PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

NASOMAH HEALTH GROUP CORPORATION

PPO PLAN

UPDATED MAY 1, 2006

TABLE OF CONTENTS

INTRODUCTION 2
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND
TERMINATION PROVISIONS 3
OPEN ENROLLMENT 19
SCHEDULE OF BENEFITS 20
MEDICAL BENEFITS 30
COST MANAGEMENT SERVICES 44
DEFINED TERMS 51
PLAN EXCLUSIONS 66
PRESCRIPTION DRUG BENEFITS 74
VISION CARE BENEFITS 77
DENTAL BENEFITS 78
HOW TO SUBMIT A CLAIM 85
COORDINATION OF BENEFITS 92
THIRD PARTY RECOVERY PROVISION 97
CONTINUATION COVERAGE RIGHTS UNDER COBRA 100
RESPONSIBILITIES FOR PLAN ADMINISTRATION 112
GENERAL PLAN INFORMATION 123

NASOMAH HEALTH GROUP

Background

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

Origination

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

Established

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

Tribal Commitment

Since Nasomah's inception, the Coquille Indian Tribe has contributed over $20 million in premiums to the Nasomah Health Group program on behalf of Tribal members and Tribal employees.

INTRODUCTION

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

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

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

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

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

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

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

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Participants All regular Full-time Participants of the ORCA Commission, Coquille Economic Development Corporation (CEDCO), The Mill Casino, the Mill Hotel, Coquille Indian Tribal Administration Office, Community Health Center (CHC), Gaming Commission, and the Nasomah Administration.

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

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

(2) completes the employment Waiting Period as stated below:

For Mill Casino, Mill Hotel, CEDCO, and ORCA Commission:

A. Executive Management Participants – the waiting period is waived. The effective date of eligibility will be from the date of hire.

B. Mid-Level Management/Technical Manager – the effective date of eligibility will be the first of the month following 30 days from the date of hire.

C. Administrative or Office Support Positions – the effective date of eligibility will be the first of the month following 90 days from the date of hire.

D. All other full-time Participants – the first of the month following 180 consecutive days as an Active Participant.

For all ORCA Commission, CHC, Gaming Commission, and the Nasomah Program Director regular full-time Participants:

A. Executive Management Participants – the waiting period is waived. The effective date of eligibility will be from the date of hire.

B. All other regular full-time Participants – the waiting period will be as defined in the Employee's "Employee Personnel Manual".

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

(1) A covered Participant's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Participant for support and maintenance. However, a Dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Participant for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on the last day of the child's birthday month. If the child does not maintain full-time status or graduates, coverage terminates independent of limiting age.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

The term "Spouse" shall mean the covered Participant's legal spouse who is a resident of the same country in which the Participant resides, and is legally recognized as the covered Participant's husband or wife under the laws of the state where the covered Participant lives. The Plan

Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption or Foster Children. Step-children who reside in the Participant's household may also be included as long as a natural parent remains married to the Participant and also resides in the Participant's household.

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

The phrase "child placed with a covered Participant in anticipation of adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Participant of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

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

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

The phrase "primarily dependent upon" shall mean dependent upon the covered Participant for support and maintenance as defined by the Internal Revenue Code and the covered Participant must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth

certificates, tax records or initiation of legal proceedings severing parental rights.

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

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

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

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

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

If both husband and wife are covered under this Plan as Participants, they may both cover each other as Dependents. In the case of Dual

Coverage, this Plan will reimburse covered expenses according to the Coordination of Benefits provision of this Plan.

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

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

FUNDING

Contributions (Payments) must be made on a timely basis as follows:

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

PRE-EXISTING CONDITIONS

> **NOTE:** The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan even if that coverage is still in effect. The Plan will reduce the length of the Pre-Existing Condition Limitation period by each day of Creditable Coverage under this or a prior plan; however, if there was a significant break in the Creditable Coverage of 63 days or more, then only the coverage in effect after the break will be counted.
>
> An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible

person in obtaining a certificate of Creditable Coverage from a prior plan.

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

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

All questions about the Pre-Existing Condition Limitation and Creditable Coverage should be directed to the Plan Administrator, Nasomah Health Group Corporation, 3201 Tremont Street, North Bend, OR 97459.

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

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

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under any Creditable Coverage within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under any Creditable Coverage. A child has Creditable Coverage within 31 days if the child’s expenses are covered under the parent’s coverage during that period, either under this Plan or another plan, whether or not the child is ever enrolled in that Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

ENROLLMENT

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

Enrollment Requirements for Newborn Children.

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

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

TIMELY ENROLLMENT

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

If two Employees (the mother and father of the child(ren)) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

Late Enrollment Provisions Have Been Eliminated. Employees who do not enroll themselves and/or their eligible dependents in the Plan when they are first eligible will have to wait until the next Open Enrolment Period, April of each year. The only exception will be those individuals who qualify under the "Special Enrollment" provisions.

SPECIAL ENROLLMENT RIGHTS

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

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

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

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

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

(a) The Participant or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Participant stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Participant or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Participant or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of Non-COBRA coverage due to loss of eligibility or termination of employer contributions, as described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(e) For purposes of these rules, a loss of eligibility occurs if:

i. The Participant or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

ii. The Participant or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (ie: part-time employees).

iii. The Participant or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as

attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

iv. The Participant or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

v. The Participant or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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

(2) Dependent beneficiaries. If:

(a) The Participant is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Participant through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Participant) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Participant may be enrolled as a Dependent of the covered Participant if the Spouse is otherwise eligible for coverage. If the Participant is not enrolled at the time of the event, the Participant must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

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

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

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

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

(1) The Eligibility Requirement.

(2) The Enrollment Requirements of the Plan.

Active Employee Requirement.

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

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

TERMINATION OF COVERAGE

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

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

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Participant ceases to be in one of the Eligible classes. This includes death or termination of Active Employment of the covered Participant. (See the Continuation of Coverage Rights under COBRA.) It also includes a Participant on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) The last day of the month in which the required contribution was paid by the Participant if the charge for the next period is not paid when due.

(4) The earliest date the Participant has a claim that is denied in whole or in part because the Participant has met or exceeded a lifetime limit on all benefits.

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

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

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

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

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

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

Rehiring a Laid Off Employee. An Employee who is laid off and subsequently rehired within 30 days of the date of layoff, will be eligible to re-enroll in this Plan immediately upon rehire. Coverage win this case will become effective on the date of rehire. Coverage will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other waiting periods will not be imposed unless they were in effect for the

Employee and/or his or her Dependents when Plan coverage terminated due to the lay off. The Employee must request re-enrollment by completing an enrollment form.

Rehiring a Terminated Participant. An Employee who is terminated and subsequently rehired within 30 days of the date of termination, will be eligible to re-enroll in this Plan immediately upon rehire. Coverage in this case will become effective on the date of rehire. Coverage will be reinstated to the same extent that it was I force when that coverage terminated. For example, Pre-Existing Conditions limitations and other waiting periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

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

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

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

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

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Participant's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

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

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The last day of the month in which the Participant's coverage under the Plan terminates for any reason including death. (See the Continuation Coverage Rights under COBRA.)

(3) The last day of the month in which a covered Spouse loses coverage due to loss of dependency status. (See the Continuation Coverage Rights under COBRA.)

(4) The last day of the month in which Dependent coverage is terminated under the Plan.

(5) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA.)

(6) The last day of the month in which the required contribution was paid by the Participant if the charge for the next period is not paid when due.

(7) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a lifetime limit on all benefits.

OPEN ENROLLMENT

Every April, the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective May 1st and remain in effect until the next May 1st unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods and Pre-Existing Conditions Limits will be considered satisfied when changing from one plan to another plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive information regarding open enrollment from the Nasomah Health Group Corporation.

SCHEDULE OF BENEFITS

Verification of Eligibility 800-442-7247

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

MEDICAL BENEFITS

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

Note: Certain services must be precertified or reimbursement from the Plan may be reduced. Please see the Cost Management Services section in the booklet for information concerning precertification.

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

The Plan is a plan which contains the following Network Provider Organization:

Name: HealthCare Direct
Address: 25 82nd Street, Suite 200
Gladstone, OR 97027
Telephone: 877-287-2922
Fax: 503-562-8087
E-mail: www.hcdirect.net

Name: MultiPlan
Address: 2273 Research Blvd., 4th Floor
Rockville, MD 20850
Telephone: 301-548-2872
Toll Free: 800-525-3669
Fax: 301-548-2069
E-mail www.multiplan.com

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher in-Network payment will be made for certain non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a non-Network Provider at an in-Network facility.

Under certain circumstances, if Utilization Review locates a Non-PPO provider that can provide the same level of care and can negotiate a charge that is less cost to the Plan, then the Non-PPO provider's negotiated charge should be considered at the PPO benefit level according to the schedule of benefits.

Deductibles/Copayments payable by Plan Participants

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

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

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

PPO SCHEDULE OF BENEFITS

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	$1,000,000	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	0	$300
Per Family Unit	0	$300 per covered person
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR- The Calendar Year Out-of-Pocket maximums for Network and Non-Network Providres are **NOT** combined.		
Per Covered Person	$1,250	$2,500
Per Family Unit	$3,125	$6,250
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Any charge excluded in the Plan Exclusions		
COVERED CHARGES		
Coquille Indian Tribe Community Health Clinic (CITCHC)	100% after $15 copayment per visit	N/A
All Reimbursement Percentages – unless otherwise specified in this document	80%	70% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospital Services		
Inpatient Facility	80% after $200 copayment per day Room & Board charges are limited to the semiprivate room rate. ICU charges are limited to the ICU rate.	70% after deductible
Emergency Room – includes emergency medical care outside of the United States	80% after $100 copayment per visit Copayment waived if admitted	70% after $100 copayment per visit 80% if admitted
Ambulatory Surgery Center, Outpatient Surgery	80% after $50 copayment per surgery	70% after deductible
Skilled Nursing Facility	80% 60 days Calendar Year maximum	70% after deductible 60 days Calendar Year maximum
Physician Services		
Inpatient visits	80%	70% after deductible
Office visits - includes Lab, X-rays & Surgery performed in the physician's office	80% after $15 copayment per visit	70% after deductible
NOTE: Procedures over $1,250 must be precertified.		
Home Visits	80% after $25 copayment per visit	70% after deductible
Inpatient Anesthesiologist	80%	70% after deductible
Inpatient Surgeon	80% after $100 copayment per surgery	70% after deductible
Outpatient Anesthesiologist	80% after $15 copayment per surgery	70% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
OutpatientSurgeon	80% after $100 copayment per surgery	70% after deductible
Outpatient/ER Physician's Visit	80%	70% after deductible
Specialist Office Visit	80% after $15 copayment per visit	70% after deductible
Abortion – elective	80% after $15 copayment per procedure	70% after deductible
Allergy testing	80% after $15 copayment per visit	70% after deductible
Ambulance Service	80%	80%
Antigen Administration & Therapeutic injections	80% after $3 copayment per visit	70% after deductible
Blood/Blood Derivatives – donor and processing charges	80%	70% after deductible
Diabetes Education	80% $300 Calendar Year maximum	70% after deductible $300 Calendar Year maximum
Durable Medical Equipment - includes diabetic supplies, insulin pumps & orthotics. Must be precertified when over $1,250. Not to exceed the purchase price	80% $2,000 Calendar Year maximum	80% $2,000 Calendar Year maximum
EKG and Ultrasounds	80% after $20 copayment per procedure	70% after deductible
Family Planning Services – for services rendered in the physician's office or clinic	80% after $15 copayment per visit	70% after deductible
Home Health Care	80% 100 visits Calendar Year maximum	70% after deductible 100 visits Calendar Year maximum

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Home Oxygen & Related Supplies	80%	70% after deductible
NOTE: Maintenance and repair are limited to $500 Calendar Year Maximum.		
Hospice Care - including Bereavement Counseling	80%	70% after deductible
Injectables – outpatient Specialty Pharmacy Program	80%	80%
Jaw Joint/TMJ	80% after $15 copayment $500 Calendar Year Maximum	70% after deductible $500 Calendar Year Maximum
Laboratory & Radiology – performed outside of the physician's office	80% after $15 copayment per visit	70% after deductible
Mental Disorders		
Inpatient	80% after $200 copayment per day	70% after deductible
Outpatient	80% after $20 copayment per visit	70% after deductible
MRI, CT's, EEG's, Echocardiography, Holter Moniter, Treadmill Stress Tests	80% after $100 copayment per procedure	70% after deductible
Neurodevelopmental Therapy	80% after $15 copayment per visit	70% after deductible
Obesity – office visits covered for treatment planning of weight loss or dietary control of morbid obesity	80% after $15 copayment per visit	70% after deductible
Occupational Therapy	80% after $15 copayment per visit	70% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Organ and Bone Marrow Transplants		
Donor – when recipient is a Covered Person	80% $10,000 Lifetime maximum per transplant	70% after deductible $10,000 Lifetime maximum per transplant
Recipients Benefits	80%	70% after deductible
Physical Therapy - includes MIRE Treatment	80% after $15 copayment per visit	70% after deductible
Pre-admission Testing	80%	70% after deductible
Pregnancy - Prenatal & Postnatal Care	80% after $15 copayment per visit	70% after deductible
Birthing Center	80% after $200 copayment per day	70% after deductible
Dependent daughters not covered.		
Preventive Care		
Routine Well Adult Care - covered persons age 18 and over	80% after $15 copayment per visit	70% after deductible
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, vision tests, and immunizations/flu shots.		
Frequency limits for mammogram Ages 35 and over . . . . annually		
Routine Well Newborn Care - service performed outside of the hospital	80% after $15 copayment per visit	70% after deductible
Routine Well Child Care - age 2 through 17	80% after $15 copayment per visit	70% after deductible
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests, vision tests, and immunizations through age 17.		
Prosthetics	80%	70% after deductible

	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
Radiation Therapy & Chemotherapy	80% after $15 copayment per visit	70% after deductible
Second Surgical Opinion – referral required	80% after $15 copayment per visit	70% after deductible
Speech Therapy	80% after $15 copayment per visit	70% after deductible
Spinal Manipulation Chiropractic/ Massage Therapy/ Acupuncture - combined	80% after $10 copayment per visit $1,000 Calendar Year maximum	80% after $10 copayment per visit $1,000 Calendar Year maximum
Substance Abuse		
In addition to the following, ALL substance abuse services are limited to a Lifetime Maximum Benefit of $25,000. Each setting below has its own 24 month maximum benefit limit. This is the maximum benefit payable for the specific area noted, provided the combined maximum for all settings does not exceed $6,500 in a 24 month period.		
Inpatient	80% after $200 copayment per day $4,500 maximum every 24 months	70% after deductible $4,500 maximum every 24 months
Residential Facility & Day Program	80% after $20 copayment per visit $3,500 maximum every 24 months	70% after deductible $3,500 maximum every 24 months
Outpatient	80% after $20 copayment per visit $1,500 maximum every 24 months	70% after deductible $1,500 maximum every 24 months
Urgent Care Center	80% after $15 copayment per visit	80% after $15 copayment per visit
Wig After Chemotherapy	80% $250 Lifetime maximum	80% $250 Lifetime maximum

PRESCRIPTION DRUG BENEFIT

Retail Pharmacy Option

Generic drugs

Copayment $8

Percentage payable... 100%

Formulary Brand Name drugs

Copayment $25

Percentage payable... 100%

Non-Formulary Brand Name drugs

Copayment 30%

Percentage payable... 100%

Mail Order Prescription Drug Option

Generic drugs

Copayment $16

Percentage payable... 100%

Formulary Brand Name drugs

Copayment $50

Percentage payable... 100%

Non-Formulary Brand Name drugs

Copayment 30%

Percentage payable... 100%

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

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

VISION CARE BENEFITS

Calendar Year Maximum ....$250 per covered person

The Calendar Year Maximum includes charges for eye exams, eyeglass lenses and frames, prescription sunglasses, contact lenses and laser eye surgery.

DENTAL BENEFITS

Calendar Year deductible,
per person $50

per Family Unit $100

The deductible applies to these Classes of Service:
- Class B Services - Basic
- Class C Services - Major

Dental Percentage Payable

Class A Services -
Preventive.. 100%

Class B Services -
Basic..80%

Class C Services -
Major...50%

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

Maximum Benefit Amount

Per person per
Calendar Year $1,500

MEDICAL BENEFITS

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

DEDUCTIBLE

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

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

COPAYMENTS PAYABLE BY PLAN PARTICIPANTS

A copayment is the amount that a Covered Participant must pay directly to the provider each time a service or procedure is provided or performed before benefits are payable. Typically, that may be copayments on some services and other services will not have nay copayments.

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

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

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

LIFETIME MAXIMUM BENEFIT

Payments made for all Covered Expenses during the entire period of coverage for one Covered Person is limited to the Lifetime Maximum Benefit specified in the Schedule of Benefits.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

COVERED CHARGES

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

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

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Participant or covered Spouse.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally

does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

There is no coverage of Pregnancy for a Dependent child.

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

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

Covered charges for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule of Benefits.

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

- **(a)** Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:
  - **(i)** If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the

same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

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

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled

Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

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

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

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

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

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

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

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(e) **Circumcision** within 6 months of birth, or when deemed medically necessary by the physician.

(f) Initial **contact lenses** or glasses required following cataract surgery.

(g) **Cosmetic / Reconstructive Surgery.** Cosmetic / Reconstructive surgery, only if such surgery is to restore bodily function or correct deformity resulting from:

- **(i)** Illness;
- **(ii)** Accidental Injury
- **(iii)** For care and services for breast reconstruction and / or implantation or removal of breast prostheses only when such care and services are performed solely and directly as a result of mastectomy.

(h) **Dental Care.** Dental care, treatment, or x-rays only when necessitated as the direct result of an accidental injury to sound natural teeth and the jaw, occurring within 12 months from the date of an accident.

In addition, eligible expenses for necessary hospitalization (including prescription drug charges) incurred in conjunction with other dental care may be considered for payment if the primary reason for such confinement is deemed to be an underlying serious and hazardous medical condition.

(i) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(j) **Electrocardiograms and Electroencephalograms.** Magnetic resonance imaging (MRI), basal metabolism tests, or similar well established diagnostic tests generally approved by physicians throughout the United States.

(k) **Family Planning services,** including voluntary sterilization, birth control and elective abortions. Benefits are based on level of care. Refer to the schedule of benefits. **No pregnancy benefits are provided for dependent children, even if they are covered under this Plan.**

(l) **Home Oxygen.** Includes rental, but not to exceed purchase price (or if less costly to buy, initial purchase) of medically necessary Home Oxygen and equipment for its administration and related consumable and/or disposable supplies, as shown in the Schedule of Benefits. Benefits are not to be provided for Home Oxygen or related equipment that is customized or more elaborate than the cost of the least expensive adequate equipment.

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

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

Replacement of equipment due to normal use is covered.

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

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

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

(o) **Laboratory studies.**

(p) Treatment of **Mental Disorders and Substance Abuse**. Covered charges for care, supplies, Prescription Drugs and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximum shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(q) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving

orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(r) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(s) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

The maximum benefit for all transplant procedures performed during a Covered Person's lifetime is shown in the Schedule of Benefits.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Benefit payments for transplant charges are included under the Organ Transplant Maximum Benefit Limit shown in the Schedule of Benefits.

(t) **Orthotics.** The initial purchase, fitting, repair and replacement of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness that occurred while covered under the Plan.

(u) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. MIRE therapy is included.

(v) **Preadmission Testing.** Physician and Hospital outpatient services for preadmission testing for surgery at the Hospital where confined, provided admission occurs within (4) days after testing begins, as specified in the Schedule of Benefits.

(w) **Prescription** Drugs (as defined).

(x) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

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

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

(y) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(z) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

(aa) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

(bb) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. for the treatment of a musculoskeletal disorder (bone, muscle, tendon and joint) and for related diagnostic x-rays performed and billed by the chiropractor. Massage Therapy by a licensed massage therapist, and acupuncture are also covered up to the maximum specified in the Schedule of Benefits.

(cc) **Sterilization** procedures.

(dd) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(ee) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is

Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.
This coverage is only provided if the newborn child is an eligible dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth and the newborn child is an eligible Dependent and is neither injured nor ill.

This benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

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

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

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

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

(ff) Charges associated with the purchase of **wigs or artificial hair** pieces for hair loss due to injury, disease or treatment for a disease, to the maximum stated in the Schedule of Benefits. Wigs for Androgeneic alopecia (aka male pattern baldness) are not covered.

(gg) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

HealthComp Administrators
800-755-7247

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 5 days in advance of services being rendered or within 48 hours after an emergency.

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

UTILIZATION REVIEW

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

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalizations
Diagnostic Imaging over $1,250 including, but not limited to MRI/CAT scans
Diagnostic Procedures over $1,250 including, but not limited to Thallium treadmills, EGD, Sleep Studies, Colonoscopy and Mammography (other than routine screenings)
Substance Abuse/Mental Disorder treatments
Skilled Nursing Facility stays
Home Health Care or Home Infusion Therapy
Hospice Care

Durable Medical Equipment over $1,250 including but not limited to, respiratory products; orthotics/prosthetics
Injectables & Specialty Pharmacy Program
Physical, speech and/or occupational therapy
Cardiac rehabilitation therapy
Outpatient surgical procedures, to include procedures over $1,250 performed in the provider's office or in a facility connected with the provider's office
Residential Day Treatment programs
Referrals to Out-of-Network Providers

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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

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

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

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

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator HealthComp Administrators at 800-755-7247 **at least 5 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Participant
- The name, Social Security number and address of the covered Participant
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

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

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

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

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care

Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

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

SECOND AND/OR THIRD OPINION PROGRAM

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

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

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

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

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

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy

Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

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

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

CASE MANAGEMENT

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

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

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

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

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

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

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

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

"MOMMIES 2-B" PROGRAM

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

It is highly recommended that the expectant mother call Utilization Management's toll-free number: 1-800-755-7247, during the first trimester of pregnancy or upon confirmation of pregnancy. The "Mommies 2-B" Registered Nurse (RN) may also generate calls to the expectant mother. During the call, the RN will ask her questions about her general health and medical history in order to determine any risk factors for the pregnancy.

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

INJECTABLES & SPECIALTY PHARMACY PROGRAM

The Injectables & Specialty Pharmacy program is designed for covered persons receiving outpatient medical treatment by means of self-injectables or specialty medications. These medications may be prescribed for chronic conditions such as Multiple Sclerosis, Rheumatoid Arthritis, Psoriasis, Hepatitis C, Growth & Developmental Disorders, Cancer, and Hemophilia. Enrollment into this program is beneficial because you will receive your medications and supplies delivered to your home at a substantial savings. The program provides excellent customer service to you and your medical provider, and they will bill HealthComp directly for the cost of the drug. The member will also be billed by the Pharmacy Program, if applicable, for their coinsurance amount as determined in the schedule of benefits listed in their Plan document. **Precertification is mandatory in order to receive this benefit.** Contact 1-800-755-7247 to learn more about this excellent program.

DEFINED TERMS

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

Accidental Injury means physical harm caused by a sudden and unforeseen event at a specific time and place. It is independent of illness, except for infection of a cut or wound.

Active Employee is an Employee who is on the regular payroll of the Coquille Indian Tribe or one of its subsidiaries and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowable Charges means you will be reimbursed up to the Allowable Charges for the services you received. This program will not cover doctor's, dentist's or other provider's charges which exceed the prevailing charge in the local area for similar services.

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

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

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

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

Brand Name means a trade name medication.

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

Certified Nurse Midwife is a licensed registered nurse who has been certified by the American College of Nurse Midwives as a Nurse Midwife.

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

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

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

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

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

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

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

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed;

assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

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

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

Emergency is a sudden, serious and unexpected acute illness, injury or condition (including without limitation sudden and unexpected severe pain) which could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with the Claims Administrator.

Emergency Services are services provided in connection with the initial treatment of an emergency.

Employee is a person who is employed and compensated by the Coquille Indian Tribe or one of its subsidiaries.

Employer is The Mill Casino & Hotel, Coquille Indian Tribe, Coquille Economic Development Corporation, ORCA Commission, and Nasomah Health Group.

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

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

Expense Incurred is an expense incurred on the date the service is received or the supply is ordered.

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

community or government oversight agencies at the time services were rendered.

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

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or

protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

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

Fiduciary is the person or organization that has the authority to control and manage the operation and administration of the Plan. The Fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of This Plan. The Named Fiduciary for This Plan is the Employer.

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

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

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

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

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

Genetic Information means information about 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.

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

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

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

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

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

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

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

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

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

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

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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

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

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

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

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

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

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

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

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

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

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

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

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

Non-Participating Organ and Bone Marrow Transplant Centers means healthcare providers such as Hospitals, Physicians, or medical treatment centers who, as part of their services to the public, customarily provide Organ and Bone Marrow Transplant services, but are not under contract to provide services for one or more of a specified Organ and Bone Marrow Transplant procedure.

Non-Preferred Provider is a provider or facility that at the time services were rendered is in a category of providers which this Plan may have offered a preferred contract to, but has not signed such a contract.

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

Organ and Bone Marrow Transplant means a human-to-human

Organ Transplant of a liver, heart, heart and lung, lung, kidney, pancreas, kidney and pancreas, cornea and autologous or allogenic bone marrow and includes all related expenses incurred prior to the Organ Transplant and post-surgical treatment for (365) days following the Organ Transplant.

Organ and Bone Marrow Transplant Network means designated healthcare providers including Hospitals, medical treatment centers and Physicians who are under contract to provide services for one or more of the specified organ or tissue Organ and Bone Marrow Transplant procedures.

Orthodontics is the branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

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

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

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

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

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

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

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

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

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan (e.g. the six month look back period for an Enrollment Date of August 15 is February 15 through August 14).Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under any Creditable Coverage within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under any Creditable Coverage. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

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

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

Program is the benefits, terms and limitations set forth in this benefit booklet. Also called "this Plan".

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

Provider is a physician or other health care professional or facility named in this program that is licensed, registered or certified as required by the state in which the services were received to provide a medical service or supply and who does so within the lawful scope of that license, registration or certification.

Psychologist is a provider who is licensed as such by the state in which he or she practices; licensed psychologists must have a doctorate in psychology. A psychological associate or assistant or a provider who has just a masters in social work is not a psychologist under The Plan.

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

Serious Health Condition is an Illness, Injury, impairment or physical or mental condition that involves inpatient care in a Hospital, Hospice, or residential medical care facility; or continuing treatment by a health care provider as defined in Public Law 103-3.

Sickness is:

For a covered Participant and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Significant Break in Coverage means a period of 63 (or more) days without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

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

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

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

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

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

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

Transplant Allowances means the maximum eligible expenses considered for services, supplies and drugs furnished for a specified Organ and Bone Marrow Transplant rendered by the Organ and Bone Marrow Transplant Network.

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

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Waiting Period is the time between the first day of full-time employment and the first day of coverage under the Plan. The waiting period is counted in the Pre-Existing Conditions exclusion time.

PLAN EXCLUSIONS

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

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

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

(1) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(2) **Amniocentesis** charges, except when done in the last trimester for the purpose of determining fetal lung maturity or in the **first 20 weeks** for genetic testing for the purpose of determining the need for fetal therapy or to determine a medically necessary intervention for the mother.

(3) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(4) **Contract or Insurance.** Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering motor vehicle medical, motor vehicle no-fault or personal injury protection (PIP) coverage or commercial premises or homeowner's medical premises coverage or similar type of coverage or insurance.

(5) **Counseling.** Legal and financial Counseling services. Charges for counseling, education or training services, except for the

support services if stated in the Substance Abuse Treatment Benefit and the Mental and Nervous Conditions benefits plan. This includes vocational assistance and outreach and family, marital, social, sexual, lifestyle, nutritional and fitness counseling.

(6) **Court-Ordered Confinement** any confinement for a Covered Person in a public or private institution as the result of a court order.

(7) **Court Mandated.** Treatment and services ordered or mandated by a court for psychiatric or substance abuse treatment.

(8) **Criminal Activities.** Any injury resulting from or occurring during the Covered person's commission or attempt to commit an aggravated assault or felony, or any injury resulting from a Covered Person being involved in illegal activities or an illegal occupation.

(9) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(10) **Dental Care.** Charges for dental care, treatment, orthodontics, including casts, models x-rays, photographs, examinations, appliances, braces and retainers except as specified. However, this program will cover the services of a dentist or denturist to repair an accidental injury to functionally sound natural teeth when the injury is not caused by biting or chewing and the repair is performed within 12 months of the accidental injury.

(11) **Dental Procedures.** Hospital care for dental procedures, unless adequate treatment cannot be provided without the use of hospital facilities, **and** you have a medical condition besides the one requiring treatment that makes hospital care medically necessary.

(12) **Drugs in testing Phases,** medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing.

(13) **Dysfunctions.** Charges for artificial insemination, in-vitro fertilization, or diagnosis and treatment of sexual dysfunctions and defects not related to organic disease, or treatment relating

to the inability to conceive.

(14) **Educational or vocational testing.** Services for educational or vocational testing or training.

(15) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(16) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(17) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(18) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. However, refer to the Schedule of Benefits for Vision Benefits and coverage under the Vision Plan. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(19) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(20) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(21) **Genetic (DNA) Testing.**

(22) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(23) **Habilitative**, education or training services or supplies for dyslexia, for attention deficit disorders (except as provided under the Mental Health Care Benefit) and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations therefore. However, this exclusion does not apply to treatment of neurodevelopmental disabilities in children under age seven.

(24) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

(25) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding, jet ski operating or bungee jumping.

(26) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.

(27) **Homemaker** or housekeeping services except by home health aides as ordered in the home health care treatment plan.

(28) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(29) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of

imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(30) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(31) **Infertility** Services and supplies. Artificial insemination, in vitro fertilization, diagnosis and treatment of infertility.

(32) **Injectables.** A charge for hypodermic syringes and /or needles, injectables or any prescription directing administration by injection (other than insulin or the Injectables and Specialty Pharmacy Program).

(33) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(34) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(35) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(36) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(37) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(38) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(39) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(40) **Obesity.** All surgical procedures performed for the treatment of obesity, whether or not it is, in any case a part of the treatment plan for another Sickness.

EXCEPTION: Medical office visits will be covered for the treatment of obesity, whether or not it is, in any case a part of the treatment plan for another Sickness.

(41) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(42) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(43) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(44) **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.

(45) **Prescription Drug**. Charges for outpatient prescription drugs except as specified in the prescription drug expense

benefit section of the booklet or the Injectables and Specialty Pharmacy Program. Non-prescription drugs or medicines that are not approved under the United States Food & Drug Act or its successor.

(46) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(47) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(48) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(49) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(50) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(51) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(52) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(53) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

(54) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(55) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

(56) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Retail Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Please refer to your ID card for the administrator of the Prescription Drug plan.

Copayments

The copayment is applied to each covered retail pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a covered charge under the medical Plan. Any one retail pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.This Plan participates in a special retail pharmacy program which allows the Covered participant to purchase maintenance medications at participating pharmacies. Your doctor must authorize a 90-day supply of medication. Some medications may not be available in 90-day supplies under applicable law.

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

Percentages Payable

The percentage payable amount is applied to each covered retail pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Mail Order Drug Benefit Option

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

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered.

Limits To This Benefit

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

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Prescription Drugs filled under this Plan will apply towards the $1,000,000 Lifetime Maximum Benefit per covered Person under the Medical Benefits of this Plan.

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

Expenses Not Covered

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

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(3) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(4) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, when used as an anti-wrinkle medication, pigmenting/de-pigmenting medications or medications for hair growth or removal.

(5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(6) **FDA.** Any drug not approved by the Food and Drug Administration.

(7) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(8) **Immunization.** Immunization agents or biological sera.

(9) **Infertility.** A charge for infertility medication.

(10) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

(11) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(15) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

VISION CARE BENEFITS

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

BENEFIT PAYMENT

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

VISION CARE CHARGES

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

LIMITS

No benefits will be payable for the following:

(1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

(4) **No prescription.** Charges for lenses ordered without a prescription.

(5) **Not listed.** Services or products not specifically listed as covered benefits.

(6) **Orthoptics.** Charges for orthoptics (eye muscle exercises).

(7) **Sunglasses.** Charges for safety goggles or non-prescription sunglasses.

(8) **Training.** Charges for vision training or subnormal vision aids.

DENTAL BENEFITS

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

DEDUCTIBLE

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

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

BENEFIT PAYMENT

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

MAXIMUM BENEFIT AMOUNT

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

DENTAL CHARGES

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

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

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

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

(1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each Calendar year.

(2) One bitewing x-ray series every 2 Calendar Years.

(3) One full mouth x-ray every 2 years.

(4) Fluoride treatment for covered Dependent children under age 19 each Calendar Year. Limited to 2 treatments each Calendar Year.

(5) Space maintainers, but not their replacement, for covered Dependent children under age 19 to replace primary teeth.

(6) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 14, once per tooth in any 36 consecutive months.

Class B Services:
Basic Dental Procedures

(1) Dental x-rays not included in Class A.

(2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

(3) Periodontics (gum treatments).

(4) Endodontics (root canals).

(5) Extractions. This service includes local anesthesia and routine post-operative care.

(6) Stainless Steel Crowns (Temporary Crowns).

(7) Fillings, other than gold.

(8) General anesthetics, upon demonstration of Medical Necessity.

(9) Apicoectomy (surgical removal of the tip of the root of a tooth).

(10) Emergency Palliative Treatment for pain.

Class C Services:
Major Dental Procedures

(1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) All Crowns, including crowns for the purpose of periodontal splinting.

(3) Installing precision attachments for removable dentures.

(4) Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during 6 months following the installation.

(5) Addition of clasp or rest to existing partial removable dentures.

(6) Bruxism splints/night-guards & Periodontal splints.

(7) Initial installation of fixed bridgework to replace one or more natural teeth which were extracted while the person was covered for these benefits.

(8) Repair of crowns, bridgework and removable dentures.

(9) Rebasing or relining of removable dentures.

(10) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits.

(b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

(c) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

(11) Appliances or restorations necessary to increase vertical dimensions or restore occlusion.

(12) Orthodontic appliances, services and/or treatment.

(13) Appliances for the correction of harmful habits, such as thumb sucking.

(14) Temporomandibular Joint Dysfunction Syndrome (TMJ). Treatment, by any means, (including specialized appliances) of jaw joint problems including temporomandibular joint dysfunction syndrome (TMJ) and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint. Jaw augmentation or reduction (orthognathic surgery).

(15) Charges for root canal therapy for which the pulp chamber was opened before the effective date of coverage under this Plan.

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

PREDETERMINATION OF BENEFITS

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

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

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

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

HealthComp Administrators
P.O. Box 45018
Fresno, California 93718-5018
559-499-2450 or 800-442-7247

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

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of

necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

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

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

INTEGRATION WITH MEDICAL BENEFITS

In the event benefits are available for the same expenses under both the medical and dental provisions of this plan, such charges will first be considered for payment as a medical expense, with any remaining (eligible) balance of expenses considered for payment under the Dental Expense Benefit. There will be no duplication of benefits.

If hospital or prescription drug charges are incurred in connection with a course of dental treatment, those charges will be considered for payment as medical expenses. No coverage shall be provided for such a service under the Dental Expense Benefit.

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments.** Charges for broken or missed dental appointments.

(3) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(4) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(5) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

(6) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(7) **No listing.** Services which are not included in the list of covered dental services.

(8) **Personalization.** Personalization of dentures.

(9) **Replacement.** Replacement of lost or stolen appliances.

HOW TO SUBMIT A CLAIM

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

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

(1) Obtain a Claim form from the Personnel Office or the Plan Administrator.

(2) Complete the Participant portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or Dentist complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Participant's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

HealthComp Administrators
P.O. Box 45018
Fresno, California 93718-5018
559-499-2450 or 800-442-7247
Facsimile Number 559-499-2464

WHEN CLAIMS SHOULD BE FILED

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

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

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

CLAIMS PROCEDURE

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

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

The definitions of the types of Claims are:

Urgent Care Claim

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

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

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

Notification to claimant of benefit determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours

Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

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

Pre-Service Claim

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

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

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

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

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

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

Notice to claimant of adverse benefit determinations

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

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under

section 502 of ERISA following an adverse benefit determination on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

(7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

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

(1) Request from the Plan Administrator a review of any claim for benefits. Such request must be in writing and must include: the name of the **Participant**, the name of the patient and the Group Name; and

(2) File the written request for review, stating in clear and concise terms the reason or reasons for this disagreement with the decision to deny benefits payment and any other relevant comments.

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

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

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

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

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

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

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

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

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

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

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

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

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered

Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

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

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

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

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

- **(a)** The benefits of the plan which covers the person directly (that is, as a Participant, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

- **(b)** The benefits of a benefit plan which covers a person as a Participant who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Participant. The benefits of a benefit plan which covers a person as a Dependent of a Participant who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Participant. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- **(c)** The benefits of a benefit plan which covers a person as a Participant who is neither laid off nor retired or a

Dependent of a Participant who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be

considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

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

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other

person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

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

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

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

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

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

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

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

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator is Nasomah Health Group Corporation, 3201 Tremont Street P.O. Box 921, North Bend, Oregon 97459, 541-751-0940. COBRA continuation coverage for the Plan is administered by HealthComp Administrators, P.O. BOX 45018, Fresno, California 93718, 559-499-2450 or 800-442-7247. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

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

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a

covered Participant, the Spouse of a covered Participant, or a Dependent child of a covered Participant. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

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

The term "covered Participant" includes not only common-law Participants (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

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

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

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

(1) The death of a covered Participant.

(2) The termination (other than by reason of the Participant's gross misconduct), or reduction of hours, of a covered Participant's employment.

(3) The divorce or legal separation of a covered Participant from the Participant's Spouse. If the Participant reduces or eliminates the Participant's Spouse's group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Participant's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

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

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a Participant does not return to employment at

the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Participant and family members will be entitled to COBRA continuation coverage even if they failed to pay the Participant portion of premiums for coverage under the Plan during the FMLA leave.

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

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified

Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

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

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

(1) the end of employment or reduction of hours of employment,

(2) death of the Participant,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the Participant in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures

specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

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

HealthComp Administrators
P.O. BOX 45018
Fresno, California 93718

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

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

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

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

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage,

COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

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

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

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Participant.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

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

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Participant's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Participant ends on the later of:

- **(a)** 36 months after the date the covered Participant becomes enrolled in the Medicare program; or

- **(b)** 18 months (or 29 months, if there is a disability extension) after the date of the covered Participant's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Participant during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a

36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator.

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

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

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

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Participants or Qualified

Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

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

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

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Participant Benefits Security

Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

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

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

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

DUTIES OF THE PLAN ADMINISTRATOR. With respect to the following duties, the Plan Administrator shall be a fiduciary:

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

(10) Any duties delegated to the Plan Administrator by the NASOMAH HEALTH GROUP.

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

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

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

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

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

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

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

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Participants are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the following provisions apply:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Nasomah Health Group's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Nasomah Health Group's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care

operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Participants.** The Plan shall disclose Protected Health Information only to members of the Nasomah Health Group's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Nasomah Health Group's workforce" shall refer to all Participants and other persons under the control of the Nasomah Health Group.

(a) **Updates Required.** The Nasomah Health Group shall amend this document promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Nasomah Health Group's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Nasomah Health Group's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy

official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Nasomah Health Group must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Nasomah Health Group with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Nasomah Health Group;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes

aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Nasomah Health Group still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

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

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

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the Nasomah Health Group.

Therefore, the following provisions apply:

(1) The Nasomah Health Group agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Nasomah Health Group creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Nasomah Health Group shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Nasomah Health Group shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Participants and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

AMENDING AND TERMINATING THE PLAN

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

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

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Participant Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

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

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

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

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

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

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

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

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

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

PLAN NAME

Nasomah Health Group Corporation

TAX ID NUMBER: 93-1250047

PLAN EFFECTIVE DATE: May 1, 1998

PLAN YEAR ENDS: April 30th

PLAN ADMINISTRATOR

Nasomah Health Group Corporation
3201 Tremont Street
P.O. Box 921
North Bend, Oregon 97459
541-751-0940

NAMED FIDUCIARY

Nasomah Health Group Corporation
3201 Tremont Street
P.O. Box 921
North Bend, Oregon 97459
541-751-0940

AGENT FOR SERVICE OF LEGAL PROCESS

Coquille Indian Tribe
3050 Tremont Street
North Bend, Oregon 97459

CLAIMS ADMINISTRATOR

HealthComp Administrators
P.O. Box 45018
Fresno, California 93718-5018
559-499-2450 or 800-442-7247

EMPLOYERS

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

Coquille Indian Tribe
3050 Tremont Street
North Bend, OR 97459

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

Nasomah Health Group
3201 Tremont Street
P.O. Box 924
North Bend, OR 97459

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

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

This PPO Plan Document is effective May 1, 2006.

By______________________________________
Nasomah Health Group Corporation

Date ____________________________________

Witness_________________________________

Date ____________________________________