PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

STOCKBRIDGE-MUNSEE COMMUNITY BAND OF THE MOHICAN INDIANS EMPLOYEE GROUP BENEFIT PLAN

Effective: July 1, 1995
Restated: January 1, 2003

STOCKBRIDGE-MUNSEE COMMUNITY
BAND OF THE MOHICAN INDIANS
EMPLOYEE GROUP BENEFIT PLAN

Amendment #21

Effective October 1, 2017, the Employee Group Benefit Plan for the Stockbridge-Munsee Community Band of the Mohican Indians, which was established July 1, 1995, last restated January 1, 2003, and last amended June 1, 2017, shall be amended as described herein.

*With regards to **AMENDMENT #16** effective January 1, 2014, the **entire Amendment** shall be deleted in its entirety.*

*With regards to the **PLAN EXCLUSIONS** section on pages 45-49 of this Master Plan Document, add exclusion #21, **Indian Health Service Coverage** and renumber subsequent entries.*

21. **Indian Health Service Coverage.** The Plan will exclude all direct service care or services provided at a federal Indian Health Service facility in accordance with 25 U.S.C. Section 1621e.

*With regards to the **PLAN EXCLUSIONS** section on pages 45-49 of this Master Plan Document, add exclusion #40, **Purchased/Referred Care Coverage** and renumber subsequent entries.*

40. **Purchased/Referred Care Coverage.** The Plan will exclude all care or services eligible for coverage by a Purchased/Referred Care program formerly referred to as a Contract Health Services program (referred to herein as "PRC" or "CHS") operated pursuant to a self-determination contract or self-governance compact under P.L. 93-638, as amended (or other applicable federal law governing tribal health care and Indian Health Service programs); such PRC program services are entitled to Medicare-like rate ("MLR") discounts. This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Sections 1621e and 1623. The Plan Administrator reserves the right to waive this exclusion in full or in part for designated care in order to act in the best interest of the PRC program operated by the Plan Administrator. To the extent applicable, if exclusion is waived for PRC program services, then MLR eligible care paid for on a provisional basis must be refunded to the Plan as an excess payment unless accepted by the provider as payment in full on behalf of the Plan Administrator Purchased/Referred Care Program at MLR in accordance with the Section titled **Coordination of Benefits**.

*With regards to the **COORDINATION OF BENEFITS** section on pages 67-69 of this Master Plan Document, the **entire** section shall be deleted in its entirety and replaced with the following:*

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 Charge.

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.

In the case of care or service that is eligible for re-pricing at Medicare-like rates (“MLR”), the “allowable charge” will not exceed the MLR unless the provider has entered into an express reimbursement agreement with the Plan Administrator for full or partial waiver of the MLR exclusionary clause for designated care or services.

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 an employee, 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 an Employee 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 Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee 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 Employee. 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 an Employee who is neither laid off nor retired or a Dependent of an Employee 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. This provision does not apply to Purchased Referred Care (formerly referred to as Contract Health Services) eligible members.

(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.

Order of Benefit Determination- PRC Eligible Persons

This tribally-funded self-insurance plan is the "Payor of Last Resort." This plan will be secondary to all programs for the payment of health services, including, but not limited to:

1) Private health insurance;
2) Medicare, Medicaid, State Children's Health Insurance Plan;
3) State and local health care programs;
4) Purchased/Referred Care, except as noted in plan exclusions.

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.

IN WITNESS WHEREOF, **Stockbridge-Munsee Community Band of the Mohican Indians** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

Date Signed	Authorized Signature & Title
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
BAND OF THE MOHICAN INDIANS
EMPLOYEE GROUP BENEFIT PLAN
Amendment #19

Effective October 1, 2016 the Employee Group Benefit Plan for the Stockbridge-Munsee Community, Band of the Mohican Indians, which was established July 1, 1995, last restated January 1, 2003, and last amended May 1, 2015, shall be amended as described herein.

*With regards to the **COORDINATION OF BENEFITS** section on pages 67-69 of this Master Plan Document, **benefit Plan Payment order (3)** shall be deleted in its entirety and replaced as follows:*

(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. This provision does not apply to Purchased Referred Care (formerly referred to as Contract Health Services) eligible members.

IN WITNESS WHEREOF, **Stockbridge-Munsee Community Band of the Mohican Indians** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____ _____
Date Signed Authorized Signature & Title

_____ _____
Location Witness

STOCKBRIDGE-MUNSEE COMMUNITY
BAND OF THE MOHICAN INDIANS
EMPLOYEE GROUP BENEFIT PLAN
Amendment #18

Effective May 1, 2015 the Employee Group Benefit Plan for the Stockbridge-Munsee Community, Band of the Mohican Indians, which was established July 1, 1995, last restated January 1, 2003, and last amended January 1, 2015, shall be amended as described herein.

*With regards to the **SCHEDULE OF BENEFITS** section on pages 15-18 of this Master Plan Document and last addressed in Amendment #12, the benefit box regarding **Preventive Care** as last amended in Amendment #4 shall hereby be deleted and replaced with the following:*

	TIER I PROVIDERS	**TIER II PROVIDERS**	**TIER III PROVIDERS**
Preventive Care			
Routine Well Adult Care	100% deductible waived Up to a $500 Calendar Year maximum	100% deductible waived Up to a $500 Calendar Year maximum	Not covered
Routine mammogram*	100% deductible waived	100% deductible waived	Not covered
Frequency limits for mammogram • Ages 35 through 39: a single Baseline mammogram • Ages 40 through 49: 1 every 2 years • Ages 50 and over: annually			
Routine Colonoscopy*	80% deductible waived	80% deductible waived	Not covered
Routine PSA Test* Limited to one test per Calendar Year	100% deductible waived	100% deductible waived	Not covered
Immunization from Birth to age 2*	100% deductible waived	100% deductible waived	Not covered
Annual Flu and Shingles Vaccinations*	100% deductible waived	100% deductible waived	Not covered
Flu and Shingles Vaccinations at any Pharmacy are 100% deductible waived. Member must pay first and submit claim receipt to health plan for reimbursement.*			
***Not subject to the $500 Calendar Year maximum**			

IN WITNESS WHEREOF, **Stockbridge-Munsee Community Band of the Mohican Indians** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians
EMPLOYEE GROUP BENEFIT PLAN

Amendment #17

Effective October 1, 2014 and January 1, 2015 the Employee Group Benefit Plan for the Stockbridge-Munsee Community, Band of the Mohican Indians, which was established July 1, 1995, last restated January 1, 2003, and last amended January 1, 2014, shall be amended as described herein.

EFFECTIVE OCTOBER 1, 2014

*With regards to the **TABLE OF CONTENTS** section on page 2 of this Master Plan Document, the **Pre-Existing Conditions** section shall be deleted in its entirety.*

*With regards to the **ELIGIBILITY** section on pages 4-6 of this Master Plan Document and last amended in Amendment #9, the **Eligibility Requirements for Employee Coverage** shall be deleted in its entirety and replaced with the following **Eligible Class and Waiting Period**:*

EMPLOYEE ELIGIBILITY: Employees who belong to an **Eligible Class** of Employees are eligible for coverage under this Plan following the waiting period.

ELIGIBLE CLASS:

- Full-time, Active Employees who work for The Employer at least 32 hours per week on a Regular Basis. Regular Basis means an Employee is regularly at work for a continuous and indefinite period of time; such work may occur either at the usual place of business of the Employer or at a location to which the business of the Company requires the Employee to travel and for which he or she receives regular earnings from the Employer.

- Elected and Appointed Officials of the Tribe.

- Part-time Employees, Temporary Employees, Seasonal, Flex and College Bound Employees will not be eligible for coverage under the Plan.

WAITING PERIOD: An Employee is eligible on the first of the month following a waiting period of 60 days of continuous full-time employment with the Employer. The Employee shall be eligible on the 60th day if that day falls upon the 1st of the month.

A "waiting period" is the time between the first day of full-time employment and the first day of coverage under the plan.

A group health plan may not base rules for eligibility for coverage upon an individual being "actively at work," if a health factor is present. If a Plan Participant is absent from work due to a health factor, for purposes of plan eligibility, the individual is to be considered actively at work.

Temporary or part-time Employees who become full-time Employees will not be given credit towards satisfaction of the waiting period while employed on a temporary or part-time basis. However, Employees who have had coverage under the previous Part-Time Employee provision prior to January 1, 2003 shall continue to remain covered.

EMPLOYEE EFFECTIVE DATE

Employee Coverage under the Plan shall become effective on the date of the Employee's eligibility provided he/she has made written application for such coverage on or before such date. The Employee must apply for coverage within 31 days of eligibility for coverage to be effective on the date of eligibility. Please see the Enrollment section for all requirements of Timely and Special Enrollees.

*With regards to the **ELIGIBILITY** section on pages 4-6 of this Master Plan Document and last amended in Amendment #10, the **Eligible Classes of Dependents (1)** shall be deleted in its entirety and replaced with the following:*

(1) A covered Employee's Spouse and children from birth to age 26. An Employee's child up to age 26 is eligible for coverage through this plan regardless of marital status or employment status. When the child reaches limiting age, coverage will end on the last day of the child's birthday month.

If both a parent and a dependent child are employed by the Employer and are both eligible for Coverage, the Dependent is not required to elect his/her own Employee Coverage. The child may remain as a Dependent on the parent's plan until the age of 26.

The term "Spouse" shall mean the person recognized as the covered Employee's legal husband or wife who is a resident of the same country in which the Employee resides. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children living in the same country as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Stepchildren who reside in the same country as the Employee may also be included.

If a covered employee 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 Employee in anticipation of adoption" refers to a child whom the Employee 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 Employee 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.

*With regards to the **PRE-EXISTING CONDITIONS** section on pages 6-7 of this Master Plan Document and last amended in Amendment #10, this section shall be deleted in its entirety.*

*With regards to the **TIMELY AND LATE ENROLLMENT** section on pages 7-8 of this Master Plan Document and last amended in Amendment #7, the **(2) Late enrollment** shall be deleted in its entirety.*

*With regards to the **SPECIAL ENROLLMENT PERIODS** section on pages 8-9 of this Master Plan Document and last amended in Amendment #10, the **Pre-existing condition Exclusion and Special Enrollees** shall be deleted in its entirety.*

*With regards to the **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS** section on pages 4-12 of this Master Plan Document, the **Rehiring a Terminated Employee** shall be deleted in its entirety and replaced with the following:*

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period.

*With regards to the **SCHEDULE OF BENEFITS** section on pages 15-18 of this Master Plan Document and last addressed in Amendment #12, **Maximum plan year benefit amount** shall be deleted in its entirety and replaced with the following:*

MAXIMUM PLAN YEAR BENEFIT AMOUNT	Unlimited

*With regards to the **DEFINED TERMS** section on pages 34-44 of this Master Plan Document and last addressed in Amendment #10, the **Experimental and/or Investigational** shall be deleted in its entirety and replaced with the following:*

EXPERIMENTAL
Services, supplies, care and treatment which do 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 community or government oversight agencies at the time services were rendered.

Experimental or investigational services typically include:

a. Care, procedures, treatment protocol or technology which is:
    i. Not widely accepted as safe, effective and appropriate for the Injury or Sickness throughout the recognized medical profession and established medical societies in the United States; or
    ii. Experimental, in the research or investigational stage or conducted as part of research protocol, or has not been proved by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies.

b. Drugs, tests, and technology which are:
    i. Not FDA-approved for general use;
    ii. Considered Experimental; or
    iii. For investigational use.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental 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 Plan Administrator will be guided by the following principles in review; if

1. 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. 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. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of any on-going phase of clinical trial, 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. 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. The Plan Administrator may also rely on the Data project of the American Medical Association, the National Institute of Health, the U.S. Food and Drug Administration, The National Cancer Institute, The National Comprehensive Cancer Network (NCCN), Office of Health Technology

Assessment, the Health Care Financing Administration of the U.S. Department of Health and Human Services, and Congressional Office of Technology Assessment in determining investigational or experimental services.

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

Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

1. The named drug is not specifically excluded under the General Limitations of the Plan; and
2. The named drug has been approved by the FDA; and
3. The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and
4. If the drug is used for the treatment of cancer, the American Hospital Formulary Service Drug Information or the NCCN Drugs and Biologics Compendia recognize it as an appropriate treatment for that form of cancer.

*With regards to the **DEFINED TERMS** section on pages 34-44 of this Master Plan Document and last addressed in Amendment #10, the **Pre-Existing Condition** shall be deleted in its entirety.*

*With regards to the **PLAN EXCLUSIONS** section on pages 45-49 of this Master Plan Document and last addressed in Amendment #10, the **Experimental and/or Investigational** shall be deleted in its entirety and replaced with the following:*

Experimental and/or Investigational procedures. Charges for procedures, drugs, or research studies, or for any services or supplies considered Experimental and/or Investigational are not eligible for coverage through this Plan. Please see the Definitions section of this plan for more information.

EFFECTIVE JANUARY 1, 2015

*With regards to the **ELIGIBILITY** section on pages 4-6 of this Master Plan Document and last amended in Amendment #9, the **Eligible Class** shall be deleted in its entirety and replaced with the following:*

ELIGIBLE CLASS:

- Full-time, Active Employees who work for The Employer at least 30 hours per week on a Regular Basis. Regular Basis means an Employee is regularly at work for a continuous and indefinite period of time; such work may occur either at the usual place of business of the Employer or at a location to which the business of the Company requires the Employee to travel and for which he or she receives regular earnings from the Employer.

- Elected and Appointed Officials of the Tribe.

- Part-time Employees, Temporary Employees, Seasonal, Flex and College Bound Employees will not be eligible for coverage under the Plan.

IN WITNESS WHEREOF, **Stockbridge-Munsee Community Band of the Mohican Indians** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians
EMPLOYEE GROUP BENEFIT PLAN

Amendment #16

Effective January 1, 2014, the Employee Group Benefit Plan for the Stockbridge-Munsee Community, Band of the Mohican Indians, which was established July 1, 1995, last restated January 1, 2003, and last amended August 1, 2013, shall be amended as described herein.

*With regards to the **SCHEDULE OF BENEFITS PPO NETWORK PLAN**, PAGE 15 of this Master Plan Document the following paragraph shall be added as the last paragraph:*

Payor of Last Resort
Stockbridge-Munsee Community has designated this tribally funded self-insurance plan as Payor of Last Resort for eligible and covered services for eligible tribal members as permitted by the Indian Health Care Improvement Act (IHCIA). This plan will not pay for services eligible under the Indian Health Service or Contract Health Services.

*With regards to **Order of Benefit Determination** on Page 78 of this Master Plan Document, the following paragraph shall be added:*

Order of Benefit Determination- CHS Eligible Persons
This tribally-funded self-insurance plan is the "Payor of Last Resort." This plan will be secondary to all programs for the payment of health services, including, but not limited to:

1) Private health insurance;
2) Medicare, Medicaid, State Children's Health Insurance Plan;
3) State and local health care programs;
4) Contract Health

IN WITNESS WHEREOF, **Stockbridge-Munsee Community Band of the Mohican Indians** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians
EMPLOYEE GROUP BENEFIT PLAN

Amendment #15

Effective August 1, 2013 the Employee Group Benefit Plan for the Stockbridge-Munsee Community, Band of the Mohican Indians, which was established July 1, 1995, last restated January 1, 2003, and last amended July 1, 2013, shall be amended as described herein.

*Regarding the **OPEN ENROLLMENT** section on page 13 of the Master Plan Document and as addressed in Amendment #7, this section shall be deleted in its entirety and replaced with the following:*

OPEN ENROLLMENT

Every year during the month of September, the open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective the following October 1st.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

IN WITNESS WHEREOF, **Stockbridge-Munsee Community Band of the Mohican Indians** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians
EMPLOYEE GROUP BENEFIT PLAN

Amendment #14

Effective July 1, 2013, the Employee Group Benefit Plan for the Stockbridge-Munsee Community, Band of the Mohican Indians, which was established July 1, 1995, last restated January 1, 2003, and last amended December 1, 2011, shall be amended as described herein.

*With regards to the **COVERED CHARGES** section on pages 22-29 of the Master Plan Document, **(8)(f) Cochlear Implants** shall be added as follows and all following items renumbered sequentially:*

(f) Charges for **cochlear implants** and all services, supplies and treatment provided in connection with cochlear implants will be covered if the loss of hearing is the result of a congenital condition. Pre-authorization is required.

*With regards to the **PLAN EXCLUSIONS** section on pages 45-49 of this Master Plan Document, **(18) Hearing Therapy** shall be deleted in its entirety and replaced with the following:*

(18) **Hearing therapy.** Charges for hearing therapy. This exclusion shall not apply to therapy provided in relation to approved cochlear implants.

IN WITNESS WHEREOF, **Stockbridge-Munsee Community Band of the Mohican Indians** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians
EMPLOYEE GROUP BENEFIT PLAN

Amendment #13

Effective October 1, 2007, the Stockbridge-Munsee Community Band of the Mohican established July 1, 1995, last restated January 1, 2003, and last amended January 1, 2012 shall be amended as described herein.

*With regards to the **SHORT TERM DISABILITY BENEFITS** section on page 50 of this Master Plan Document and as addressed in Amendment #8, **(1) Eligibility Provision** shall be deleted and replaced with the following:*

(1) Total Disability starts while the Employee is covered for this benefit. This benefit is only available to Regular Full-Time Employees and the eligibility requirements are the same as the Stockbridge-Munsee Community Group Health and Dental Plan. The Employee must be a participant in one of those Plans to participate in this Plan.

IN WITNESS WHEREOF, **Stockbridge-Munsee Community Band of the Mohican Indians** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians
EMPLOYEE GROUP BENEFIT PLAN

Amendment #12

Effective October 1, 2011 and December 1, 2011, the Stockbridge-Munsee Community Employee Group Benefit Plan established July 1, 1995, last restated January 1, 2003, and last amended October 1, 2011 shall be amended as described herein.

EFFECTIVE OCTOBER 1, 2011

*With regards to the **SCHEDULE OF BENEFITS** section on page 15 of this Master Plan Document and as addressed in Amendment #10, **Maximum Lifetime Benefit Amount and Maximum Plan Year Benefit Amount** shall be deleted and replaced with the following:*

MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited
MAXIMUM PLAN YEAR AMOUNT	$2,000,000
Note: The maximums listed below are the total for Participating and Non-Participating 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 Participating and Non-Participating providers.	
Note: ALL services under the PPO Plan must be provided by participating providers to be covered at the Network benefit level. Services received elsewhere will be paid at the Non-Network level. If any of the following circumstances apply, benefits will be payable at the Network level, however, Usual and Customary will apply to those Non-Network fees: **The Plan pays Tier II benefits for certain ancillary services provided by Tier III practitioners, as long as they are performed at a Tier II facility. These services include anesthetics, radiology, pathology and emergency care. For example, if you go to a Tier II facility for an X-ray and are treated by a technician who does not belong to Tier II, you will receive Tier II benefits for that service.** **In addition, if X-rays or labs that are performed at a Tier I provider is sent to a non-Tier I provider to be read, charges for the reading shall be paid at the Tier I benefit level.**	

EFFECTIVE DECEMBER 1, 2011

*With regards to the **COVERED CHARGES** section on pages 22-29 of this Master Plan Document, **(8) Other Medical Services and Supplies (e) Chemotherapy** shall be deleted and replaced with the following:*

(e) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included. Pre-authorization is required for prescribed treatment.

*With regards to the **UTILIZATION REVIEW** section on pages 30-31 of this Master Plan Document and as addressed in Amendments #9 and #10, **a) Precertification** shall be deleted and replaced with the following:*

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

Please call HealthCorp at (877) 457-6223 for pre-certification on the following:
Hospitalizations (Hospital, Skilled Nursing Facility, Birthing Center and other facilities)
MRI/MRA/CT/PET scans

Please call Auxiant at (800) 475-2232 for pre-authorization on the following:
Home Health Services
Medical equipment purchases over $300
Medical equipment rentals
Chemotherapy
Radiation Therapy
Morbid Obesity

Any other service where medical necessity or experimental nature is in question, please call Auxiant for pre-treatment review.

IN WITNESS WHEREOF, **Stockbridge-Munsee Community** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians
EMPLOYEE GROUP BENEFIT PLAN

Amendment #11

Effective October 1, 2011, the Stockbridge-Munsee Community Employee Group Benefit Plan established July 1, 1995, last restated January 1, 2003, and last amended October 1, 2010 shall be amended as described herein.

*With regards to the **SCHEDULE OF BENEFITS** section on pages 15-18 of this Master Plan Document, **Dialysis Therapy** shall be added as follows:*

	TIER I PROVIDERS	**TIER II PROVIDERS**	**TIER III PROVIDERS**
Dialysis Therapy (Home/Office/Outpatient) For at home treatment (peritoneal dialysis) $10,000 maximum per month begins the first month of treatment. For office/outpatient treatment $10,000 maximum per month begins the fourth month of treatment.	80% after deductible	80% after deductible	60% after deductible

*With regards to the **COVERED CHARGES** section on pages 22-29 of this Master Plan Document, **(8)(i) Dialysis** shall be added as follows and all following items renumbered sequentially:*

(i) Charges for **dialysis** as an Inpatient or at a Medicare-approved Outpatient dialysis center.

For the first 90 days of outpatient dialysis (see below for home dialysis), the Plan will cover dialysis treatments at the applicable deductible and coinsurance as listed in the Schedule of Benefits. After 90 days, the plan will pay no more than $10,000 per month including dialysis treatments, supplies, and blood support products. Dialysis services, equipment and supplies are those services and items used in the treatment of acute renal failure, chronic kidney disease and end stage renal disease.

When dialysis treatments are administered at home, or for peritoneal dialysis, the plan will pay no more than $10,000 per month including dialysis treatments, supplies, and blood support products beginning the first month of treatment. Dialysis services, equipment and supplies are those services and items used in the treatment of acute renal failure, chronic kidney disease and end stage renal disease.

Dialysis: Dialysis services, equipment, supplies and medications are a covered expense under the plan as long as they are considered medically necessary (subject to the coverage as identified in the schedule of benefits) for the treatment of the patient.

IN WITNESS WHEREOF, **Stockbridge-Munsee Community** has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians
EMPLOYEE GROUP BENEFIT PLAN

Amendment # 10

Effective October 1, 2010, the Stockbridge-Munsee Community Employee Group Benefit Plan, established July 1, 1995 and last restated January 1, 2003 and last amended on October 1, 2009 shall be amended as described herein.

*The following **GRANDFATHERED PLAN NOTICE** is being added to the Master Plan after page 3 as follows:*

GRANDFATHERED PLAN NOTICE

This Plan Sponsor believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

*Regarding the **ELIGIBILITY** section on pages 4-6 of this Master Plan Document, and as addressed in Amendment #1, **Eligible Classes of Dependents (1)** shall be deleted in its entirety and replaced with the following:*

(1) A covered Employee's Spouse and children from birth to age 26. An Employee's child up to age 26 is eligible for coverage through this plan regardless of marital status or employment status. If the child has other employer-based coverage available to them either through their own employer or through the employer of their Spouse or Domestic Partner, then the child is not eligible for coverage through this plan. When the child reaches limiting age, coverage will end on the child's birthday.

The term "Spouse" shall mean the person recognized as the covered Employee's legal husband or wife who is a resident of the same country in which the Employee resides. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children living in the same country as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the same country as the Employee may also be included.

If a covered Employee 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 Employee in anticipation of adoption" refers to a child whom the Employee 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 Employee 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.

*Regarding the **PRE-EXISTING CONDITIONS** section on pages 6-7 of this Master Plan Document, and as addressed in Amendment #6, **Exception to Pre-Existing Conditions #1** shall be deleted in its entirety and replaced with the following:*

1. The Plan's Pre-Existing Condition exclusion does not apply to any person who is under the age of 19, in cases of Pregnancy, or to a Newborn, an adopted child under age 19, or a child placed for adoption under age 19, if the child becomes covered within 31 days of birth, adoption or placement for adoption.

*Regarding the **SPECIAL ENROLLMENT PERIODS** section on pages 8-9, of this Master Plan Document and as amended in Amendment #6, the entire section shall hereby be deleted and replaced with the following:*

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.

Individuals losing other coverage (proof is required). An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

1. The Employee or Dependent was covered under a group health plan or had health insurance coverage or coverage through a state Medicaid or Children's Health Insurance Program (CHIP) program, at the time coverage under this Plan was previously offered to the individual.

2. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

3. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and:

a. the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment or other cancellation by the Medicaid or CHIP program providing coverage), or
b. employer contributions towards the coverage were terminated, or
c. an individual incurs a claim that would meet or exceed a Plan Year limit on all benefits.

4. The Employee or Dependent requests enrollment in this Plan no later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, 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.

5. If the loss of coverage was through a Medicaid or CHIP program, the Employee or Dependent requests enrollment in this Plan no later than 60-days after the date of exhaustion or cancellation by the Medicaid or CHIP program. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee 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), that individual does not have a Special Enrollment right.

Dependent beneficiaries If:

1. The Employee 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

2. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

3. The Dependent was previously covered through a Medicaid or CHIP program, and has lost eligibility for coverage through said program,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

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. If the reason for enrollment is loss of coverage through a Medicaid or CHIP program, the Special Enrollment Period is a period of 60-days and begins on the date of loss of coverage through that plan.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

1. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

2. in the case of a Dependent's birth, as of the date of birth; or

3. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

4. in the case of a loss of coverage through Medicaid or CHIP, the date of the loss of said coverage.

Pre-existing Condition Exclusion and Special Enrollees

Special enrollees and their Dependents will not be treated as late enrollees. The Plan will apply a Pre-Existing Condition exclusion period of 12 months to a special enrollee. The Plan will not apply a Pre-Existing Condition exclusion to any enrollee under the age of 19, situations of Pregnancy or to a Newborn or adopted child who is enrolled under the special enrollment provisions.

Special Enrollment Period for Children up to Age 26 and Participants previously Terminated due to reaching a Plan Year Limit under this Plan

For a Dependent who had coverage ended, or was denied coverage (or was not eligible for coverage) under this Plan because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26, the Plan is providing a one-time Special Enrollment Opportunity. The opportunity to enroll begins on the first day of the first plan year beginning on or after September 23rd, 2010, and continues for 30 days, regardless of whether the Plan offers an open enrollment period and regardless of when any open enrollment period might otherwise occur.

For an individual who had coverage end, or was denied coverage (or was not eligible for coverage) under this Plan because the individual had reached a plan year maximum dollar level for claims under the Plan, the Plan is providing a one-time Special Enrollment Opportunity. The opportunity to enroll begins on the first day of the first plan year beginning on or after September 23rd, 2010, and continues for 30 days, regardless of whether the Plan offers an open enrollment period and regardless of when any open enrollment period might otherwise occur.

Additionally, if the individual is not enrolled in the Plan, or if an enrolled individual is eligible for but not enrolled in any benefit package under the Plan, then the Plan is providing the individual with an opportunity to enroll that continues for at least 30 days starting on the first day of the first plan year beginning on or after September 23, 2010.

*Regarding the **EFFECTIVE DATE** section on pages 10-12, of this Master Plan Document, **Employee Effective Date** section shall hereby be deleted and replaced with the following*:

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

(4) 180 days of continuous active, full time work.

*Regarding the **TERMINATION OF COVERAGE** section on pages 9-10, of this Master Plan Document, **Continuation during Family and Medical Leave** section shall hereby be deleted and replaced with the following*:

Family and Medical Leave Act Provision

Regardless of the established leave policies mentioned elsewhere in this document, 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 Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee 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 Condition 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.

Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. A Participant with questions concerning any rights and/or obligations should contact the Plan Administrator or his Employer.

The FMLA Act generally provides for 12 weeks of leave for personal illness or injury or that of a family member. However, there are special time restrictions for the family of Military employees who were injured during active duty in the armed forces:

1. **Leave During Family Member's Active Duty** – Employees who have a spouse, parent, or child who is on or has been called to active duty in the Armed Forces may take up to 12 weeks of FMLA leave yearly when they experience a "qualifying exigency."
2. **Injured Service member Family Leave** – Employees who are the spouse, parent, child, or next of kin of a service member who incurred a serious injury or illness on active duty in the Armed Forces may take up to 26 weeks of leave to care for the injured service member in a 12-month period (in combination with regular FMLA leave).

*Regarding the **SCHEDULE OF BENEFITS** section on page 15 of this Master Plan Document, **Maximum Lifetime Benefit Amount** shall be deleted in its entirety and replaced with the following:*

	TIER I PROVIDERS	**TIER II PROVIDERS**	**TIER III PROVIDERS**
MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited		
MAXIMUM PLAN YEAR BENEFIT AMOUNT	$1,000,000		

*Regarding the **SCHEDULE OF BENEFITS** section on page 16 of this Master Plan Document, **Out-of-pocket maximum** shall be deleted in its entirety and replaced with the following:*

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Copayments Charges that exceed the Usual & Reasonable. Charges for services that are excluded.

*Regarding the **SCHEDULE OF BENEFITS** section on page 17 of the Master Plan Document, **Psychiatric Care – Mental Disorders and Substance Abuse** shall be deleted and replaced as follows:*

	TIER I PROVIDERS	**TIER II PROVIDERS**	**TIER III PROVIDERS**
Psychiatric Care - Mental Disorders/Substance Abuse			
Inpatient Facility and Residential Treatment – This includes any services while done during an inpatient or residential stay	80% after deductible	80% after deductible	60% after deductible
Emergency Room	$50* copayment then 80% after deductible	$50* copayment then 80% after deductible	$50* copayment then 80% after deductible
* The copayment is waived if the Covered Person is admitted to the Hospital on an emergency basis. The Utilization Review Administrator must be notified within 24 hours of the admission, even if the patient is discharged within 24 hours of the admission.			
Urgent Care Room	100% after $10 copayment	100% after $20 copayment	60% after deductible
Outpatient Facility and other Transitional Treatment - This includes any services billed as outpatient or in a partial stay facility	80% after deductible	80% after deductible	60% after deductible
Office Evaluation and Management fees	100% after $10 copayment	100% after $20 copayment	60% after deductible
Office Counseling fees	100% after $10 copayment	100% after $20 copayment	60% after deductible

Diagnostic Lab & X-ray- Office – incurred during the same day as the office visit	100% deductible waived	80% after deductible	60% after deductible
Diagnostic Lab & X-ray- other	80% after deductible	80% after deductible	60% after deductible
Urgent Care Clinic	100% after $10 copayment	100% after $20 copayment	60% after deductible
Maehnowesekiyah Clinic shall be considered a Tier II provider for the purpose of Mental Disorders and Substance Abuse benefit payments.			

*Regarding the **UTILIZATION REVIEW** section on pages 30-31 of this Master Plan Document and as addressed in Amendment #9, **#a** shall be deleted and replaced as follows:*

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

Hospitalizations (Hospital, Skilled Nursing Facility, Birthing Center and other facilities)
Biopsies
Breast surgeries
Chemotherapy
Radiation therapy
Cardiovascular surgeries
Spinal surgeries
Morbid Obesity

*Regarding the **DEFINITIONS** section on pages 34-44 of this Master Plan Document, **Full Time Student** shall be deleted in its entirety.*

*Regarding the **DEFINITIONS** section on pages 34 -44 of this Master Plan Document**, Lifetime** shall be deleted in its entirety.*

*Regarding the **DEFINITIONS** section on pages 34-44 of this Master Plan Document, **Plan Year** shall be deleted in its entirety and replaced with the following:*

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. This Plan recognizes Plan Year as October 1st through September 30th.

*Regarding the **DEFINITIONS** section on pages 34-44 of this Master Plan Document**, Pre-Existing Conditions** shall be deleted and replaced with the following:*

PRE-EXISTING CONDITIONS
A Pre-Existing Condition is a condition for which medical advice, diagnosis; care or treatment was recommended or received within three 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 any person under the age of 19, in cases of Pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 19 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 this 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.

IN WITNESS WHEREOF, Stockbridge-Munsee Community has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians

EMPLOYEE GROUP BENEFIT PLAN

Amendment #9

Effective October 1, 2009, the Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan established July 1, 1995 and last restated January 1, 2003, shall be amended as described herein.

*With regards to the **GENERAL PLAN INFORMATION** section, page 3 of this Master Plan Document, **Stockbridge-Munsee Community Band of the Mohican Indians Employee Group Benefit Plan** shall be deleted in its entirety and replaced with the following throughout the entire document:*

PLAN NAME
Stockbridge-Munsee Community Band of the Mohican Indians Contract Health Services Eligible Employee Plan

*With regards to the **ELIGIBILITY** section, pages 4-6 of this Master Plan Document, **Eligibility Requirements for Employee Coverage** shall be deleted in its entirety and replaced with the following:*

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

(1) is a, Regular, Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 32 hours per week on a Regular Basis.

(2) Part-time Employees, Seasonal, Flex, and College Bound Employees will not be eligible for coverage under the Plan. However, employees who have had coverage under the previous Part-Time Employee provision prior to January 1, 2003 shall continue to remain covered.

(3) Elected and Appointed Officials of the Tribe

(4) is in a class eligible for coverage.

(5) completes the employment Orientation Period of as an Active Employee as determined by the Company. An "Orientation Period" will be the time between the first day of employment and the first day of coverage under the

Plan. The Orientation Period, also known as the Waiting Period, is counted in the Pre-Existing Conditions exclusion time.

(6) A contract health services eligible member is a plan eligible employee or dependent that meets the eligibility requirements of Contract Health Services as defined by Indian Health Services.

*With regards to the **SCHEDULE OF BENEFITS** section, pages 15-18 of this Master Plan Document, **Hospital Services** shall be deleted and replaced as follows:*

Hospital Services Charges for Hospital Facility Claims (UB92) will be paid at 100% with approved Contract Health Services purchase order.			
Room and Board the semiprivate room rate	80% after deductible	80% after deductible	60% after deductible
Intensive Care Unit Hospital's ICU Charge	80% after deductible	80% after deductible	60% after deductible
Miscellaneous Services and Supplies	80% after deductible	80% after deductible	60% after deductible
Outpatient Hospital Expenses	80% after deductible	80% after deductible	60% after deductible
Skilled Nursing Facility the facility's semiprivate room rateThere must be at least a 90 day separation between convalescent periods for benefits to apply as a new convalescent period.	80% after deductible 90 days per convalescent confinement	80% after deductible 90 days per convalescent confinement	60% after deductible 90 days per convalescent confinement
Emergency Room	$50* copayment then 80% after deductible	$50* copayment then 80% after deductible	$50* copayment then 80% after deductible
* The copayment is waived if the Covered Person is admitted to the Hospital on an emergency basis. The Utilization Review Administrator must be notified within 24 hours of the admission, even if the patient is discharged within 24 hours of the admission.			
Urgent Care Clinic	100% after $10 copayment	100% after $20 copayment	60% after deductible

	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Physician Services			
Inpatient visits	80% after deductible	80% after deductible	60% after deductible
Office visits	100% after $10 copayment	100% after $20 copayment	60% after deductible
Lab, X-ray, injections and/or supplies incurred during the same day visit as the office visit	100% deductible waived	80% after deductible	60% after deductible
Surgery	80% after deductible	80% after deductible	60% after deductible
Allergy shots Without an office visit	80% after deductible	80% after deductible	60% after deductible
Lab & X-rays Without an office visit	80% after deductible	80% after deductible	60% after deductible
Home Health Care	80% after deductible 50 visits per Calendar Year	80% after deductible 50 visits per Calendar Year	60% after deductible 50 visits per Calendar Year
Ambulance Service	Paid as Tier II	80% after deductible	Paid as Tier II
Oral Surgeries	Not Applicable	80% after deductible	60% after deductible
Cardiac Rehab	80% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment & Diabetic equipment	80% after deductible	80% after deductible	60% after deductible
Occupational, Speech, and Physical Therapy	80% after deductible 60 visits combined per Calendar Year	80% after deductible 60 visits combined per Calendar Year	60% after deductible 60 visits combined per Calendar Year
Chiropractic Care	100% after $10 copayment 12 visits per Calendar Year	100% after $20 copayment 12 visits per Calendar Year	60% after deductible 12 visits per Calendar Year

*With regards to the **UTILIZATION REVIEW** section, pages 30-31 of this Master Plan Document, the section shall be deleted and replaced as follows:*

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
Biopsies
Breast surgeries
Chemotherapy
Radiation therapy
Cardiovascular surgeries
Spinal surgeries
Morbid Obesity

In addition members must call Contract Health Services for Plan required purchase order prior to any hospital services

(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.

Purchase Order Certification is a request for care and services issued by the appropriate ordering Contract Health Services official to the medical care provider.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis, 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.

This Plan complies with Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 which provides authorization to pay no more than "Medicare-like" rates for referred Hospital services furnished by Medicare-participating and critical access Hospitals.

Hospital is defined as long-term care Hospitals, independent rehabilitation facilities and Inpatient psychiatric facilities, as well as all levels of care furnished by a Medicare participating Hospital that provides Inpatient, Outpatient, Skilled Nursing Facility care, and other services of a department, subunit, distinct part or other component of a Hospital (including services furnished directly by the Hospital or under arrangements), and to critical access Hospitals.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 24 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- 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

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 the utilization review administrator **within 24 hours** of the first business day after the admission. (To avoid penalty the Utilization Review Administrator must be contracted within 72 hours of an Emergency Hospital admission.)

The utilization review administrator will determine the number of days of Medical Care Facility confinement 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 for hospitalizations, the benefit payment will be reduced by $200. In addition if a

purchase order is not obtained, services will be paid at the applicable Tier level. Coinsurance and deductibles will apply.

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.

*With regards to the **DEFINED TERMS** section, pages 34-44 of this Master Plan Document, **Contract Health Services Eligible Person** and **Contract Health Services** shall be added as follows:*

Contract Health Services Eligible Person - A person of Indian descent belonging to the Indian community served by the local IHS facilities and program who resides within the United States (U.S.) on a reservation located within a Contract Health Service Delivery Area, (CHSDA); or resides within a CHSDA and either is a member of the tribe or tribes located on that reservation; or maintains close economic and social ties with that tribe or tribes.

Contract Health Services - Health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service. (e.g., dentists, physicians, hospitals, ambulances).

*With regards to the **RESPONSIBILITIES FOR PLAN ADMINISTRATION** section, pages 79-83 of this Master Plan Document, **Plan Administrator** shall be deleted in its entirety and replaced with the following:*

PLAN ADMINISTRATOR. Stockbridge-Munsee Community Band of the Mohican Indians Employee Group Benefit Plan is the benefit plan of The Mohican Nation, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA and Section 506 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. An individual may be appointed by The Mohican Nation to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, The Mohican Nation 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.

IN WITNESS WHEREOF, Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan has caused this Amendment to take effect, be attached to and form a part of its Employee Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians

EMPLOYEE GROUP BENEFIT PLAN

Amendment #8

Effective October 1, 2007, the Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan established July 1, 1995 and last restated January 1, 2003, shall be amended as described herein.

*With regards to the **SHORT TERM DISABILITY BENEFITS** section, page 50 of this Master Plan Document the follow **(1) Eligibility Provision** shall be deleted in its entity and replaced with the following:*

(1) Total Disability starts while the Employee is covered for this benefit. This benefit is only available to Regular Full-Time Employees and the eligibility requirements are the same as the Stockbridge-Munsee Community Group Health and Dental Plan. The Employee must be a participant in the Health Plan to participate in this Plan. Employee's who are enrolled in only the Dental Plan will not be eligible to participate in the Short Term Disability Benefit.

IN WITNESS WHEREOF, Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan has caused this Amendment to take effect, be attached to and form a part of its Employee Benefit Plan.

_____ _____

Date Signed Authorized Signature & Title

_____ _____

Location Witness

STOCKBRIDGE-MUNSEE COMMUNITY
Band of the Mohican Indians

EMPLOYEE GROUP BENEFIT PLAN

Amendment #7

Effective January 1, 2006, the Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan established July 1, 1995 and last restated January 1, 2003, shall be amended as described herein.

*With regards to the **TIMELY AND LATE ENROLLMENT** section, page 8 of this Master Plan Document the **Late Enrollment** sections shall hereby be deleted and replaced with the following:*

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

The Plan is permitted to treat late enrollees differently from individuals who enroll when first eligible, except with regard to health factors. A Plan may not treat late enrollees differently based on health factors.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1.

*With regards to the **OPEN ENROLLMENT** section, page 13 of this Master Plan Document the entire sections shall hereby be deleted and replaced with the following:*

OPEN ENROLLMENT

OPEN ENROLLMENT

Every year during the month of December, the open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective the following January 1st.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

IN WITNESS WHEREOF, Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan has caused this Amendment to take effect, be attached to and form a part of its Employee Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

Stockbridge-Munsee Community
Band of the Mohican Indians Employee Group Benefit Plan

Amendment # 6

Effective **July 1, 2005**, the Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan established July 1, 1995 and last restated January 1, 2003, shall be amended as described herein.

*With regards to the **SPECIAL ENROLLMENT PERIODS** section, of this Master Plan Document the entire sections shall hereby be deleted and replaced with the following:*

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.

Individuals losing other coverage (proof is required). An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

1. The Employee 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.

2. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

3. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and:

    a. the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, the plan is no longer offering any benefits to a class of similarly situated individuals) or,

    b. employer contributions towards the coverage were terminated, or

    c. an individual incurs a claim that would meet or exceed a lifetime limit on all benefits.

4. The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, 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.

If the Employee 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), that individual does not have a Special Enrollment right.

Dependent beneficiaries. If:

1. The Employee 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

2. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

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.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

1. in the case of marriage, the first of the month coinciding with or next following the date of the marriage or the first of the month coinciding with or next following the date of application, if application is made after the event;

2. in the case of a Dependent's birth, as of the date of birth; or

3. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Pre-existing Condition Exclusion and Special Enrollees. Special enrollees and their Dependents will not be treated as late enrollees. The Plan will apply a Pre-Existing Condition exclusion period of twelve (12) months to a special enrollee. The Plan will not apply a Pre-Existing Condition exclusion to Pregnancy, or to a Newborn or adopted child who is enrolled under the special enrollment provisions.

*With regards to the **PRE-EXISTING CONDITIONS** section, of this Master Plan Document the entire sections shall hereby be deleted and replaced with the following:*

PRE-EXISTING CONDITIONS

A Pre-Existing Conditions is a disease, Injury, or Sickness of a Covered Person for which the Covered Person has been under the care of a licensed Physician or has received medical care, services, or supplies within the three (3) month period of the Covered Person's enrollment date.

Timely Enrollees:
For a Covered Person who enrolls in this Plan within thirty-one (31) days after the date of his eligibility for coverage (Timely Enrollees) claims in relation to or resulting from Pre-Existing Conditions within the three (3) month period immediately preceding their date of employment will be excluded from coverage under the Plan until the Covered Person has been employed by the Company for a period of twelve (12) consecutive months, in which case the pre-existing conditions limitation will no longer apply, and all eligible charges incurred thereafter will be considered under the Plan.

Special Enrollees:
For a Covered Person who enrolls in the Plan under the Special Enrollment (Special Enrollees), claims in relation to or resulting from Pre-Existing Conditions within the three (3) month period immediately preceding their enrollment date with the Company will be excluded from coverage under the Plan until the Covered Person has been enrolled for coverage under the Plan for a period of twelve (12) consecutive months, in which case the pre-existing conditions limitation will no longer apply, and all eligible charges incurred thereafter will be considered under the Plan.

Late Enrollees:
For a Covered Person who enrolls in this Plan more than thirty-one (31) days after the date of his eligibility for coverage (Late Enrollees), claims in relation to or resulting from Pre-Existing Conditions within the three (3) month period immediately preceding his effective date of coverage) are excluded from coverage under the Plan until the Covered Person has been enrolled under the Plan for a period of eighteen (18) consecutive months, in which case the pre-existing conditions limitation will no longer apply, and all eligible charges incurred thereafter will be considered under the Plan.

Exceptions to the Pre-Existing Condition Limitation:

1. The Plan's pre-existing condition exclusion does not apply to pregnancy, or to a newborn, an adopted child under age eighteen (18), or a child placed for adoption under age eighteen (18), if the child becomes covered within thirty (30) days of birth, adoption or placement for adoption.

2. If the Plan Administrator contracts with a drug card company for payment of Outpatient Prescription Drugs, charges for Outpatient Prescription Drugs purchased through a pharmacy are not subject to this Pre-Existing Limitation.

3. The Pre-Existing Condition Limitation will be waived wholly or in part in the event an individual was insured previously by Creditable Coverage, and providing there was no break in such coverage longer than sixty-three (63) days immediately prior to: 1) for new hires, his date of employment; or 2) for Special and Late Enrollees, the date of enrollment in this Plan. Any time periods used to satisfy the individual's Pre-Existing Condition Limitation under the prior plan will be credited towards the satisfaction of this Plan's Pre-Existing Conditions Limitation, to the extent that such time was satisfied under the prior plan.

For the purposes of this Plan, **"Creditable Coverage"** means, with respect to an individual, coverage of
the individual provided under any of the following:

a. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

b. A group health plan;

c. An individual health insurance policy that provides benefits similar to or exceeding benefits provided under a basic health benefit plan;

d. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 (the program for distribution of pediatric vaccines);

e. Chapter 55 of Title 10, United States Code (military-sponsored health care);

f. A State health benefits risk pool;

g. A health plan offered under chapter 89 of Title 5, United States Code (FEHBP);

h. A public health plan (as defined in the regulations); or A medical care program of the Indian Health Service or of a tribal organization; or

i. A health benefit plan under section 5(e) of the Peace Corps Act (22 D.S.C. 2504(e)).

j. A public health plan provided by a foreign country.

k. A Children’s Health Insurance Program of any State.

*Effective April 20, 2005, the following section regarding **HIPAA SECURITY STANDARDS** shall be added to this Master Plan Document as follows:*

HIPAA SECURITY STANDARDS

I. *Definitions*

A. *Electronic Protected Health Information* – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

B. *Plan* – The term "Plan" means the Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan.

C. *Plan Documents* – The term "Plan Documents" means the group health plan's governing documents and instruments (*i.e.,* the documents under which the group health plan was established and is maintained), including but not limited to the Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan.

D. *Plan sponsor* – The term "Plan Sponsor" means the entity as defined at section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan sponsor is Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan.

E. *Security Incidents* – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

II. Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan sponsor on behalf of the Plan, the Plan sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

A. Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;

B. Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

C. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

D. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

1. Plan sponsor shall report to the Plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

2. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

*Effective December 10, 2004, with regards to the **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT ACT (USERRA)** section, of this Master Plan Document the entire sections shall hereby be deleted and replaced with the following:*

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT ACT (USERRA)

Employees on Military Leave. Employees 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 Employees 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:

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

    - The day after the date on which the person was required to apply for or return to a position or 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 Employee'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.

IN WITNESS WHEREOF, Stockbridge-Munsee Community Band of the Mohican Indians Group Benefit Plan has caused this Amendment to take effect, be attached to and form a part of its Employee Benefit Plan.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

Stockbridge Munsee Community
EMPLOYEE BENEFIT PLAN

Amendment # 5

I. Effective November 1, 2004, the Stockbridge Munsee Community Employee Benefit Plan, shall be amended as described herein: With regards to the entire Plan Document all references to the **Claims Administrator/TPA** shall hereby deleted and replaced as follows:

DELETE:
Medical Benefit Administrators

REPLACE WITH:
Auxiant

II. Effective November 1, 2004, the Stockbridge Munsee Community Employee Benefit Plan, shall be amended as described herein: With regards to the **THIRD PARTY RECOVERY PROVISION** section, the entire section in this Plan Document shall be deleted and replaced with the following:

SUBROGATION AND REIMBURSEMENT PROVISIONS

A. Payment Condition

1. The Plan may elect, but is not required, to conditionally advance payment or extend credit of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of covered persons and their dependants ("Plan Beneficiary") where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision or other insurance policies or funds ("Coverage") is available.

2. Plan Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees, by acceptance of the Plan's payment of medical benefits, to maintain one hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without dissipation except for reimbursement to the Plan or its assignee. By accepting benefits under the Plan, the Plan Beneficiary recognizes this property right or equitable interest of the Plan in any cause of action the Plan Beneficiary may have or the proceeds thereof.

3. In the event a Plan Beneficiary settles, recovers or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid as a result of said injury or condition. The Plan Beneficiary acknowledges that the Plan has the first priority right of recovery and a first lien to the extent of benefits provided by the Plan and shall be paid before any other claims for the Plan Beneficiary as the result of the illness or injury. If the Plan Beneficiary fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the Plan Beneficiary will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

B. Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any Coverage for which the Plan Beneficiary claims an entitlement to benefits under this Plan, regardless of how classified or characterized and to reimburse the Plan for any such benefits paid when recovery is made.

2. If the Plan Beneficiary decides to pursue a third party or any Coverage available to he/she as a result of the said injury or condition, the Plan Beneficiary agrees to include the Plan's subrogation claim in that action and if there is a failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Plan Beneficiary decides not to pursue any third parties or Coverage the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the plan in the prosecution of any such claims.

3. The Plan may in its own name or in the name of the Plan Beneficiary or their personal representative commence a proceeding or pursue a claim against such other third person for the recovery of all damages in the full extent of the value of any such benefits or services furnished or payments advanced or credit extended by the Plan.

4. If the Plan Beneficiary fails to make a claim against or pursue damages against:

   a) the responsible party, its insurer, or any other source on behalf of that party;
   a) any first party insurance through medical payment coverage or personal injury protection;
   b) the Plan Beneficiary's uninsured or underinsured motorist coverage;
   c) any policy or contract of insurance from any insurance company or guarantor of a third party;
   d) worker's compensation or other liability insurance company or
   e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and no-fault or school insurance coverages;

   then the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary, or his or her guardian or the estate of a Plan Beneficiary, assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

C. Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs, or application of the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory, or other deductions, without regard to whether the Plan Beneficiary is fully compensated by his/her net recovery from all sources. The obligation exists whether or not the judgment or settlement specifically

designates the recovery or a portion of it as including medical, disability, or other expenses. The obligation exists regardless of how classified or characterized and to reimburse the Plan for any such benefits paid when recovery is made. Said right and/or lien may be filed with any person or organization responsible, or potentially responsible, to the Plan Beneficiary for indemnification, the Plan Beneficiary's attorney, or the Court. If the Plan Beneficiary's net recovery is less than the benefits paid, then the Plan is entitled to be paid all of the net recovery achieved.

2. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Plan Beneficiary pursuing a claim against any Coverage. The Plan Beneficiary agrees to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Plan Beneficiary.

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

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

D. Excess Insurance

1. If at the time of injury, sickness, disease or disability there is available, or potentially available based on information known or provided to the Plan, to the Plan Beneficiary any other Coverage, including but not limited to judgment at law or settlements, the benefits under this Plan shall apply only as excess insurance over such other sources of indemnification. The Plan's benefits shall be excess to:
   a) the responsible party, its insurer, or any other source on behalf of that party;
   b) any first party insurance through medical payment coverage or personal injury protection;
   c) the Plan Beneficiary's uninsured or underinsured motorist coverage;
   d) any policy or contract of insurance from any insurance company or guarantor of a third party;
   e) worker's compensation or other liability insurance company or
   f) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and no fault or school insurance coverages.

E. Obligations

1. It is the Plan Beneficiary's obligation to:

   a) to cooperate with the Plan or its agents in defining, verifying and protecting its rights of subrogation and reimbursement;
   b) to provide the Plan with pertinent information regarding the injury or sickness, including various forms of documentation, accident reports, settlement reports and any other requested additional information;
   c) to take such action, furnish such information and assistance, and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
f) to not settle, without the prior consent of the Plan, any claim that the Plan Beneficiary may have against any legally responsible party or insurance carrier and
g) to refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Plan Beneficiary for the injury or condition without obtaining the Plan's written approval.

2. Failure to comply with any of these requirements by the Plan Beneficiary, his or her attorney, or guardian may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld to satisfy the Plan Beneficiary's obligation. If the Plan Beneficiary fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursed received, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

F. Minor Status

1. In the event the Plan Beneficiary is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian, as the case may be, shall take and cooperate in any and all action requested by the Plan to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail or refuse to take such action, the Plan shall have no obligation to advance payment or extend credit of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

G. Language Interpretation

1. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation/reimbursement rights. The Plan Administrator may amend the Plan in its sole discretion at anytime without notice.

H. Severability

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

III. Effective October 1, 2005, the Stockbridge Munsee Community Employee Benefit Plan, shall be amended as described herein: With regards to the **CORBA CONTINUATION OPTIONS** section, the entire section in this Plan Document shall be deleted and replaced with the following:

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Stockbridge Munsee Community Plan Document (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 Stockbridge Munsee Community, N8705 Moheconnuck Rd, Bowler, WI 54416. COBRA continuation coverage for the Plan is administered by Stockbridge Munsee Community, N8705 Moheconnuck RdN8705 Moheconnuck Rd, Bowler, WI 54416. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator 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 employees 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 Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. 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 Employee 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 Employee" includes not only common-law employees (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 Employee 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 Employee 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 Employee.

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

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(4) A covered Employee'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 Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), 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 Employee, or the Spouse, or a Dependent child of the covered Employee, 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 an Employee 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 Employee and family members will be entitled to COBRA continuation coverage evenif they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

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 employee 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 employee 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 Employee 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 employee,

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

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

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee 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:

Human Resources Department
Stockbridge Munsee Community
N8705 Moheconnuck Rd
Bowler, WI 54416

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 employee** 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 employees 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 under your plan the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. "on the date of the Qualifying Event"). 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.

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 employee.

(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 Employee'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 Employee ends on the later of:

(a) 36 months after the date the covered Employee 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 Employee'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 Employee 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 Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee'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 employees 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 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee 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.

IN WITNESS WHEREOF, Stockbridge Munsee Community has caused this Amendment to take effect, be attached to and form a part of its Employee Benefit Plan.

STOCKBRIDGE-MUNSEE COMMUNITY
BAND OF THE MOHICAN INDIANS

EMPLOYEE GROUP BENEFIT PLAN

Amendment #4

Effective October 1, 2004, the Stockbridge Munsee Community Employee Group Benefit Program, established July 1, 1995 and last restated January 1, 2003 shall be amended as described herein.

*With regards to the **SCHEDULE OF BENEFITS** section, PAGE 18 of this Master Plan Document the benefit box regarding **Preventive Care** shall hereby be deleted and replaced with the following:*

	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Preventive Care			
Routine Well Adult Care	100% deductible waived up to $500 Calendar Year maximum	100% deductible waived up to $500 Calendar Year maximum	Not Covered
Routine Mammograms*	100% deductible waived	100% deductible waived	Not Covered
Frequency limits for mammogram Ages 35 through 39 . . . . . single Baseline mammogram Ages 40 through 49 . . . . . every two years Ages 50 and over . . . . . annually			
Routine Colonoscopy*	80% after deductible	80% after deductible	60% after deductible
Routine PSA Test* Limited to one test per Calendar Year	100% deductible waived	100% deductible waived	Not Covered
Immunization from Birth to Age 2*	100% deductible waived	100% deductible waived	Not Covered
*$500 Calendar Year maximum does not apply to these services.			

*With regards to the **PRESCRIPTION DRUG BENEFIT** section, PAGE 54 of this Master Plan Document item 6 of **Covered Prescription Drugs** shall hereby be deleted and replaced with the following:*

(6) Prenatal vitamins and non combination legend vitamins A, D, E and K.

*With regards to the **PRESCRIPTION DRUG BENEFIT** section, PAGE 54 of this Master Plan Document the following **Covered Prescription Drugs** shall hereby be added as follows:*

(8) Nuva Ring and emergency contraceptives
(9) Self-Injectable medications.

*With regards to the **PRESCRIPTION DRUG BENEFIT** section, PAGE 55 of this Master Plan Document item 3 of **Expenses Not Covered** shall hereby be deleted and replaced with the following:*

(3) Contraceptives. Charges for contraceptive medications or devices, except for oral contraceptives, the Nuva Ring and emergency contraceptives, which are covered. This includes injectables, implants, diaphragms, and IUDs.

*With regards to the **PRESCRIPTION DRUG BENEFIT** section, PAGE 55 of this Master Plan Document item 9 of **Expenses Not Covered** shall hereby be added and all subsequent items shall hereby be renumbered:*

(9) Growth hormones. Charges for growth hormones, unless Medically Necessary.

*With regards to the **PRESCRIPTION DRUG BENEFIT** section, PAGE 55 of this Master Plan Document item 12 of **Expenses Not Covered** shall hereby be deleted and all subsequent items shall hereby be renumbered:*

DELETE:
(12) Injectables. Any charges for injectables, except for insulin.

*With regards to the **PRESCRIPTION DRUG BENEFIT** section, PAGE 56 of this Master Plan Document item 18 of **Expenses Not Covered** shall hereby be deleted and all subsequent items shall hereby be renumbered:*

DELETE:
(18) Over the counter medications. Any charges for over-the-counter drugs or medications.

*With regards to the **PRESCRIPTION DRUG BENEFIT** section, PAGE 56 of this Master Plan Document item 21 of **Expenses Not Covered** shall hereby be deleted and replaced with the following:*

(21) **Vitamins.** A charge for vitamins including multivitamins and supplemental agents. However, prenatal vitamins and non combination legend vitamins A, D, E and K.

IN WITNESS WHEREOF, Stockbridge Munsee Community has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Program.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
BAND OF THE MOHICAN INDIANS

EMPLOYEE GROUP BENEFIT PLAN

Amendment #3

Effective July 1, 2004, the Stockbridge Munsee Community Employee Group Benefit Program, established July 1, 1995 shall be amended as described herein.

*With regards to the **SCHEDULE OF BENEFITS** section, PAGE 17 of this Master Plan Document the benefit box regarding **Durable Medical Equipment and Diabetic Equipment** shall hereby be deleted and replaced with the following:*

	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Durable Medical Equipment	80% after deductible	80% after deductible	60% after deductible
Diabetic Equipment	80% after deductible	80% after Tier I deductible	60% after deductible

IN WITNESS WHEREOF, Stockbridge Munsee Community has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Program.

_____ _____
Date Signed Authorized Signature & Title

_____ _____
Location Witness

STOCKBRIDGE-MUNSEE COMMUNITY
BAND OF THE MOHICAN INDIANS

EMPLOYEE GROUP BENEFIT PLAN

Amendment #2

Effective July 1, 2004, the Stockbridge Munsee Community Employee Group Benefit Program, established July 1, 1995 shall be amended as described herein.

*With regards to the **TERMINATION OF COVERAGE** section, PAGE 11 of this Master Plan Document the following section regarding **Continuation During Paid Leave** shall hereby be added after the Continuation During an Absence due to Total Disability as follows:*

Continuation During Paid Leave. If an Employee is absent from work but is still on the payroll receiving compensation, as they are using sick leave, vacation time or other compensation, coverage will continue while the Employee remains to be paid.

*With regards to the **TERMINATION OF COVERAGE** section, PAGE 11 of this Master Plan Document the following section regarding **Donation of Vacation/Sick Leave Transfer Program** shall hereby be added after the Continuation During Paid Leave as follows:*

Donation of Vacation/Sick Leave Transfer Program. This program is set forth and administered through the Stockbridge-Munsee Band of Mohicans and is a process whereby one employee may donate vacation/sick leave time to a fellow employee to provide sick leave to employees who have exhausted their leave. Eligibility to transfer vacation/sick leave time will be limited to employees who have been employed at least one (1) year with the Tribe. Employees receiving transfer leave time must have utilized all accrued vacation, sick, regular and special compensatory leave. To receive transferred leave the employee cannot be covered by disability leave with pay except that the employee may receive donated time during the 30-day short term waiting period.

Vacation/Sick Leave transfers must be used for the employee's personal illness, accident or Injury or for time off required by an employee due to family, accident, medical appointments or other unforeseen needs which will be documented by a licensed physician, excluding workers' compensation injury. An employee may donate up to 40 hours of leave time during each week provided the transferee maintains a minimum balance of 40 hours. Leave cannot be transferred to a recipient who has returned to full-time employment.

For further information regarding this program see the Stockbridge-Munsee Band of Mohicans Policy and Procedures, section: Human Resources, section number: 101:02.

IN WITNESS WHEREOF, Stockbridge Munsee Community has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Program.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

STOCKBRIDGE-MUNSEE COMMUNITY
BAND OF THE MOHICAN INDIANS

EMPLOYEE GROUP BENEFIT PLAN

Amendment #1

Effective July 1, 2004, the Stockbridge Munsee Community Employee Group Benefit Program, established July 1, 1995 shall be amended as described herein.

*With regards to the **ELIGIBLE CLASSES OF DEPENDENTS**, PAGE 4 of this Master Plan Document the following paragraph shall be added after the second paragraph in item #1 as follows:*

> Annually the Claims Supervisor will send out full-time student verification forms to Employee's who have Dependents on the Plan who are age 19 and older. If the Employee does not respond to this request of verification within 30 days, the Claims Supervisor will terminate the Dependent child's coverage as of the last day of an attended school term. However, if the Employee can provide the completed student verification form to the Claims Supervisor within 90 days of the termination date, the Dependent child will be reinstated on the Plan. For administrative purposes, unless otherwise notified, the Claims Supervisor will consider that the school term ends on May 31st. However, the following exception will be in place for those notices sent out in June, 2003, the Employee will have 120 days to return the information.

*With regards to the **SCHEDULE OF BENEFITS – SHORT TERM DISABILITY BENEFITS**, PAGE 19 of this Master Plan Document the **Weekly benefit limit** shall be deleted and replaced with the following:*

Weekly benefit limit.....	66.67% of covered weekly earnings to a maximum of $3,000 a month**

**** Benefits may be subject to the Work with Restriction Provision. See the Work with Restrictions Provision in the Short Term Disability Benefit section.**

*With regards to **SHORT TERM DISABILITY BENEFITS**, PAGE 51 of this Master Plan Document the **Benefit Payment** section shall be deleted and replaced with the following:*

BENEFIT PAYMENT

Benefits will be paid for a Total Disability up to a Weekly Benefit Limit as described in the Schedule of Benefits. The Weekly Benefit will be payable after the Waiting Period has been satisfied. With regards to the Waiting Period only those days the Employee is regularly schedule to work but cannot do so because of the medically disabling condition will be applied to the thirty (30) days. And the duration of payments will not exceed the Maximum Period for any one period of disability and will automatically terminate the date you are no longer under a Physician's care. Benefits may be subject to the Work with Restrictions Provision, see explanation below.

*With regards to **SHORT TERM DISABILITY BENEFITS**, PAGE 51 of this Master Plan Document the following section titled **Work with Restriction Provision** shall hereby be added follows:*

WORK WITH RESTRICTION PROVISION

This Plan has a provision in place that if an Employee's doctor indicates that the Employee may return to work with restrictions, that the Employee must take the position that the Stockbridge-Munsee Community offers them. If the Employee refuses to take the position offered than the short-term disability benefits will be reduced by the hours that their doctor indicates that they can work with restrictions (e.g., If the Physician indicates eight hours of restricted work and the Employee refuses, they will get zero. And if the Physician indicates four hours and they refuse, then the Employee's STD benefit is decreased in half.)

IN WITNESS WHEREOF, Stockbridge Munsee Community has caused this Amendment to take effect, be attached to and form a part of its Employee Group Benefit Program.

_____	_____
Date Signed	Authorized Signature & Title
_____	_____
Location	Witness

DISCLAIMER OF PLAN SUPERVISOR

We have prepared these documents for your review and consideration; however, we are not legal counsel, nor are we in the business of practicing law. As your plan's fiduciaries and/or trustees, you are fully responsible for all legal issues that concern the plan. If you are not an expert in this area, we urge you to hire an attorney to help you review this plan.

BY THIS AGREEMENT, Stockbridge-Munsee Community Band of the Mohican Indians Employee Group Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for the Stockbridge-Munsee Community on or as of the day and year first below written.

By_____
The Stockbridge-Munsee Community

Date _____

Witness _____

Date _____

TABLE OF CONTENTS

INTRODUCTION

This document is a description of Stockbridge-Munsee Community Band of the Mohican Indians Employee Group Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against lost income during periods of disability or certain catastrophic health expenses.

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

The Employer 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. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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.

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.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health and disability Plan and the administration is provided through a Third Party Claims Supervisor. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not a fully insured plan.

PLAN NAME
Stockbridge-Munsee Community Band of the Mohican Indians Employee Group Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 39-1727595

PLAN EFFECTIVE DATE: July 1, 1995; Restated: January 1, 2003

PLAN YEAR ENDS: September 30

EMPLOYER INFORMATION

Stockbridge-Munsee Community
P.O. Box 70
N8705 Moh He Con Nuck Road
Bowler, Wisconsin 54416

PLAN ADMINISTRATOR

Stockbridge-Munsee Community
P.O. Box 70
N8705 Moh He Con Nuck Road
Bowler, Wisconsin 54416

NAMED FIDUCIARY AND AGENT FOR SERVICE OF LEGAL PROCESS

Stockbridge-Munsee Community
P.O. Box 70
N8705 Moh He Con Nuck Road
Bowler, Wisconsin 54416

CLAIMS SUPERVISOR

Medical Benefit Administrators
5940 Seminole Centre Court
Madison, Wisconsin 53711
(800) 279-6772

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer

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

(1) is a, Regular, Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 32 hours per week on a Regular Basis.

(2) Part-time Employees, Seasonal, Flex, and College Bound Employees will not be eligible for coverage under the Plan. However, employees who have had coverage under the previous Part-Time Employee provision prior to January 1, 2003 shall continue to remain covered.

(3) Elected and Appointed Officials of the Tribe

(4) is in a class eligible for coverage.

(5) completes the employment Orientation Period of as an Active Employee as determined by the Company. An "Orientation Period" will be the time between the first day of employment and the first day of coverage under the Plan. The Orientation Period, also known as the Waiting Period, is counted in the Pre-Existing Conditions exclusion time.

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

(1) A covered Employee's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Employee 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 college or university, primarily dependent upon the covered Employee 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 closes 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 person recognized as the covered Employee's legal husband or wife who is a resident of the same country in which the Employee resides. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children living in the same country as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the same country as the Employee may also be included.

If a covered Employee 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 Employee in anticipation of adoption" refers to a child whom the Employee 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 Employee 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 Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee 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 Employee for support and maintenance and unmarried. The Plan Administrator may require subsequent proof of the child's Total Disability and dependency.

After the receipt of initial proof, 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 Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, 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 mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee 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

Cost of the Plan. The Mohican Nation shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

The Plan is prohibited to charge different premium to individuals based on health factors, whether or not it is the individual or the plan sponsor who pays the premium. In addition, a group health plan may not establish a rule for eligibility or set any individual's contribution rate based on whether an individual is confined to a hospital or other health care institution.

PRE-EXISTING CONDITIONS

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months, or 18 months if a Late Enrollee after the person's Enrollment Date. This time may be offset if the person has Creditable Coverage from his or her previous plan.

> **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. The Pre-Existing Condition Limitation exclusion period will be reduced by any creditable coverage not including any coverage preceding a Significant Break in Coverage of sixty-three (63) days or more determined to exist under a previous health plan. The determination about the length of any Pre-Existing Conditions Limitation exclusion period that applies to the covered Person will be made within a reasonable time period after receipt of a certificate of coverage or other reliable information relating to prior creditable coverage.
>
> 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.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within three 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 this Plan 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 this 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. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If the Employee chooses to cover Dependents, the covered Employee is required to enroll for Dependent coverage also.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee 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 required to be enrolled and 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 required to be enrolled and 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.

If the child is required to be enrolled and is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **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 (husband and wife) 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.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

The Plan is permitted to treat late enrollees differently from individuals who enroll when first eligible, except with regard to health factors. A Plan may not treat late enrollees differently based on health factors.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on February 1 and August 1.

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.

(1) **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee 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 Employee 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 Employee 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 (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, 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.

If the Employee 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), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

(a) The Employee 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 Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

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.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the date of marriage;

(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.

INDIVIDUALS PREVIOUSLY DENIED COVERAGE BASED ON A HEALTH FACTOR

Individuals, who were previously denied coverage based on a health factor before HIPAA took effect for the plan and have never been given a subsequent opportunity to enroll, must be given the chance to enroll. The individual has the option to begin coverage retroactively to the date the plan became subject to HIPAA (renewal month beginning on or after 7/1/97) or prospectively from the date they request enrollment in the plan.

EFFECTIVE DATE

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

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) 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.

A group health plan may not base rules for eligibility for coverage upon an individual being "actively at work," if a health factor is present. If a plan participant is absent from work due to a health factor, for purposes of plan eligibility, the individual is to be considered actively at work.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee 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 coverage under this Plan. Please contact the Plan Administrator for further details.

When Employee Coverage Terminates. Employee 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 COBRA Continuation Options):

(1) The date the Plan is terminated; or with respect to any benefit of this Plan, the date of termination of such benefit. (Note: with regard to Short Term Disability, should the Plan be terminated, disabled Employees will continue to receive benefits until completion of the Benefit period specified in the Plan.)

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) The date the individual maximum has been paid.

(6) With regards to Short Term Disability, the expiration of the benefit period or failure to provide doctor's release.

Continuation During an Absence due to Total Disability. In the event of an Employee's absence for a disability that entitles the Employee to Short Term Disability benefits under the Company's benefit program, benefits for the Employee and covered Dependents will continue until the Employee is no longer eligible for Short Term Disability benefits. Any costs associated with this continued coverage are the responsibility of the party paying such costs prior to the reduction of working hours.

This continued coverage would also apply if the Employee returns to work for less than the regularly scheduled hours per week if the attending Physician restricts working hours.

If the Employee has not returned to work by the end of the continuation period, coverage is terminated and COBRA is offered.

This provision runs concurrently with the Family and Medical Leave Act (FMLA) when applicable.

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 Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee 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 Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the 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.

Employees on Military Leave. Employees 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 Employees 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 18 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 or 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 Employee'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 COBRA Continuation Options):

(1) The date the Plan or Dependent coverage under the Plan is terminated; or with respect to any benefit of this Plan, the date of termination of such benefit.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)

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

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) The date the individual maximum has been paid.

OPEN ENROLLMENT

Every January 1 and July 1, the open enrollment periods, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective the first of the following month.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SCHEDULE OF BENEFITS

Verification of Eligibility (800) 279-6772
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.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

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.

Hospitalizations
Biopsies
Breast surgeries
Chemotherapy
Radiation therapy
Cardiovascular surgeries
Spinal surgeries
Morbid Obesity

Please see the Cost Management section in this booklet for details.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating 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 Participating Provider, **Tier II**, that Covered Person will receive a higher payment from the Plan than when a Non-participating Provider is used. It is the Covered Person's choice as to which Provider to use.

Benefits are broken down into three tiers based on Preferred Provider Organization membership. These tiers are:

Tier I Providers: Stockbridge Munsee Health Center
Tier II Providers*: Preferred Providers
Tier III Providers: All other Providers

* Providers in Tier II may change based on negotiated contracts. A current list of Tier II Providers is available from the Mohican Nation Insurance Department.

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 services. Each January 1st, a new deductible amount is required. However, covered expenses incurred in, and applied toward the deductible in October, November and December will also be applied to the deductible in the next Calendar Year.

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. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

	TIER I PROVIDERS	**TIER II PROVIDERS**	**TIER III PROVIDERS**
MAXIMUM LIFETIME BENEFIT AMOUNT	$1,000,000		
Note: The maximums listed below are the total for Participating and Non-Participating 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 Participating and Non-Participating providers.			
Note: The Plan pays Tier II benefits for certain ancillary services provided by Tier III practitioners, as long as they are performed at a Tier II facility. These services include anesthetics, radiology, pathology and emergency care. For example, if you go to a Tier II facility for an X-ray and are treated by a technician who does not belong to Tier II, you will receive Tier II benefits for that service. **In addition, if X-rays or labs that are performed at a Tier I provider is sent to a non-Tier I provider to be read, charges for the reading shall be paid at the Tier I benefit level.**			
DEDUCTIBLE, PER CALENDAR YEAR			
Per Covered Person	$100	$250	$500
Per Family Unit	$200	$500	$1,000
The Calendar Year deductible is waived for the following Covered Charges: - Tier 1 and 2 office visits - Tier 1 related office diagnostic lab and x-rays, injections, and supplies. - Tier 1 and 2 Chiropractic Care - Tier 1 and 2 preventive care			

	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$500	$1,000	$2,000
Per Family Unit	$1,000	$2,000	$4,000
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%. Outpatient Mental Disorder/substance abuse treatment charges Inpatient Mental Disorder/substance abuse treatment charges Cost containment penalties Copayments Charges that exceed the Usual & Reasonable. Charges for services that are excluded.			
COVERED SERVICES			
Hospital Services			
Room and Board the semiprivate room rate	80% after deductible	80% after deductible	60% after deductible
Intensive Care Unit Hospital's ICU Charge	80% after deductible	80% after deductible	60% after deductible
Miscellaneous Services and Supplies	80% after deductible	80% after deductible	60% after deductible
Outpatient Hospital Expenses	80% after deductible	80% after deductible	60% after deductible
Skilled Nursing Facility the facility's semiprivate room rateThere must be at least a 90 day separation between convalescent periods for benefits to apply as a new convalescent period.	80% after deductible 90 days per convalescent confinement	80% after deductible 90 days per convalescent confinement	60% after deductible 90 days per convalescent confinement
Emergency Room	$50* copayment then 80% after deductible	$50* copayment then 80% after deductible	$50* copayment then 80% after deductible
* The copayment is waived if the Covered Person is admitted to the Hospital on an emergency basis. The Utilization Review Administrator must be notified within 24 hours of the admission, even if the patient is discharged within 24 hours of the admission.			
Urgent Care Clinic	100% after $10 copayment	100% after $20 copayment	60% after deductible

	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Physician Services			
Inpatient visits	80% after deductible	80% after deductible	60% after deductible
Office visits	100% after $10 copayment	100% after $20 copayment	60% after deductible
Lab, X-ray, injections and/or supplies incurred during the same day visit as the office visit	100% deductible waived	80% after deductible	60% after deductible
Surgery	80% after deductible	80% after deductible	60% after deductible
Allergy shots Without an office visit	80% after deductible	80% after deductible	60% after deductible
Lab & X-rays Without an office visit	80% after deductible	80% after deductible	60% after deductible
Home Health Care	80% after deductible 50 visits per Calendar Year	80% after deductible 50 visits per Calendar Year	60% after deductible 50 visits per Calendar Year
Ambulance Service	Paid as Tier II	80% after deductible	Paid as Tier II
Oral Surgeries	Not Applicable	80% after deductible	60% after deductible
Cardiac Rehab	80% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment & Diabetic equipment	80% after deductible	80% after deductible	60% after deductible
Occupational, Speech, and Physical Therapy	80% after deductible 60 visits combined per Calendar Year	80% after deductible 60 visits combined per Calendar Year	60% after deductible 60 visits combined per Calendar Year
Chiropractic Care	100% after $10 copayment 12 visits per Calendar Year	100% after $20 copayment 12 visits per Calendar Year	60% after deductible 12 visits per Calendar Year
Mental Disorders and Substance Abuse			
Inpatient & Transitional Treatment	80% after deductible** 10 days per Calendar Year	80% after deductible** 10 days per Calendar Year	60% after deductible** 10 days per Calendar Year
*Two days of Transitional Treatment will be considered one (1) *unused* inpatient day for the purpose of this provision.			
Outpatient	80% after deductible** 24 treatment hours/visits per Calendar Year	80% after deductible** 24 treatment hours/visits per Calendar Year	60% after deductible** 24 treatment hours/visits per Calendar Year
**The portion of Covered Medical Expenses which the Covered Person pays for treatment of Mental Disorders and Substance Abuse do not apply to the maximum Out-of-Pocket. Benefit payment does not increase to 100%.			
Maehnowesekiyah Clinic shall be considered a Tier II provider for the purpose of Mental Disorders and Substance Abuse benefit payments.			

	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Preventive Care			
Routine Well Adult Care	100% deductible waived up to $150 Calendar Year maximum	100% deductible waived up to $150 Calendar Year maximum	Not Covered
Routine Mammograms*	100% deductible waived	100% deductible waived	Not Covered
Frequency limits for mammogram Ages 35 through 39 . . . . . single Baseline mammogram Ages 40 through 49 . . . . . every two years Ages 50 and over . . . . . annually			
Routine Colonscopy*	80% after deductible	80% after deductible	60% after deductible
Routine PSA Test* Limited to one test per Calendar Year	100% deductible waived	100% deductible waived	Not Covered
Immunization from Birth to Age 2*	100% deductible waived	100% deductible waived	Not Covered
*$150 Calendar Year maximum does not apply to these services.			
Vision Exams (Limited to one exam each 24 consecutive month period)	100% deductible waived up to a $40 maximum	100% deductible waived up to a $40 maximum	100% deductible waived up to a $40 maximum
100% deductible waived up to a $200 maximum	100% deductible waived up to a $200 maximum		100% deductible waived up to a $200 maximum
Organ Transplants when performed at a Transplant Network Facility	Not Covered	80% after deductible	Not Covered
Pregnancy	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Other Covered Expenses	80% after deductible	80% after deductible	60% after deductible

SHORT TERM DISABILITY BENEFITS

Weekly benefit limit	66.67% of covered weekly earnings to a maximum of $3,000 a month

Waiting Period
Benefits are payable:

For Injury	31st day of Total Disability
For Sickness	31st day of Total Disability
Maximum period payable	26 weeks*

* The maximum payment period for a Maternity Short Term Disability claim, without complications, is limited to six (6) weeks. This applies to both vaginal and Cesarean Section deliveries. In the event that there are complications, cases will be subject to a second, independent exam performed by a licensed physician of the Plan's choice. Under no conditions will benefits be paid beyond a period of twelve (12) weeks for a maternity related condition.

Partial Disability Reduction: The Plan provides for a partial disability to be paid at 50% of the normal eligible benefit.

PRESCRIPTION DRUG BENEFIT

Pharmacy Option
Generic drugs

Copayment	$10.00

Formulary Brand Name drugs

Copayment	$20.00

Non-Formulary Brand Name drugs

Copayment	$35.00

Mail Order Prescription Drug Option
Generic drugs

Copayment	$10.00

Formulary Brand Name drugs

Copayment	$40.00

Non-Formulary Brand Name drugs

Copayment	$70.00

DENTAL BENEFITS

Dental Percentage Payable

Deductible	None
Diagnostic & Preventive	100%

Note: No benefits are payable for Services other than Diagnostic and Preventative Services in the first 6 months of the Covered Person's coverage under the Plan.

Ancillary	80%
Simple Extractions	80%
Endodontics	80%
Oral Surgery	80%
Periodontics	80%
Direct/Indirect Restorations- Fillings, Semi-precious or Non-precious Crowns	80%
Inlays & Onlays	80%
Gold Fillings, Cast, Inlays & Onlays	50%
Prosthodontics- Bridges/Bridgework	80%
Dentures (Complete or Partial Dentures)	50%
Denture Repair	80%
Orthodontics	50% (Limited to Dependent children under age 19)
Sealants Covered to a paid lifetime maximum of $250	50% (Sealants are covered for Covered Dependents under age 17 only.)

Maximum Benefit Amount

For all Dental services and Orthdontia services:

Per person per Calendar Year	$1,000

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.

A plan cannot restrict benefit for a group in direct relation to health factors of an individual(s) of the group. A plan may limit coverage for a specific disease, but not if the limit is directed at individual participants based on a health factor.

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.

Deductible Three Month Carryover. Covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

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.

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.

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.

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, Ambulatory Surgical Center, Rehabilitation Facility or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits.

Room charges made by a Hospital having only private rooms will be paid at 90% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

Necessary services and supplies other than room and board furnished by the hospital including inpatient miscellaneous services and supplies, outpatient hospital treatments for chronic conditions and emergency room use, physical therapy treatments, hemodialysis, and x-ray and linear therapy.

Additional charges which a Hospital makes for the parent of a Covered child Dependent to remain in the room with their child while the child is Hospital confined. The following provisions apply:

a. the benefit is available under the child's own claim;
b. the benefit is available for a child who is twelve (12) years of age or younger;
c. benefit is available for a maximum of 72 hours per confinement;
d. benefit is limited to the additional charge for room and board and meals provided by the Hospital.

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

The Plan does not covers an elective abortion, regardless of the reason. However, treatment of complications that arise after an abortion is covered.

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).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility during the first one ninety (90) days of a convalescent confinement in any one convalescent period. Only charges incurred in connection with the convalescence from the Injury or Sickness for which the Covered Person is confined will be eligible for benefits. These expenses include:

(a) Room and board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily room and board allowed will not exceed the facility's average semi-private charges or an average semi-private charge made by a representative correction of similar institutions in the area;

(b) Medical services customarily provided by the Skilled Nursing Facility, with the exceptional private duty or special nursing services and physicians; fees; and

(c) Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent period, but no other supplies.

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

(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.** Home health care, subject to the limit stated in the Schedule of Benefits. A doctor (either the person's primary care doctor or the primary doctor in the hospital) must order home health care, which must be provided by a licensed home health care provider. A doctor must certify that:

(a) The covered person would have to be hospitalized or inpatient at a Skilled Nursing Facility if home health care were not available;

(b) It would cause the person's immediate family (spouse, children, parents, grandparents, siblings and their spouses) undue hardship to provide the necessary care; and

(c) A licensed Medicare-certified home health care agency will provide or coordinate the services.

Services must be provided according to a written home health care plan. Covered home health care services include:

(a) Evaluation of the need for a home health care plan and development of the plan by an R.N. or medical social worker;

(b) Home care visits by a doctor;

(c) Part-time or intermittent home health aide services that are supervised by a registered nurse or medical social worker and are medically necessary for patient care;

(d) Part-time or intermittent nursing care by or under the supervision of a registered nurse;

(e) Physical, respiratory, inhalation, occupational and speech therapy;

(f) Medical equipment, supplies and medications prescribed by a qualified practitioner;

(g) Lab services by or on behalf of a hospital (as long as they would have been covered for an inpatient) and

(h) Nutritional counseling from or supervised by a registered dietician.

The plan covers a set number of visits per person in a calendar year, stated in the Schedule of Medical Benefits. A home health care visit is any visit of up to four hours by a home health care provider.

The plan does not pay home health care benefits for:

(a) Services or supplies not included in the home health care plan.

(b) Services for a family member.

(c) Custodial care.

(d) Food housing, homemaker services or meals delivered to the home.

(e) Transportation to and from the patient's home.

(7) **Hospice Care Services and Supplies.** Hospice care for a terminally ill person provided in the hospice, an outpatient facility or the patient's home. A doctor must order the care and certify that the patient has no more than six months to live. The plan may extend hospice care benefits beyond six months if the patient's doctor certifies that he or she is still terminally ill. Covered hospice services and supplies are:

(a) Room and board.

(b) Part-time nursing care provided or supervised by a registered nurse.

(c) Part-time services of a home health aide.

(d) Physical therapy provided by a licensed therapist.

(e) Medical supplies, drugs and medical appliances prescribed by a qualified provider.

(f) Doctors' services including consultation and case management.

(g) Dietary counseling.

(h) Services of a licensed social worker for counseling for the patient.

(i) Bereavement counseling for the patient's immediate family.

Hospice care benefits do not include:

(a) Private or special duty nursing, except as part of a home health care plan.

(b) Confinement not required to manage pain or other acute chronic symptom.

(c) Services of volunteers.

(d) Services of a social worker other than a licensed clinical social worker.

(e) Homemaker or caretaker services including sitter or companion, housecleaning or household maintenance.

(f) Financial or legal counseling including estate planning or drafting a will.

(g) Services of a licensed pastoral counselor if the patient or family member belongs to his or her congregation.

(h) Funeral arrangements.

(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.

(b) Charges made by an **ambulatory surgical center** or minor emergency medical clinic when treatment has been rendered.

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

(d) **Cardiac rehabilitation** as deemed Medically Necessary.

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

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

(g) **Contraceptive** devices and medications including, but not limited to Norplant implant, coils, diaphragms and Depo-Provera. There is no coverage allowed for removal of birth control devices or medications.

(h) Initial **diabetic self-management training** and education for the control of all types of diabetic mellitus when the training or education is prescribed by a licensed physician and provided by a state-certified program or prescribed and/or provided by a tribally-certified physician or tribal facility.

(i) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. This includes charges for the rental of a wheelchair, hospital bed or iron lung or other DME required for temporary therapeutic use. 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) Charges for **electrocardiograms**, electroencephalograms, pneulmoencephalograms, basal metabolism tests, or similar well established diagnostic tests generally approved by physicians throughout the United States.

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

(m) **Laboratory studies.**

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

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

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

Outpatient Treatment performed by: a Hospital, a licensed Psychiatrist (MD); a state licensed psychologist; an Outpatient Substance Abuse Treatment Facility; or a state licensed mental health treatment facility or prescribed and/or provided by a tribally-certified physician or tribal facility.

Transitional Treatment while the patient is partially confined in a licensed residential treatment facility.

(o) 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:

Treatment and replacement of natural teeth required because of an accidental bodily injury to natural teeth (excluding dentures). Such expenses must commence without ninety (90) days of the date of the accident.

Removal of impacted teeth and related x-rays (no allowance for other extractions).

An Alveolectomy.

A Gingivectomy.

Osseous surgery.

Extraction of seven (7) or more natural teeth at one time.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth.

(p) **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 expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(q) **Organ transplant**. Services and supplies in connection with transplant procedures, subject to the following conditions:

A second surgical opinion must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

If the donor is covered under this Plan, eligible medical expenses incurred by the donor will be considered for benefits.

If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to participant eligibility requirements, will be considered eligible expenses to the extent that such expenses are not payable by the donor's plan. In no event will Benefits be payable in excess of the Maximum Benefit still available to the recipient.

If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately for each person.

The Usual and Reasonable cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge of removal of the organ and a hospital's charge for storage or transportation of the organ, will be considered a Covered Expense.

(r) The initial purchase 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, but not the replacement thereof, unless the current orthotic appliance is not functional.

(s) **Physical therapy** by a licensed physical therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Injury or Sickness.

(t) **Prescription** Drugs. Charges for drugs requiring the written prescription of a licensed physician; such drugs must be necessary for the treatment of an Injury or Sickness.

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

(v) The initial purchase of fitted **prosthetic devices** which replace body parts, such as artificial limbs, eyes or larynx, but not the replacement thereof, unless the current prosthetic device is not functional.

(w) **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.

(x) Fees for legally qualified Physician or qualified speech therapist for restorative or rehabilitory **speech therapy** for speech loss or impairment due to Injury or Sickness, other than a Functional Nervous Disorder, or due to surgery performed on account of an Injury or Sickness. If your speech loss is due to a congenital anomaly, surgery to correct the anomaly, if available or appropriate, must have been performed prior to the therapy. All cases will be reviewed, on a individual basis, for eligibility.

(y) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(z) **Sterilization** procedures.

(aa) **Surgical dressings**, splints, casts, trusses, braces and other medical supplies, with the exception of dental braces or corrective shoes.

(bb) 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.

Hospital and Physician charges, for a healthy Newborn Dependent will be covered up to fourteen (14) days old or initial Hospital discharge, whichever occurs first.

The 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.

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

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Employee ID card for the Cost Management Services phone number.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 24 hours in advance of services being rendered or within 24 hours (or the next business day) after an emergency. To avoid penalty, the Cost Management Services must be contacted within 72 hours of an Emergency Hospital Admission.

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
Biopsies
Breast surgeries
Chemotherapy
Radiation therapy
Cardiovascular surgeries
Spinal surgeries
Morbid Obesity

(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, 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 at the telephone number on your ID card **at least 24 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- 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

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 the utilization review administrator **within 24 hours** of the first business day after the admission. (To avoid penalty the Utilization Review Administrator must be contracted within 72 hours of an Emergency Hospital admission.)

The utilization review administrator will determine the number of days of Medical Care Facility confinement 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 for hospitalizations, the benefit payment will be reduced by $200.

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.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The 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.

COST SAVING MEASURES – GETTING THE MOST OF YOUR HEALTH CARE DOLLAR

Health care costs are skyrocketing. If you are not part of the solution, you could be part of the problem. Here is what you can do about it:

1. For all medical care short of a true emergency, call your doctor first. Do not go to the emergency room. It is too expensive.
2. When treatment is prescribed, ask your doctor if it can be done in his or her office of the outpatient department of a hospital. X-rays, diagnostic tests and minor surgery can be done in the office or outpatient department of the hospital, avoiding costly inpatient care and allowing you to return to the comfort of your own home the same day;
3. When inpatient care is required, avoid weekend admissions and agree to discharge as soon as possible. Often tests order on the weekend are not performed until Monday. Thus, adding unnecessary days to your hospital bill;
    a. Ask your doctor about Home Care Services such as visiting nurses, which can shorten your hospital stay; and
    b. When your doctor says you can go home, make preparations to leave. Many hospitals charge for assistance in checking you out;
4. When your doctor writes a prescription, ask him to use the generic brand when possible;
5. Take responsibility for your good health by taking care of your body:
    a. Eat nutritious, balance meals. Maintain your ideal weight. Avoid fad diets;
    b. Drink moderately;
    c. Quit smoking;
    d. Take up an aerobic exercise such as jogging or biking;
    e. Learn to control stress by taking time to relax each day;
    f. Take advantage of community free testing services such as high blood pressure testing;
    g. Be sure your immunizations are up to date; and
    h. If you do not have a personal doctor, get on as soon as possible. You will be more effectively and efficiently treated by a doctor who knows your health history.

DEFINED TERMS

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

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

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.

Beneficiary is the person or persons designated by the Covered Person to receive the proceeds of the Group Master Term Life Policy payable upon their death. If the Covered Person has more than one beneficiary and has not designated a share for each, the benefits will be paid equally, or to the survivors.

Benefit Period means a time period of one (1) year, as shown in the Schedule of Benefits. Such benefit period will terminate on the earliest of the following dates:

a. The last day of the one (1) year period so established; or
b. The day the Maximum Benefit applicable to the Covered Person becomes payable; or
c. The day the Covered Person ceases to be covered for Major Medical Expense Benefits.

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.

Coinsurance means the percentage portion of eligible expenses to be paid by the Covered Person in accordance with the coverage provisions of the Plan and as shown in the Schedule of Benefits.

Convalescent Period means a period of time commencing with the date of confinement by a Covered Person to a Skilled Nursing Facility. Such confinement must meet both of the following conditions:

a. Such confinement must commence within fourteen (14) days of being discharged from a hospital and both the hospital and the Skilled Nursing Facility confinement must have been for the care and treatment of the same Injury or Sickness; and
b. Said hospital confinement must have been for a period of not less than three (3) consecutive days.

A Convalescent Period will terminate when the Covered Person has been free of confinement in any and all institutions providing Hospital or nursing care for a period of ninety (90) consecutive days. A new Convalescent Period shall not commence until a previous Convalescent Period has terminated.

Copayments are a smaller amount of money that is paid by the Covered Person each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Service means any procedure performed primarily:

1. to improve physical appearance; or
2. to treat a mental or nervous disorder through a change in bodily form; or
3. to change or restore bodily form without correcting or materially improving a bodily function.

Covered Person is an Employee 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 or Medicare.

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

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.

Deductible means a specific dollar amount of Covered Expenses which must be incurred during a year before any other Covered Expense can be considered for payment according to the applicable Benefits.

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.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is The Mohican Nation.

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 Employee Retirement Income Security Act of 1974, as amended.

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 and Medical Leave Act (FMLA) means the Family and Medical Leave Act of 1994, enacted August 5, 1993, entitling qualified employees to a maximum of twelve (12) weeks of unpaid leave in any twelve (12) month period for reasons that qualify under FMLA. To be eligible for an FMLA leave, an employee must have worked for the employer for at least twelve (12) months and 1,250 hours in the year immediately preceding the start of the leave.

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

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan. These are medications, which are clinically equivalent to non-preferred brand name drugs but are usually less expensive. The Prescription Drug Program packet contains a list of prescriptions that qualify for this category.

Full-Time Employment means a basis whereby an Employee is employed, and is compensated for services, by the Company for at least the number of hours per week stated in the eligibility requirements. The work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the Employee to travel.

Full-Time Student means an Employee's Dependent child who is enrolled in and regularly attending an accredited college or university for the minimum number of credit hours required by the college or university in order to maintain full-time student status.

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.

Incurred Expenses means those services and supplies rendered to a Covered Person. Such expenses shall be considered to have occurred at the time of date the service or supply was actually provided.

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

Inpatient refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such admission.

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.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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.

Licensed Practical Nurse means an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

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.

Minor Emergency Medical Clinic means a free-standing facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A Physician, a Registered Nurse, and a Registered X-ray technician must be in attendance at all times that the clinic is open. The clinic’s facilities must include x-ray and laboratory equipment and a life support system.

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.

Newborn means an infant from the date of birth until the initial Hospital discharge or until the infant is fourteen (14) days old, whichever occurs first.

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

Non-Formulary drugs are often new drugs (made from different ingredients then the generic or brand name) and do not yet have a generic equivalent and therefore usually cost more.

Orthotic Appliance means an external device intended to correct any defect in form or function of the human body.

Outpatient Alcoholism Treatment Facility means an institution which provides:

1. A program for diagnosis, evaluation, and effective treatment of Alcoholism;
2. Provides detoxification services needed with its effective treatment program;
3. Provides infirmary-level medical service or arrangements at a hospital in the area for any other medical services that may be required;
4. Is at all times supervised by the staff of Physicians;
5. Providers at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); and
6. Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social need which supervised by a Physician, and meets licensing standards.

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.

Outpatient Psychiatric Facility means an administratively distinct governmental, public, private or independent until or part of such unity that provides Outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

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.) who is duly licensed and qualified under the law or jurisdiction in which treatment is received. Any duly licensed chiropractor (D.C.), chiropodist, podiatrist (D.P.M.), optometrist (O.D.), dentist (D.D.S.) or registered nurse (R.N.) certified to engage in advance nursing practice roles such as a nurse anesthetist, nurse practitioners or nurse midwife, or licensed psychologist, acting within the scope of his or her license, will be

considered on the same basis as a Physician to the extent that services are covered under this Plan. Physician includes a licensed Psychologist who is listed in the National Registrar of Health Service Providers in psychology. Physician also include a Physician's Assistant operating within the scope of his or her license and providing a service that is a Covered Medical Expense under this Plan.

Plan means Stockbridge-Munsee Community Band of the Mohican Indians Employee Group Benefit Plan, which is a benefits plan for certain employees of The Mohican Nation and is described in this document.

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

Plan Supervisor means the person or firm employed by the Company to provide consulting services to the Company in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

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. 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 this Plan 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 this 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.

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.

In regards to drugs and drug therapies newly approved by the U.S. Food and Drug Administration (FDA) and available to the consumer market after the Summary Plan Descriptions have been distributed, the Plan reserves the right to:

- extend coverage to medications that have recently met the FDA guidelines;
- assign a unique co-payment or coinsurance to new drugs entering the market;
- limit quantities of new lifestyle type drugs entering the market; and
- add drugs to the exclusion list if the FDA has issued a warning or a recall, voluntary or otherwise, to the consumer market.

Plan participants will receive notices regarding any Plan modifications regarding drugs or therapies at such time that they present a prescription for drugs or drug therapies impacted by modifications to the Plan. Participating pharmacies are charged to communicate any updates or changes to the Plan pharmacy program, which impact a participant.

Psychiatric Care means treatment for a Mental Illness or Disorder, a Functional Nervous Disorder, Alcoholism or Drug Addiction.

Psychologist means an individual holding the degree of Ph.D., licensed by the jurisdiction in which he or she practices an acting within the scope of his or her license.

Qualified Medical Child Support Order (QMCSO) is any state court judgment, decree, or order which gives a plan participant's child a right to be enrolled in the Plan and the right to receive benefits under the Plan if the judgment, decree, or order meets certain specific requirements, including:

1. The name and the last known mailing address of the plan participant and each alternative recipient covered by the order;
2. A reasonable description of the type of coverage or benefits to be provided to the alternate recipient;
3. The period to which the medical child support order applies; and
4. Each plan to which the order applies.

A QMCSO cannot require the Plan to provide any type or form of benefits, or any other option, not otherwise available under the Plan except to the extent mandated by Section 1908 of the Social Security Act.

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

Room and Board refers to all charges by whatever name called which are made by a Hospital, Hospice, or Convalescent Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

Semi-Private refers to a class of accommodations in a Hospital or Skilled Nursing Facility in which at least two (2) patient's beds are available per room.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Significant Break in Coverage means a period of 63 (or more) consecutive 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. For this purpose, an HMO affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

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.

Special Enrollee means an Employee or Dependent who is entitled to and who requests Special Enrollment within 30 days of losing other health coverage, or a newly acquired dependent for whom coverage is requested within 30 days of the marriage, birth, adoption, or placement for adoption.

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 an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person

is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer.

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.

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.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

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

It is the intent of this Plan to conform to the non-discrimination provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The premise of the non-discrimination provisions is that similarly situated individuals may not be treated differently based on a health factor. All claims will be reviewed upon receipt with regard to the applicability of these provisions, and any benefit exclusion that is in conflict with this provision will be made to conform. For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered. This Plan does cover treatment of complications that arise after an abortion, whether or not the abortion was Medically Necessary.

(2) **Alternative medical treatments.** Charges for alternative medical treatments or educational programs including, but not limited to, hypnotism, biofeedback, holistic medicine, acupuncture, massage therapy, rolfing, health education, homeopathy, reiki and programs intending to provide complete personal fulfillment or harmony.

(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. Complications from a non-covered abortion are covered.

(4) **Cosmetic services.** Charges incurred in connection with the care or treatment of a surgery performed for cosmetic purposes. This exclusion does not apply to treatment of a traumatic injury or congenital anomaly or in connection with breast reconstruction after a mastectomy.

(5) **Court-ordered examinations.** Services and supplies related to court-order examinations to rule on voluntary or involuntary commitment or detention.

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

(7) **Dental services.** Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or a molar process and any other dental, orthodontic or oral surgical charges unless expressly included elsewhere as a Covered Benefit. This exclusion shall not apply to any inpatient hospital charges.

(10) **Developmental delays.** Services, supplies and procedures to treat developmental delays. Also care and treatment for charges for remedial education, and charges incurred for services (other than diagnostic services) for mental retardation or for non-treatable mental deficiency.

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

(12) **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.

(13) **Experimental and/or Investigational.** Charges for Experimental and/or Investigational procedures, drugs, or research studies, or for any service or supplies not considered legal in the United States or not recognized by the American Medical Association or the American College of Surgeons and/or the United States Food & Drug Administration.

(14) **Eye care.** Radial keratotomy; Lasik or other eye surgery to correct refractive disorders. Charges incurred in connection with eye refraction, the purchase or fitting of eyeglasses, contact lenses, or such similar aids. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.

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

(16) **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.

(17) **Hearing aids.** 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. This exclusion shall not apply to the initial purchase of a hearing aid if the loss of hearing is the result of a surgical procedure or a congenital condition. The Plan will also cover replacement of a hearing aid required because of a congenital condition if the replacement is required because of growth of the Covered Person or because of a charge in prescription. Hearing Aids to compensate for normal/expected hearing loss due to the aging process are excluded.

(18) **Hearing therapy.** Charges for hearing therapy.

(19) **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.

(20) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior, including driving under the influence; or by participating in a riot or public disturbance. 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.

(21) **Infertility.** Diagnosis and treatment of infertility, including artificial insemination or in vitro fertilization and all other procedures meant to induce ovulation and/or promote spermatogenesis and/or achieve conception; and all related treatment of infertility.In addition, services, supplies and procedures in connection with the pregnancy of a surrogate mother, donor semen or egg, and sperm banking.

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

(23) **Non-compliance.** Expenses incurred due to or as a consequence of non-compliance with any applicable state or federal statute or regulation.

(24) **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.

(25) **Non-enrolled individual.** Services and supplies which were actually incurred by another person.

(26) **Non-necessary Hospitalization.** Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the actual Injury or Sickness.

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

(28) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician.

(29) **Not Medically Necessary.** Care and treatment that is not Medically Necessary.

(30) **Not recognized treatment.** Charges for services, supplies or treatment not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Injury or Sickness; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.

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

(32) **Nursing services.** Charges for professional nursing services if rendered by other than a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) unless such care is specifically listed as a Covered Expense elsewhere in the Plan.

(33) **Nutritional supplements.** Charges incurred for nutritional supplements, or services not necessary for the treatment of an Injury or Sickness unless specifically stated as covered on the Schedule of Benefits.

(34) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity must be precertifed and preauthorized in order to be covered.

(35) **Occupational.** Expenses for injury of illness arising out of or in the course of any occupational or employment for wage or profit, of for which the Covered Person is entitled to benefits under any Workers Compensation or Occupational Disease Law, whether or not any coverage for such benefits are actually in force.

(36) **Orthopedic devices.** Charges for orthopedic shoes, arch supports, and foot inserts.

(37) **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.

(38) **Physicians' fees.** Charges for Physician's fees for any treatment which is not rendered by or in the physical presence of a Phsyician.

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

(40) **Radioactive contamination.** Expenses incurred as a result of radioactive contamination or the hazardous properties of nuclear material.

(41) **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.

(42) **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.

(43) **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.

(44) **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.

(45) **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.

(46) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches.

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

(48) **Third party examinations.** Non-medical evaluations for employment, marriage license, judicial or administrative proceedings, travel or purchase of insurance, etc. Exams for school or sports are covered.

(49) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(50) **War.** Any loss that is due to a declared or undeclared act of war or caused during service in the armed forces of any country.

SHORT TERM DISABILITY BENEFITS

This benefit applies when an Employee has a Total Disability that meets all of these tests:

(1) Total Disability starts while the Employee is covered for this benefit. This benefit is only available to Regular Full-Time Employees and the eligibility requirements are the same as the Stockbridge-Munsee Community Group Health and Dental Plan. The Employee must be a participant in one of those Plans to participate in this Plan.

(2) Total Disability is being continuously treated by a Physician, and that Physician must provide the Employer, The Stockbridge-Munsee Community appointed representative Mohican Nation Insurance, with an acceptable statement as to the extent of the Employee's disability.

(3) Total Disability is due to an Injury or Sickness that, in either case, is nonoccupational -- that is, not arising from work for wage or profit.

(4) Total Disability (Totally Disabled) means the complete inability to perform any and every duty of the Employer's occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness.

The Employer shall reserve the option of requesting periodic physical examinations from either the current Physician on the case or a Physician of the Employer's choice. Failure to provide requested Physicians' statements will result in termination of benefits. Employees are responsible for providing the following information in a clearly understandable format:

- History regarding when symptoms first appeared or accident happened;
- Diagnosis;
- Dates of treatment;
- Nature of treatment;
- Progress;
- Prognosis;
- Suitability for rehabilitation;
- Physician's signature and tax I.D. number.

Additional information may be required based upon the individual Illness or Injury.

BENEFIT PAYMENT

Benefits will be paid for a Total Disability up to a Weekly Benefit Limit as described in the Schedule of Benefits. The Weekly Benefit will be payable after the Waiting Period has been satisfied. With regards to the Waiting Period only those days the Employee is regularly schedule to work but cannot do so because of the medically disabling condition will be applied to the thirty (30) days. And the duration of payments will not exceed the Maximum Period for any one period of disability and will automatically terminate the date you are no longer under a Physician's care.

Benefits are payable as described in the Schedule of Benefits.

PERIOD OF TOTAL DISABILITY

Period of Total Disability is the period of time that an Employee is Totally Disabled. New periods due to the same or related causes must be separated by return to Active Work for at least four (4) weeks in a row. New periods due to different causes must be separated by return to Active Work for at least one day.

PERIOD OF PARTIAL DISABILITY

The Plan will pay a Partial Disability for each week of Partial Disability which follows the Waiting Period. The amount payable will be equal to the Weekly Benefit less a portion of the weekly earning during the Partial Disability. The portion which will be deducted is the Partial Disability Reduction shown in the Schedule of Benefits.

Partial Disability Benefits will cease on the earlier of:

1. The date your earnings from such employment equal or exceed 100% of your pre-Disability Salary; or
2. The end of the Maximum Benefit Period.

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.

Initial Claims

A Claim must be resolved, at the initial level, within 45 days of receipt. A Plan may, however, extend this decision making period for an additional 30 days for reasons beyond the control of the Plan.

If, after extending the time period for a first period of 30 days, the Plan Administrator determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension period, the Plan may extend decision making for a second 30-day period.

Appropriate notice must be provided to the claimant before the end of the first 45 days and again before the end of each succeeding 30-day period. This notice will explain the circumstances requiring the extension and the date the Plan Administrator expects to render a decision to the claimant. It will

explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues.

The claimant will have 45 days to provide the information required.

Adverse Benefit Determinations

The Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state:

The specific reason or reasons for the adverse determination.

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

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

A description of the Plan's review procedures and the time limits applicable to such procedures. 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.

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

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

If the adverse benefit determination is based on the Medical Necessity or Experimental and/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

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The claimant will be notified of the determination on review of the adverse benefit determination no later than 45 days after receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, the claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is

expected. If an extension is provided, the Plan Administrator must notify the claimant of the determination on review no later than 90 days after receipt of the request for review.

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

was relied upon in making the benefit determination;

was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

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

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be considered by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

COVERED WEEKLY EARNINGS

Covered weekly earnings is the Employee's rate of weekly earnings from the Employer in effect on the later of: (1) the Employee's effective date of coverage under the Plan; or (2) the start of the Total Disability. The Weekly Earnings Benefits will only be provided for those days the Employee is regularly scheduled to work had the Employee not become Disabled. Covered weekly earnings are based on the average number of actual hours worked based on a 12-week period.

Covered Weekly Earnings does **not** include these payments made by the Employer to the Employee:

Overtime pay.

Commissions.

Bonuses.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Copayments

The copayment is applied to each covered 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 pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating 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 pharmacy drug or mail order drug charge and is shown in the schedule of benefits. This amount is not a covered charge under this Plan or the medical plan.

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 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, when prescribed by a physician.

(4) Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (Retin-A).

(5) Oral Contraceptives.

(6) Prenatal vitamins.

(7) Syringes, needle devices, pump supplies, blood test strips (Glucose or Ketone), Lancets, and Lancet devices for diabetic treatment.

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.

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) **Contraceptives.** Charges for contraceptive medications or devices, except for oral contraceptives which are covered. This includes injectables, implants, diaphragms, IUDs, and emergency contraceptives.

(4) **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.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Renova or medications for hair growth or removal.

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

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

(8) **Fluoride.** A charge for fluoride products.

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

(10) **Impotence.** A charge for impotence medications, including Viagra.

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

(12) **Injectables.** Any charge for injectables, except for insulin.

(13) **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.

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

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

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

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

(18) **Over-the-counter medications.** Any charge for over-the-counter drugs or medications.

(19) **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.

(20) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.

(21) **Vitamins.** A charge for vitamins including multivitamins and supplemental agents. However, prenatal vitamins will be covered.

(22) **Weight loss medications.** Any charge for weight loss medications. However, Medically Necessary charges for medications to treat Morbid Obesity must be precertified and preauthorized in order to be covered.

DENTAL BENEFITS

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

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount. 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 the following cases a dental expense will be deemed incurred on:

1. In the case of fixed bridges, inlays, onlays, or crown work, on the date the preparation of the tooth is begun;
2. In the case of root canal therapy, on the date the pulp chamber is opened and explored to the apex;
3. In the case of periodontal surgery, on the date the surgery is performed;
4. In the case of orthodontic treatment, the date the band or appliance is inserted, or the date the work is performed if completed on the same date as begun;
5. In the case of any other work, the date the work is performed.

COVERED DENTAL SERVICES

Preventive and Diagnostic Dental Procedures

The limits on Preventive and Diagnostic 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 one per Covered Person each 6 months.

(2) One bitewing x-ray series every six months.

(3) One full mouth x-ray every 36 months.

(4) Other dental x-rays required to diagnose a specific condition requiring treatment.

(5) One fluoride treatment for covered Dependent children under age 25 each 12-month period.

(6) Space maintainers that replace prematurely lost teeth. Limited to one per Lifetime.

Ancillary Procedures

(1) Emergency palliative treatment for pain.

(2) Emergency denture repair and adjustments.

(3) General anesthetics, upon demonstration of Medical Necessity and administered in connection with oral or dental surgery.

(4) Antibiotic drugs and the injection of, by the attending dentist, and drugs requiring a prescription by a Doctor of Dental Surgery or Medical Dentistry.

Extraction Procedures

(1) Simple extractions.

Endodontic Procedures

(1) Root canal treatment.

Oral Surgery Procedures

(1) Oral Surgery, except those dental services covered under the Covered Person's Medical Plan.

Periodontic Procedures

(1) Treatment of the gums and supportive tissues of the teeth.

Direct Restorations Procedures

(1) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased to broken teeth.

Indirect Restoration Procedures

(1) Inlays, onlays, or crowns to restore diseased or broken teeth, only if the teeth cannot be restored by direct fillings because of severe decay or fracture.

(2) Non-Precious, Semi-Precious and Gold Restorations. If the Covered Person or their dentist choose an indirect restoration when it is not dentally necessary, the Plan will pay an amount equal to the cost of a direct restoration. The Covered Person will pay the balance. Indirect restorations are also called cast restorations. No benefits will be paid for charges for veneers or similar properties of crown and pontics placed on or replacing teeth, except the ten most anterior upper or lower teeth (not on the molars).

Prosthodontic Procedures

(1) Bridges. This includes the time the appliance is first put in and any adjustments needed during the next six (6) months.

(a) Inlays and crowns used as abutments for the appliance. Double abutments are covered only if dentally necessary.

(b) If the Covered Person and their dentist choose a more complex or fancier appliance (such as a precision attachment), the Plan will pay the cost of a standard appliance. The Covered Person would pay the balance.

(c) If the Covered Person and the dentist choose to use special procedures, the Plan will pay the cost of the standard dental procedure. The Covered Person would pay the balance.

(2) Repairs to an existing bridge or denture if it can be fixed so that it is usable.

(3) The addition of teeth to an existing bridge if teeth are pulled after the appliance was first made.

(4) Replacement of an existing bridge only if the existing bridge was put in at least five (5) years before and cannot be fixed so that it is usable.

Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Dependent children under age 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance. Extractions related to orthodontics are paid under the dental oral surgery benefit.

The Plan first pays 25% of the whole Treatment Plan charges of the dentist's initial fee, whichever is less. The remaining balance is paid each remaining quarter in even amounts. Co-insurance will be applied to both the initial fee and quarterly payment. It does not matter what services are done in any one quarter. The same payment method applies to any part of the Treatment Plan done while coverage is in effect. If the Covered Person stops treatment for any reason before it is done, payment stops on that day. If the Covered Person begins service again, any benefits they had start again.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be $200.00 or more, a predetermination of benefits form must be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee 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 Supervisor at this address:

Medical Benefit Administrators
5940 Seminole Centre Court
Madison, Wisconsin 53711
(800) 279-6772

The Claims Supervisor 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.

All non-covered services or charges above the predetermination benefit are the Covered Person's responsibility. Of course, the final decision regarding work to be performed is the Covered Person's.

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.

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) **Anesthesia.** Charges for general anesthesia, unless it is Medically Necessary and administered in connection with oral or dental surgery. However, local anesthesia will be covered.

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

(4) **Cosmetic.** Dental services for birth defects or mainly for cosmetic or esthetic purposes. This exclusion applies to existing teeth and not to congenitally missing teeth.

(5) **Employer's union.** Dental services received from the employer's union, associations, trusts, school's or similar group's dental or medical department.

(6) **Excess charges.** Charges above the Usual and Reasonable allowance.

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

(8) **Experimental and/or Investigational.** Services or supplies which are experimental, investigational, etc. or which require but have not received U.S. Government approval. "Experimental, Investigational" means treatments, services or supplies which are largely confined to lab or research settings or which have progressed to limited human use but lack wide recognition as proven and effective in clinical medicine. Based upon the recommendations of its Dental Policy review Consultants and Advisors, the Plan will ascertain whether it is a covered or excluded service. Questions concerning a specific service should be directed to the Plan Administrator: MBA.

(9) **Government coverage.** Dental services available under any government law, including Medicare.

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

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

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

(13) **Mouth guards.** Charges for athletic mouth guards.

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

(15) **No charge.** Dental service furnished without charge.

(16) **Not covered.** Charges for anything the Covered Person and their dentist choose other than covered standard dental treatment, appliances or procedures.

(17) **Not Medically Necessary.** Services and supplies which are not "Medically Necessary". "Medically Necessary" means it is required to treat or diagnose the dental condition and the Plan determines, based upon the recommendation of its Dental policy Review Consultants and Advisors or Utilization Review findings, that it is:

a. consistent with and appropriate for the diagnosis or treatment of your condition;
b. of proven value or usefulness, is likely to yield further information and is not redundant when done with other procedures;
c. the most appropriate means to safely care for the Covered Person; and
d. not solely for the convenience of the Covered Person, their family or dentist.

(18) **Occupational.** Workers' Compensation cases, whether or not you claim benefits.

(19) **Personalization.** Personalization of dentures.

(20) **Prior to coverage.** Charges incurred prior to the Covered Person's effective date of coverage.

(21) **Replacement.** Replacement of lost or stolen appliances, or duplicate appliances.

(22) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

(23) **Temporomandibular Joint Dysfunction.** Charges for treatment of temporomandibular (TMJ) joint dysfunction.

(24) **Termination of benefits.** Dental service after the Covered Person's coverage ends. Procedures begun before and completed in one visit within 31 days after the Covered Person's coverage ends are paid (i.e., root canal or crown).

(25) **Vertical dimension.** Appliances, restorations or procedures to adjust vertical dimension or to restore occlusion (i.e., overbite).

(26) **War.** Dental services due to war or while serving in any armed forces.

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 Employee 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
- Employee'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 Supervisor at this address:

Medical Benefit Administrators
P.O. Box 909991
Milwaukee, Wisconsin 53209-9991
(800) 279-6772

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Supervisor 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 Supervisor 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:

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 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	30 days
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	60 days

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be orally 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

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

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

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

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

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

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 an employee, 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 an Employee 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 Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee 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 Employee. 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 an Employee who is neither laid off nor retired or a Dependent of an Employee 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 OPTIONS

COBRA CONTINUATION COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the 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. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

Note: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002.

The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage 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 employee who qualifies or may qualify for assistance under this special provision should contact his or her Plan Administrator for further information.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's 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 employees who have not experienced a Qualifying Event (in other words, similarly situated nonCOBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

(i) 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 Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. 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.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. 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.

(iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (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 Employee 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 is not 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 Employee 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:

(i) The death of a covered Employee.

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

(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(iv) A covered Employee's enrollment in the Medicare program.

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

(vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in

effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, 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 occurs, however, if an Employee 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 Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. 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.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.

(ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

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 Employer or Plan Administrator, as applicable.

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:

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

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

(iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(iv) 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.

(v) 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).

(vi) 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 nonCOBRA 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.

(i) 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.

(ii) In the case of a covered Employee'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 Employee ends on the later of:

(a) 36 months after the date the covered Employee 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 Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

(iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee 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.

(v) 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.

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 Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee'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.

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

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 payment that is made to the Plan by the date that is 30 days after the first day of that 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 Employees 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 nonCOBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot 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 sent 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 must, 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 nonCOBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

EXTENSION OF BENEFITS

If upon the date of termination of coverage for a Covered Person’s Major Medical Expense Benefits the Covered Person is totally disabled, coverage for the Covered Person will be extended during subsequent period of continuous total disability, but no longer than the end of the benefit period in which termination of coverage occurred.

Under this provision, a Covered Person will receive benefits for eligible expenses that are incurred if such expenses are due solely to the condition causing the total disability.

Certification of total disability must be made by the physician. The Covered Person must remain under the care of a Physician; additional proof of total disability may be recorded from time to time.

The provision applicable to this Extension of Benefits provision will be the same as would have been applied has the Covered Person's coverage not terminated; however, if the Employee becomes totally disabled and receives benefits under this provision, no further medical coverage will be provided to the Dependents of such Employee after the date the Employee becomes totally disabled.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Stockbridge-Munsee Community Band of the Mohican Indians Employee Group Benefit Plan is the benefit plan of The Mohican Nation, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by The Mohican Nation to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, The Mohican Nation 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.

(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 Supervisor 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.

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. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees 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 SUPERVISOR IS NOT A FIDUCIARY. A Claims Supervisor 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.

PROCEDURE FOR RECEIPT OF QUALIFED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Upon receipt of a Qualified Medical Child Support Order (QMCSO), the Plan Administrator:

(1) Will notify the Employee and alternate recipient (i.e., the child or the child's representative) of the Plan's receipt of the order and the Plan's procedures for determining whether the order is qualified;

(2) Will determine whether the order is qualified within a reasonable period;

(3) Will notify the Employee and each alternative recipient of the determination; and

(4) If the order is qualified, will administer the provision of benefits under such orders.

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 Employees.

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

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

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.

The Employer 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 Employee 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 Pension and Welfare Benefits 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. Employees 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 an Employee or dependent has Creditable Coverage from another plan. The Employee 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 or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

HIPAA PRIVACY
Privacy of Protection Health Information

Effective April 14, 2003:

Plan Administrator's Certification of Compliance

Neither the Health Plan nor any business associate servicing the Health Plan will disclose Health Plan Enrollees' Protected Health Information to the Plan Administrator unless the Plan Administrator certifies that the Health Plan's Plan Document has been amended to incorporate this section and agrees to abide by this section.

Purpose of Disclosure to Plan Administrator

The Health Plan and any business associate servicing the Health Plan will disclose Health Plan Enrollees' Protected Health Information to the Plan Administrator only to permit the Plan Administrator to carry out plan administration functions for the Health Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and it implementing regulations (45 C.R.R. Parts 160-64). Any disclosure to and use by the Plan Administrator of Health Plan Enrollees' Protected Health Information will be subject to and consistent with the provisions of Restrictions of Plan Administrator's Use and Disclosure of Protected Health Information and Adequate Separation Between the Plan Administrator and the Health Plan of this section.

Neither the Health Plan nor any business associate servicing the Health Plan will disclose Health Plan Enrollees' Protected Health Information to the Plan Administrator unless the disclosures are explained in the Notice of Privacy Practices distributed to the Health Plan Enrollees'.

Restrictions on Plan Administrator's Use and Disclosure of Protected Health Information

The Plan Administrator will neither use nor further disclose Health Plan Enrollees' Protected Health Information, except as permitted or required by the Health Plan's Plan Document, as amended, or required by law.

The Plan Administrator will ensure that any agent, including any subcontractor, to whom it provides Health Plan Enrollees' Protected Health Information agrees to the restrictions and conditions of the Health Plan's Plan Documents, including this section, with respect to Health Plan Enrollees' Protected Health Information.

The Plan Administrator will not use or disclose Health Plan Enrollees' Protected Health Information for employment-related actions or decisions or in connection with any other benefits or employee benefit plan of the Plan Administrator.

The Plan Administrator will report to the Health Plan any use or disclosure of Health Plan Enrollees' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

The Plan Administrator will make Protected Health Information available to the Health Plan Enrollee who is the subject of the information in accordance with 45 Code of Federal Regulations §164.524.

The Plan Administrator will make Health Plan Enrollees' Protected Health Information available for amendment, and will on notice amend Plan Enrollees' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.

The Plan Administrator will track disclosures it may make of Health Plan Enrollees' Protected Health Information so that it can make available the information required for the Health Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations §164.528.

The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of Health Plan Enrollees' Protected Health Information, to the Health Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

The Plan Administrator will, if feasible, return or destroy all Health Plan Enrollee Protected Health Information, in whatever form or medium, received from the Health Plan when the Health Plan Enrollees' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Health Plan Enrollee Protected Health Information, the Plan Administrator will limit the use or disclosure of any Health Plan Enrollee Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation Between the Plan Administrator and the Health Plan

The following employees or classes of employees or other workforce members under the control of the Plan Administrator may be given access to Health Plan Enrollees' Protected Health Information received from the Health Plan:

The Mohican Nation Insurance Department
The Tribal Council
The Legal Department
Contract Health Services

This list includes every employee or class of employees or other workforce members under the control of the Plan Administrator who may receive Health Plan Enrollees' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Health Plan in the ordinary course of business.

The employees, classes of employees or other workforce members identified in the list above of the section will have access to Health Plan Enrollees' Protected Health Information only to perform the plan administration functions that the Plan Administrator provides for the Health Plan.

The employees, classes of employees or other workforce members identities above in the list of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Administrator, for any use or disclosure of Health Plan Enrollees' Protected Health Information in breach or violation of or noncompliance with the provisions of this section to the Health Plan's Plan Document.