

**Summary Plan Description
Suquamish Tribe Indian Health Plan
Effective January 1, 2026**



SUQUAMISH TRIBE

Third Party Benefits Administrator:
Healthcare Management Administrators, Inc.



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

This Plan Document and Summary Plan Description ("SPD"), made by the Suquamish Indian Tribe of the Port Madison Reservation (the "Tribe" or the "Plan Sponsor") as of January 1, 2026 hereby amends and restates the provisions of The Suquamish Tribe Indian Health Plan (the "Plan"), which was originally adopted by the Tribe, effective January 1, 1985.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

Adoption of the Plan Document

The Suquamish Indian Tribe is a federally recognized Indian Tribe. Notwithstanding anything to the contrary in the Plan, nothing in the Plan may be construed as a waiver of the Suquamish Indian Tribe's sovereign immunity which is hereby expressly retained. The Tribe, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

Suquamish Indian Tribe of the Port Madison Reservation

By:  _____

Name: Leonard Forsman

Title: Suquamish Tribe Chairman

Date: 02/23/2026

GENERAL PLAN INFORMATION

Plan Name: Suquamish Tribe Indian Health Plan

Type of Plan: This Plan is a tribal health care benefits program established by The Suquamish Tribe to provide Purchased Referred Care (PRC) formerly, Contract Health Service (CHS) benefits for the exclusive benefit of Suquamish Tribal Members.

Plan Number: 525

Participating Tribe:

Suquamish Indian Tribe of the Port Madison Reservation
P.O. Box 498, Suquamish, WA 98392

Plan Administrator/Plan Sponsor:

Suquamish Indian Tribe of the Port Madison Reservation
P.O. Box 546, Suquamish, WA 98392
Telephone: 360-394-8466

Plan Sponsor Tax ID Number (EIN): 91-0854725

Original Plan Effective Date: January 1, 1985

Restatement Date: January 1, 2026

Plan Year: January 1st through December 31st

Third Party Administrator:

Healthcare Management Administrators, Inc. (HMA)
PO Box 85008, Bellevue, Washington 98015-5008
Telephone: 888-450-4491

Care Management Program Administrator:

Healthcare Management Administrators, Inc. (HMA)
PO Box 85008, Bellevue, Washington 98015-5008
Telephone: 888-450-4491

Preferred Provider Organization (PPO) Network:

HMA Preferred
Telephone: 888-450-4491
Website: www.accesshma.com

PURPOSE OF THE PLAN

The Tribe has determined that the most effective process for delivering the Purchased Referred Care (PRC) formerly, Contract Health Service (CHS) benefits to its Tribal citizens is to contract with Healthcare Management Administrators, Inc. (HMA) for Third Party Benefits Administration. The purpose of this Summary Plan Description is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses.

Plan benefits are intended to qualify as self-insured tribal health program benefits under 25 U.S.C. §§1623(b), 1621e(f), and 1603. Plan Sponsor reserves the right to receive federal funding for benefits provided under this section in accordance with 25 U.S.C. § 1642, if applicable. In accordance with the Tribe PRC program's eligibility policies and procedures, this Plan acts in coordination with and supplemental to the Plan Sponsor's PRC program, and may make payments on behalf of the Tribe's PRC. This program must not pay before available federal, tribal, and other third party programs or payors.

PLAN CONSTRUCTION

This Plan is to be construed in accordance with the provisions set forth by the Suquamish Tribe and the laws applicable to that preserve rights for Indian Sovereign Nations. Except when otherwise indicated by context, any masculine terminology will also include the feminine and non-binary (and vice-versa) and any term in the singular will also include the plural (and vice-versa). Some of the words and phrases used to describe this Plan have special meanings and are specifically defined terms. Their definitions are contained in the Defined Terms Section of this document and in applicable sections.

PLAN ADMINISTRATOR RESPONSIBILITIES AND DISCRETION

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures, and applicable Federal laws and regulations. The Plan Administrator's responsibilities include those delegated by the Suquamish Tribe to Healthcare Management Administrators, Inc., the Third Party Administrator, as set forth in an administration agreement and any addenda thereto. It is the express intent of this Plan that the Plan Administrator will retain sole, full, and final discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. Discretionary authority may be delegated to the claims administrator or Plan Supervisor if charged with deciding appealed claims. The Plan Administrator's decisions will be binding on all Members, dependents, and beneficiaries.

THIRD PARTY ADMINISTRATOR NOT A FIDUCIARY

The Third Party Administrator is not a fiduciary with respect to this engagement and shall not exercise any discretionary authority or control over the management or administration of the Plan, or the management or disposition of the Plan's Assets. The Third Party Administrator shall limit activities to carrying out ministerial acts of notifying Covered Members, and making benefit payments as required by the Plan. Any matters for which discretion is required shall be referred by the Third Party Administrator to the Plan Administrator, and the Third Party Administrator shall take direction from Plan Administrator in all such matters. The Third Party Administrator shall not be responsible for advising the Tribe or Plan Administrator with respect to fiduciary responsibilities under the Plan nor for making any recommendations with respect to the investment of Plan Assets. The Third Party Administrator may rely on all information provided to it by the Tribe, Plan Administrator, and the Trustees, as well as the Plan's other vendors. The Third Party Administrator shall not be responsible for determining the existence of Plan Assets. This Section does not prohibit the delegation of discretion to construe Plan terms and eligibility in connection with the administration of plan appeals.

ELIGIBILITY AND ENROLLMENT

COVERAGE WHEN ELIGIBLE FOR ALTERNATE RESOURCES

If you are eligible for medical benefits under a group health plan, private insurance plan, Medicaid, Medicare, Tricare Administration, homeowners, automobile PIP insurance, or other Federal or State program, you must use these alternate resources first unless an exemption to this requirement is processed by Health Benefits and approved by the Suquamish Tribal Council. The Suquamish Tribe's Indian Health Plan is a secondary resource; it is not insurance. It will pay only the medical expenses that are not covered by any available alternate resources. Enrollment in any and all alternate resources which are available at no cost to you is mandatory.

Covered Members who have questions about the coordination of coverage with alternate resources should contact The Suquamish Tribe's Health Benefits Office at 360-394-8424.

WHO IS ELIGIBLE TO ENROLL IN THIS PLAN

- Enrolled Suquamish Tribal Members who reside within Kitsap, Jefferson, King, Mason, Pierce, Snohomish, and Whatcom Counties.
- Suquamish Tribal Members who are full time college students, under the age of 25, enrolled in the Higher Education Program, attending school outside of Kitsap, Jefferson, King, Mason, Pierce, Snohomish, and Whatcom Counties.
- Non-Suquamish females when pregnant with a Suquamish Tribal Member's child, including post-partum period (usually 6 weeks) as approved by the Health Benefits Office.
- Eligible Suquamish Tribal Members who have Washington State Medicaid will be enrolled in the Supplemental Plan. Please refer to the Schedule of Benefits for this Plan's coverage.

Member enrollment is dependent on Indian Health Services funding criteria established and administered by the Health Benefits Office and approved by the Suquamish Tribal Council. There is no retroactive eligibility or coverage on this Plan. Any lapse in coverage will be the Covered Member's responsibility.

ENROLLMENT PROCEDURE

To enroll in this Plan, the eligible Member must complete and sign a registration form and submit the form to the Plan Administrator. The registration form must include complete information for the eligible Member to be enrolled. The Health Benefits Office will submit the completed enrollment form to the Third Party Administrator (HMA).

Members may be required to complete a registration form annually. Failure to complete a registration form when notice has been made to each enrollee will result in termination of coverage.

Covered Members are required to report other insurance coverage or a change in such coverage, or a change in demographics, or a change in employment/income, by completing a registration form. Failure to provide notice may result in termination of coverage. The Plan Administrator retains the right to request documentation at any time that is necessary to confirm whether a Covered Member meets the Plan's participation rules. The Plan Administrator also requires a Social Security number for each Covered Member.

EFFECTIVE DATE

Coverage will be effective on the first of the month, following receipt of the original signed registration form approved by the Health Benefits Office.

For newborns the effective date may vary, please contact the Health Benefits Office within 30 days of birth.

TERMINATION OF COVERAGE

Coverage will end at 11:59 p.m. on the earliest of the following dates:

- The date this Plan is terminated.
- The last day of the month in which the Covered Member ceases to satisfy the coverage requirements or date of death.
- The effective date of the month in which a Covered Member becomes eligible for Medicaid.
- The date a Covered Member voluntarily declines other coverage that is available at no cost.

LOSS OF OTHER COVERAGE

Your enrollment in the Indian Health Plan is contingent upon your enrollment in any other health plan for which you pay no premiums. If you lose your other health coverage for any reason, contact the Health Benefits Office.

RESCISSION OF COVERAGE

Your Plan coverage may be terminated retroactively. The Plan Administrator at its discretion may terminate coverage retroactively when the Covered Member is no longer eligible and in the following cases:

- In the case of fraud
- An intentional misrepresentation of material fact
- A delay in notice of eligibility for alternate resources

CURRENT ADDRESS

In order to protect your rights and continue your benefits under this plan, you must notify the Health Benefits Office of any address changes. Persons who leave the county in which they are eligible for CHS and who are neither students nor transients are eligible to request continuation of coverage for a period not to exceed 180 days from such departure.

CARE MANAGEMENT

PRE-AUTHORIZATION OF INPATIENT MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES

At the time that your doctor recommends surgery or an inpatient admission for you, your doctor should contact HMA's Care Management Department to request pre-authorization. All inpatient and outpatient non-emergency surgeries and all non-emergency admissions (excluding normal vaginal deliveries where the length of stay is 48 hours or less and cesarean section deliveries where the length of stay is 96 hours or less) must be pre-authorized in advance. Your provider must call no later than 5 days prior to the medical facility admission or surgery. Some surgeries performed in the doctor's own office may need to be pre-authorized. Your provider should contact the Care Management Department for confirmation.

Pre-authorization is not required for services provided in an emergency room of a hospital. It is recommended that all emergency medical facility admissions and emergency surgeries be authorized within 48 hours after the medical facility admission or surgery, or by the next business day, if later.

Special Note Concerning Mothers and Newborns: Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time your provider recommends the extended stay.

Please see the Care Management provisions of this SPD for additional services which require pre-authorization. Failure by your provider to obtain pre-authorization from the HMA Care Management Department prior to the receipt of these services may result in the denial of your claim.

Pre-authorization does not guarantee payment of benefits. The Care Management Department should be contacted at the following numbers:

**HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
425-462-1000 - SEATTLE
888-450-4491 - OTHER AREAS NATIONWIDE**

CERTIFICATION OF ADDITIONAL DAYS

If your physician/provider is considering lengthening a stay, your physician/provider, the hospital, or the medical facility must call HMA's Care Management Department to request certification for additional days. Call no later than the last day previously certified. If medically necessary, additional days of stay may be certified at that time.

STEPS TO TAKE

When an inpatient admission or surgery is recommended, your physician/provider must call HMA's Care Management Department at least five (5) days prior to the admission or surgery to obtain authorization. If an emergency admission or emergency surgery occurs, the attending physician/provider or the medical facility should contact HMA's Care Management Department within 48 hours of admission or surgery, or by the next business day, if later. Your provider should be prepared to give HMA's Care Management Department the following information when they make the call for authorization:

- Your name and your age.
- Your subscriber identification number.
- Your group number (090583).
- Your medical facility name and address.
- The name and phone number of your admitting physician/provider.
- Your admission date.

- Your diagnosis.
- The procedure being performed.

The Care Management Department will send written confirmation of the approved admission to you, your provider, and the facility once authorized.

CARE MANAGEMENT

Care Management services are provided for you if you are receiving acute or on-going care that is considered serious, high dollar or complex in nature. Acute or catastrophic events, high dollar claims and other unique or complex conditions will be monitored by Care Management. The following services may be reviewed for medical necessity and other conditions of the Plan; claims received without pre-authorization may be evaluated prior to payment to assess whether all benefit terms are met:

- Inpatient admissions and Outpatient surgeries.
- Home Health and Hospice Care.
- Radiation therapy (other than conformal).
- Durable Medical Equipment that exceeds \$2,500 and Prosthetics that exceeds \$2,500.
- Infusions, Injections and Chemotherapy.
- Inpatient Acute Rehabilitation and Skilled Nursing Facility admissions.
- Residential, Partial Hospital Programs, and Intensive Outpatient Programs.
- Kidney Dialysis.
- Blood/Marrow and Solid Organ Transplants.
- Maxillofacial Prosthetic Services.
- Formula for PKU or other inborn errors of metabolism.
- Non-urgent ambulance or cabulance services.
- Gene therapy and adoptive cellular therapy.
- Genetic testing.

Assessment tools and evidenced based guidelines are used by Care Management for all case determinations. This SPD is the primary source for specific benefit language and is the default directive for any potential subsequent referenced guideline(s). Please see the Evidence Based Medicine provisions within the General Plan Provisions section of this SPD for information regarding guidelines and compendia used by this Plan for medical necessity and length of stay determinations.

Care Management will work with you to ensure that the right care at the right time is delivered and to lower the cost of health care to you and the Plan. The Care Manager shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of your care and when a higher level of care would be the reasonable outcome if lower level provisions of the Plan are not available. In order to qualify for alternative treatment, medical necessity criteria must be met for the higher cost service line that would be a reasonable expectation without access to the proposed lower cost alternative. Reasonable outcomes and expectations are determined by Care Management and/or Medical Director assessment.

Alternate care will be determined on the merits of each individual case and any care or treatment provided will not be considered setting any precedent or creating any future liability, with respect to you or any other covered Member.

CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS

Healthcare Management Administrators, Inc. (HMA) is the Third Party Administrator. You are encouraged to contact HMA with questions you have regarding this Plan. HMA's Customer Care Department is available to answer questions about claims and how your benefits work. You may contact HMA's Customer Care Department at:

**HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
P.O. Box 85008, Bellevue, WA 98015-5008
425-462-1000 - Seattle
888-450-4491 - Other Areas Nationwide**

You may also contact Health Benefits Office at 360-394-8424.

PLAN PAYMENT PROVISIONS

The Suquamish Tribe Indian Health Plan will pay 100% of the Allowable charges for all Medically Necessary Covered Expenses after all alternate resources have been exhausted. There is no Deductible, and no lifetime maximum benefit. The following services are covered with some of the Limitations indicated. For a list of non-covered services see the Exclusion Section.

PREFERRED PROVIDERS

Preferred Provider Organizations (PPOs) are Networks of preferred Physicians, Hospitals, and other health care Providers who have agreed to provide their services at reduced fees. **To receive the coverage available under the medical benefits of this Plan, a Covered Member must utilize the services of Preferred Providers (except in the event of a medical Emergency when seeking Urgent Care or when traveling outside the PPO Network area).**

Providers within PPO Networks are subject to change. Each person covered under this Plan is responsible for verifying the PPO status of the Providers they use. To verify the current status or eligibility of a Provider, a Covered Member may call the PPO Network, check the Provider's status on the PPO's website, or call the Provider.

If you do not have access to a computer at your home, please contact your Health Benefits Office. You may also contact your PPO Network or HMA at the phone number listed on your ID card.

What happens if my Provider no longer participates with the PPO Network? If your Provider chooses to terminate their agreement with the HMA Preferred Network, depending on the services you are being provided you may be able to either: (i) complete your course of treatment, or (ii) appropriately transfer your care to another Preferred Provider. Services received from a Provider who has terminated their PPO agreement will only be covered at the Preferred Provider benefit level when approved by the Plan Administrator. This does not mean coverage for future visits will also be covered at the Preferred Provider benefit level. Covered Members are responsible for seeking care within the Preferred Provider Network.

PURCHASED/REFERRED CARE (PRC) AND PRICING APPLICABLE TO ELIGIBLE MEMBERS ONLY

Under federal law, certain eligible Tribal members covered by this Plan may also be eligible for Purchased/Referred Care (PRC) services (historically referred to as Contract Health Services) from The Suquamish Tribe's PRC program. Consistent with federal law and applicable federal and Tribal policies, this Plan will be administered in coordination with The Suquamish Tribe PRC to ensure the best rates are obtained for services provided to PRC-eligible Plan Members.

Relevant Law

For all Medicare-participating hospital based claims with a date of service on or after July 5, 2007, the regulations at 42 C.F.R. Part 136, subpart D and 42 C.F.R. Part 489, subpart B, describe the processing requirements and payment standards and methodologies that covered providers must comply with for services authorized by The Suquamish Tribe PRC. These payment standards apply to all levels of care furnished by a Medicare-participating hospital, whether provided as inpatient, outpatient, skilled nursing facility care, as other services of a department, subunit, distinct part, or other component of a hospital (including services furnished directly by the hospital or under arrangements).

The PRC regulations implement "Medicare Like Rates" (MLR) as defined under Section 506 of the Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. 108-173, (which added a new subparagraph (U) to Section 1866(a)(1) of the Social Security Act, 42 U.S.C. 1395cc(a)(1)). Under 42 C.F.R. § 136.30, the payment of an authorized PRC claim made in accordance with that section constitutes payment in full, which the hospital must accept no more than, and the hospital or its agent may not impose any additional charge on the individual.

MLR for purposes of this Plan also includes Professional Services and Non-Hospital Based Discounting, as applicable, to the extent permitted under 42 C.F.R. §136.201-136.204.

Where a Tribe operates both a PRC program and a Tribal Self Insurance Program (TSIP), the Indian Health Care Improvement Act (IHCIA) affirms that such health programs operated by tribes or tribal organizations shall be the payor of last resort, 25 U.S.C. § 1623, and permits, at the Tribe's discretion, the coordination of benefits and payments by the Tribal PRC and TSIP to maximize efficiency in billing and ensure the best rates are obtained. 25 U.S.C. § 1621e;

Redding Rancheria v. Hargan, 296 F. Supp. 3d 256 (2017). Absent a written authorization by the Tribe, a TSIP shall not be considered an Alternative Resource for IHS or PRC purposes.

Applicable Pricing

Tribal members covered by this Plan may be eligible for PRC benefits and receive services that were validly authorized by The Suquamish Tribe PRC in accordance with the applicable law and Tribal policies. The Plan Sponsor authorizes MLR eligible care through its PRC program and coordinates payment through the Third Party Administrator to apply MLR pricing. Where an enrolled tribal member qualifies for both employment based and member based benefits, the benefits paid under the program will be presumed to be paid as member based benefits. For such services to which Medicare Like Rates or other pricing applies pursuant to the PRC regulations referenced above, the Plan will process the claims and pay them at the lesser of either the applicable payment rate under the PRC regulations or the discounted rate negotiated by or on behalf of the Plan. When the Plan pays Medicare Like Rates or other applicable pricing on a claim pursuant to the PRC regulations, such payment shall include any Member deductible, co-payment, or co-insurance in the payment to the provider.

The Plan may pay any claim covered by the express terms of the Plan on a provisional basis pending a final determination under the COB. Payments made by the Plan on authorized PRC claims will be on behalf of the Tribe. Payments made by the Plan on PRC authorized claims in accordance with 42 C.F.R. 136 Part D and this Plan, shall constitute payment in full.

The Plan is entitled to reimbursement on authorized PRC claims provisionally paid by the Plan in accordance with 42 C.F.R. 136 Part D; and the Plan may seek reimbursement from Tribe PRC or IHS consistent with applicable law and Tribal policy.

As a TSIP, this Plan shall not be considered Alternate Resources for purposes of the Indian Health Service payor of last resort rule as applied either by the Indian Health Service directly or by the Tribe. Consistent with Section 206(f) of the Indian Health Care Improvement Act, 25 U.S.C. § 1621e(f), and 42 CFR § 136.61, the Indian Health Service has no right of recovery against this Plan for health services the Indian Health Service has provided to an eligible patient, and no payment will be made by this Plan to the Indian Health Service. (See Alternate Resources under the General Exclusions to the Medical Plan and Alternate Resources under the General Definitions).

SCHEDULE OF BENEFITS

This Plan does not require the designation of a primary care provider or to obtain a referral for services received from a specialist. There are no out of network benefits except those services that are specifically designated with an exemption to this requirement.

Your Preferred Provider Organization is:

If you receive services in Idaho/Oregon/Utah/Washington:

HMA Preferred Provider Network

888-450-4491

OR

Log in to the myHMA member portal at www.accesshma.com

If you receive services outside of WA, OR, ID, or UT:

PHCS Network

888-450-4491

OR

Log in to the myHMA member portal at www.accesshma.com

You can access a directory of Preferred Network providers and facilities at any time on our online portal at www.accesshma.com. This directory is updated at least every 90 days. While we strive to provide accurate provider network status, the listings can change. We recommend you verify with your provider for the most up to date network contract status prior to receiving services.

Eligible expenses will be paid at the Preferred level when (any of the following apply):

- The services are billed by a Preferred provider, hospital or medical facility.
- The services are for non-emergent care provided by a non-preferred Assistant Surgeon or Anesthesiologist, where the medical facility and the primary surgeon are both Preferred providers.
- You receive services outside the area serviced by the Preferred provider organization.
- You receive emergency services (includes Ambulance, Anesthesiologist, Assistant Surgeon, Emergency Room Services, Primary Surgeon, and Urgent Care) inside or outside the network area.
- The services are for Durable Medical Equipment (DME) distributed by a Preferred provider but the DME company is non-preferred.
- The services are for non-preferred diagnostic testing, lab and imaging services, where the physician/provider who ordered the services is a Preferred provider. Eligible services will be covered based upon 250% of the Medicare allowable charge.
- The services are for a non-preferred inpatient physician visit, where the hospital or medical facility where the services were rendered is a Preferred provider. Eligible services will be covered based upon 250% of the Medicare allowable charge.

This Schedule of Benefits is a summary of the benefits provided under this Plan. **Please read the entire booklet for details on specific benefit limitations, benefit maximums, waiting periods and exclusions.**

Covered Members who are enrolled in The Suquamish Tribe Indian Health Plan are considered to be eligible for Purchased Referred Care (PRC) formerly, Contract Health Service (CHS) benefits.

Annual Deductible: There is no annual Deductible.

Annual Out-of-Pocket Maximum: There is no annual Out-of-Pocket Maximum.

Medical Benefits	Preferred and Participating Provider	Out-of-Network Provider
Annual Deductible Per Calendar Year	None	None
Out-of-Pocket Maximum	None	None
Annual Benefit Maximum	None	None
Acupuncture Limited to 12 visits per calendar year.	100% of allowed	Not Covered
Allergy Testing and Injections	100% of allowed	Not Covered
Ambulance (Air and Ground)	100% of allowed	Not Covered
Anesthesiology/Anesthesiologist Includes analgesia	100% of allowed	Not Covered
Assistant Surgeon	100% of allowed	Not Covered
Breast Pumps	100% of allowed	100% of billed charges
Chiropractic Services include initial office visit, x-rays and spinal adjustments. Limited to 12 visits per calendar year.	100% of allowed	Not Covered
Circumcision	100% of allowed	Not Covered
Colonoscopy	100% of allowed	Not Covered
Cologuard	100% of allowed	100% of billed charges
Contraceptive Services	100% of allowed	Not Covered
Dental Implants All dental implants require preauthorization from Health Benefits. Must use Kitsap Gentle Dentistry. If another provider is used (and approved by Health Benefits), there is a limit of \$3,500 per tooth.	100% of allowed	Not Covered
Diabetic Education	100% of allowed	Not Covered
Diabetic Education, Training, Nutritional Counseling	100% of allowed	Not Covered
Diagnostic Testing, Laboratory, and X-ray	100% of allowed	No Covered
Dietary Education	100% of allowed	No Covered
Durable Medical Equipment (DME)* Preauthorization is required for equipment over \$2,500.	100% of allowed	Not Covered
Elemental Enteral Formula	100% of allowed	Not Covered
Emergency Room Services	100% of allowed	100% of allowed

Medical Benefits	Preferred and Participating Provider	Out-of-Network Provider
Gene and Cellular Therapy	100% of allowed	Not Covered
Travel Expenses Limited to \$10,000 maximum per course of treatment.	100% of allowed	100% of allowed
Genetic Testing*	100% of allowed	Not Covered
Hearing Exams	100% of allowed	Not Covered
Hearing Aids Limited to one pair every 60 months.	100% of allowed	Not Covered
Home Health Care*	100% of allowed	Not Covered
Hospice Care* Respite care is limited to 5 days continuous care for every 3 month period. Inpatient care limited to 7 days.	100% of allowed	Not Covered
Immunizations, Flu Shots, and Vaccines	100% of allowed	100% of billed charges
Infusion Therapy*	100% of allowed	Not Covered
Injections	100% of allowed	Not Covered
Kidney Dialysis*	100% of allowed	Not Covered
Lactation Specialist	100% of allowed	Not Covered
Massage Therapy Annual maximum of 12 visits. Referral is not required.	100% of allowed	Not Covered
Maternity Care	Paid the same as any other condition	Not Covered
Medical Facility Services Inpatient	100% of allowed	Not Covered
Outpatient Surgical Facility	100% of allowed	Not Covered
Miscellaneous Services	100% of allowed	Not Covered
Mental Health Services - Inpatient* Room and Board, Ancillary charges.	100% of allowed	Not Covered
Mental Health Services - Outpatient	100% of allowed	Not Covered
Naturopathic Services	Paid the same as any other condition	Not Covered
Neurodevelopmental Therapies	100% of allowed	Not Covered
Office Visits	100% of allowed	Not Covered
Preadmission Testing	100% of allowed	Not Covered

Medical Benefits	Preferred and Participating Provider	Out-of-Network Provider
Preventive Gynecological Services	100% of allowed	Not Covered
Preventive Lab and X-ray	100% of allowed	Not Covered
Preventive Mammography	100% of allowed	Not Covered
Preventive/Wellness Exam (all ages)	100% of allowed	Not Covered
Private Duty Nursing Limited to 120 hours per calendar year.	100% of allowed	Not Covered
Prosthetics* Preauthorization is required for prosthetics that exceed \$2,500.	100% of allowed	Not Covered
Radiation and Chemotherapy*	100% of allowed	Not Covered
Rehabilitation Services - Inpatient* Includes Physical, Occupational, Speech, Cardiac, and Pulmonary Therapy	100% of allowed	Not Covered
Rehabilitation Services - Outpatient Includes Physical, Occupational, Speech, Cardiac, and Pulmonary Therapy. Limited to 30 visits per calendar year.	100% of allowed	Not Covered
Second Surgical Opinion	100% of allowed	Not Covered
Skilled Nursing Facility* Includes extended care facility. Excludes: Custodial Care or care principally for senile deterioration, mental deficiency or Mental Illness	100% of allowed	Not Covered
Sterilization (Elective)	100% of allowed	Not Covered
Substance Use Disorder Services - Inpatient* Room and Board, Ancillary charges.	100% of allowed	Not Covered
Substance Use Disorder Services - Outpatient	100% of allowed	Not Covered
Surgery*	100% of allowed	Not Covered
Telemedicine	Paid the same as any other condition	Not Covered
Temporomandibular Joint Disorder (TMJ) Lifetime maximum \$10,000.	100% of allowed	Not Covered
Tobacco Cessation	100% of allowed	Not Covered

Medical Benefits	Preferred and Participating Provider	Out-of-Network Provider
Transplants*	Paid the same as any other condition	Not Covered
Donor Benefits	Paid the same as any other condition	Not Covered 100% of allowed
Travel, Meals, and Lodging Limited to \$10,000 per transplant.	100% of allowed	
Urgent Care Facility	100% of allowed	Not Covered
Wigs Limited to 2 wigs per calendar year following radiation or chemotherapy, alopecia, or required due to burns.	100% of allowed	Not Covered

*Preauthorization required. For a full listing of services that require Preauthorization, see the Care Management section. Additional information is also included in the Covered Expenses section.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

ELIGIBLE EXPENSES

When medically necessary for the diagnosis or treatment of an illness or an accident, the following services are eligible expenses for yourself covered under this Plan. Eligible expenses are payable as shown in the Schedule of Benefits and are limited by certain provisions listed in the General Exclusions. Major Medical expenses are subject to all Plan conditions, exclusions, and limitations.

ACUPUNCTURE

Acupuncture services when performed by a provider acting within the scope of their license are eligible for coverage by the Plan.

ALLERGY INJECTIONS/TESTING

Eligible charges for the injections, testing, syringes and medication will be payable as shown in the Schedule of Benefits.

AMBULANCE (AIR AND GROUND)

Services of a licensed ambulance company for transportation to the nearest medical facility where the required service is available, if other transportation would endanger your health and the purpose of the transportation is not for personal or convenience reasons.

Cabulance

The Plan will cover charges of a licensed ground cabulance service for non-emergent medical transport if you are a medically stable patient who cannot otherwise use private transportation without endangering your safety. You will be eligible for ground cabulance services when:

- You are medically stable and require a wheelchair with portable oxygen, a non-active IV, hep lock, Foley catheter or NG tube.
- You are medically stable, non-ambulatory and you require movement by wheelchair, or you are ambulatory but you require assistance to transfer.

To be eligible for coverage, cabulance services must be provided to you by a licensed cabulance company and must be pre-authorized by HMA's Care Management Department. Failure by your provider to pre-authorize services may result in denial of your claim. Cabulance staff are ADA certified and the vehicle is ADA compliant.

BLOOD BANK

Eligible charges made by a blood bank for processing of blood and its derivatives, cross-matching and other blood bank services; charges made for whole blood, blood components, and blood derivatives to the extent not replaced by volunteer donors will be covered by the Plan. Storage of any blood and its derivatives are not covered under the Plan.

CHIROPRACTIC CARE

Covered chiropractic services include spinal manipulation, adjunctive therapy, vertebral alignment, subluxation, spinal column adjustments and other chiropractic treatment of the spinal column, neck, extremities or other joints, provided for as defined under the definition of physician/provider. Examinations and x-rays in connection with chiropractic care are subject to the chiropractic limit shown in the Schedule of Benefits.

CONTRACEPTIVE SERVICES

Benefits will be provided for consultations, counseling, all contraceptive methods which require a prescription and have been approved by the United States Food and Drug Administration (FDA), software applications with FDA approval, and Member education. Benefits are also provided for insertion and removal of intrauterine devices and implants.

This benefit does not cover contraceptives that can be purchased without a prescription, such as condoms, sponges, or contraceptive foam or jelly.

DENTAL IMPLANTS

In order to receive coverage for eligible Dental Implant expenses your care must be provided by Kitsap Gentle Dentistry. This applies even if this Plan is not primary coverage. Contact Kitsap Gentle Dentistry at 360-698-1990. Dental Implants not obtained at Kitsap Gentle Dentistry must be appealed through Tribal Council. Tribal Council Appeals have a \$3500 maximum reimbursement amount if approved.

DENTAL SERVICES

Dental services provided by a dentist, oral surgeon, or physician/provider, including all related medical facility inpatient or outpatient charges, including an outpatient surgical center, for only the following:

- Treatment for accidental injuries to natural teeth. Treatment for up to 12 months from the date of the accident for accidental injuries is provided under this Plan. Injuries caused by biting or chewing are not covered under the medical plan.
- Treatment to excise and/or biopsy suspected lesions, excised confirmed tumors or malignancies of the oral cavity, tongue, or jaw; when performed by a provider who is acting within the scope of their license, whether done in a dental office or hospital.
- Benefits for anesthesia for dental services are covered the same as relevant services listed on your Schedule of Benefits. Services must be prior authorized by the Plan and are only provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:
 - Mental handicaps.
 - Physical disabilities.
 - A combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
 - Emotionally unstable, uncooperative, combative Members where treatment is extensive and impossible to accomplish in the office.

All other dental services are excluded.

DIABETIC EDUCATION

Diabetic education is a covered benefit, if provided by a physician/provider as defined under this Plan. Benefit will be provided for diabetic self-management training and education, including nutritional therapy. The Plan will be the final authority on which education programs will meet the criteria of eligibility.

DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT TRAINING

Covered expenses include charges for the following services, supplies, equipment, and training for the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy based upon your medical needs. Pharmacy exclusive supplies and durable medical equipment (as determined by the manufacturer) are not covered under the medical benefits of the Plan. Coverage for these exclusive items may be available under your prescription drug plan. The following are covered under the medical benefits:

Services and Supplies:

- Foot care to minimize the risk of infection including routine and preventive foot care;
- Dilated retinal examinations;
- Diabetic needles and syringes;
- Injection aids for the blind;
- Diabetic test agents; urine test strips, ketone test strips;
- Lancets/lancing devices;

- Alcohol swabs;
- Injectable glucagon's; and
- Glucagon emergency kits.

Durable Medical Equipment:

- External insulin pumps;
- Blood glucose monitors; and
- Foot care appliances for prevention of complications associated with diabetes.

Training:

- Diabetes outpatient self-management training and medical nutrition therapy services must be ordered by a physician and provided by appropriately licensed or registered healthcare professionals.

DIAGNOSTIC X-RAY AND LABORATORY

Benefits will be provided for medical services, administration, and interpretation of diagnostic X-ray, pathology, and laboratory tests. Dental x-rays are excluded. 3D mammograms are covered.

DIETARY EDUCATION

Dietary education is a covered benefit, if provided by a physician/provider as defined under this Plan. Benefits will be provided for education, guidance, and nutritional therapy for individuals with illnesses or diseases that can be improved with diet, including, but not limited to diabetes, high blood pressure, and high cholesterol. The Plan will be the final authority on which education programs will meet the criteria of eligibility.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for rental or purchase (if more economical in the judgment of HMA's Care Management Department) of medically necessary durable medical equipment. Durable medical equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally used in the absence of illness or injury. The durable medical equipment must be prescribed by a physician/provider for therapeutic use, and include the length of time needed, the cost of rental and cost of purchase prior to any benefits being paid. Examples of durable medical equipment include: crutches; wheelchairs; kidney dialysis equipment; beds and mattresses; traction equipment; footwear (corrective shoes, diabetic shoes and orthopedic shoes); keyboard language or assistive communication devices; non-invasive positive pressure ventilation systems (CPAP, BiPAP) and equipment for administration of oxygen. Repairs or replacement of eligible equipment shall be covered when necessary to meet your medical needs and when necessary to make the equipment serviceable, but not where repairs suggest malicious damage or culpable neglect.

Benefits are not provided for certain equipment including, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, orthopedic chairs, personal hygiene items, purifiers, heating pads, enuresis (bed-wetting) training equipment, exercise equipment, whirlpool baths, weights, or hot tubs. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided. Please see the sections covering Medical Supplies, Orthotics, and Prosthetics for further information. Pharmacy exclusive supplies and durable medical equipment (as determined by the manufacturer) are not covered under the medical benefits of the Plan. Coverage for these exclusive items may be available under your prescription drug plan. The following are covered under the medical benefits:

Services for manual and electronic breastfeeding equipment or supplies will be covered under the Breast Pump benefit as outlined in the Schedule of Benefits. Hospital grade equipment is covered under the Durable Medical Equipment benefit and is subject to all applicable plan provisions.

Purchase or rental of durable medical equipment that is over \$2,500 must be reviewed by HMA's Care Management Department. Failure by your provider to pre-authorize services may result in the denial of the claim.

EMERGENCY ROOM & SERVICES

Benefits will be provided for emergency room treatment of an accidental injury or a medical emergency. Charges for emergency room facility fees and services provided by the attending emergency room physician are paid at the level shown in the Schedule of Benefits under the Emergency Room & Services benefit. All other eligible services provided in an emergency room (including, but not limited to, outpatient physician visits, diagnostic testing, laboratory, and x-ray) will be covered at the level shown in the Schedule of Benefits for the specific service received. For example if you receive an x-ray during an emergency room visit, the Diagnostic X-ray, Imaging, and Laboratory benefit will apply to x-ray, not the Emergency Room benefit.

If services are received from an Out-of-Network provider, the plan will use a reasonable method of calculating reimbursement so payment is in line with reimbursement of services if received from an In-Network provider. Please see the definition of Maximum Allowable Charge in the General Definitions section.

ELEMENTAL ENTERAL FORMULA

Formula must be medically necessary for the treatment of severe intestinal malabsorption. The formula comprises the sole source or essential source of nutrition.

GENDER AFFIRMATION SERVICES

Medically necessary medical and surgical services for gender affirmation, including related mental health services and prescription drugs, are covered by the Plan. Services must be pre-authorized by HMA's Care Management Department. Surgeries or other treatments that are cosmetic in nature or are deemed experimental or investigative based upon current medical policy are not covered by the Plan. Such services and coverage determination shall be made using approved industry standard medical criteria and Evidence Based Compendia used by this Plan, which may be informed in part, but is not limited to guidelines and recommendations put forth by World Professional Association for Transgender Health (WPATH).

The Plan does not cover any related services which are not medically necessary nor does it cover travel expenses, unless the Plan includes a separate Medical Travel/Transportation benefit.

GENE AND ADOPTIVE CELLULAR THERAPY

This Plan covers services for medically necessary inpatient and outpatient adoptive cellular therapy and gene therapy and associated services. Covered services will be determined based upon industry standard medical criteria and Evidence Based Compendia used by this Plan and the services are provided by a Center of Excellence or a designated provider approved by the Plan. Services must be pre-authorized in advance by HMA's Care Management Department. Failure by your provider to pre-authorize services may result in the denial of the claim. Services received from a non-designated provider will not be covered.

GENETIC TESTING

This Plan covers charges for medically necessary genetic testing and genetic counseling when received by a provider acting within the scope of their license.

Charges are covered for the examination of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or to provide information to guide the selection of treatment of certain diseases, including cancer.

Covered services includes genetic counseling when provided in conjunction with medically necessary genetic testing and when performed by a provider with specialized education in genetics (including genetic counselors, physician geneticists, and physicians with advanced training in genetics).

Genetic counseling includes counseling about the benefits and risk of potential genetic testing and interpretation of genetic testing results to guide further health care decisions.

Charges for genetic testing must be pre-authorized in advance by HMA's Care Management Department. Failure by your provider to pre-authorize services may result in the denial of the claim.

HEARING BENEFIT

The Plan will pay as outlined in the Schedule of Benefits for a hearing aid device.

In order to receive services through this hearing benefit, examination by a licensed physician/provider, as defined under the definition of physician/provider, must be obtained before a hearing aid is received.

Services will be provided for:

- Otologic (ear) examination by a physician/provider.
- Audiologic (hearing) examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation.
- The hearing aid (monaural or binaural) prescribed as a result of the examinations.
- Ear mold(s).
- The hearing aid instrument.
- The initial batteries, cords, and other necessary ancillary equipment.
- A follow-up consultation within 30 days following delivery of the hearing aid with either the prescribing physician/provider or audiologist.
- Repairs, servicing, and alteration of hearing aid equipment.

HOME HEALTH CARE

Services for Home Health Care must be ordered by a physician/provider, include a treatment plan, and must be pre-authorized by the Care Management Department prior to services being rendered. Failure by your provider to pre-authorize services may result in the denial of the claim.

Charges made by a home health care agency (approved by Medicare or state certified) for the following services and supplies furnished to you in your home for care in accordance with a home health care treatment plan are included as covered medical expenses. Charges for home health care services described below will be applied to the home health care benefit and subject to the home health care maximum as shown in the Schedule of Benefits. Outpatient rehabilitation provided in a home setting are covered under the Rehabilitation Services benefit when medically appropriate for the patient. This benefit is not intended to provide custodial care but is provided for care in lieu of inpatient hospital, medical facility or skilled nursing facility care for you if you are homebound.

The following services will be considered eligible expenses:

- Part-time or intermittent nursing care by a registered nurse, a licensed vocational nurse, or by a licensed practical nurse.
- Physical therapy by a licensed, registered, or certified physical therapist.
- Speech therapy services by a licensed, registered, or certified speech therapist.
- Occupational therapy services by a registered, certified, or licensed occupational therapist.
- Nutritional guidance by a registered dietitian.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.
- Respiratory therapy services by a certified inhalation therapist.
- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records.
- Medical supplies, drugs and medicines prescribed by a physician/provider, and laboratory services normally used by you in a skilled nursing facility, medical facility or hospital, but only to the extent that they would have been covered under this Plan if you had remained in the hospital or medical facility.
- Assessment by a Masters of Social Work (M.S.W.).

Exclusions to Home Health Care

- Non-medical or custodial services except as specifically included as an eligible expense.
- Meals on Wheels or similar home delivered food services.
- Services performed by a member of your family or household.
- Services not included in the approved treatment plan.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.

HOSPICE CARE

Services for Hospice Care must be ordered by a physician/provider, include a treatment plan, and must be pre-authorized by HMA's Care Management Department prior to services being rendered. Failure by your provider to pre-authorize services may result in the denial of the claim.

If you are terminally ill, the services of an approved hospice will be covered for medically necessary treatment or palliative care (medical relief of pain and other symptoms), subject to the conditions and limitations specified below. Services and supplies furnished by a licensed hospice (Medicare approved or state certified) for necessary treatment will be eligible for payment as shown in the Schedule of Benefits. The following services will be considered eligible expenses:

- Confinement in a hospice facility or at home.
- Ancillary charges furnished by the hospice while you are confined.
- Medical supplies and drugs prescribed by your attending physician/provider, but only to the extent such items are necessary for pain control and management of the terminal condition.
- Physician/provider services and/or nursing care by a registered nurse, licensed practical nurse, master in social work, or a licensed vocational nurse.
- Home health aide services and home health care.
- Nutritional advice by a registered dietitian, nutritional supplements, such as diet substitutes, administered intravenously or through hyperalimentation.
- Physical therapy, speech therapy, occupational therapy, respiratory therapy.
- Inpatient and outpatient respite care up to a maximum of 5 days in each three-month period of hospice care, to relieve anyone who lives with and cares for you if you are terminally ill. The first three-month respite care period begins on your first day of covered hospice care.

With respect to hospice care, a treatment plan must include:

- A description of the medically necessary care to be provided to you if terminally ill for palliative care or medically necessary treatment of an illness or injury but not for curative care.
- A provision that care will be reviewed and approved by your physician/provider at least every 60 days.
- A prognosis of six months or less to live.

Exclusions to Hospice Care

- Non-medical or custodial services except as specifically included as an eligible expense.
- Meals on Wheels or similar home delivered food services.
- Services performed by a member of your family or household.
- Services not included in your approved treatment plan.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.
- Hospice bereavement services.

IMMUNIZATIONS

Immunizations for routine use in children, adolescents, and adults if ordered by your physician/provider and are medically necessary, based upon shared clinical decision making, are recommended by the Federal Drug Administration (FDA) or Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and listed on the Immunization Schedules of the CDC for children and adults, or are recommended by other science based organizations, are covered as shown in the Schedule of Benefits. Covered services do not include immunizations for the purpose of travel, occupation or residence in a foreign country.

INFERTILITY TESTING

The Plan covers charges incurred for outpatient evaluation and testing of infertility. Charges for procedures to restore fertility or to induce pregnancy are not covered under this Plan.

INFUSION THERAPY BENEFIT

Inpatient and outpatient services and supplies for infusion therapy are provided at the level shown in the Schedule of Benefits. Your attending physician/provider must submit, and periodically review, a written treatment plan that specifically describes the infusion therapy services and supplies to be provided. The treatment plan must be approved in advance by HMA's Care Management Department. Failure by your provider to pre-authorize services may result in the denial of the claim. Drugs and supplies used in conjunction with infusion therapy will be provided only under this benefit.

To ensure clinically appropriate delivery of treatment, lower overall cost of care and increase patient satisfaction and quality of life, the Plan has partnered with HMA's Care Management Department to offer an infusion/specialty drug program. This Plan requires utilization of an optimal site of care for infusion administration. Optimal sites of care include a physician's office, a pharmacy, an outpatient infusion center, or a home-based setting. The Care Management Department will work with you and your treating provider to ensure that the infusion services and any high cost specialty oral drugs are delivered through the most cost effective and medically appropriate channels. Site of care review criteria will be waived for payment of the first dose of a medication, to allow for adequate transition time to an approved site of care for subsequent infusions. The Plan reserves the right to require use of a specialty drug vendor who has contracted with the Plan or with HMA to manage this benefit. If an approved site of care is available under the infusion site of care program, the coverage of administering an infusion in an unapproved site of care may be denied.

KIDNEY DIALYSIS (OUTPATIENT SERVICES)

Charges for professional treatment, supplies, medications, labs, and facility fees related to outpatient kidney dialysis are covered services under the Plan. When kidney dialysis is recommended, your provider must first contact HMA's Care Management Department to pre-authorize the treatment. Failure by your provider to pre-authorize services may result in the denial of the claim. Eligible services will be covered as shown in the Schedule of Benefits and will be paid in accordance with the applicable provider network agreements, or in accordance with other Out-of-Network payment methodologies.

Eligible services include, but are not limited to, hemodialysis, peritoneal dialysis, and hemofiltration. You may elect to enroll in Medicare coverage as a secondary insurance and the Plan will coordinate benefits as primary payer during the applicable Medicare coordination period.

The assigned Care Manager will work with you to understand how the benefit works.

Notwithstanding the above, upon the conclusion of the coordination period as required under Federal Medicare regulations, this Plan will take a secondary position to Medicare as permitted pursuant to Medicare Secondary Payer regulations.

MASSAGE THERAPY

Massage therapy is covered when performed by a provider acting within the scope of their license. Services are paid as shown in the Schedule of Benefits.

MATERNITY SERVICES

Pregnancy and complications of pregnancy will be covered as any other medical condition. Medical facility, surgical and medical benefits are available on an inpatient or outpatient basis for the following maternity services:

- Normal delivery.
- Cesarean delivery.
- Routine prenatal and postnatal care.
- Treatment for complications of pregnancy.
- Voluntary termination of pregnancy.

Breastfeeding support and services will be covered under the Preventive Care benefits of the Plan.

MEDICAL FACILITY SERVICES

Inpatient Care

The following benefits will be provided for inpatient care in an accredited hospital or medical facility when you are under the care of a physician/provider:

- Room and board in a semi-private room.
- Intensive care, cardiac care, isolation or other special care unit.
- Private room accommodations, if medically necessary.
- Nursing care services.
- Prescribed drugs and medications administered in the hospital or the medical facility.
- Anesthesia and its administration.
- Oxygen and its administration.
- Dressings, supplies, casts, and splints.
- Diagnostic services, including but not limited to x-ray, laboratory, and radiological services.
- The use of durable medical equipment.

Outpatient Care

Benefits will be provided for minor surgery, including x-ray, laboratory, and radiological services, and for emergency room treatment of an accidental injury or a medical emergency.

Miscellaneous

All other charges made by a hospital or the medical facility during an inpatient confinement are eligible, exclusive of: personal items; services not necessary for the treatment of an illness or injury; or services specifically excluded by the plan.

MEDICAL SUPPLIES

When prescribed by your physician/provider, and medically necessary, the following medical supplies are covered; including but not limited to: braces; surgical and orthopedic appliances; colostomy bags and supplies required for use; catheters; syringes and needles necessary for diabetes or allergic conditions; dressings for surgical wounds, cancer, burns, or diabetic ulcers; oxygen; back brace; and cervical collars.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Benefits are available for inpatient or outpatient care for mental health and substance use disorder conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the diagnosis when rendered by a covered provider. Covered services also include neurobiological disorders as **defined in General Definitions**, and

treatment of eating disorders (such as anorexia nervosa, bulimia, or any similar condition) when medically necessary. Medical services associated with Medication Assisted Treatment (MAT) for substance use disorder is covered under this benefit. Applied Behavioral Analysis is covered as outlined in the Schedule of Benefits.

Benefits are available for residential treatment facility, partial hospitalization, and intensive outpatient services.

Mental Health and Substance Use Disorder Services benefits include those received by you on an inpatient or intermediate care basis in a hospital or an alternate facility, and those received on an outpatient basis in your provider's office, alternate facility or home setting.

When inpatient or intermediate treatment (including Residential Treatment, Partial Hospital Program or Intensive Outpatient Program) for Mental Health Services, including neurobiological disorders, are recommended, your provider must first contact HMA's Care Management Department to pre-authorize the treatment.

Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following are covered:

- Provided by or under the direction of a psychiatrist and/or a licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing a danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a covered condition under the Plan and is paid under the applicable benefit for the service being provided.

NEWBORN NURSERY CARE BENEFIT

Medical facility charges incurred by your well newborn during the initial period of confinement will be covered as charges of your baby. In addition, a circumcision performed in an outpatient setting within 31 days of the birth of your baby will be covered under this benefit.

- Medical facility nursery expenses for your healthy newborn, including circumcision.
- Routine pediatric care for your healthy newborn child while confined in a hospital or medical facility immediately following birth.
- Phenylketonuria (PKU) testing within the first seven days of life.

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

Charges for preventive care (routine immunizations and examinations) will be considered eligible expenses only to the extent specifically shown in the Schedule of Benefits.

OBESITY SURGERY (BARIATRIC SURGERY)

If you have clinically severe obesity, the Plan may cover corrective bariatric surgery. Medical necessity must be documented in order for benefits to be allowed for surgical correction of clinically severe obesity. Please contact HMA's Care Management Department for specific medical criteria required for approval of bariatric surgery. You can find the obesity medical policy at: <https://blue.regence.com/trgmedpol/surgery/sur58.pdf>. Please contact the Suquamish Health Benefits Office at 360-394-8424 for more information. The Plan does not cover lap band surgery.

The surgery must be pre-authorized by HMA's Care Management Department prior to services being rendered.

Coverage is available for:

- The Plan may approve one (1) medically necessary surgical procedure.
- The Plan may also cover medically necessary revision or replacement surgery of a previous bariatric surgical procedure or conversion to another medically necessary procedure.
- Complications arising from a previous bariatric (obesity) surgical procedure covered by this Plan including but not limited to hernia repair and iron infusions.

No coverage is available for:

- Complications arising directly from a bariatric (obesity) surgery that was previously denied under this Plan. Complications arising from a surgery obtained prior to your enrollment under this Plan will be covered.
- Travel expenses associated with non-surgical or surgical services are not covered.
- The Plan does not pay for cosmetic surgery, including body sculpting desired as a result of significant weight loss.
- Surgeries provided or complications resulting from a bariatric surgery performed outside of the United States are not covered.

OUTPATIENT SURGICAL FACILITY

An outpatient surgical facility refers to a lawfully operated facility that is established, equipped, and operated to perform surgical procedures. Services rendered by an outpatient surgical facility are covered when performed in connection with a covered surgery.

PALLIATIVE CARE

Palliative care is covered if you have a serious illness and your provider has assessed that you are in need of palliative services. Covered services include counseling, symptom management, and treatment within scope of palliation concurrently with disease-directed therapies.

Palliative Care focuses on providing you with relief from the symptoms, pain and stress of a serious illness, regardless of the diagnosis. The goal is to improve quality of life for both you and your family. It is appropriate at any age and at any stage of a serious illness and can be provided along with curative treatment. Typically, the palliative care interdisciplinary team is composed of a physician board-certified in hospice and palliative medicine, an advanced practice nurse, a social worker and a chaplain. This benefit is available in conjunction with or without hospice benefits.

PHENYLKETONURIA (PKU) DIETARY FORMULA

This Plan covers tube feeding or orally administered formula which is medically necessary for the treatment of phenylketonuria (PKU) and other inborn errors of metabolism, based on medical evaluation and under the supervision of a Physician. Services must be pre-authorized by HMA's Care Management Department. Failure by your provider to pre-authorize services may result in denial of your claim. This benefit does not cover foods related to dietary restrictions or gluten free diets.

PHYSICIAN SERVICES

Physician's fees for medical and surgical services are covered.

PRE-ADMISSION TESTING

Charges for laboratory and x-ray examinations to determine if you are suitable for surgery prior to admission are covered as shown in the Schedule of Benefits.

PRESCRIPTION DRUGS

Inpatient drugs are covered when administered to you for the treatment of a covered illness or accident, while confined. Inpatient prescription drugs will be paid as shown in the Schedule of Benefits and are subject to the deductible.

Outpatient prescription drugs are reimbursable through your prescription drug card plan.

PREVENTIVE CARE

This benefit covers routine physician/provider services and related diagnostic tests that are regularly performed without the presence of symptoms, including school or sports examinations, school admission examinations, and examinations required by the Department of Transportation.

PREVENTIVE COLONOSCOPY OR FECAL DNA TESTING WITH COLOGUARD®

Preventive routine screening colonoscopies are covered for all Plan Members. Services are payable as shown in the Schedule of Benefits. Additionally, fecal DNA testing with Cologuard®, may be considered medically necessary in lieu of colonoscopy. Any positive test must be followed up by colonoscopy.

PREVENTIVE MAMMOGRAPHY

Preventive routine screening mammograms, including 3D mammograms, are covered by the Plan. Services are payable as shown in the Schedule of Benefits. Mammograms, other than routine screening mammograms, are covered when medically necessary if prescribed by your physician/provider and payable at the Diagnostic, X-Ray and Laboratory Benefit as shown in the Schedule of Benefits.

PROSTHETIC APPLIANCES

Benefits are provided for artificial devices which are medically necessary to replace a missing or defective body part, including (but not limited to) artificial limbs, eyes, breasts, cochlear implant, BAHA and artificial shoulder, knee, or hip. Benefits will also be payable for an external and permanent internal breast prosthesis following a mastectomy. Benefits are available for a testicular prosthesis if related to a medically necessary orchiectomy. A prosthesis ordered before your effective date of coverage will not be covered. A prosthesis ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be covered. Repair or replacement of prostheses due to normal use or growth of your child will be covered. Benefits are not provided for cosmetic prostheses. Additional services may be authorized based upon medical necessity review by Care Management services.

Purchase of a prosthetic that is over \$2,500 must be reviewed by HMA's Care Management Department. Failure by your provider to pre-authorize services may result in the denial of the claim.

RADIATION THERAPY AND CHEMOTHERAPY

X-ray, radium, radioactive isotope therapy, and chemotherapy are covered expenses under this Plan. Services must be pre-authorized by the Care Management Department prior to services being rendered. Failure by your provider to pre-authorize services may result in the denial of the claim.

REHABILITATION BENEFIT

The Plan covers charges for you on an inpatient or outpatient basis in a rehabilitation center. Services for inpatient rehabilitation must be ordered by a physician, include a treatment plan and must be pre-authorized by HMA's Care Management Department. Failure by your provider to pre-authorize services may result in the denial of the claim. All services specified below will be provided if continued measurable progress is demonstrated at regular intervals

Rehabilitative services are provided when medically necessary to restore and improve bodily function previously normal, but lost due to illness or injury, including function lost as a result of congenital anomalies. Rehabilitation services for the treatment of autism are covered under this benefit.

Occupational, physical, respiratory, speech therapy, pulmonary rehabilitation, neurodevelopmental therapy, and cardiac rehabilitation in the office, medical facility, or hospital will be paid under the rehabilitation benefit as shown in the Schedule of Benefits. Services may be provided in the home setting when medically appropriate for the patient.

Cardiac Rehabilitation Therapy - Benefits for an approved hospital-based cardiac rehabilitation program will be provided, when necessary to restore a bodily function lost or impeded due to illness or injury and such services are recommended by provider.

Neurodevelopmental Therapy - Benefits will be provided for medically necessary neurodevelopmental therapy treatment to restore and improve bodily function. This benefit includes maintenance services where significant deterioration of your condition would result without the service. Neurodevelopmental therapy means therapy designed to treat structural or functional abnormalities of the central or peripheral nervous system. Its purpose is to restore, maintain, or develop age appropriate functions. Covered therapy includes, but is not limited to, occupational therapy, physical therapy, speech therapy, and feeding therapy (the goal of feeding therapy is to help patients develop normal, effective feeding patterns and behaviors). This neurodevelopmental therapy benefit is not intended to cover enteral feeding, please see the Home Health Care benefit for additional information.

Occupational Therapy - Charges of a registered, certified, or licensed occupational therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

Physical Therapy - Charges of a registered, certified, or licensed physical therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

Pulmonary Rehabilitation Therapy - Benefits for an approved hospital-based pulmonary rehabilitation program will be provided, when necessary to restore a bodily function lost or impeded due to illness or injury and such services are recommended by your provider.

Respiratory Therapy - Charges of a registered, certified, or licensed respiratory therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

Speech Therapy - Charges are covered when prescribed by your physician/provider and when necessary to restore a bodily function lost or impeded due to illness or injury. Excluded from speech therapy services are services related to changing an accent; hearing loss which is not medically documented, and any service that falls under the Neurodevelopmental Therapy benefit, such as dyslexia or specific learning disorders (SLDs). See the Neurodevelopmental Therapy benefit for additional information.

Inpatient Treatment

The eligible expenses for inpatient rehabilitation are payable as shown in the Schedule of Benefits for the following services and supplies furnished while you require 24-hour care and are under continuous care of your attending physician/provider:

- Room, board and other services and supplies furnished by the facility for necessary care (other than personal items and professional services).
- Use of special treatment rooms.
- X-ray and laboratory examinations.
- Cardiac, occupational, physical, pulmonary, respiratory, and speech therapy.
- Oxygen and other gas therapy.

No benefits will be provided for the following inpatient or outpatient services:

- Custodial care.
- Maintenance, non-medical self-help, recreational, educational, or vocational therapy.
- Psychiatric care (see the Mental Health and Substance Use Disorder Services benefit for coverage).
- Learning disabilities or developmental delay, except as may be provided under coverage for neurodevelopmental therapy.
- Chemical dependency/substance use rehabilitative treatment (see the Mental Health and Substance Use Disorder Services benefit for coverage).
- Gym therapy.
- Aquatic or swim therapy.

SECOND SURGICAL OPINION

A second surgical opinion is not normally required but may be requested by you or by HMA's Care Management Department. This benefit is paid as shown in the Schedule of Benefits.

Please note that all non-emergency surgery other than surgery done in your doctor's own office must be pre-authorized by HMA's Care Management Department. When requested, the Plan will pay the maximum allowable fee for a second surgical opinion, and for a third and final opinion in case of conflict between the first two opinions.

Second or Third Opinion: Must be an opinion of an independent second or third surgeon acting on a consulting basis. A surgeon in association or practice with a prior surgical consultant will not be accepted.

SELF-ADMINISTERED MEDICATION BENEFIT

Coverage for self-administered medications is exclusively provided through the pharmacy benefits of the Plan. Please see the Prescription Drug Card Program provisions of this SPD for information regarding the Pharmacy Benefit Manager (PBM). Pre-authorization from the PBM may be required. (See the Infusion Therapy Benefit for infusion services provided under the medical benefits of the Plan.)

Please contact your PBM to determine if your medication can be self-administered and how it will be covered.

If you are unable or unwilling to self-administer an injectable medication, or the prescription drug plan does not carry the medication on its formulary, your attending physician must submit a written pre-authorization request to administer the injectable medication under the medical benefits of the Plan. Drugs must meet the Plan's Off Label Drug Use and Medical Necessity language criteria to be considered for pre-authorization. The request must be pre-authorized in advance by HMA's Care Management Department. Failure by your provider to pre-authorize the administration or purchase of the injectable medication may result in the denial of your claim. Self-administered benefit criteria may be waived for reimbursement purposes for the initial dose of the medication when multiple administrations are required and allow coverage under the major medical benefit if all terms and conditions are met, to allow for adequate transitioning of the prescription to your pharmacy benefit manager.

SKILLED NURSING FACILITY CARE

Services for Skilled Nursing Facility Care must be ordered by your physician/provider, include a treatment plan, and must be pre-authorized by the Care Management Department prior to services being rendered. Failure by your provider to pre-authorize services may result in the denial of the claim.

This Plan will pay benefits for confinement in a Skilled Nursing Facility, as specified in the Schedule of Benefits, provided such confinement is not for Custodial Care.

Charges for medically necessary services and supplies furnished by a licensed Skilled Nursing Facility will be applied to the Skilled Nursing Facility benefit and subject to the Skilled Nursing Facility maximum as shown in the Schedule of Benefits.

STERILIZATION - ELECTIVE

The Plan pays for elective sterilization procedures such as tubal ligations and vasectomies. These procedures shall be paid under the Major Medical benefits.

Eligible expenses under this Plan shall not include reversal or attempted reversal of these procedures.

SURGERY AND RELATED SERVICES

Benefits are provided for the following inpatient or outpatient services:

- Surgeon's charges.
- Assistant surgeon's charges.
- Anesthesia.

If two or more surgical procedures are performed through the same incision during an operation, full benefits are only provided for the primary procedure and one half for the lesser procedure.

TELEMEDICINE

This telemedicine benefit covers medically necessary healthcare services between you and your physician to consult, treat, and prescribe for medical conditions. This benefit includes audio and video communication services, such as video conferencing and scheduled telephone visits. Telemedicine visits must be initiated at the request of you or your authorized provider and replace the need for an in-person office visit. Scheduling and record-keeping standards that apply to in-person visits also apply to telemedicine visits.

TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

This Plan covers medically necessary surgical and non-surgical treatment of Temporomandibular Joint Disorders (TMJ) when provided by your physician/provider, approved medical facilities, licensed physical therapist or licensed oral surgeon. Oral surgeons will be covered only for the surgical treatment of TMJ disorders under this benefit.

TOBACCO CESSATION

The services of a provider listed under the definition of physician/provider, operating within the scope of their license, will be covered. Acupuncture for tobacco cessation will be covered under this benefit. Benefits are payable as shown in the Schedule of Benefits.

For medications to aid with nicotine withdrawal, please contact your Pharmacy Benefit Manager for further information.

TRANSPLANTS

Benefits are payable for charges for organ or tissue transplant services which are incurred while you are covered by this Plan. Such covered charges must be due to an accidental injury or sickness covered by this Plan.

You must contact HMA's Care Management Department prior to any testing that may occur to determine whether you are a transplant candidate. A written treatment plan must be submitted in order to obtain pre-authorization.

Also remember that pre-authorization is required before any medical facility admission. See Pre-Authorization of Inpatient Medical Facility Admissions And Outpatient Surgeries in the Important Information Section.

Organ or tissue transplant services include the following medically necessary services and supplies:

- Organ or tissue procurement. These consist of removing, preserving, and transporting the donated part.
- Compatibility testing undertaken prior to procurement is covered if medically necessary. This includes costs related to the search for, typing and testing, and identification of a bone marrow or stem cell donor for allogeneic transplant.
- Medical facility or Hospital room and board and medical supplies.
- Diagnosis, treatment, and surgery by a doctor.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) (please refer to the Private Duty Nursing benefit for coverage).
- The rental of wheelchairs, hospital-type beds, and mechanical equipment required to treat respiratory impairment.
- Local ambulance services, medications, x-rays and other diagnostic services, laboratory tests, and oxygen.
- Rehabilitative therapy consisting of: speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy. Any of these must be in direct respect to rehabilitation from the covered transplant procedure.
- Surgical dressing and supplies.
- Transportation, lodging, and meals.
- Other services approved by HMA's Care Management Department.

Benefits for a donor are payable only in the absence of other coverage and shall not exceed the benefit limitation as shown in the Schedule of Benefits. Donor expenses are payable only when the organ recipient is covered under this Plan and are considered expenses of the recipient.

No benefits will be provided for the following:

- Any procedure that has not been proven effective, is experimental or investigative, or is not standard of care for the community. **(See definition of Experimental and Investigative.)**
- When donor benefits are available through other group coverage.
- When government funding of any kind is available.
- When the recipient is not covered under this Plan.

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits	Preferred Pharmacies	Non-Preferred Pharmacies	
RETAIL OPTION - Up to 31-day Supply			
Generic - Tier 1	No Copay	Coverage is for Emergencies only. The Covered Member would be required to pay the retail price upfront and submit the receipt to Prescriptive for reimbursement to be considered.	
Brand Name Drugs - Tier 2	No Copay		
Non-preferred Generic and Brand - Tier 3	No Copay		
RETAIL OPTION — Up to 90-day Supply			
Generic - Tier 1	No Copay		
Brand Name Drugs - Tier 2	No Copay		
Non-preferred Generic and Brand - Tier 3	Not Available in 90-day supply		
MAIL ORDER OPTION - Up to 90-day Supply. This is a voluntary option.			
Walmart Mail Order Services Mail Order Customer Service	800-273-3455	Not Covered	
Generic - Tier 1	No Copay		
Brand Name Drugs - Tier 2	No Copay		
Non-preferred Generic and Brand - Tier 3	No Copay		
SPECIALTY PHARMACY - Up to 30-day Supply.			
Amber Specialty Pharmacy Services	206-413-9371	Not Covered	
Generic - Tier 1	No Copay		
Brand Name Drugs - Tier 2	No Copay		
Non-preferred Generic and Brand - Tier 3	No Copay		

PREAUTHORIZATION FOR PRESCRIPTION MEDICATION

Preauthorization forms may be required to determine if a prescription medication is Medically Necessary before it is dispensed. In those instances, pharmacies receive a rejection message. When the pharmacy receives a rejection message, they will fax the provider and request a preauthorization. It is the provider's responsibility to fax back the preauthorization. This may also be sent to the pharmacy electronically.

Preauthorization is not required when primary insurance has obtained Preauthorization.

Important: If you have questions about your medication coverage, please contact Prescriptive at 206-686-9016 and of course the Health Benefits Staff is also available to assist you.

WHAT IS A SPECIALTY MEDICATION?

A specialty medication is an injectable, an oral, or an inhaled medication if it:

- May require on-going clinical oversight and additional education for best management
- Has unique storage or shipping requirements
- May not be available at retail pharmacies

You can fill your specialty medications at any specialty Pharmacy that is contracted with Amber Specialty Pharmacy. Contact Amber Specialty Pharmacy if you have questions on locating a specialty Pharmacy.

WHAT IS MAIL ORDER

Maintenance medications are typically those Drugs you take on a regular basis for a chronic or long term condition. By using Walmart Mail Service Pharmacy, you can order your maintenance medications from the comfort of your home, saving you time and energy. You can fill and refill your maintenance medications with a single phone call, without visiting your Pharmacy or waiting in line. Mail Order is not required.

WHAT IS STEP-THERAPY?

Most medical conditions have multiple medication options. Although their clinical effectiveness may be similar, prices can vary widely. With the Step Therapy program, you get the treatment you need, usually at a lower cost to the Plan. With this program, you need to try a Step 1 medication first, before a Step 2 medication may be covered. When you bring a prescription to the Pharmacy, Prescriptive's system will automatically screen the medication for step therapy requirements. If your prior Pharmacy claim shows you have tried a Step 1 medication in the recent past, the Step 2 medication may be processed. If not, the pharmacist will contact your doctor for further explanation.

There are some Drugs that require three steps before a specific medication is covered. You must try Step 1 and Step 2 medications before receiving benefit coverage for a Step 3 medication.

We encourage you to discuss your treatment and medication options with your doctor.

If you have questions about the Step Therapy program, contact Prescriptive at 206-686-9016. This contact number is also listed on your ID card.

PRESCRIPTION BENEFITS

Benefits are provided for the purchase of Drugs through the Plan's Prescription Drug Program administered by Prescriptive. The Covered Member must purchase the Prescription Drugs through the Prescription Drug Program, and use either a preferred Pharmacy or the "mail order option."

Prescription Drugs that are not purchased directly through the Plan's Prescription Drug Program or those which are not reimbursable under the Plan's Prescription Drug Program will not be Covered Expenses and are not eligible for reimbursement.

The Plan's Prescription Drug Program is administered by Prescriptive. Prescriptive has a Network of pharmacies which can identify Covered Members and the Plan's coverage provisions. To find out which pharmacies participate, contact Prescriptive at 206-686-9016. These contact numbers can also be found on your ID Card.

Detailed procedures for obtaining Prescription Drugs under this Plan are explained in this section. Certain Drugs are not covered, even when prescribed by your Physician.

PREFERRED PHARMACY COPAYMENTS

Our program has no Copayments. If a Drug is covered under the Plan, it will be covered at 100%.

If your Physician prescribes a Brand Name Drug and requires that the prescription be "Dispensed as Written" (DAW) then the Drug will be covered at 100%.

If your Physician does not specifically indicate "no substitutions" on a Brand Name Drug, and there is a generic equivalent Drug that may be substituted for the Brand Name Drug, the pharmacist will dispense the generic equivalent. If you request that the Brand Name Drug be dispensed instead of the generic equivalent then you will be responsible for paying the full cost of the Drug.

PRESCRIPTIONS OBTAINED AT NON-PREFERRED PHARMACIES

Prescription Drugs purchased at retail pharmacies outside of the Network will not be covered except for emergencies. Prescription Drugs purchased through mail order at pharmacies outside the Network will not be covered.

RETAIL PHARMACY PROGRAM

Prescription Drugs may be obtained from any Pharmacy participating in Prescriptive National Network. You can find a list of Preferred Pharmacies on Prescriptive website at <https://www.prescriptive.com/member>.

PRESCRIPTIVE SERVICES RETAIL 90 PROGRAM

Up to a 90-day supply of Generic and Preferred Brand Drugs may be obtained from any Pharmacy participating in Prescriptive National Network. Non-Preferred Brand Drugs are not eligible for this program and will be limited to a 31-day supply.

To find a Preferred Pharmacy, contact Prescriptive at 206-686-9016.

MAIL ORDER PHARMACY PROGRAM

This is an optional benefit. You determine whether you want to participate.

This option is available for "Maintenance Drugs". Maintenance Drugs are those prescriptions required on an ongoing basis for control of chronic medical conditions such as high blood pressure, stomach ulcers, diabetes, asthma or allergies, and arthritis. Oral contraceptives and other medications taken on a "regular" basis may also be obtained through this program; up to a 90-day supply.

To obtain maintenance prescriptions through the mail under this program the Covered Member must contact Walmart Mail Order Pharmacy. Contact Walmart Mail Order Pharmacy at 800-273-3455.

Ordering Refills. Refills may be obtained by calling Walmart Mail Order at 800-273-3455.

Dispensing Limitations. Each prescription filled will be limited to a 90-day supply.

PREAUTHORIZATION FOR PRESCRIPTION MEDICATION

Preauthorization forms may be required to determine if a prescription medication is Medically Necessary before it is dispensed. When the pharmacy receives a rejection message, they will fax the provider and request a pre-authorization. It is the provider's responsibility to fax back the prior authorization. This may also be sent to the pharmacy electronically.

Prescriptive will pay secondary to primary insurance coverage. Preauthorization will not be required under this Plan if the primary insurance plan obtained Preauthorization.

If you have questions about your medication coverage, you may contact Prescriptive at 206-686-9016 and of course you may contact the Health Benefits Office at 360-394-8424.

OTHER EXPENSES COVERED BY THE PRESCRIPTION DRUG PLAN

Under the Prescription Drug Program, Covered Expenses include:

- Blood Glucose Test Strips
- Lancets
- Spring-powered device for lancets
- Syringes
- Alcohol Pads
- Over the Counter Emergency Contraception

COVERED PRESCRIPTION DRUG EXPENSES

This Plan will provide coverage for the following Drugs:

- Any Drug or medicine, including injectable medications, that relates directly to the treatment of an Illness or Injury that cannot legally be dispensed without a prescription, and that by law must bear the legend "Caution — Federal law prohibits dispensing without a prescription"
- Insulin and insulin syringes
- Diabetic Supplies including blood testing supplies
- Oral Contraceptive Drugs taken for Medically Necessary reasons and for birth control
- Vaccinations to treat influenza, pneumonia, whooping cough, and shingles will be covered when purchased and administered at a retail Pharmacy

DENTAL BENEFITS

Dental Services	Ameritas Preferred Providers
Preventive and Diagnostic: Routine cleanings and x-rays are limited to 4 per year, or Periodontal cleaning limited to 4 (overall 4 cleaning maximum routine and Periodontal combined). Fluoride limited to 2 per year for adults and children.	
Basic Dental: Simple extractions and fillings.	100% coverage In-Network only.
Major Dental: Crowns, Bridges, and Dentures.	Must receive services through the Ameritas PPO Network.
Accident Injury	
TMJ: See Medical Benefits	Find Preferred Providers at https://dentalNetwork.ameritas.com/ or by calling 800-487-5553.
Orthodontia: for Covered Members under age 19. Covered members age 19 and older 100% coverage, up to \$5,500 maximum per person per lifetime.	
Dental Services	Processed through HMA
Dental Implants: for replacement of individual tooth (teeth)	Must utilize the contracted service Provider (Kitsap Gentle Dentistry) for this benefit. Contact Kitsap Gentle Dentistry at 360-698-1990. The Plan requires Kitsap Gentle Dentistry to obtain a prior authorization for services. Benefits will begin when the authorization has been issued by the Health Benefits Office.
Mini Implants: for stabilizing Dentures	This benefit will have a maximum of 6 upper implants and 4 lower implants for both mini and regular implants. Dental Implant Services not obtained at Kitsap Gentle Dentistry must be Appealed through Tribal Council. Tribal Council Appeals have a \$3500 maximum reimbursement amount if approved.

DENTAL BENEFITS

Ameritas Preferred Providers – All Except Dental Implants

In order to receive coverage for eligible dental expenses, your care must be provided by a Preferred Dentist in the Ameritas PPO Network. To find a Preferred Dentist:

Phone: 800-458-5553

Website: <https://dentalNetwork.ameritas.com>

For Members with coverage through a primary plan:

- Members must follow the requirements of their primary plan
- Providers do not have to be a Preferred Dentist under this Plan as long as the Provider is a Preferred Dentist under the primary plan

DENTAL SERVICES

Includes Medically Necessary treatment of the mouth, gums, teeth, mouth tissues, maxillae or mandible bones or attached muscle, Orthodontic appliances, Dentures, and any service generally recognized as dental work. Coverage is subject to the Limitations and Exclusions, services, supplies, or treatment listed below. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

DIAGNOSTIC AND PREVENTIVE DENTAL SERVICES

- Routine oral examination: Initial or periodic, limited to twice per benefit year
- Prophylaxis: Scaling and cleaning of teeth, limited to four per benefit year
- Dental X-rays as follows:
 - Bite-wing X-rays, limited to once per benefit year
 - Panorex or full mouth series limited to one or the other every 5 years
 - Other dental X-rays necessary for the diagnosis of a specific condition requiring treatment
- Topical application of Fluoride (no age limit), limited to 2 treatments per benefit year
- Space maintainers, designed to preserve the space between teeth caused by premature loss of primary tooth (also called a baby tooth) including all adjustments within 6 months of installation, limited to children through the age of 12. This does not include space maintainers used in Orthodontics to create a space between teeth. Replacement of a space maintainer previously covered under this Plan is an Exclusion
- Topical application of sealant to permanent bicuspid and molar teeth, for children through the age of 17, limited to 1 treatment per tooth within a 4 year period
- Emergency Palliative Treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except X-rays) is rendered during the visit

BASIC DENTAL SERVICES

- Restorations, using Amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or Injury
- Periodontics as follows:
 - Gingivectomy, gingivoplasty, or gingival flap procedure
 - Scaling and Root Planing is limited to once per quadrant per 2 year period
 - Pedicle and free soft tissue grafts, and vestibuloplasty
 - Limited Occlusal Adjustment, but only when in conjunction with a covered Periodontal Surgery
 - Periodontal Prophylaxis is limited to 4 per benefit year
 - Osseous Surgery; limited to once per quadrant every 5 years

- Full mouth Debridement; limited to once every 5 years
- Endodontics as follows:
 - Pulpotomy
 - Root canal therapy
 - Apicoectomy
 - Hemisection
 - Retrograde fillings
- Oral Surgery, including customary postoperative treatment furnished in connection with Oral Surgery, as follows:
 - Simple extraction of one or more teeth
 - Surgical extraction of erupted teeth and soft tissue, partially bony, and completely bony impacted teeth
 - Extraction of tooth root
 - Incision and drainage of an abscess
 - Alveoloplasty, and frenectomy
 - Hyperplastic tissue
 - Removal of cysts or tumors
 - Re-implantation or transplantation of a natural tooth
 - General Anesthesia, only when provided in conjunction with a Surgical Procedure
- Repair or re-cementing of Crowns, Inlays, Onlays, or Bridgework
- Repairs and adjustments to full or partial Dentures
- Treatment of pathological conditions and traumatic facial injuries

MAJOR DENTAL EXPENSES

- Occlusal Guards (Night Guards)
- Post and core. Core buildup
- Stainless steel Crowns limited to once per tooth per 1 year period
- Gold foil and Inlay restorations
- Crowns, Onlays and Veneers

ORTHODONTIC SERVICES

- Up to age 18, 100% covered
- Age 19, and in high school, 100% covered
- Age 19+, and not in high school, covered up to \$5,500 maximum, per lifetime

Subject to the Limitations specified on the Schedule of Benefits, Covered Expenses shall include Active appliances, Diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

VISION BENEFITS

Vision benefits will be paid for the charges for covered vision expenses for Covered Members. The benefits will apply when charges are incurred for vision care by a legally Licensed Physician or professional Provider.

COVERED VISION BENEFITS

- One Routine Exam will be covered in a 12 month period from the first date of service.
- Vision exams can be provided by any Licensed Provider.
- Lenses, contacts, and frames can be obtained from any Licensed vision Provider.
- Limited to \$645 every 24 months for all hardware combined. The maximum hardware allowance under this plan can be used in any combination of lenses, contacts (and contact lens fittings), and/or frames every 24 months (rolling 24 month period) from the first date of service.
- Anti-glare coatings are covered, subject to the 24 month maximums noted above.
- Scratch resistant coatings are covered, subject to the 24 month maximums noted above.
- Progressive lenses are covered, subject to the 24 month maximums noted above.
- Transitions lenses are covered, subject to the 24 month maximums noted above.

SUPPLEMENTAL PLAN SCHEDULE OF BENEFITS

The Suquamish Tribe Indian Health Plan offers a Supplemental Plan to eligible Suquamish Tribal Members with Washington State Medicaid.

Dental Benefits	
Dental providers must be in network with Ameritas PPO Network. Services rendered by non-network providers will not be covered.	
Preventive, Basic, and Major	These services are administered by Ameritas. Contact Ameritas at 800-487-5553 for benefit information.
Dental Implants	Prior Authorization from Suquamish Health Benefits is required 360-394-8424 (this applies even if other coverage is primary). Implants must be received from Kitsap Gentle Dentistry. If another provider is used (and approved by Suquamish Health Benefits), there is a limit of \$3,500 per tooth.
Dental Prescriptions	Dental Prescriptions are covered by Prescriptive. Washington State Medicaid coverage does not cover prescriptions written by Ameritas Dental Providers.
Orthodontia Benefit	Up to age 18 (age 19 if in high school), 100% covered. Age 19 and over (if not in high school), 100% covered up to a \$5,500 maximum.
Vision Benefits	
Annual exams are covered by Washington State Medicaid and must be provided by Washington State Medicaid providers.	
Vision Exam	You are required to use your Washington State Medicaid coverage for your annual vision exam, be sure that the provider accepts your primary insurance Coverage.
Vision Hardware & Contacts	<p>Lenses, contacts, and frames can be obtained from any licensed vision provider.</p> <ul style="list-style-type: none"> • Limited to \$645 every 24 months for all hardware combined. The maximum hardware allowance under this plan can be used in any combination of lenses, contacts (and contact lens fittings), and/or frames every 24 months (rolling 24 month period) from the first date of service. • Anti-glare coatings are covered, subject to the 24 month maximums noted above. • Scratch resistant coatings are covered, subject to the 24 month maximums noted above. • Progressive lenses are covered, subject to the 24 month maximums noted above. • Transitions lenses are covered, subject to the 24 month maximums noted above.
Medical Benefits	
Acupuncture	Services received from a Preferred or Participating Network provider are covered at 100% Limited to 12 visits per calendar year.
Massage	Services received from a Preferred or Participating Network provider are covered at 100% Limited to 12 visits per calendar year.
Chiropractic	Chiropractic Services include initial office visit, x-rays, and spinal adjustments. Services received from a Preferred or Participating Network provider are covered at 100% Limited to 12 visits per calendar year.
Naturopathic Physicians	Plan Exclusion. Services must be provided by Suquamish Healing House Health Clinic.

PLAN EXCLUSIONS AND LIMITATIONS

This section of your booklet explains circumstances in which all the medical benefits of this Plan are limited or in which no benefits are provided. Benefits may also be affected by the Care Management provisions of the Plan. Your eligibility and expenses are subject to all Plan conditions, exclusions, and limitations, including medical necessity. In addition, some limitations may apply to benefits.

In addition to the specific limitations stated elsewhere in this booklet, the Plan will not provide benefits for:

Absence of Coverage - That would not have been made in the absence of coverage. This includes charges that are submitted to the Plan equal to any amount for which the Provider has discounted fees or has "written off" amounts due.

Adoption Expenses - Adoption expenses or any expenses related to surrogate parenting, except as provided herein under the maternity and preventive benefits for a covered member acting as a surrogate. Covered services are subject to the Plan's subrogation rights.

After the Termination Date - Charges arising from care, supplies, treatment, and/or services that are Incurred Charges by the Member on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alternate Resources Coverage - Coverage that is available at no cost to the Member and provided by any group Hospital or medical program, plan, policy, contract or agreement, or governmental programs including, but not limited to, Medicare, Medicaid, Tricare, or Indian Health Services. This may also include Hospital Financial Assistance Programs.

This Tribal Self-Insurance Plan shall not in any circumstances be considered Alternate Resources for purposes of the Indian Health Service payor of last resort rule. In accordance with Section 206(f) of the Indian Health Care Improvement Act, 25 U.S.C. § 1621e(f), and 42 CFR § 136.61, the Indian Health Service has no right of recovery against this tribal self-insurance plan for health services the Indian Health Service has provided to an eligible patient; no payment will be made by this plan to the Indian Health Service. See "General Definitions" for definition of "Alternate Resources." Subject to its right to coordinate benefits, this Plan excludes all coverage for which the Plan is the payor of last resort.

Ambulance Service - "Scheduled" or "non-emergent" Ambulance Services, unless authorized by the Plan.

Appointments (Missed, Cancelled, Telephonic and Electronic) - Missed or cancelled appointments or for telephone and electronic consultations, except as provided herein.

Biofeedback - Charges for biofeedback treatment.

Breast Implants - Charges for breast implants except as provided herein.

Broken Appointments - Charges arising from care, supplies, treatment, and/or services that are charged solely due to the Member's having failed to honor an appointment.

Civil Insurrection or Riot - Resulting from Injuries incurred or exacerbated while participating in a civil insurrection or riot.

Clinical Trials - Costs incurred due to the participation in a clinical trial, including but not limited to, the costs of the investigative item, device, or service; the costs of items and services provided solely to satisfy data collection and analysis, and the cost for a service that is inconsistent with commonly accepted and established standard of care for the diagnosis. However, routine medical expenses associated with an approved clinical trial (see Approved Clinical Trials at <https://clinicaltrials.gov>) will be covered under the Plan if medically necessary.

Completion or Preparation of Forms - Charges for completing or preparing claim forms, medical reports, or itemized billings.

Confinement or Admission for Primarily Rehabilitative Care - Admissions or treatment primarily for rehabilitative care including, but not limited to, speech and occupational therapy. Further, when the type of care rendered during a continuous period of Hospital confinement develops into primarily rehabilitative care, that portion of the stay beginning on the day of such development is not covered under this Health Plan.

Convalescent or Custodial Services - Convalescent or Custodial services regardless of where such services are provided, or any portion of a Hospital stay that is primarily convalescent or Custodial.

Cosmetic and Reconstructive Surgery - Cosmetic surgery or related medical facility admissions are excluded, unless made necessary due to one or more of the following:

1. When authorized for an illness or injury that is a covered benefit under this Plan, except as excluded herein.
2. Except as specifically excluded by this Plan, for correction of congenital anomalies when medically necessary.
3. If you are receiving benefits for a medically necessary mastectomy and elect breast reconstruction after the mastectomy, you will also receive coverage for:
 - Reconstruction of the breast on which the mastectomy has been performed
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance
 - Prostheses
 - Treatment of physical complications of all stages of mastectomy, including lymphedemas
 - Areola tattooing.

This reconstructive surgery coverage will be provided in consultation with your attending physician/provider and yourself, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Counseling or Training Services - Charges for counseling or training services. This includes vocational assistance and outreach; job training such as work hardening programs; religious counseling; treatment by a pastoral or financial counselor; fitness counseling; and other services or supplies that are primarily educational in nature other than as defined herein.

Custodial Care - Charges for custodial care, except as specifically provided herein. Custodial care is care whose primary purpose is to meet personal rather than medical needs and which is provided by individuals with no special medical skills or training. Such care includes, but is not limited to: helping you walk, getting in or out of bed, and taking normally self-administered medicine.

Dental Services - As noted below are not covered:

- Dental charges for any device ordered while the individual was covered under this Plan and not delivered or installed prior to termination of coverage
- Dental Injections or Medications
- Dental Labs and Cultures which are separate charges for cultures or post-operative care following root canal treatment
- Dental charges for instruction in dental Plaque control, oral hygiene instructions, dietary instruction or nutritional counseling, and home Fluoride kits
- Dental Pulp capping
- Dental Space Maintainer for those over the age of 12 or replacement of an existing Dental Space Maintainer
- Application of desensitizing medicaments
- Charges for local anesthesia, sterilization, and supplies if billed as separate charges
- Provisional or Periodontal splints
- Customized dental procedures, personalized restorations, or special techniques
- Dental care and materials that do not have ADA endorsement
- Dental Replacement of sound dental restorations

- Duplicate x-rays
- Caries Susceptibility Tests
- Cleaning of Prosthetic Appliances
- Temporary Crowns, except when used for short-term pain relief
- Temporary Dentures, except when used to replace anterior teeth lost as a result of an Accident and replacement with a permanent Denture is authorized
- Crowns, except when tooth cannot be restored by basic restoration.
- Crowns in conjunction with Overdentures
- Crowns and Onlays placed for the purpose of Periodontal splinting
- Replacement of a space maintainer previously covered under the Plan
- Dental Study Models
- Replacement of duplicate, lost, missing, or stolen appliances or prosthetic devices

Documentation - Charges for documentation, including photocopies when required.

Doulas - Services provided by a birth doula.

Durable Medical Equipment - Corrective Shoes - Arch supports, shoe orthotics, and corrective shoes except as specifically provided for under the Diabetes benefit.

Education or Training Services - Education or training services or supplies for disorders or delays in the development of a child's language, cognitive, motor, or social skills, including evaluations therefore, except as provided herein under the Neurodevelopmental Therapy, Mental Health and Substance Use Disorder Services, and Rehabilitation Services benefits.

Employment - Services performed expressly for employment purposes, whether the individual is self-employed or employed by an entity.

Environmental Services - Milieu therapy and any other treatment designed to provide a change in environment or a controlled environment.

Excess - Charges arising from care, supplies, treatment, and/or services that exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Excess Over Semi-private Rate - Charges which are in excess of the semi-private room rate, except as otherwise noted.

Excluded Providers and Facilities - Services which are rendered or provided by the following excluded Providers or facilities: hypnotists and marriage counselors.

Experimental or Investigational Medicine - Services which are still considered Experimental or Investigational (e.g., clinical trials), as defined by the Plan in the Defined Terms Section, regardless of whether or not such treatment, services, Drugs, or supplies are "Generally Accepted" by the medical or dental profession. In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered Experimental or Investigational, and hence, not covered by this Plan.

Facility Charges - Facility charges for care, services or supplies provided in:

- Rest homes.
- Assisted living facilities.
- Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care.
- Health resorts.

- Spas, sanitariums.
- Infirmaries at schools, colleges, or camps.
- Boarding schools, academies or other institutions providing academic and scholastic services.
- Wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Fertility and Infertility - Except as provided herein, charges in association with infertility, and procedures to restore fertility or to induce pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; embryo transfer; artificial insemination, gamma intra-fallopian transfer (G.I.F.T.); fertility drugs (including but not limited to Clomid, Pergonal or Serophene); or any other artificial means of conception. Expenses related to fertility preservation are not covered.

Food Supplements - Related to food supplements or augmentation, in any form, unless Medically Necessary to sustain life in a critically ill person.

Foot Care Services (Routine) - Routine foot care procedures such as trimming of nails, corns or calluses; fallen arches or other symptomatic complaints of the feet. Such foot care for Elders is provided at the Suquamish Tribal Center. For more information, contact the Community Health Nurse at 360-394-8468.

Government Facility - Charges by a facility owned or operated by the United States or any state or local government unless you are legally obligated to pay. This does not apply to covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to you for a non-service related illness or injury. The exclusion also does not apply to covered expenses rendered by a United States military medical facility to you if you are not on active military duty.

Growth Hormone Therapy - Unless authorized by the Plan.

Hospice Bereavement - Charges for hospice bereavement treatment.

Hospital Dental Care - Hospital care for the extraction of teeth or other dental processes, except when adequate care cannot be provided outside the Hospital and when there is an underlying medical condition that requires Hospitalization.

Hospitalization for Non-Medically Necessary Diagnostic Exams and Testing - Hospitalization solely for physiotherapy or Diagnostic studies; medical examinations or tests not Medically Necessary for the diagnosis or treatment of actual illness, disease, or Injury.

Hypnosis - Whether or not used in lieu of Anesthesia.

Hypnotherapy - Charges for hypnotherapy

Illegal Treatment - Charges for any illegal treatment under the laws of the state where the care is rendered and treatment listed by the American Medical Association (AMA) as having no medical value.

Immunizations - For the purpose of travel.

Impotence; Sexual Dysfunction - Impotence and sexual dysfunction treatment and medications, including, but not limited to, penile implants, sexual devices, or any medications or Drugs pertaining to sexual dysfunction, inadequacies, or impotence.

Incurred by Other Persons - Charges arising from care, supplies, treatment, and/or services that are expenses actually incurred charges by other persons.

Lap Band - Including complications from Lap Band placement.

Late Claims - For which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.

Licensed/Certified - Any services outside the scope of the provider's license, registration, or certification, or that is furnished by a provider that is not licensed, registered or certified to provide the service or supply by the State in which the services or supplies are furnished. Treatment or services provided by anyone other than a physician/provider operating within the scope of their license, as defined herein.

Mail Expenses - Mailing and/or shipping and handling expenses.

Medical Facility - Medical facility services performed in a facility other than as defined herein.

Medical Records and Reports - Expenses or provider fees for preparing medical reports, itemized bills, or claim forms, except as expressly requested by or on behalf of the Plan when required by the Provider's contract with the Network(s) utilized by the Plan.

Medical Tourism - Expenses for any care, services, drugs, or supplies incurred outside of the United States if you traveled to such a location for the purpose of obtaining the care, services, drugs, or supplies.

Mental Health and Substance Use Disorder Services - Charges are not covered for the following:

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
3. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
4. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Plan.
5. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
6. Educational or correctional services or sheltered living provided by a school or halfway house, including any academic component of treatment; however, you may receive covered outpatient services while living temporarily in a sheltered living situation.
7. A court-required screening interview or treatment program unless determined to be medically necessary.
8. Support groups, including Alcoholics Anonymous or similar programs.
9. Personal items.
10. Custodial care or long-term care.
11. Investigational therapies, including wilderness or outdoor treatment programs.
12. Tobacco cessation programs are not covered under the Mental Health and Substance Use Disorder benefit, please see the Tobacco Cessation benefit for coverage.
13. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

The Plan may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

Milieu Therapy - Milieu therapy (treatment in an Institution intended primarily to provide a change in environment or a controlled environment).

Military Service - Resulting from, or prolonged as a result of, performing a duty as a member of the military service of any State or Country.

Missed Appointments - Charges for failure to keep a scheduled visit.

Negligence - Charges arising from care, supplies, treatment, and/or services that are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or

provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Charge - Any services or supplies for which no charge is made, or for which a charge is made because this program is in effect, or for services or supplies for which you are legally liable for because this program is in effect.

No Coverage - Charges arising from care, supplies, treatment, and/or services that are incurred charges at a time when no coverage is in force for you.

No Legal Obligation - Services that are provided to a Covered Member for which the Provider customarily makes no direct charge or for which the Covered Member is not legally obligated to pay.

Non-Covered Services - Services or supplies directly related to any condition, service, or supply that is not covered by this Plan. This includes any complications arising from any treatment, services or supplies not covered by this Plan, except as provided herein.

Non-Customary Charges - Services or procedures that are not customary and services or procedures which are Experimental or for research.

Non-U.S. Providers - Expenses are not covered for any care, services, drugs, or supplies incurred outside of the United States. This exclusion does not apply to emergency care received outside of the United States.

Not Actually Rendered or Not Eligible for Coverage - That were never actually rendered, or that were rendered or received prior to, or after, any period of coverage under this Plan, except as specifically provided for in this Summary Plan Description.

Not Generally Accepted - That are not Generally Accepted in the United States as being necessary and appropriate for the treatment of the patient's illness or injury.

Not Medically Necessary - Services and supplies not medically necessary (as defined in the Definition Section) for the diagnosis or treatment of an illness or injury, unless otherwise listed as covered.

Nursing Home Care Services - Any services provided by an Institution which is primarily a rest home, a home for the aged, a nursing home, or a convalescent home or any of like character, except as specifically covered by this Health Plan.

Obesity (and Morbid Obesity) - Treatment for obesity (excessive weight and morbid obesity) including non-surgical treatment, surgery or complications of such surgery, wiring of the jaw or procedures of similar nature, diet programs and/or other therapies, except as provided herein.

Occupational Coverage - Any condition, ailment, or Injury for which you may receive benefits from occupational insurance purchased by your employer; benefits provided under State or Federal Worker's Compensation acts, Federal liability laws or similar laws; benefits available under any State or Federal act, even though you waive rights to such benefits; services provided by a Hospital owned or operated by a State or Federal agency.

Off Label Drug Use - Expenses related to Off-Label Drug Use, unless medically necessary; would otherwise be a covered expense under the Plan; and the use meets the definition of Off-Label Drug Use, (as defined in the General Definition section).

Orthoptics - (eye exercise programs), pleoptics, visual analysis therapy and/or training.

Orthotics/Supports Non-custom - Arch supports, shoe orthotics, corrective shoes, except as specifically provided under the Diabetes Education, Equipment and Supplies benefit.

Other than Attending Physician - Charges arising from care, supplies, treatment, and/or services that are other than those certified by your attending physician, as being required for the treatment of injury or disease, and performed by an appropriate provider.

Over-the-Counter - Over the counter drugs, supplies, food supplements, foods related to dietary restrictions or gluten free diets, infant formulas, and vitamins.

Patient Convenience - Related to the modification of homes, vehicles, or personal property to accommodate patient convenience. This includes, but is not limited to, installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment, and cervical pillows. This Exclusion also applies to any services or supplies that are provided during a course of treatment for an illness or injury that are solely for the personal comfort and convenience of the patient.

Personal Hygiene - For personal hygiene or convenience.

Podiatry/Foot care - Non-Surgical treatment of deformities for the toes and feet, including routine foot care, unless it is directly related to the treatment of diabetes.

Prescription Exclusions - The Plan will not cover the following Drugs, even when prescribed by the Covered Member's Physician.

- Over the counter Drugs for which a prescription is not required, unless specifically provided for in this Group Plan
- Over the counter contraceptive devices and/or supplies unless specifically stated as covered
- Drugs for treatment of obesity, including appetite suppressants or weight loss products (Unless enrolled in a medically supervised weight loss program)
- Fluoride preparations
- Drugs used for Cosmetic purposes
- Drugs taken home following an Inpatient hospital stay
- Non self-administered Drugs
- Drugs for the treatment of impotence and Infertility
- Over the counter Drugs intended to ease nicotine withdrawal
- Drugs specifically designated as not covered, such as Infertility Drugs
- Drugs which are not approved by the FDA
- Drugs which are not Medically Necessary for the treatment of specific conditions
- Investigational Drugs and/or Drugs used for investigation or Experimental purposes
- Drugs for travel purposes
- Compounded Hormone Replacement Therapy Drugs which have not been approved by the FDA and which are not manufactured by a recognized Drug company
- Replacement of lost or stolen medications, unless specifically included as a covered benefit under this Health Plan
- Drugs that require Preauthorization if your Provider has not obtained Preauthorization

Prior to Coverage - Charges arising from care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Professional (and Semi-Professional) Athletics (Injury/Illness) - Charges in connection with any injury or illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law - Charges arising from care, supplies, treatment, and/or services that are to the extent that payment under this Plan is prohibited by law.

Provider Error - Charges arising from care, supplies, treatment, and/or services that are required as a result of unreasonable provider error.

Providers - Charges submitted for services by an unlicensed hospital, physician or other health care provider or not within the scope of the health care provider's license.

Public Programs - Charges that are reimbursed, or that are eligible to be reimbursed by any public program except as otherwise required by law.

Relatives - Charges incurred for treatment or care by any provider if he or she is your relative, or treatment or care provided by any individual who ordinarily resides with you.

Rest Home - Any services rendered by an institution, which is primarily a place of rest, a place for the aged, a nursing home, sanitarium, or a convalescent home.

Routine Services - Services or supplies that are not directly related to an illness, injury, or distinct physical symptoms. Routine services include health examinations required:

- By a third party, including examinations and treatments required to obtain or maintain employment (excluding exams required by the Department of Transportation), or which
- An employer is required to provide under a labor agreement;
- For securing insurance or for professional or other licenses;
- For administrative purposes;
- As a premarital requirement;
- To travel;
- To attend a camp, sporting event, or to participate in other recreational activities;
- Any special medical reports not directly related to treatment except when provided as part of covered service.

This exclusion does not apply to services and supplies specified under the Preventive Care Benefit, or to routine mammograms.

Self-Help Programs - Non-medically necessary, self-help programs such as "Outward Bound" or "Wilderness Survival", recreational, or educational therapy.

Sterilization - Reversal of reproductive sterilization procedure.

Subrogation - That are not payable under the Plan by virtue of its Subrogation provisions.

Therapy - Alternative Types - Services which are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama, or megavitamin therapy.

Third Party Liability - Benefits payable under the terms of any automobile medical, personal injury protection, automobile no fault, homeowner, commercial premises, or similar contract of insurance when such contract of insurance is issued to, or makes benefits available to you. This also includes treatment of illness or injury for which the third party is liable.

Transportation - Transportation by private automobiles, taxi service or other ground transportation, except as specifically provided herein.

Travel - For travel, even though prescribed by a Physician.

Trusses, Corsets and Other Support Devices - Unless postoperative.

Types of Care - The following types of care are excluded from coverage under the Plan:

1. Custodial Care or maintenance care.
2. Domiciliary care.

3. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program for services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care Benefits within this Summary Plan Description.
4. Rest cures.
5. Services of personal care attendants.
6. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

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

Vision Correction - Radial keratotomy, keratomileusis, Lasik Surgery, or other vision correction procedures.

Vitamins (Over the Counter) – Charges for over the counter vitamins.

Vision Exclusions. In addition to the Plan Exclusions, no benefits will be provided under this Plan for vision expenses incurred by a Covered Member for the following:

- Services or supplies required as a condition of employment or by any governmental body
- Replacing lenses or frames which have been lost, stolen, or broken sooner than the benefit limitation time frame
- Safety lenses or goggles
- Medical or Surgical care of the eye, except as provided under Covered Medical Expenses
- Any lenses not prescribed by a legally Licensed Physician or optometrist
- Any service performed or supplies provided for special procedures such as orthoptics
- Lenticular Lenses
- Prescription sunglasses

War - Conditions caused by an act of war, armed invasion or aggression, whether declared or undeclared, or any act of aggression, and any complication thereof. Includes any Injury or Illness sustained as a member of the United States Armed Forces.

Without Approval - Furnished without recommendation and approval of a Physician or Dentist acting within the scope of his or her license.

Work-related Illness or Injury - Any condition, ailment, or Injury for which you may receive benefits from occupational insurance purchased by your employer; benefits provided under State or Federal Worker's Compensation acts, Federal liability laws or similar laws; benefits available under any State or Federal act, even though you waive rights to such benefits; services provided by a Hospital owned or operated by a State or Federal agency.

CLAIMS PROCEDURES

A claim is defined as any request for a Plan benefit payment, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for making benefit claims.

HOW TO FILE A CLAIM

Each Covered Member will receive an identification card which will include the Covered Members' name and Identification number. This card contains important information including the Tribal Plan name and contact information for the Preferred Provider Network, Preauthorization, and the Third Party Administrator's information. The card should be presented to the Provider of care when treatment is received.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Third Party Administrator within 365 days after the occurrence or commencement of any loss covered by this Plan. Benefits are based on the Plan's provisions at the time the charges were incurred. Charges are considered incurred when a treatment or care is given or a procedure is performed, unless noted differently in the Benefits Section. Failure to give such notice and proof within 365 days will neither invalidate nor reduce any claim if it is shown that:

- It was not reasonably possible for the claimant to give written notice and proof within 365 days
- Written notice and proof are given as soon as reasonably possible, but in no case later than one year after the loss occurs or commences, unless the claimant is not legally capable of submitting the claim

Pre-Service Claim. A pre-service claim means any claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, needs approval in advance of obtaining medical care. These are, for example, claims subject to Preauthorization.

Post-Service Claim. A post-service claim means any claim for a Plan benefit that is not a pre-service claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the member.

In the case of a Pre-Service Claim, the following time frames apply:	
You will receive a response within:	
Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim: <ul style="list-style-type: none">• Notification to claimant• Response by claimant	15 days 45 days
Ongoing courses of treatment: <ul style="list-style-type: none">• Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days

In the case of a Post-Service Claim, the following time frames apply:	
You will receive a response within:	
Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim: <ul style="list-style-type: none">• Notification to claimant• Response by claimant	15 days 45 days
Review of adverse benefit determination	60 days

NOTICE OF ADVERSE BENEFIT DETERMINATIONS

The Third Party Administrator shall provide written or electronic notification of any adverse benefit determination to the Covered Member in the standard Explanation of Benefits (EOB). The notice will state, in a manner calculated to be understood by the claimant:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures, and the time limits applicable to such procedures.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.
- If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar Exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

HEALTH BENEFITS DECISION APPEAL PROCESS

Any person, including the parent or legal guardian of a minor or incompetent, who has been rejected for payment of health care services, including Mental Health care services, has a right to Appeal the decision.

FIRST LEVEL APPEAL

If you disagree with the Third Party Administrator's claim processing decision, you have up to 180 days following the decision to file an administrative Appeal with the Third Party Administrator. You may submit written comments, documents, records, and other information relating to the claim. You will be provided if requested and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The request for an Appeal must be submitted to the address shown below, in writing, within 180 days after the decision is received or up to one year from the date of service.

Healthcare Management Administrators, Inc.
Attn: Appeals
P.O. Box 85016
Bellevue, Washington 98015-5016
425-462-1000 - Seattle Area
888-450-4491 - All Other Areas
855-462-8875 - Fax
appeals@accesshma.com - E-mail

The period of time within which a benefit decision on review is required to be made shall begin at the time an Appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- Was relied upon in making the decision
- Was submitted, considered, or generated in the course of making the benefit decision, without regard to whether it was relied upon in making the benefit decision
- Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit decisions are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants

- Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit

The review shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial decision and will be conducted by the Third Party Administrator who is neither the individual who made the decision nor a subordinate of that individual.

If the decision was based on a medical judgment, including determinations with regard to whether a particular treatment, Drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Third Party Administrator shall consult with a health care professional who was not involved in the original benefit decision. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial decision will be identified.

The Third Party Administrator shall issue a written decision for the first level Appeal no later than 45 days after the first level Appeal is filed.

SECOND LEVEL APPEAL

All Appeals of decisions denying payment of health care expenses by the Third Party Administrator shall be heard by the Tribe's Executive Director.

The applicant Appealing a decision of the Third Party Administrator will bear the burden of proof on Appeal.

All Appeals must be made in writing to the Health Benefits Department. An applicant will have forty-five (45) calendar days from the date of the adverse decision to file an Appeal with the Health Benefits Department.

Parties may submit any additional supporting evidence or documents which were not previously furnished to the Third Party Administrator and may include a copy of or reference to applicable medical records or records of the Washington State Department of Social and Health Services.

The Health Benefits Supervisor will examine records submitted on Appeal and hear facts that support or refute the application for health benefits. The sole issue before the Health Benefits Supervisor will be to determine if the Third Party Administrator made an error in denying payment of health benefits. The burden of proof will remain with the individual affected by the decision of the Third Party Administrator. If no error is found and it is determined the service is not covered then the appeal will be presented to the Executive Director for approval or denial.

FINAL APPEAL

If the applicant for health benefits is dissatisfied with the decision of the Executive Director, the applicant, including the parent or legal guardian of a minor or incompetent, has a right to Appeal the Executive Director's decision within 90 days of the Executive Director's decision being issued, to the Suquamish Tribal Council, as provided in this subsection.

The Appeal shall be instituted by filing a letter requesting a hearing with the Executive Assistant for the Suquamish Tribal Council. This letter of request may be mailed to PO Box 498, Suquamish, WA 98392.

The Appeal may be heard by the Tribal Council at its next regular meeting, or at a special meeting, according to the preference of the Tribal Council. The evidence presented to the Tribal Council, together with all documentation submitted to the Health Benefits Program Manager, shall constitute the record on Appeal.

The Appealing party, if requested by the Tribal Council, may be present at the meeting and may be entitled to present arguments. The Health Benefits Supervisor and/or Executive Director will also be present and will report on the reasons for rejection of the health benefit.

The decision of the Suquamish Tribal Council will be issued within thirty (30) days of the Tribal Council meeting at which the Appeal is addressed. The decision of Council will be final, and there will be no further Appeal or judicial review of the subject matter of the Appeal, with the exception of dual covered members as laid out below.

All claim review procedures provided for in the Plan, including Appeals, must be exhausted in a timely manner and in the order set forth above. Any Appeal that is not filed within the stated timeframes or does not comply with deadlines set forth

in the Plan shall be deemed to be waived. Members who were not employed by the Tribe at the time the disputed health services were provided will have no additional dispute resolution rights after the claim review procedures and all Appeals are completed or deemed waived. A Member who was employed by the Tribe at the time the disputed health services were provided and who has timely completed all claim review procedures and Appeals under the Plan may seek judicial review in the Suquamish Tribal Court if he believes that there has been an abuse of discretion in the resolution of his claim or Appeal. Any such judicial review must be requested within one (1) year of the Tribal Council's decision on the final Appeal and only after the Tribal Council has authorized such judicial review pursuant to tribal law. Neither the Plan Administrator nor any individual representative of the Tribe is authorized to waive Tribal sovereignty, which may be waived only by specific and express action of the Tribal Council. The Tribal Court's review shall not be a *de novo* review, but will be limited to a determination of whether there has been an abuse of discretion in the processing or review of the claim or any Appeal.

COORDINATION OF BENEFITS

Coordination of Benefits sets out rules for the order of payment of covered charges when a Covered Member is covered by more than one plan. When a Covered Member is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received, as outlined in this section.

When an individual is covered under more than one plan, one plan normally pays its benefits in full and the other plan or plans pay a reduced amount. This Plan will always pay its benefits in full or a reduced amount, if any, that when added to the benefits payable by the other plan or plans will not exceed 100% of the Allowable expenses as calculated under this Plan. Only the amount paid by this Plan will be charged against the Plan Benefit Maximums of this Plan.

DEFINITION OF OTHER HEALTH PLANS

This Plan will coordinate the health benefits of other health plans. The term “other health plan” means any one of the following plans, without limitations:

- Group insurance or any other arrangement for coverage for Covered Members in a group whether on an insured or self-funded basis
- Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans
- Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision
- A licensed Health Maintenance Organization (HMO)
- Any coverage for students which is sponsored by, or provided through, a school or other educational Institution
- Any coverage under a Government program, and any coverage required or provided by a statute
- Group automobile insurance
- Individual automobile insurance coverage on an automobile leased or owned by the Tribe
- Individual automobile insurance coverage based upon the principles of “no-fault” coverage
- Any plans or policies funded in whole or in part by an Employer or deductions made by an Employer from a person’s compensation benefits
- Labor/management trustee, union welfare, Employer organization or Covered Member benefit organization

PREAUTHORIZATION REQUIREMENTS

The Preauthorization requirements under this Plan will not be imposed when this Plan pays as other than primary, except for the following services: Dental Implants.

HEALTH PLAN PAYMENT ORDER

For all Covered Members of the Plan, all other plans are primary payors, including Medicare. In accordance with 42 C.F.R. § 136.61, the Suquamish Tribe Indian Health Plan is the Payor of Last Resort for health services provided to patients eligible for Purchased Referred Care (PRC) formerly, Contract Health Services (CHS).

INDIAN HEALTH SERVICE/TRIBAL PROGRAMS/URBAN INDIAN HEALTH PROGRAM — I/T/U

Covered Members may receive services from an IHS, Tribal, or Urban Indian Clinic. This Plan will not pay for charges for services provided by the I/T/U programs.

INDIAN HEALTH SERVICE EXCLUSION

In accordance with Section 206(f) of the Indian Health Care Improvement Act, P.L. 94-437, 25 U.S.C. § 1621e(f), and notwithstanding 42 C.F.R. § 136.61, the Indian Health Service has no right of recovery against this tribal self-insurance Plan for health services the Indian Health Service has provided to an eligible patient; no payment will be made by this Plan to the Indian Health Service.

COORDINATION OF BENEFITS WITH MEDICAID

If a Covered Member is eligible for Medicaid, they are not eligible for coverage under this Plan for services covered by Medicaid, unless those services are covered under the Supplemental Plan.

RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION

In order to coordinate benefits, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Member will give this Plan information it asks for about other plans and their payment of Allowable charges.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

RIGHT OF RECOVERY: WRONGFUL PAYMENT AND RECOVERY OVERPAYMENT

If the Plan makes a payment by mistake to you, or on behalf of you, or if we make a payment to someone who is not eligible to receive payments at all, we have the right to recover that payment. We can recover the amount either from the person who received the payment or from anyone who benefited from the payment.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

RIGHT OF REIMBURSEMENT AND SUBROGATION

Situations may arise in which the payment of your medical or dental expenses are the responsibility of a source other than the Plan. In such cases, the rules of this Section will apply.

THE PLAN'S RIGHTS

If the Plan pays any medical or dental expenses for you on account of an Injury or Illness caused by another person, the Plan has a right to recover those payments from that person. The Plan also has the right to recover from that person if that person may be liable or responsible for medical, prescription, dental, or vision benefits arising from that Injury or Illness. The Plan has this right regardless of whether that person's liability or responsibility is under contract, tort or a statute, or government regulation. The Plan has the right to sue that person on your behalf. The Plan also has the right to obtain a judgment against, or to settle your claim with the other person (or the other person's insurance company).

THIRD-PARTY RESPONSIBILITY

If you incur medical, prescription, dental, or vision expenses in connection with an Illness or Injury for which one or more third parties may be responsible, then such expenses will not be covered under the Plan to the extent that you directly or beneficially receive a recovery from or on behalf of the responsible third-party. The rules that will apply in these third-party responsibility situations include those described below. If a claim for medical, prescription, dental, or vision expenses is filed with the Plan and you have not yet received recovery from the responsible party, the Plan may continue to provide benefits for Covered Expenses.

However, you must hold any recovery in trust and execute a trust agreement in the full amount of the benefits that the Plan pays to you from any recovery until such time as a final determination or settlement has been reached regarding the amount that fully compensates you for your loss. If the Plan has already paid benefits for that Illness or Injury, it will be entitled to reimbursement of the full amount (100 percent) of the benefits it has paid from the proceeds of any recovery you receive from or on behalf of the third-party. For this purpose, the proceeds of a recovery include, but are not limited to, any money or item of value obtained from or on account of such other person, firm or corporation, or insurance carrier as a result of claim or litigation for the recovery of special or general punitive damages or in the consideration or any releases, receipt, covenant not to sue, a quitclaim or agreement of any kind, written or oral.

MOTOR VEHICLE INSURANCE COVERAGE

Motor vehicle insurance is considered the primary coverage for expenses arising from a motor vehicle Accident. Personal Injury Protection and uninsured motorist policies are also primary insurance coverages for motor vehicle Accident injuries. If the Plan pays any medical, prescription, dental, or vision expenses for you now or in the future, on account of an Injury covered under motor vehicle, Personal Injury Protection, or uninsured motorist policies, the Plan has a right to recover those payments from that insurance carrier. A person who was involved in a motor vehicle Accident may have rights both under motor vehicle insurance coverage and against a third-party who may be responsible for the Accident. In that case, both this provision and the prior Third-Party Responsibility provision will apply.

SUBROGATION

To the maximum extent permitted by law, and in addition to the rights of reimbursement described above, the Plan is subrogated to your rights against any third-party who is responsible for the Illness or Injury for which medical, prescription, dental, or vision expenses have or will be paid under the Plan. By reason of such Subrogation, the Plan, or the Plan Administrator on behalf of the Plan, has the right to sue and assert rights against any such third-party in your name. In addition, the Plan has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan, and for expenses incurred by the Plan in obtaining a recovery.

RECOVERY OF FUTURE EXPENSES

If you incur medical, prescription, dental, or vision expenses for treatment of the Illness or Injury after receiving a recovery, the Plan will not pay benefits for Covered Expenses until the total amount of the Covered Expenses incurred after the recovery exceeds the net recovery amount (e.g., the amount of the recovery minus the amount previously reimbursed to the Plan).

COLLECTION COSTS AND ATTORNEY'S FEES

If the Plan has to take legal or other action to enforce the Plan's lien or to be reimbursed by you, you may also have to reimburse the Plan for the costs it had to pay to collect the amount you owed, including the Plan's attorney's fees.

YOUR REIMBURSEMENT OBLIGATION

If you collect on a judgment, award, settlement, or other arrangement with a third-party (or that third-party's insurance company), you must reimburse the Plan for any medical, prescription, dental, or vision expenses the Plan paid on account of that illness or injury. You must reimburse the Plan even if:

- The total amount you recover is less than the amount of your suffered loss
- The expenses are not specifically itemized or included in your recovery
- The third-party (or third-party's insurance company) does not admit liability

Any amount which you recover must first go to repay the Plan. The amount of recovery to be reimbursed or otherwise paid to the Plan is not reduced by any expenses, such as attorney's fees, incurred in connection with the recovery. Accordingly, the common fund doctrine is not to be applied. In addition, the "make-whole" rule of insurance law, which holds that an insurance company may not enforce a right of Subrogation or third-party responsibility until the insured party has been fully compensated for any injuries, also does not apply. Once the Plan has been reimbursed for the medical, prescription, dental, or vision expenses which it paid, the rest of the judgement or settlement amount can be paid out to you.

THE PLAN'S LIEN RIGHTS

The Plan has a lien against the amount of any settlement or judgment you may obtain against the other person (or that person's insurance company). This lien is for the full amount of the medical, prescription, dental, or vision expenses the Plan paid on account of the Injury or Illness caused by the other person. The Plan also has a similar lien if the other person did not cause the Injury or Illness, but is legally responsible for covering the medical, prescription, dental, or vision claims from the Injury or Illness. The lien will stay in effect until the Plan has been reimbursed in full from any judgment or settlement obtained, or until the Plan agrees to waive some or the entire lien. If the Plan requests, you must sign a lien form directing your attorney or the third-party who caused the Injury or Illness or the party who is legally responsible for paying the claims arising from that Injury or Illness (or the party's insurance company) to make payments directly to our Plan. The fact that you or your Dependent do not properly sign such lien form does not affect the Plan's rights with respect to such lien.

YOUR COOPERATION REQUIRED

If you file a claim for medical, prescription, dental, or vision expenses for an Injury or Illness caused by a Third Party or for which another third-party is legally responsible, you must do the following:

- Promptly notify the Plan of the Injury or Illness.
- You and/or your attorney or representative agree to provide the Third Party Administrator, in writing, the details of the Injury or Illness, the names and addresses of the party or parties believed to be responsible and any insurer who may offer coverage, and any other information reasonably necessary to protect the Plan's Subrogation rights.
- Complete the forms required, including an Accident/Injury Report Form and a Reimbursement Agreement.
- Notify the Plan if you file any claim or start any legal action against the other party or any insurance company.
- Cooperate with us in investigating, presenting, and settling the claim and recovering any over payments.
- Include the benefits paid by the Plan as part of the damages you are seeking to recover in any claim or legal action you file against the party who caused the Injury or Illness or who is legally responsible for paying medical, prescription, dental, or vision expenses or benefits for that Injury or Illness (or that party's insurance company). Your claims for medical, prescription, dental, or vision expenses from the Injury or Illness will not be processed until we receive the forms and the other information needed from you to pursue our Subrogation rights. The Plan may further require that you sign an agreement guaranteeing the Plan's right to reimbursement before it provides any further benefits to or on behalf of you.

UNDERINSURED OR UNINSURED MOTORIST COVERAGE

In addition to the agreements set out above, when you recover benefits under any automobile uninsured or underinsured motorist (UIM) coverage, this Plan shall be entitled to reimbursement from your recovery.

HIPAA PRIVACY AND SECURITY

Use and Disclosure of Protected Health Information

Under the HIPAA privacy rules the Plan Sponsor must establish the permitted and required uses of Protected Health Information (PHI).

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose summary health information to the Plan Sponsor, provided that the Plan Sponsor requests the summary health information for the purpose of obtaining premium bids, determining Member enrollment status, or for modification, amendment or termination of the Plan.

Plan Sponsor's Certification of Compliance

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the Tribe (Plan Sponsor) unless the Tribe (Plan Sponsor) certifies its compliance with 45 Code of Federal Regulations §164.504(f)(2) (collectively referred to as The Privacy Rule) as set forth in this Article and agrees to abide by any revisions to The Privacy Rules.

Notice of Privacy Practices

The Plan provides each Member with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling your Health Benefits Office.

Restrictions on Disclosure of Protected Health Information to the Tribe (Plan Sponsor)

The Plan and any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the Tribe (Plan Sponsor) only to permit the Tribe (Plan Sponsor) to carry out plan administration functions for the Plan consistent with the requirements of the Privacy Rule. Any disclosure to and use by the Tribe (Plan Sponsor) of your Protected Health Information will be subject to and consistent with the provisions of paragraphs on **Tribe (Plan Sponsor) Obligations Regarding Protecting Health Information** and **Adequate Separation Between the Tribe (Plan Sponsor) and the Plan** of this Article.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the Tribe (Plan Sponsor) unless the disclosures are explained in the Notice of Privacy Practices distributed to you.

Tribe's (Plan Sponsor) Obligations Regarding Protecting Health Information

The Tribe (Plan Sponsor) will:

- Neither use nor further disclose your Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.
- Ensure that any agent, including any subcontractor, to whom it provides your Protected Health Information, agrees to the restrictions and conditions of the Plan Documents, including this Article, with respect to your Protected Health Information.
- Not use or disclose your Protected Health Information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Tribe (Plan Sponsor).
- Report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under this Article promptly upon learning of such inconsistent use or disclosure.
- If you are the subject of information, make Protected Health Information available to you in accordance with 45 Code of Federal Regulations § 164.524.
- Make your Protected Health Information available for amendment, and will on notice amend your Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.

- Track disclosures it may make of your Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.
- Make available its internal practices, books, and records, relating to its use and disclosure of your Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.
- If feasible, return or destroy all of your Protected Health Information, in whatever form or medium (including in any electronic medium under the Tribe's (Plan Sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of you if you are the subject of the Protected Health Information, when your Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all of your Protected Health Information, the Tribe (Plan Sponsor) will limit the use or disclosure of any of your Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation Between the Tribe (Plan Sponsor) and the Plan

The following classes of employees or other workforce members under the control of the Tribe (Plan Sponsor) may be given access to your Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:

- Privacy Officer
- Health Benefits Supervisor
- Health Benefits Coordinator
- IT Director
- IT Electronic Health Records Administrator
- The Suquamish Tribe PRC Program and related Administration.

This list includes every class of employees or other workforce members under the control of the Tribe (Plan Sponsor) who may receive your Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The identified classes of employees or other workforce members will have access to your Protected Health Information only to perform the plan administration functions that the Tribe (Plan Sponsor) provides for the Plan.

The identified classes of employees or other workforce members will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Tribe (Plan Sponsor), for any use or disclosure of your Protected Health Information in breach or violation of or noncompliance with the provisions of this Article to the Plan Documents. The Tribe (Plan Sponsor) will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance for you, if the privacy of your Protected Health Information may have been compromised by the breach, violation or noncompliance.

Tribe (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

Tribe (Plan Sponsor) will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure that the adequate separation between the Plan and Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

GENERAL PROVISIONS

ADMINISTRATION OF THE GROUP MEDICAL PLAN

The Plan is administered through the Plan Administrator. The Plan Administrator has retained the services of an independent Third Party Administrator experienced in claims processing. The Plan Administrator has the right to determine eligibility for benefits and to construe the terms of the Plan. The Plan Administrator has made the Third Party Administrator its minister to carry out its decisions.

Legal notices may be filed with, and legal process served upon the Plan Administrator.

AMENDMENT OF PLAN DOCUMENT

The Plan Administrator may terminate, modify, or amend the Plan in its sole discretion without prior notice. The Plan Administrator must notify the Third Party Administrator in writing requesting an amendment to the Plan. The Third Party Administrator will prepare an amendment to be signed by the Plan Administrator. Once the Plan Administrator has signed the amendment, such termination, amendment or modification which affects you and your dependents will be communicated to you in the manner of a new Plan document or Tribal communication. The amended Plan Benefits will be the basis for determining all Plan payments for all expenses incurred on or after the effective date of such amendment. Plan payments made under the Plan prior to amendment shall continue to be included as Plan payments in determining the total benefits remaining toward satisfaction of any benefit maximums calculated on a Plan year, calendar year or lifetime basis.

ASSIGNMENT OF BENEFITS

Assignment by you to your provider of your right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an assignment of benefits, if and only if your provider accepts said assignment of benefits as consideration in full for services rendered. If benefits are paid, however, directly to you, the claimant – despite there being an assignment of benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be your responsibility to compensate the applicable provider(s). The Plan will not be responsible for determining whether an assignment of benefits is valid; and you shall retain final authority to revoke such assignment of benefits if a provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by you, the Claimant, has been received.

You shall not, at any time, either during the time in which you are a Claimant in the Plan, or following your termination as a claimant, in any manner, have any right to assign your right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which you may have against the Plan or its fiduciaries. This prohibition applies to providers as well.

A provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Preferred Provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

AUDIT AND REVIEW FEES

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

The analysis will be employed to identify charges billed in error and/or charges that are not maximum allowable and/or medically necessary and reasonable, if any, and may include your medical billing records review and/or audit of your medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the maximum allowable amounts or other applicable provisions, as outlined in this Plan Document. Cost containment fees may be charged as a percent of savings under the Plan due to the application of cost containment provisions and are considered covered expenses under the Plan.

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

BALANCE BILLING

In the event that a claim submitted by a Preferred or Non-Preferred Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that you should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over Out-of-Network Providers that engage in balance billing practices.

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

You are responsible for any applicable payment of coinsurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

You or your dependent shall present the Plan identification card to the provider of service upon admission to a medical facility or upon receiving service from a physician/provider.

Written proof of the nature and extent of service performed by a physician or other provider of service shall be furnished to the Third Party Administrator within one year after the service was rendered. Claim forms are available through the Third Party Administrator and are required along with an itemized statement with a diagnosis, your name and subscriber identification number and the name of the Plan Administrator or the Participating Group.

You and all your dependents agree that in order to receive benefits, any physician, nurse, medical facility or other provider of service, having rendered service or being in possession of information or records relating thereof, is authorized and directed to furnish the Third Party Administrator, at any time, upon request, any and all such information and records, or copies thereof.

The Third Party Administrator shall have the right to review these records with the Plan's Insurance Company and with any medical consultant or with the UR Coordinator as needed to determine the medical necessity of the treatment being rendered.

CREDIT FOR PRIOR GROUP COVERAGE

This Plan amends, replaces, and supersedes the prior Plan. You and your dependents who were covered under the prior Plan sponsored by the Tribe immediately prior to the time this Plan became effective will not lose eligibility or benefits due to the change in Plans. All charges incurred on or after the effective date of this Plan will be subject to the benefits available under this Plan and not the prior Plan. Credit will be given for time enrolled under the prior Plan for payments towards coinsurance and deductibles.

EFFECT OF TERMINATION OF THE PLAN

Upon complete or partial termination of the Plan, the Plan Administrator may, after the payment or provision for payment of all benefits to you if you have incurred covered expenses and charges properly payable, including all expenses incurred and to be incurred in the liquidation and distribution of the Trust Fund or separate account, direct the disposition of all assets held in the Trust Fund or separate account to the Participating Group or Groups, subject to any applicable requirement of an accompanying Trust Document or applicable law or regulation.

EVIDENCE BASED MEDICINE

In making a medical necessity determination, the discretion and standard of review is neither arbitrary nor capricious and is based upon the following provisions and approved citations:

- MCG, Milliman Care Guidelines.
- NCCN, National Cancer Care Network.
- Cambia Medical Policy including clinical practice guidelines, clinical position statements and referenced citations.
- Wolters Kluwer Facts and Comparisons.
- Other authoritative compendia (references) as identified from time to time by the Federal Secretary of Health and Human Services or other approved policy.

FACILITY OF PAYMENT

If, in the opinion of the Third Party Administrator, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Third Party Administrator may, at its option, make such payment to the individuals as have, in the Third Party Administrator's opinion, assumed the care and principal support of you and are therefore equitably entitled thereto. In the event of your death prior to such time as all benefit payments due you have been made, the Third Party Administrator may, at its sole discretion and option, honor benefit assignments, if any, prior to your death.

Any payment made by the Third Party Administrator in accordance with the above provisions shall fully discharge the Plan and the Third Party Administrator to the extent of such payment.

FIDUCIARY OPERATION

Each fiduciary shall discharge duties with respect to the Plan solely in the interest of you and your beneficiaries and: (1) for the exclusive purposes of providing benefits to you and your beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan.

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of your application shall not deprive you or your dependents of benefits otherwise due, provided that such inadvertent error is corrected by the Plan Administrator within ninety (90) days after it was made.

MISREPRESENTATION

Any material misrepresentation on the part of the Plan Administrator or yourself in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage null and void.

NOTICE

Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Third Party Administrator, when addressed to it at its office; or if given to you, when addressed to you at your address as it appears on the records of the Third Party Administrator on your enrollment form and any corrections made to it.

PAYMENT INTEGRITY

This Plan includes a payment integrity program focused on ensuring claims are paid accurately and appropriately. In alignment with applicable provider and network contracts, the payment integrity program may include a process of review for pre-service, pre-payment, and post-payment of proposed treatments and medical claim details to help ensure proper claim payment and detect patterns of fraud, waste, and abuse.

PHOTOCOPIES

Reasonable charges made by a provider for photocopies of medical records when the copies are requested by the Third Party Administrator shall be payable. The Plan does not reimburse administrative fees charged related to records requests.

PLAN ADMINISTRATION

The Plan Administrator shall be responsible for compliance by the Plan.

RIGHT OF RECOVERY OF PAYMENTS

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

You, your dependent, your provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied. If the Plan must bring an action against you, your provider or other person or entity to enforce the provisions of this section, then you, your provider, or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

STATE AND FEDERAL EMERGENCY OR EXECUTIVE ORDER

This Plan intends to comply with and shall deem its Plan terms automatically amended to conform to any Plan coverage requirement deemed mandatory or otherwise necessary as a result of a declared public health emergency or other Suquamish Tribe, state, or federal executive order(s) that is applicable to this Plan and/or any regulatory action or sub-regulatory guidance that applies directly to this Plan as a result of a declared emergency and its associated order(s). Upon the conclusion of such declared emergency and expiration of any such Suquamish Tribe, state or federal executive orders, the Plan's terms will automatically revert to pre-emergency order coverage terms, unless express

action is taken by the Plan Sponsor or Plan Administrator to modify this Plan's terms via an executed amendment or restated Summary Plan Description to extend such coverage beyond the timeframe of the emergency order.

STATUTE OF LIMITATIONS CLAUSE

Any and all claims or legal cause of action against this Plan and its designated fiduciaries must be brought and filed with the courts within the time periods specified under WA State Law not to exceed 3 years from the date the Plan Member exhausts their internal appeal rights under this Plan.

TAXES

Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) and other state imposed surcharges (as applicable to the Plan), will be considered covered expenses by this Plan. Local, State and Federal taxes, associated with supplies or services covered under this Plan, will also be considered covered expenses by this Plan.

MISCELLANEOUS INFORMATION

ASSIGNABILITY

The benefits of this Plan are personal to the Covered Member, and neither the Plan, its payments, nor its benefits are assignable.

UNIFORMITY

This Health Plan is intended to apply uniformly to all persons who are PRC/CHS eligible without discrimination.

COVERAGE LIMITS

The services and benefits offered under this Health Plan are subject to the coverage limits and maximums set forth.

FUNDING THE PLAN

The Plan is funded by the Suquamish Indian Tribe.

CIRCUMSTANCES RESULTING IN LOSS OF BENEFITS

There are circumstances that may result in ineligibility or in denial of benefits that a Covered Member might reasonably expect the Plan to provide. These circumstances include, but are not limited to:

- Coordination of benefits when a Covered Member is enrolled in more than one plan since this Plan is the Payor of Last Resort
- Subrogation, reimbursement, and third-party recovery rights of the Plan
- Denials due to services that are not Generally Accepted as appropriate, and/or which are considered as Over-utilization, and/or which are not Medically Necessary
- Treatment, services, and supplies that are excluded from coverage under the Plan, whether or not Medically Necessary
- Non-compliance with the Plan's claims filing deadline
- Non-compliance with the Plan's Preauthorization requirements

ERROR/DELAY

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan with respect to Covered Members.

SOVEREIGNTY

The Suquamish Indian Tribe is a federally recognized Indian tribe that expressly retains various rights and immunities, including immunity from suit.

The Tribe's rights and immunities are reserved unless expressly waived by the Tribe. By adopting this Summary Plan Description, The Suquamish Indian Tribe does not waive, alter, or otherwise diminish its sovereign immunity. Nor does The Suquamish Indian Tribe waive its sovereign immunity for any administrative or any other legal proceeding which may arise under this Plan.

FRAUDULENT CLAIMS

The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of your coverage under this Plan. Examples include, but are not limited to:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Member on the Plan
- Attempting to file a claim for a Covered Member for services that were not rendered or Drugs or other items that were not provided
- Providing false or misleading information in connection with enrollment in the Plan
- Providing any false or misleading information to the Plan

HOW YOU CAN STOP HEALTH CARE FRAUD

The Claim Administrator is committed to helping you meet your health care needs and is dedicated to controlling expenses and protecting Covered Members of The Suquamish Tribe. We are actively fighting health care fraud and want to increase your awareness of how to combat potential fraudulent acts and situations. Because fraud increases health care expenses, it ultimately results in higher costs to the Tribe. Beyond financial losses, fraudulent health care practices can threaten your health and safety.

The following precautions you may take include, but are not limited to:

- Beware of “free” medical treatment offers
- Beware of people offering money to you if you agree to have medical procedures done (possibly unnecessary and dangerous to your health)
- Be wary of people requesting that you travel to other states for medical procedures
- Protect your health insurance information and do not give it out to solicitors or to people over the telephone without ensuring that person has the “right to know”
- Avoid using health care Providers who say that a service is not usually covered, but they know how to bill us to have it paid
- Review your Explanation of Benefits (EOB) form to assess the accuracy of the claims payment information. As an example, fraud may appear on an EOB as charges for tests or procedures you did not have
- Remember, if something sounds too good to be true, it likely is
- Ensure that only qualified Members are enrolled on the health Plan
- Participating in health care fraud is illegal and dangerous

Your continued health is our goal. If you suspect health care fraud, please contact the Third Party Administrator or the Health Benefits Office.

INTERPRETATION OF THIS DOCUMENT

The use of masculine pronouns in this Summary Plan Description shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Summary Plan Description are used for convenience of reference only. Covered Members are advised not to rely on any provision because of the heading.

The use of the word “you” throughout this Summary Plan Description applies to Covered Members.

WAIVING OF PLAN PROVISIONS

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

SUMMARY PLAN DESCRIPTION NOT A CONTRACT

This Summary Plan Description and any amendments constitute the terms and provisions of coverage under this Plan. The Summary Plan Description will not be deemed to constitute a contract of any type between the Plan and any Covered Member.

COVERAGE THROUGH WORKERS' COMPENSATION

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. If benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This Exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you received from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the Subrogation, Third-Party Recovery & Reimbursement Section, even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise
- No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment
- The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier
- The health care expense is specifically excluded from the Workers' Compensation settlement or compromise

You are required to notify the Plan Administrator immediately when you file a claim for coverage under Workers' compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so, or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

ALTERNATE COURSES OF TREATMENT

The Plan Administrator may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this Plan, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply. Such payments will be considered as being in accordance with the terms of this Summary Plan Description.

NO VERBAL MODIFICATIONS

The Covered Member shall not rely on any oral statement from the Third Party Administrator which modifies or otherwise affects the benefits, general Limitations and Exclusions, or other provisions of this Plan and increases, reduces, waives, or voids any coverage or benefits under this Plan.

In addition, such oral statement shall not be used in prosecution or defense of a claim under this Plan.

This booklet is not a contract. It explains in non-technical language the essential features of your Indian Health Plan. Contact the Plan Administrator if there are any questions concerning this booklet.

DEFINED TERMS

In this section you will find the definitions for the many terms found throughout this Summary Plan Description. There may be additional words, phrases, and terms which have specific meanings or that pertain to certain sections within this book. Those definitions may also be found in the section to which they apply.

These definitions are not an indication that charges for particular care, supplies, or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description or contact the Third Party Administrator for details concerning this Plan and its provisions.

Accident or Accidental Injury/Injuries means a bodily Injury caused solely by external, traumatic, and unforeseen means. Accidental Injury does not include disease or infection, hernia, or cerebral vascular Accident. Dental Injury caused by chewing, biting, or malocclusion is not considered an Accidental Injury. Accidental Injury includes sprains and strains.

Acute Nursing Care services requiring the technical proficiency of a Licensed registered nurse. Services requested by or for the convenience of the patient or the patient's family or to enable family members to work outside the home are not considered acute care. Services which consist primarily of bathing, feeding, exercising, homemaking, moving or turning the patient, giving medication, routine skin care, or acting as a companion are likewise not considered acute care.

ADA means the American Dental Association.

Adverse Benefit Determination means any of the following: (1) a denial in benefits; (2) failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in the Plan; (3) a reduction in benefits; (4) a rescission of coverage, even if the rescission does not impact a current claim for benefits; (5) termination of benefits; (6) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; (7) a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigative or not medically necessary or appropriate.

AHA means the American Hospital Association.

Allowable Amount means the maximum allowable charge for any medically necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's allowable expenses shall in no event exceed the other plan's allowable expenses.

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

Alternate Resources are any Federal, State, local, or private source of coverage for which the patient is eligible. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under the Social Security Act (i.e., Medicare and Medicaid), State and local health care programs, and private insurance. See 42 CFR § 136.21; 42 CFR § 136.61. Note: This Plan is a Tribal Self-Insurance Plan (TSIP), which is considered a health program operated by an Indian tribe for purposes of the payor of last resort rule. See 25 U.S.C. § 1623(b). Therefore, this Plan shall not be considered Alternate Resources for purposes of the payor of last resort rule without express written authorization from the Tribe pursuant to Section 206(f) of the Indian Health Care Improvement Act, 25 U.S.C. § 1621e(f).

Alveolar means pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

AMA means the American Medical Association.

Amalgam means a mostly silver filling often used to restore decayed teeth.

Ambulance Service is a service provided by a vehicle that is used for the transportation of ill or injured individuals to a hospital or other medical facility.

Ambulatory Surgical Center means any public or private State licensed and approved (whenever require by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the Institution, and which does not provide service or other accommodations for patients to stay overnight.

Ancillary Services means services rendered in connection with Inpatient or outpatient care in a Hospital or in connection with a medical Emergency including the following: Ambulance, anesthesiology, assistant surgeon, pathology, and radiology. This term also includes the attending Physician or primary surgeon in the event of a medical Emergency.

Appeal(s) means an oral or written request from a Covered Member or an authorized representative concerning any adverse benefit determination for the reconsideration of a decision regarding a previously submitted Complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits. The act of submitting such requests is considered an Appeal.

Approved Clinical Trial means a clinical trial as defined at <https://clinicaltrials.gov>.

Approved Treatment Facility means an alcohol/Drug abuse treatment facility operating under the direction and control of the Washington State Department of Social and Health Services and is an "Approved Treatment Facility".

Approved Treatment Program is a written outline of proposed treatment that is submitted by the attending physician/provider to the Third Party Administrator for review and approval.

Assignment of Benefits is an arrangement whereby you, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to your provider. If your provider accepts said arrangement, your providers' rights to receive Plan benefits are equal to yours and are limited by the terms of this Plan Document. If your provider accepts this arrangement and indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an assignment of benefits previously issued to your provider at its discretion and continue to treat you as the sole beneficiary.

Autism Spectrum Disorders is a group of neurobiological disorders that may include, but are not limited to Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrative Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

Biofeedback therapy is an electronic method which allows you to monitor the functioning of the body's autonomic systems (e.g., body temperature, heart rate) that were previously thought to be involuntary.

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

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

Bitewing X-ray means an X-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gum line, as well as a portion of the roots and supporting structures of these teeth.

Brand Name Drug means Drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

Brand Name Formulary Drugs are Drugs included in the approved list of Drugs (the Formulary) used by this Plan.

Bridge means a replacement for a missing tooth or teeth. The Bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

Calendar Year means the 12-month period beginning January 1 and ending December 31.

Cardiac Care Unit means a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area
- It contains at least two beds for the accommodation of critically ill patients
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis

Care Management means the individual or organization designated by the Plan Administrator to authorize medical facility admissions and surgeries and to determine the medical necessity of treatment for which Plan benefits are claimed.

Caries means decay. A disease process initiated by bacterially produced acids on the tooth surface.

Caries Susceptibility Test means a test done to determine how likely someone is to develop tooth decay. The test is usually done by measuring the concentration of certain bacteria in the mouth.

Certificate of Creditable Coverage means a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Chemical Dependency means the addiction to or abuse of Drugs, alcohol, or any other chemical substances. Chemical Dependency is characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. Chemical Dependency does not include addiction to, or dependence on, tobacco, tobacco products or foods.

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic care is used most often to treat neuromusculoskeletal complaints, including but not limited to back pain, neck pain, and pain in the joints of the arms or legs, and headaches.

Claimant means a Member in the Plan, or an entity acting on your behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

Cochlear Implant is a device for treatment of severe-to-profound hearing loss in individuals who only receive limited benefit from amplification with hearing aids.

Complaint means an oral or written report by a Covered Member or authorized representative regarding dissatisfaction with customer service or the availability of a health service.

Complications of Pregnancy means conditions whose diagnoses are distinct from Pregnancy, but adversely affected by Pregnancy or caused by Pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, and eclampsia. They may also be due to a non-elective cesarean section Surgical Procedure or a terminated ectopic Pregnancy.

Complications of Pregnancy does not mean false labor; occasional spotting; prescribed rest during the period of Pregnancy; or similar conditions associated with the management of a difficult Pregnancy, but not constituting

a distinct complication of Pregnancy.

Comprehensive Oral Evaluation means a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It is typically used by a general Dentist and/or Specialist when evaluating a patient comprehensively.

Contraception Management and Family Planning Services means planning intended to determine the number and spacing of one's children through birth control.

Coping means a thin thimble of a Crown with no anatomic features. It is placed on teeth prior to the placement of either an Overdenture or a large span Bridge. The purpose of a Coping is to allow the removal and modification of the Bridge without requiring a major remake of the Bridgework, if the tooth is lost.

Cosmetic or Cosmetic Surgery means any Surgery, medical, dental, or vision service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by a covered Illness, and when approved as Medically or Dentally Necessary, or an Injury.

Covered Expense(s) means a charge for a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the maximum allowable charge for an eligible medically necessary service, treatment or supply, meant to improve a condition or your health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the covered expense is the least costly option that is no less effective than any other option.

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

Covered Member means a person that is eligible for benefits under the Plan.

Crown means a restoration that replaces the entire surface of the visible portion of tooth.

Custodial Care means care or service which is not medically necessary and is designed essentially to assist you in the activities of daily living. Such care includes, but is not limited to: bathing, feeding, preparation of special diets, assistance in walking, dressing, getting into or out of bed and supervision over taking of medication which can normally be self-administered.

Debridement is the removal of excessive amounts of Plaque or tartar from teeth.

Delivery Date means the date a prosthetic appliance is permanently cemented into place.

Dental Hygienist means a person who is Licensed to practice dental hygiene and who is practicing within the scope of their License.

Dentally Necessary means services or supplies that are determined by the Third Party Administrator to be:

- Appropriate and necessary for the symptoms, diagnosis, or direct care and treatment of the dental condition, Injury or Illness
- Provided for the diagnosis or direct care and treatment of the dental condition, Injury or Illness
- Within standards of good dental practice within the organized dental community
- Not primarily for the convenience of the Covered Member, the Covered Member's Dentist or another Provider
- The most appropriate supply or level of service which can safely be provided

Dental Implant means a device specifically designed to be placed Surgically within the jawbone as a means of providing an anchor for an artificial tooth or Denture.

Dentist or Dentists means an individual or individuals holding a D.D.S. or D.M.D. degree, who are Licensed to practice dentistry in the jurisdiction where such services are provided.

Denture means a removable prosthesis that replaces missing teeth. A complete (or "full") Denture replaces all of the upper or lower teeth. A partial Denture replaces one to several missing upper or lower teeth.

Denturist means a person who is Licensed to make, fit and repair Dentures and who is practicing within the scope of their license.

Detoxification means the process whereby an alcohol-intoxicated person, or person experiencing the symptoms of Substance Abuse, is assisted in a facility licensed by the Department of Health through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with Drugs as determined by a Licensed Physician, while keeping the physiological risk to the patient to a minimum.

Diagnosis is the act or process of identifying or determining the nature and cause of a disease or injury through evaluation of your history, examination, and review of laboratory data.

Diagnostic Service or Diagnostic Services means tests or procedures performed for specified symptoms to detect or to monitor an Illness or Injury. They must be ordered by a Physician or other professional Provider.

Donor is the individual who provides the organ for the recipient in connection with organ transplant surgery. A donor may or may not be covered under the provisions of this Plan.

Drug(s) means insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a State restricted Drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a Licensed Drug dispenser only upon a prescription of a currently Licensed Physician.

Durable Medical Equipment (DME) means equipment prescribed by the attending physician/provider which meets all of the following requirements:

- Is medically necessary;
- Is designed for prolonged and repeated use;
- Is for a specific purpose in the treatment of an Illness or Injury and not solely your convenience;
- Would have been covered if provided in a medical facility;
- Is necessary for activities of daily living; and
- Is appropriate for use in the home.

Elective Surgical Procedure is a surgical procedure that need not be performed on an emergency basis because reasonable delay will not cause life endangering complications.

Emergency Care means the care required in connection with a sudden and unexpected onset of a medical condition that could be considered life threatening.

Emergency Dental Condition means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

Emergency Examination means otherwise covered dental or medical care services Medically Necessary to evaluate and treat an Emergency Dental Condition or an Emergency medical condition.

Emergency Services means, with respect to a medical emergency, the following:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition.
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

When furnished with respect to an emergency medical condition, emergency services shall also include an item or service provided by an Out-of-Network provider or Out-of-Network health care facility (regardless of the department of the hospital in which items or services are furnished) after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency services are furnished, until such time as the provider determines that the Member is able to travel using non-medical transportation or non-emergency medical transportation, and the Member is in a condition to, and in fact does, give informed consent to the provider to be treated as an Out-of-Network provider.

Endodontics means the diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Exclusions means those services that are not covered benefits under the Plan.

Experimental or Investigative Treatment means for the purpose of determining eligible expenses under this Plan (other than off-label drug use, see definition for "Off-Label Drug Use"), a treatment will be considered by the Plan to be experimental or investigative if:

1. The treatment is governed by the United States Food and Drug Administration ("FDA") or another United States governmental agency and the FDA or the other United States governmental agency has **not** approved the treatment for the particular condition at the time the treatment is provided;
2. The treatment is the subject of ongoing clinical trials as defined by the National Institute of Health, National Cancer Institute or the FDA, see <https://clinicaltrials.gov>; or
3. There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity, or efficacy of the treatment.

FDA means the United States Food and Drug Administration.

Filled Resin means tooth-colored plastic materials that contain varying amounts of special glass-like particles that add strength and wear resistance.

Fluoride means a chemical agent used to strengthen teeth to prevent cavities.

Fluoride Varnish means Fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular Fluoride and is typically more effective than other Fluoride delivery systems.

General Anesthesia is the induction of a State of unconsciousness with the absence of pain sensation over the entire body through the administration of anesthetic Drugs.

Generally Accepted means considered by the medical profession as necessary and appropriate for treatment of a patient's Illness or Injury.

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

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Homebound is when leaving the home could be harmful, involves a considerable and taxing effort, and you are unable to use transportation without the assistance of another.

Home Health Care means certain services and supplies required for treatment of an Illness or Injury in the Covered Members' home as part of a formal treatment plan certified by the attending Physician and approved by the Plan Administrator.

Home Health Care Agency means an agency or organization which provides a program of Home Health Care and which:

- Is approved as a Home Health Agency under Medicare
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing

Hospice Care Agency means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the State in which it is located.

Hospital means an Institution that meets all of the following requirements:

- It provides medical and Surgical facilities for the treatment and care of injured or sick persons on an Inpatient basis
- It is under the supervision of a staff of Physicians
- It provides 24-hour-a-day nursing service by registered nurses
- It is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax-supported Institution
- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a Custodial or training-type Institution, or an Institution which is supported in whole or in part by a Federal government fund
- It is accredited by the Joint Commission on Accreditation of Health Care Organizations sponsored by the AMA and the AHA or licensed by the State in which it is located

The requirement of Surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such an Institution by the Joint Commission on Accreditation of Health Care Organizations sponsored by the AMA and AHA.

Illness means a pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal state differing from other normal body states; typically indicates a disease, physical sickness or Mental Disorder. For purposes of the administration of this Plan, Illness also includes Pregnancy, childbirth, miscarriage or complications thereof.

Immediate Relative means Spouse, child, brother, sister, parents, or grandparent of the Covered Member, whether by birth, adoption, or marriage.

Impregnation and Infertility Treatment means artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra TM, in-vitro fertilization, reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial Impregnation procedure, whether or not such procedure is successful.

Incurred means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered, unless otherwise expressly denoted elsewhere in this document).

Injury means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an Accident.

Inlay means a dental filling shaped to the form of a cavity and then inserted and secured with cement.

Inpatient is when a person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24- hour-day basis.

If a Plan Member seeks emergency services through a hospital's emergency room and is admitted as a hospital inpatient at that time due to that emergency, coverage for that inpatient confinement will be provided as an inpatient hospital benefit, not as an emergency room benefit.

Inpatient Stay means an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Institution means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, Substance Abuse Treatment Center, alternative Birthing Center, Home Health Care center, or any other such facility that the Plan approves.

Intensive Care Unit means a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area
- It contains at least two beds for the accommodation of critically ill patients
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day-basis

Intensive Outpatient Treatment means a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermediate Level of Care means a Mental Health or Substance Use Disorder treatment that encompasses the following:

- Care at a residential treatment facility.
- Care at a partial hospitalization/day treatment program.
- Care through an intensive outpatient treatment program.

Intraoral x-rays Complete Series (including Bitewings) means a series of radiographs which display the root and coronal portions of all the teeth in the mouth.

Intravenous (I.V.) Sedation means a form of Sedation whereby the patient experiences a lowered level of consciousness, but is still awake and can respond.

Licensed Professional means an individual legally authorized to perform services as defined in his or her license. Licensed Professionals include, but is not limited to, a Denturist, hygienist and radiology technician.

Limitations mean those services that are subject to restricting conditions set forth in the Plan Document.

Localized Delivery of Antimicrobial Agents means treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing Drugs into the gum pocket. This therapy is viewed as an alternative to gum Surgery when conditions are favorable.

Mastectomy means the surgical removal of all or part of a breast.

Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under this Plan. The maximum allowable charge will be a negotiated rate, including a case/claims negotiation agreement, if one exists. In the event that the negotiated rate per the terms of an applicable provider contract is higher than billed, the Plan may reimburse at the higher allowance in order to comply with terms of the provider contract.

If none of the above factors are applicable, the maximum allowable charge will be at the discretion of the Plan Administrator and will be determined to be a percentage, as outlined in the Schedule of Benefits, multiplied by the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS"), a percentage of billed charges, or multiplied by a percentage that the particular provider and/or others in the area customarily accept from all payers.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on a percentage (as outlined in the Schedule of Benefits) of one of the following:

- Visium Medicare Equivalency tables (prices established by CMS utilizing standard Medicare payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS);
- Visium Approximation tool (prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care); or
- Visium Care Crosswalk (prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings).

If and only if none of the factors above are applicable, the Plan Administrator will exercise its discretion to determine the maximum allowable charge based on any of the following: Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

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

Medical Facility (Hospital) means an institution accredited by the Joint Commission on Accreditation of Healthcare Organizations and which receives compensation from its patients for services rendered. On an inpatient basis, it is primarily engaged in providing all of the following:

- Diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and ill Members, such as yourself.
- Services performed by or under the supervision of a staff of physicians/providers who are duly licensed to practice medicine.
- Continuous 24 hours a day nursing services by registered nurses.

For the services covered under this Plan and for no other purpose, inpatient treatment of mental illness or substance use, provided by any psychiatric medical facility licensed by the State Board of Health or the Department of Mental Health, will be considered services rendered in a medical facility as defined subject to the limitations shown in this booklet.

The term "Hospital" or "Medical Facility" will **not** include an institution which is primarily: a place for rest or retirement; a residential treatment facility (except as provided under the Substance Use Disorder Treatment or Mental Health Services benefit, health resort; a place for the aged; a convalescent home; or a nursing home.

Medically Necessary means medical services and/or supplies which are absolutely needed and essential to diagnose or treat an illness or injury of yours while covered by this Plan. The following criteria must be met. The treatment must be:

- Consistent with the symptoms or diagnosis and treatment of your condition.
- Appropriate with regard to standards of good medical practice.

- Not solely for the convenience of you, your family members or your provider of services or supplies.
- The least costly of the alternative supplies or levels of service which can be safely provided to you. When specifically applied to a medical facility inpatient, it further means that the service or supplies cannot be safely provided in other than a medical facility inpatient setting without adversely affecting your condition or the quality of medical care rendered.

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

Medicare means the programs established by Title XVIII of the U.S. Social Security Act as amended and as may be amended, entitled Health Insurance for the Aged Act, and which includes Part A - Hospital Insurance Benefits for the Aged; and Part B - Supplementary Medical Insurance Benefits for the Aged.

Medicare Like Rates (MLR) means the amount that a provider is required to accept as payment in full under Section 506 of the Medicare Modernization Act of 2003 and the final regulations issued thereunder (42 C.F.R. §136.30-136.36 and 42 C.F.R. §489.29). As part of a tribal health program of which this Plan is a part, these benefits are authorized by a tribe or tribal organization carrying out a Purchased Referred Care program of the Indian Health Service under the ISDEAA, and all amendments thereto. MLR for purposes of this Plan also includes Professional and Non-Hospital Based Care, as applicable.

Members means all enrolled Suquamish Tribal Members.

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

Morbid Obesity means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds, has a BMI of 40 or more, or a BMI of 35 or more and experiencing one or more obesity-related health conditions such as diabetes mellitus, hypertension, coronary artery disease, obstructive sleep apnea, high cholesterol, arthritis, venous stasis disease, or soft tissue infections.

Network means the Preferred Provider Organization (PPO) Network of Providers offering discounted fees for services and supplies to Covered Members. The Network will be identified on the Covered Member's Plan Identification Card.

Night Guard — See Occlusal Guard.

NIH means the National Institutes of Health.

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

Non-Formulary Drugs are Drugs that are not included in the approved list of medications payable by this Plan.

Non-Preferred Provider or Facility is any Provider or Facility not contracted with HMA Preferred, either directly or indirectly.

Occlusal Adjustment means modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the Temporomandibular Joints and the structure supporting the teeth.

Occlusal Guard means a removable dental appliance, sometimes called a Night Guard, which is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An Occlusal Guard is typically used at night.

Off-Label Drug Use is the use of a drug for a purpose other than that for which it was approved by the FDA. For purposes of determining whether off-label use for a FDA approved drug is eligible for coverage under the Plan versus investigative, the following will apply:

1. Medically necessary off-label drug use will be accepted if the drug is otherwise covered by the Plan and if one of the following criteria are met:
 - A. Drug Compendia: One of the following drug compendia indicates that the drug is recognized as effective for the indication:
 - The American Hospital Formulary Service Drug Information;
 - Drug Facts and Comparison;
 - The U.S. Pharmacopoeia Dispensing Information;
 - American Medical Association Drug Evaluation;
 - National Cancer Care Network;
 - National Cancer Institute; or
 - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services.
 - B. Scientific Evidence/Substantially Accepted Peer-Reviewed Medical Literature: The majority of the scientific evidence indicates that the drug is effective for the off-label indication. The evidence must:
 1. Consist of an adequate number of well-designed studies with sufficient numbers of patients in relation to the incidence of the disease;
 2. Be published in peer reviewed journals. The studies must be printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity, and reliability;
 3. There must be enough information in the peer-reviewed literature to allow judgment of the safety and efficacy;
 4. Demonstrate consistent results throughout all studies; and
 5. Document positive health outcomes and demonstrate:
 - i. That the drug is as effective as or more effective than established alternatives; and
 - ii. Improvements that are attainable outside the investigational setting.
 - C. Recognized as effective for treatment of such indication by the Federal Secretary of Health and Human Services.

Onlay means a restoration of the contact surface of the tooth that covers the entire surface.

Oral Surgical Procedures, including:

- Emergency repair due to Injury to sound natural teeth
- Excision of benign bony growths of the jaw and hardpalate
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- External incision and drainage of cellulitis
- Incision of sensory sinuses, salivary glands or ducts
- Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth

Order of Benefits Determination is the method for ascertaining the order in which the Plan renders payment. The principle applies when another plan has a Coordination of Benefits provision.

Orthodontics means diagnosis, prevention and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large, too small, too far forward, or too far back). An Orthognathic Condition may cause overbite, under bite, or open bite. Orthognathic (jaw realignment) Surgery may be performed to correct skeletal mismatches of the jaw.

Orthotics means an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve function of movable parts of your body.

Other Plan shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering you.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Outpatient Surgical Facility is a licensed surgical facility, surgical suite or medical facility surgical center in which a surgery is performed and you are not admitted for an overnight stay.

Overdenture(s) means a removable Denture constructed over existing natural teeth or implanted studs.

Over-utilization means the practice of applying more than what is necessary to evaluate and treat the problem at hand; or a redundancy in treatment options; or that which most practitioners in the discipline would consider to be in excess of sufficient measures.

Palliative Treatment means services received from a provider specialized in palliative care which can be provided in a home, inpatient or outpatient setting.

Panorex X-ray means an x-ray, taken from outside the mouth that shows the upper and lower teeth and the associated structures in a single picture.

Partial Hospitalization/Day Treatment is a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participating (PAR) Provider is a provider who is part of a network of providers who has entered into a current participating agreement with the Third Party Administrator, or a contractor for the Third Party Administrator.

Payor of Last Resort means, in accordance with 42 C.F.R. 136.31, The Suquamish Tribe Indian Health Plan is always in the Payor of Last Resort position if any other coverage is available for health services provided to the patients eligible for Purchased Referred Care (PRC) formerly Contract Health Services (CHS) from the tribe. This includes Federal, State, employer, or any other health or medical plan coverage or benefits.

Periodic Oral Evaluation (Routine Examination) means an evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

Periodontics means the diagnosis, prevention and treatment of diseases of gums and the bone that supports teeth.

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

Physical Therapy is the treatment of an Illness, Injury or condition by physical means, such as massage, hydrotherapy, heat, or similar modalities when performed by a Licensed or registered physical therapist.

Plan means the Purchased Referred Care (PRC) formerly Contract Health Services (CHS) Plan of The Suquamish Tribe, which is a health plan for certain Suquamish Tribal Members.

Plan Administrator means The Suquamish Tribe. The Plan Administrator reserves the sole discretionary authority to interpret any and all provisions of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan associated services.

Plan Benefits means covered medical services and other services provided under this Health Plan and described in this booklet.

Plan Document whenever used herein shall, without qualification, mean the document containing the complete details of the benefits provided by this Plan. The Plan Document is kept on file at the office of the Plan Administrator.

Plan Member is any Covered Member under this Plan.

Plan Sponsor means The Suquamish Tribe.

Plan Year means an annual period beginning on the effective date of this Plan and ending twelve (12) calendar months thereafter or upon termination of the Plan, whichever occurs earliest.

Plaque means the flat masses of bacteria and debris on tooth surfaces.

Posterior Tooth means any one of the last five (5) teeth (bicuspid, molars and pre-molars) at the back of the upper (maxillary) or the lower (mandibular) jaw.

PPO Negotiated Fees means amounts that PPO Providers or preferred pharmacies have contracted to accept as payment in full for Covered Expenses of the Plan.

Preauthorization means to inform HMA's Care Management Department of certain non-emergent or elective Surgical, treatment or care services and Hospital admissions as defined in the **Care Management Section** and the Schedule of Benefits Section. Notice must be provided to HMA's Care Management Department as outlined in the **Care Management Section** within the time frames specified.

Failure to Preauthorize services may result in charges being denied. Preauthorization, by itself, does not imply that services will be covered by the Plan.

Pre-Admission Tests means those Diagnostic Services done before a scheduled Hospital Inpatient admission, provided that the tests are required by the Hospital and approved by the Physician; performed on an outpatient basis prior to Hospital admission; not duplicated on admission to the Hospital; and are performed at the Hospital where the confinement is scheduled, or at a qualified facility approved by the Hospital to perform the tests.

Preferred Network Health Care Facility means a hospital or hospital outpatient department, critical access hospital, outpatient surgical center, or other provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Preferred Provider is a Provider who has contracted with HMA Preferred, either directly or indirectly, to provide health care services to Covered Members. Preferred Providers are contracted to accept PPO Negotiated Fees as payment in full for Covered Expenses of the Plan. Preferred Provider is a Provider or a facility that participates in a Preferred Provider Organization (PPO) and who has entered into a special agreement with and is included in the current listing of Preferred Providers recognized by this Plan.

Pregnancy means carrying a child, resulting childbirth, miscarriage and non-elective termination of Pregnancy. The Plan considers Pregnancy as an Illness for the purpose of determining benefits.

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

Privacy Standards means the standards for privacy of individually identifiable health information, as enacted pursuant to HIPAA.

Prophylaxis means cleaning and polishing of teeth.

Prosthodontics means the replacement of missing teeth by artificial means such as Bridges and Dentures.

Protected Health Information (PHI) is Individually Identifiable Health Information, as defined in HIPAA §164.501 (see §164.514(2)(b)(i) for individual identifiers), whether it is in electronic, paper or oral form that is created or received by or on behalf of the Plan Sponsor or the Third Party Administrator.

Provider is an entity whose primary responsibility is related to the supply of medical care. Each provider must be licensed, registered, or certified by the appropriate state agency where the medical care is performed, as required by that state's law where applicable. Where there is no applicable state agency, licensure, or regulation, the provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a provider as defined herein if that entity is not deemed to be a provider by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

Psychiatric Hospital means an Institution constituted, licensed, and operated as set forth by the laws that apply to Hospitals.

Reasonable and/or Reasonableness means in the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as related to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration (FDA); and (c) the Centers for Medicare and Medicaid Services (CMS). A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not reasonable.

To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are reasonable based upon information presented to the Plan Administrator.

Reasonableness may be based upon coding and billing standards which include but are not limited to those defined by the American Medical Association CPT (Current Procedural Terminology) and the Centers for Medicare and Medicaid Services National Correct Coding Initiative, Optum Coding resource manuals, Regence reimbursement guidelines and policies, as well as the UB04 Billing Manual coding guidelines and definitions and the National Uniform Billing Committee guidelines as applicable. Claims are subject to additional review upon submission prior to final payment.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not reasonable and therefore not eligible for payment by the Plan.

Recipient is the Member who receives the organ for transplant from the organ donor. The recipient shall be a Member covered under the provisions of this Plan. Only those organ transplants not considered experimental in nature and specifically covered herein are eligible for coverage under this Plan.

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

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

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

Rehabilitative Care means care that improves lost bodily function caused by Injury or Illness, including physical, speech and hearing therapy, rehabilitative counseling, and functional occupational therapy.

Rehabilitation Hospital (Facility) means an Institution which mainly provides therapeutic and Restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant Federal, State and local laws
- It is accredited for its stated purpose by either the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation for Rehabilitation Facilities
- It is approved for its stated purpose by Medicare

Relative when used in this document shall mean a husband, wife, domestic partner, son, daughter, mother, father, sister or brother of you, or any other person related to you through blood, marriage, domestic partnership or adoption.

Residential Treatment Facility is a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a physician/provider and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A residential treatment facility that qualifies as a hospital is considered a hospital.

Resin-Based Composite means a tooth colored filling, made of a combination of materials, used to restore teeth.

Restorative means replacing portions of lost or diseased tooth structure with a filling or Crown to restore proper dental function.

Room and Board means an Institution's charge for:

- Room and linen service
- Dietary service, including meals, special diets and nourishment
- General nursing service
- Other conditions of occupancy which are Medically Necessary

Root Planing means a procedure done to smooth roughened root surfaces.

Sealants means a material applied to teeth to seal surface irregularities and prevent tooth decay.

Seat Date means the date a Crown, Veneer, Inlay or Onlay is permanently cemented into place on the tooth.

Second Surgical Opinions include an additional opinion received by a Provider who is not affiliated with the Physician who recommended the Surgical Procedure.

Security Standards means the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Rate is the daily room and board charge which an institution applies to the greatest number of beds in its semi-private rooms containing 2 or more beds. If the institution has no semi-private rooms, the semi-private rate will be the daily room and board rate most commonly charged for semi-private rooms with two or more beds by similar institutions in the area. The term "area" means a city, a county, or any greater area necessary to obtain a representative cross section of similar institutions.

Skilled Nursing/Rehabilitation Facility is an institution or a distinct part of an institution meeting all of the following tests:

- It is licensed to provide and is engaged in providing, on an inpatient basis, for you if you are convalescing from injury or disease, professional nursing services rendered by a Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Graduate Nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
- Its services are provided for compensation from its patients and patients are under the full-time supervision of a physician/provider or Registered Graduate Nurse (R.N.).
- It provides 24 hours per day nursing services by a licensed nurse, under the direction of a full-time Registered Graduate Nurse (R.N.).
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest for the aged, drug addicts, alcoholics, the mentally handicapped, custodial, or educational care, or care of mental disorders.

Specialist means a Licensed Physician who has successfully completed an accredited education program, two or more years in length.

Spouse means the person recognized as the Covered Member's husband or wife to whom the Covered Member is legally married. The marital relationship must be legally recognized by the state of Washington.

Subgingival Curettage means the process of removing or cutting diseased soft tissue surrounding the tooth.

Subrogation means the Plan's right to pursue and lien upon the Covered Member's claims for medical or dental charges against a responsible Third Party.

Substance Use and/or Substance Use Disorder means any disease or condition that is classified as a substance use disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant state guideline or applicable sources. The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

Substance Use Treatment Center means an Institution which provides a program for the treatment of Substance Use by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

- Affiliated with a Hospital under a contractual agreement with an established system for patient referral
- Accredited as such a facility by the Joint Commission on Accreditation of Health Care Organizations

- Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State Agency having legal authority to do so

Summary Plan Description means this Plan Document.

Surgery or Surgical Procedure means any of the following:

- The incision, excision, Debridement or cauterization of any organ or part of the body, and the suturing of a wound
- The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction
- The removal by endoscopic means of a stone or other foreign object from any part of the body or the Diagnostic examination by endoscopic means of any part of the body
- The induction of artificial pneumothorax and the injection of sclerosing solutions
- Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa
- Obstetrical delivery and dilation and curettage
- Biopsy

Surgical Dressings, Splints, Casts, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an illness or injury.

Temporomandibular Joint means the joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

Temporomandibular Joint (TMJ) Disorders are defined as having one or more of the following characteristics:

- Pain in the musculature associated with the Temporomandibular Joint
- Internal derangement of the Temporomandibular Joint
- Arthritic problems with the Temporomandibular Joint
- An abnormal range of motion or limitation of motion of the Temporomandibular Joint

Therapy includes cognitive behavioral therapy, interpersonal therapy, dialectical behavior therapy, psychoanalysis, psychotherapy, family therapy, individual therapy, marriage therapy, or marital therapy.

Third Party means another person or a business entity that is not a party to this Plan.

Third Party Administrator means Healthcare Management Administrators, Inc.

Transitional Care means Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist you with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide you with stable and safe housing and the opportunity to learn how to manage your activities of daily living. Supervised living arrangements may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist you with recovery.

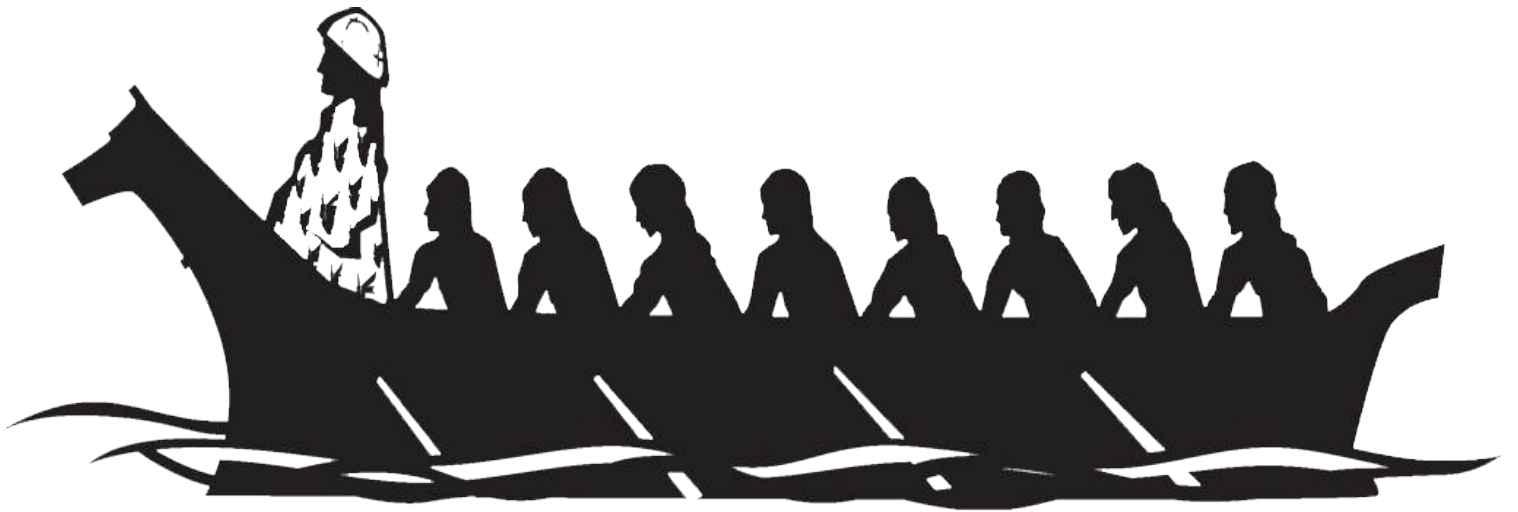
Treatment is the administration or application of remedies to you for a disease or injury; medicinal or surgical management or therapy.

Urgent Care means services for an unforeseen illness or injury that requires treatment within 24 hours to prevent deterioration of a person's health. Urgent conditions are normally less severe than true medical emergencies. Examples of conditions that could need Urgent Care are sprains and strains, vomiting, cuts, severe headaches and fever.

Urgent Care Facility is a freestanding facility which is engaged primarily in providing minor Emergency and episodic medical care. An Urgent Care Facility is not a Hospital emergency room.

Utilization Review means retrospective review of the medical necessity of Emergency hospitalizations or procedures, concurrent review of courses of treatment, and discharge planning. Utilization Review is performed to determine the scope of coverage under the Plan. It is not intended to be either the practice of medicine or a substitute for the attending Physician's medical judgment.

Veneer means a layer of tooth-colored material, usually porcelain or acrylic Resin, attached to the tooth surface by direct fusion, cementation, or mechanical retention.



THE SUQUAMISH TRIBE

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