per covered member every calendar year.
4. Lasik surgery per covered member with a limitation of five hundred (\$500) dollars lifetime maximum.

SHORT TERM DISABILITY BENEFIT PROGRAM

Short term disability benefits are available for covered employee members only.

If, as a result of a non-occupational illness or injury, a covered employee member becomes disabled, short term disability benefits will be paid following completion of any applicable waiting period. Except as stated, the terms and provisions of the Plan Document in effect at the time of a claim for short term disability benefits will apply.

SCHEDULE OF SHORT TERM DISABILITY BENEFITS

SHORT TERM DISABILITY BENEFITS TABLE	
Waiting Period	Accident – none Illness – seven (7) days
Weekly Benefit Amount	Sixty (60%) percent of weekly wages Four hundred (\$400) dollars maximum per week
Maximum Benefit Period	Fifty-two (52) weeks per period of disability

SHORT TERM DISABILITY QUALIFYING PROVISION

An covered employee member qualifying for benefit payments must:

1. Be disabled while covered under these benefits and must remain covered by these benefits continuously throughout the waiting period;
2. Be under a health care provider's care and in an active course of treatment;
3. Exhaust all available sick leave hours; and
4. Satisfy the requirements for filing a claim.

The Plan Administrator reserves the right to determine when and if a covered employee member has satisfied these conditions. The loss of an covered employee member's professional or occupational license, inability to obtain or qualify for a license for any reason, or failure to pass a regular occupational physical check, does not constitute a disability. The Plan does not accept, as proof of disability, certification from a physician who is the covered employee member, the covered employee member's business associate, or the covered employee member's close relative.

WAITING PERIOD

The waiting period is the period of time when an covered employee member is continuously disabled and not receiving any income from the employer.

Any days of disability for which this Plan does not pay benefits or any day during which the covered employee member is not disabled are not counted toward the waiting period.

EXTENSION OF BENEFIT PAYMENTS

A covered employee member must provide proof of continued disability, physician care, and receipt of any income.

The Plan Administrator may require the covered employee member to be examined by a physician of its choice. Benefit payments may be terminated or suspended if at any time the covered employee member fails to comply with any of the above requirements.

TERMINATION OF BENEFIT PAYMENTS

Benefit payments will end on the earliest of the date:

1. The disability ends;
2. The covered employee member dies;
3. The maximum benefit period ends;
4. The covered employee member fails to provide the required proof of disability;
5. The covered employee member refuses to submit to a medical examination by a physician that the Plan Administrator requires;
6. The covered employee member is no longer under the care of a physician; or
7. The covered employee member becomes eligible for any other group short term disability income plan.

RECURRING OR SUCCESSIVE PERIODS OF DISABILITY

Recurring or successive periods of disability are considered as one (1) continuous period of disability if they result from or are contributed to by the same or related causes and are not separated by the covered employee member's return to active work for two (2) weeks.

CLAIM FILING FOR DISABILITY BENEFITS

The covered employee member or someone on the member's behalf must file a claim for disability benefits with the Third Party Administrator within the time limits specified in this provision. The claim must detail the extent and nature of the disability for which claim is being filed.

The Plan requires the covered employee member to provide an authorization for the release of medical and income information, including the names and addresses of the health care providers. Any information not furnished may result in the suspension or delay of benefit payments.

TIME LIMIT FOR FILING A CLAIM

The claim for disability benefits must be filed with the Third Party Administrator as soon as reasonably possible, after the employee member ceases to be actively at work.

However, a claim must be filed no later than twelve (12) months after the disability began, unless the covered employee member is incapacitated.

CONTINUED PROOF OF DISABILITY

Written proof of continued disability by a physician must be provided to the Third Party Administrator within thirty-one (31) days after the benefit period ends.

CALCULATION OF BENEFIT PAYMENTS

The amount of disability benefit payments are calculated at sixty (60%) percent of the covered employee member's weekly wage and is limited to a maximum weekly benefit of four hundred (\$400) dollars.

The term "wage" does not include commissions, bonuses, overtime pay, or other additional compensation received from the employer participant.

If the disability lasts part of a week, the Plan pays one-seventh (1/7) of the amount that is otherwise payable for that week for each day of disability.

DISABILITY BENEFITS EXCLUSIONS AND LIMITATIONS

In addition to the requirements and limitations specifically included in this provision, short term disability benefits are subject to any applicable Plan exclusions listed elsewhere in this Plan Document.

TERMINATION OF DISABILITY COVERAGE

Short term disability coverage terminates on the date the covered employee member's employment ends. Coverage also ends on the date the covered employee member is no longer a member in a class of employees eligible for this coverage, or when this coverage ends for all employees.

If a covered employee member is totally disabled on the date his/her coverage terminates, benefits will continue as if the coverage had not been terminated, up to the earlier of the end of the maximum benefit period, or the cessation of total disability.

Short term disability benefits are not subject to federal COBRA or any state continuation rights or any conversion privilege.

CONTINUATION OF BENEFITS FOLLOWING TERMINATION OF COVERAGE

This section applies to medical, prescription drug, dental and vision coverage only. This section does not apply to coverage for loss of life, or for loss of income due to disability (short term disability benefits).

DEFINITIONS APPLICABLE TO COBRA

1. **COBRA:** The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.
2. **Qualified Beneficiary:** a covered employee member whose employment terminates, other than for gross misconduct, or whose hours are reduced, rendering him/her ineligible for coverage under the Plan; and a covered spouse or dependent who becomes eligible for COBRA continuation coverage due to a qualifying event, as defined below, and any child born to, adopted by, or placed for adoption with a covered member during a period of COBRA continuation coverage.
3. **Qualifying Event:** the following events which, but for continuation coverage, would cause the loss of coverage under this Plan for a qualified beneficiary: (1) termination of a covered employee member's employment (other than for gross misconduct) or reduction in his/her hours of employment; (2) the death of the covered employee member; (3) the divorce or legal separation of the covered employee member from his/her spouse; (4) the covered member becoming entitled to Medicare coverage; (5) a child ceasing to be eligible as a dependent child under the terms of this Plan; or (6) a proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee member retired at any time.

RIGHT TO ELECT CONTINUATION COVERAGE

If a qualified beneficiary loses coverage under the Navajo Nation Employee Benefit Plan due to a qualifying event, he/she may elect to continue coverage under the Plan in accordance with the COBRA requirements upon timely election and payment of monthly contributions as specified. A qualified beneficiary must elect the coverage within the sixty (60) day period beginning on the later of the date of the qualifying event, or the date he/she was notified of the right to continue coverage.

NOTIFICATION OF QUALIFYING EVENT

If the qualifying event is a divorce, legal separation, or a dependent child is no longer eligible under the Plan, the covered member must notify the Plan Administrator within sixty (60) days of the qualifying event.

LENGTH OF CONTINUATION COVERAGE

A qualified beneficiary, who loses coverage due to a reduction in hours or termination of employment, other than for gross misconduct, may elect to continue coverage under this Plan for up to eighteen (18) months from the date of the qualifying event.

A qualified beneficiary who loses coverage due to a divorce, legal separation, loss of life of the covered employee member, the covered employee member's entitlement to Medicare, or a dependent child who becomes ineligible for coverage, may elect to continue coverage under this Plan for up to thirty-six (36) months from the date of the qualifying event.

Special rules apply, for the duration of coverage under COBRA, for certain retirees and their dependents that lose coverage as a result of an employer's bankruptcy that is a qualifying event. In those instances, the affected retirees, spouses, and eligible dependent children may elect to continue COBRA coverage until the retiree's death. When the retiree dies, the surviving spouse or any dependent children may elect and pay for up to an additional thirty-six (36) months of coverage from the date of the retiree's death.

TOTAL DISABILITY

When a qualified beneficiary is determined under Title II or XVI of the Social Security Act to be totally disabled within sixty (60) days of a qualifying event, and the qualifying event is termination of employment or reduction in hours, that qualified beneficiary or his/her dependents may elect to continue coverage for a total of twenty-nine (29) months only if the Plan Administrator is notified within sixty (60) days of the determination made by the Social Security Administration and prior to the end of the eighteen (18) months of continuation coverage.

If the qualified beneficiary extends coverage beyond the eighteen (18) months, the Plan Administrator may charge an increased premium.

If, during the period of extended coverage for total disability, a determination is made that a qualified beneficiary is no longer totally disabled, the qualified beneficiary must notify the Plan Administrator within thirty-one (31) days of the determination. Continuation of coverage under this section will terminate the last day of the month following thirty-one (31) days from the date of the final determination.

TERMINATION OF CONTINUATION COVERAGE

Continuation of coverage will automatically end for a qualified beneficiary on the earliest of the following dates:

1. The last day of the applicable maximum required period under COBRA;
2. The first day for which payment is not made to the Plan;
3. The date upon which the Plan Administrator ceases to provide employee benefits plan, including successor plans, to any covered member;
4. The date, after the date of election of COBRA coverage, when the qualified beneficiary first becomes covered under any other group health plan as an employee or otherwise;

5. The date, after the date of election of COBRA coverage, when the qualified beneficiary first becomes entitled to Medicare benefits when he/she enrolls in either Part A or Part B;
6. The date when a qualified beneficiary becomes entitled to a total disability extension.

MULTIPLE QUALIFYING EVENTS

When a qualified beneficiary continues coverage due to a qualifying event for which the maximum continuation is eighteen (18) or twenty-nine (29) months, and a second qualifying event occurs during that period, the qualified beneficiary may elect to continue coverage under this Plan for up to thirty-six (36) months from the date of the first qualifying event. If a qualified beneficiary who is a covered employee member becomes entitled to benefits under Medicare, a qualified beneficiary, other than the covered employee member, may elect to continue coverage for a maximum of thirty-six (36) months from the date of the first qualifying event. Coverage will not continue beyond thirty-six (36) months from the original qualifying event, even if a second qualifying event occurs during the COBRA continuation period.

CONTINUATION COVERAGE EXCLUSIONS AND LIMITATIONS

The continuation coverage elected by a qualified beneficiary is subject to all of the terms, conditions, limitations and exclusions applicable to this Plan. This continuation coverage is also subject to the COBRA rules and regulations. If this Plan and COBRA permit qualified beneficiaries to add a dependent, such a dependent may be added, provided that he/she meets the definition and eligibility requirements for dependents under this Plan.

DEDUCTIBLES AND PLAN MAXIMUMS

If continuation coverage under this Plan is elected by a qualified beneficiary, expenses previously credited toward the Plan's applicable deductibles, out-of-pocket provisions, benefit limitations, and other similar Plan provisions for the year will continue into the continuation coverage for that year.

Any amounts applied toward the maximum payment limitations of the Plan will also be carried into the continuation coverage. Coverage will not be continued for any benefits for which the Plan's maximums have been reached.

PREMIUM PAYMENTS

The Plan Administrator determines the premium to be charged for continuation coverage. The qualified beneficiary's premium contribution for eighteen (18) or thirty-six (36) months of continuation coverage does not exceed one hundred two (102%) percent of the applicable premium for that period. A totally disabled qualified beneficiary's premium contribution does not exceed one hundred fifty (150%) percent of the applicable premium for the extension of continued coverage.

If continuation coverage is elected, the monthly premium contribution for coverage for those months up to and including the month in which the election is made must be made within forty-five (45) days of the date of election.

Monthly premium contributions must be made by the first day of the month for which coverage is to be effective. If payment is not received within thirty-one (31) days, continuation coverage will automatically terminate. This thirty-one (31) day grace period however does not apply to the first contribution required for a totally disabled qualified beneficiary's coverage extension.

No claim is payable under this provision for any period for which the contribution is not received from or on behalf of a qualified beneficiary.

It is the intent of this Plan to comply with all existing COBRA regulations. If for some reason the information presented in the Plan differs from actual COBRA regulations, the Plan reserves the right to administer COBRA in accordance with such actual COBRA regulations.

CONVERSION PRIVILEGE

Conversion privilege is not available when the covered member's COBRA participation terminates.

CLAIMS PROCEDURES

TIME LIMIT FOR FILING A CLAIM

A claim must be filed with the Third Party Administrator as soon as reasonably possible, after health care services or supplies are rendered, but no later than twelve (12) months.

Failure to file a claim within the time periods provided does not invalidate or reduce a claim if it can be shown not to have been reasonably possible to file such claim as required.

HOW TO FILE A CLAIM

1. When a covered member incurs an expense for health care treatment or supplies under the Plan, an itemized bill should be submitted to the claim address printed on the covered member's group health plan card. The appropriate claim forms can be obtained from the employer participants. The medical, dental and vision care providers may file claims for the covered members by submitting a current CMS/HCFA-1500 or UB-04 form for medical and vision expenses, or current ADA form for dental expenses.
2. To expedite the processing of claims, the claim form must be fully completed and include, as an attachment, the original itemized bills or statements from the health care providers. The itemized bills or statements must include the full name, address, and signature of the provider of service; the provider's federal tax identification number; the name, Social Security number and address of the covered member; the Plan name and the Plan group number; the dates of service; the diagnosis; and the procedure codes.
3. A claim must be submitted for each covered member. When a completed claim is submitted and no additional information is required, the Third Party Administrator will complete its determination of the claim within thirty-one (31) days after receipt. If additional information is needed to process the claim, both the covered member and the health care provider are notified. When a covered member or health care provider receives a letter or EOB that includes a request for additional information, the covered member or health care provider is required to complete and return the requested information within sixty (60) days so the claim can be processed.

FOREIGN CLAIMS (OUTSIDE THE UNITED STATES)

In the event a covered member incurs a covered expense in a foreign country, the covered member is responsible for providing the following information to the Third Party Administrator before payment of any benefits due are payable:

1. The claim form, health care provider billing 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 United States dollars, with a current conversion chart.

NOTICE OF CLAIM DENIAL

The Third Party Administrator shall provide adequate written notice to any covered member or COBRA participant whose claim for benefits under this Plan is denied. The notice shall set forth the specific reasons for denial that is easy to understand.

EXPLANATION OF BENEFITS

After a claim is processed, an EOB is provided to both the covered member and health care provider by the Third Party Administrator. The EOB contains the following information:

1. The name of the health care provider;
2. The dates of services;
3. The charges billed;
4. The charges allowed;
5. The deductibles reducing the reimbursable charges;
6. The charges disallowed;
7. The reason(s) the charges are disallowed (for example, discount due from PPO network provider);
8. The amount paid on allowed charges; and
9. To whom payment was made.

The covered member retains the opportunity to request a review of the decision denying any of or the entire claim according to the provisions of this Plan's Appeals Procedure, as explained below.

MEMBER PORTAL

The Third Party Administrator provides a secure online access to medical benefit information and is available 24 hours a day, 7 days a week. Features of the Member Portal allow covered members to view member information, claims detail, EOB, plan document and forms, pre-certification requests, expense limits or to request duplicate group health plan cards. Information on how to access the Member Portal may be found by calling the Third Party Administrator at the phone number on the back of the group health plan card.

ASSIGNMENT OF BENEFITS

All network benefits payable by this Plan are automatically assigned to the health care provider of services or supplies, unless evidence of previous payment is submitted with the claim. All other benefits payable by the Plan may be assigned to the provider of services or supplies at the covered member's option. Payments made pursuant to an assignment are made in good faith and release the Plan's obligation to the extent of the payment.

The Plan may also honor benefit assignments made prior to a covered member's loss of life for the remaining benefits payable by the Plan.

ALTERNATE PAYEE PROVISION

Under normal conditions, all network benefits are payable to the health care provider of services or supplies. All other benefits are payable to the covered member and can only be paid directly to another party upon signed authorization from the covered member. If conditions exist under which a valid authorization or assignment cannot be obtained, payment may be made to any individual or organization that has assumed the care or principal support for the covered member and is equitably entitled to payment.

If any benefit remains unpaid upon covered member's loss of life, or if the covered dependent is a minor, the Plan Administrator may, at its option, pay such benefits to a duly appointed authorized representative or to any one or more of the following relatives of the covered member: spouse, parents, children, brothers, or sisters. Any payment made will constitute a complete discharge of the Plan Administrator's obligation to the extent of the payment.

RIGHTS OF RECOVERY

If a benefit is paid under the Plan and is later shown that a lesser amount should have been paid, the Plan will be entitled to a refund of the excess from the health care service provider or the covered member.

APPEALS PROCEDURE

Under normal circumstances, claims are processed and payments are made promptly following receipt of the claim at the office of the Third Party Administrator. If the Third Party Administrator requests additional, clarified, or updated information regarding a claim, the covered member's timely response will facilitate the processing of the claim. Failure to provide additional information as requested may result in a reduction or loss of benefits.

If any part of the claim is denied, the EOB will explain the specific reasons for the denial and will include a specific reference to the Plan provision upon which the denial is made. A notice of the appeals process is included with the EOB. If applicable, the covered member, his/her authorized representative or health care provider will be given a description of any additional information to process the claim in the form of a pending letter.

If a covered member, his/her authorized representative or health care provider disputes the processing or denial of a claim, the following appeal procedure is available:

1. Within one hundred eighty (180) days of the date on the EOB the covered member may request, in writing, that the Third Party Administrator conduct a review of the processed claim. The Third Party Administrator will review the processed claim and inform, in writing within thirty-one (31) days of the request, the covered member, his/her authorized representative or health care provider on whether or not an error was made. All errors will be corrected promptly.
2. If a covered member, his/her authorized representative or health care provider is not satisfied with the above review, a written request for a second review may be submitted to the Plan Administrator, through the Navajo Nation Employee Benefit Program, within sixty (60) days of the date of the written review provided by the Third Party Administrator. The request should state, in clear and concise terms, the reason for the disagreement with the way the claim was processed. When the written request is received, the claim will be reviewed by the Plan Administrator in coordination with the Third Party Administrator, and the results of the review will be furnished in writing to the covered member, his/her authorized representative or health care provider within sixty (60) days of the request.

Requests for review or appeal of denied benefits should include a copy of the initial denial letter and any other pertinent information. The request for review must include all facts and theories that support the claim for benefits.

Information must be sent to:

Hawaii Mainland Administrators, LLC (HMA, LLC)
Post Office Box 22009
Tempe, Arizona 85285

REQUEST FOR INDEPENDENT EXTERNAL REVIEW

Once the internal appeal process is exhausted, and if not satisfied with the appeal decision made by the Third Party Administrator the covered member, his/her authorized representative or health care provider has the right to an External Review of an adverse Appeal decision.

The external review will be made by an independent review organization with health care professionals that have no conflict of interest with respect to the benefit determination.

To request an external review, the covered member, his/her authorized representative or health care provider must submit the external request in writing within four (4) months after the date of receipt of notice of an adverse determination to:

Hawaii Mainland Administrators, LLC (HMA, LLC)
PO Box 22009
Tempe, Arizona 85285

Upon request and free of charge, the Third Party Administrator will provide a copy of the full independent external review policy and procedure, including information on how to initiate an external appeal, and the contact information for any applicable consumer assistance established by law to assist individuals with the internal claim and appeal processes and external review processes.

The external, independent reviewer's decision is legally binding on the covered member, his/her authorized representative or health care provider, the Plan Administrator and the Third Party Administrator even if any and all parties disagree with the decision.