Summary Plan Description

DeltaVision

for

ONEIDA TRIBE OF INDIANS OF WI

40182

WYSSTA™

A Delta Dental of Wisconsin Company

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I. Plan Description Information

1. Plan Name: Oneida Tribe of Indians of Wisconsin Enterprise Group Vision Plan

2. Plan Sponsor:
Oneida Tribe of Indians of WI
2630 West Mason Street
Green Bay, WI 54303

3. Plan Administrator and Named Fiduciary:

Oneida Tribe of Indians of WI
2630 West Mason Street
Green Bay, WI 54303
920-490-3656

4. Plan Sponsor's Employer Identification Number (EIN): 39-6081138
The Plan number assigned for government reporting purposes is Plan 501. This vision component of the health and welfare benefit Plan is part of wrap-around Plan 501.

5. The Plan provides vision benefits for participating employees, certain retirees [if applicable], and their enrolled dependents. The Plan is a self-funded plan, and benefits are payable solely from the Plan Sponsor's general assets. The Plan Sponsor, as Plan Administrator, is responsible for all claims decisions and the payment of the claims.

6. Plan benefits described in this booklet are effective February 1, 2009.

7. The Plan year is January 1 – December 31.
The fiscal year is October 1 – September 30.

8. Agent for service of legal process:

Robert Keck
Oneida Tribe of Indians of Wisconsin
P.O. Box 365
Oneida, WI 54155

9. The Claims Administrator is responsible for performing certain delegated administrative duties, including the processing of claims. The Plan has full and final authority on all claim denial disputes. The Claims Administrator is:

Wyssta Insurance Company, Inc.
(A subsidiary of Delta Dental of Wisconsin, Inc.)
P.O. Box 828
Stevens Point, WI 54481
Telephone: 715-344-6087
Toll Free: 800-236-3713

The Claims Administrator has subcontracted with EyeMed Vision Care, LLC. to perform certain of its claims adjudication duties. See the Accessing your DeltaVision Benefits, Customer Service, and Claims Procedures sections of this Summary Plan Description.

10. The Plan's contributions are shared by the employer and employee. The employer contribution is subject to change each year, depending upon claims experience and Plan expenses. The employer will pay approximately 80% of the total annual premium for employees. Retirees who participate in the Plan will pay 100% of the annual premium for their coverage under the Plan.

11. Each employee participating in the Plan receives a copy of the Plan and the Summary Plan Description, both of which are this booklet. This booklet will be provided by the employer. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to covered persons as required by applicable law.

13. Upon termination of the Plan, the rights of the covered persons to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the covered persons, except that any taxes and administration expenses may be made from the Plan assets.

14. The Plan does not constitute a contract between the employer and any covered person and will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time.

15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

II. Description of Benefits

Wyssta Insurance Company, Inc. ("Wyssta") has been selected by your employer and is pleased to provide your vision benefits administration.

General Information

Eligible Employees

Employee: an active, full-time employee working 30 or more hours per week (unless otherwise specified by the employer) on a year-round basis. Temporary, part-time (under 30 hours), seasonal and retired employees are not covered under the plan.

You are eligible to participate in the Plan with Oneida Nation in Wisconsin. Benefits shall commence on the first day of the calendar month following the 90 day waiting period. The application for the benefit must be signed and returned within 30 days or you will be considered a "Late Enrollee". Two employees who are married are only eligible for limited family or family coverage. Two single contracts are not allowed. However,

1. If an otherwise eligible employee is not actively at work on the date his/her coverage would otherwise become effective under the Plan, his/her coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the employer; and;

Eligible Dependents

You may also elect to cover your immediate family members including:

1. Your spouse;
2. Your unmarried natural child, adopted child, child placed for adoption with you, step-child or legal ward under age 19; and
3. Your unmarried natural child, adopted child, child placed for adoption with you, step-child or legal ward under age 25, if he/she is a full-time student as determined by the claim administrator.

A child is not an eligible dependent if he/she provides 50% or more of his/her support.

Late Enrollment

If an employee refuses plan coverage for himself/herself or his/her eligible dependents when first eligible to participate in the plan, he/she may subsequently elect to apply for dental coverage. A late enrollment shall be any application for coverage received more than 30 days after their eligibility date for coverage under the plan. Plan dental benefits for late enrollments are not available until the first day of January following the date of application.

Change in Marital Status

You may obtain family coverage effective on the date of marriage provided an application for family coverage is made within 30 days after the date of marriage and you agree to pay any

additional premium contribution that may be required at the time of application. Such applications made after 30 days from the date of marriage will be considered late enrollments, subject to subsection "Late Enrollment."

Leave of Absence
Employees are allowed to take one 90-day medical leave, with one additional 90-day leave extended based on Supervisor's approval. Once this has been exhausted, coverage will be terminated.

Adding Newborn Children or Adoptive Children

1. Adding Newborn Children
If you wish to add your newborn child to your existing family coverage or wish to change to family coverage to add your newborn natural child, you must apply within the first 30 days following the birth of your natural child and pay the required contribution. The effective date for such family coverage will be the date of that child's birth.

If you fail to apply within the 30-day period stated above, your newborn natural child is considered a late enrollment and subject to subsection "Late Enrollment" .

2. Adding Adoptive Children
If you wish to add your adopted child to your existing family coverage or wish to change to family coverage to add a new eligible dependent because of your adoption of a child or a child placed for adoption, you must apply and pay the appropriate contribution within 30 days of the date of such adoption or placement for adoption. In the case of a child placed for adoption with you, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended. If you properly apply within that 30-day period, the effective date for family coverage will be: (a) on the date a court makes a final order granting your adoption of the child; or (b) on the date that the child is placed for adoption with you, whichever occurs first.

If you apply after the 30-day period, your new dependent is considered a late enrollment and subject to subsection "Late Enrollment".

If adoption of a child who is placed for adoption with you is not finalized, the child's coverage will terminate when the child's adoptive placement with you terminates.

Adding Dependent Due to Court Order
To the extent required by Section 632.897 (10) (am), Wisconsin Statutes, as amended, if a court orders you with single or family coverage to provide coverage for health care expenses for your dependent child, you will be issued family coverage to include that child effective as of the date that court order is issued unless another coverage date is contained in that order, provided that child is eligible for coverage under the Plan as determined by the Claim Administrator. Written application for that child's coverage must be made by either you, the child's other parent, the department, or the county designee under Section 59.07 (97), Wisconsin Statutes, as amended, using the Claim Administrator's application form. The completed form and a copy of the court order must be submitted to the Claim Administrator within 30 days of the court order being issued to you. If the application is submitted to the Claim Administrator after that 30-day period ends, the dependent child is then a late enrollee, subject to subsection "Late Enrollment". As long as you are eligible for family coverage under the policy, that child's coverage will continue under

the policy until the date that court order is no longer in effect or the date that child has coverage under another group policy or individual policy that provides comparable health care coverage, as applicable, unless that child's coverage ends sooner in accordance with the section

"Termination of Individual Coverage". You must notify the Claim Administrator in writing about that court order ending and/or that other coverage becoming effective for that child as soon as reasonably possible after you become aware of that fact.

Addition of Dependents
If you wish to add any dependents under your family coverage who were not covered previously under the Plan (other than as described above), such additional dependents will be considered late enrollments and subject to subsection "Late Enrollment".

Rehired Employees
If your single or family coverage under the plan terminates because of ineligibility due to temporary layoff, seasonal layoff, leave of absence or temporary reduction in your work hours, you may reapply for single or family coverage if reemployed as a regular employee by the employer. If you make written application for coverage to the Claim Administrator within 30 days of the date of reemployment, your new coverage will commence upon your return to full-time employment, provided that all premiums for coverage, if any, are paid and the plan remains in effect.

EyeMed PPO Vision Providers

Your DeltaVision Plan is supported by the EyeMed Vision Care, LLC (“EyeMed”) provider network. This large network includes private practice optometrists, ophthalmologists, and opticians, as well as many leading optical retailers nationwide.

An EyeMed PPO Vision Provider is a provider who has entered into an agreement with EyeMed to provide vision benefits to you and your covered dependents. With your DeltaVision benefit, you will save on a wide selection of frames and lenses when using an EyeMed network provider location.

For the most up-to-date listing of EyeMed providers in your area, visit EyeMed’s website at www.eyemedvisioncare.com and use the Provider Locator service to locate the Access Network. You can also contact your current eye care professional and ask if he or she is a member of the EyeMed network.

Non-contracted Vision Providers

If your vision care provider has not entered into an agreement with EyeMed, he/she is not a member of the EyeMed provider network, and a different level of benefits will apply to you and your covered dependents. See Summary of Benefits.

Accessing your DeltaVision Benefits

Using an In-Network Provider:

Follow these simple steps to access your in-network vision benefits:

1. Present your EyeMed card to your provider and provide your name, Member Identification Number, Social Security Number or date of birth.

2. Your provider will confirm your eligibility as a DeltaVision Plan member.

3. You will receive services and your provider will calculate any out-of-pocket expenses after your DeltaVision benefit has been applied. You are responsible for any out-of-pocket expenses at the time of service.

Using an Out-of-Network Provider:

When you visit an out-of-network provider you may file a claim as follows:

1. You pay in full for services and materials to your out-of-network provider at the time of service.

2. You request an itemized receipt from your provider.

3. You contact EyeMed via phone or website to obtain a claim form.

4. You submit your total claim on the EyeMed claim form, attaching your itemized receipt.

5. You will be reimbursed by EyeMed at out-of-network DeltaVision Plan benefit levels.

Customer Service

You can find answers to most DeltaVision customer service questions by contacting EyeMed Vision Care at 800-521-3606 or online at www.eyemedvisioncare.com.

EyeMed Benefits & Claims

Contact EyeMed's benefits and claims service center for questions concerning benefits and claims payment.

Hours: **Monday-Saturday 7 a.m. to 10 p.m. (CT)** Toll-free: **866-723-0513**
Sunday 10 a.m. to 7 p.m. (CT)

Provider Locations

For a list of the most convenient EyeMed Vision Provider locations, members may visit the Delta Dental of Wisconsin, Inc. website, or the EyeMed Vision Care website, or call EyeMed customer service.

www.deltadentalwi.com and look for the DeltaVision link
www.eyemedvisioncare.com/memweb/ProviderLocator?ClientId=DDWIAC

Hours: **Monday-Saturday 7 a.m. to 10 p.m. (CT)** Toll-free: **866-246-9041**
Sunday 10 a.m. to 7 p.m. (CT)

Member ID Request

For additional or replacement member ID cards, please contact EyeMed customer service.

Hours: **Monday-Saturday 7 a.m. to 10 p.m. (CT)** Toll-free: **800-521-3605**
Sunday 10 a.m. to 7 p.m. (CT)

Member Address Updates
Eligibility & Enrollment Updates

Please contact your human resources administrator and the Claims Administrator for any address changes (such as new address if you've moved), or any other information changes related to member eligibility and enrollment.

Hours: **Monday-Friday 8:00 a.m. to 4:30 p.m. (CT)** Toll-free: **800-236-3713**

Summary of Benefits

Group Number: 40182

Effective Date of Program: February 1, 2009

SCHEDULE OF BENEFITS, LIMITATIONS AND COVERAGE PERCENTAGE:

This Plan provides the following benefits subject to the allowance or co-payment amount listed for each benefit. The allowances and co-payments may vary based upon the network membership of the vision provider at the time the services are rendered.

Dependents to Age: 19 **Full-time Students to Age: 25**

Network = EyeMed PPO Vision Provider

Non-Network = Non-contracted Vision Provider

DeltaVision

	Network Benefit	Non-Network Reimbursement
Comprehensive Spectacle Exam	**Member pays $0**	**$40**
Contact lens fit and follow-up		
Standard – lenses that are spherical power only, soft lens materials, including planned replacement and conventional lenses. Lenses are to be used in a daily wear (removed prior to sleep) mode only	**Member pays $0**	**$40**
Premium – includes all lens powers and designs other than spherical powers (i.e., toric, multifocal, etc.), modes of wear that are extended or overnight schedules and rigid or gas permeable materials.	**Member pays $0**	**$40**
Frames -- *Any available frame at provider location.*	**$130 allowance, then 20% off balance**	**$45**
Standard plastic lenses		
Single vision	**Member pays $0**	**$40**
Bifocal	**Member pays $0**	**$60**
Trifocal	**Member pays $0**	**$80**
Lenticular	**Member pays $0**	**$80**
Lens options		
UV coating	**Member pays $15**	**None**
Tint (solid & gradient)	**Member pays $15**	**None**
Standard scratch resistance	**Member pays $0**	**None**
Standard polycarbonate	**Member pays $0**	**None**
Standard progressive	**Member pays $0**	**None**
Premium progressive	**Member pays $0**	**None**
Standard anti-reflective coating	**Member pays $45**	**None**
Other add-ons and services	**20% off retail price**	**None**

Contact lenses – In lieu of Spectacles *Contact lens allowance covers materials only*		
Conventional	**$125 allowance, then 15% off balance**	**$125**
Disposable	**$125 allowance, Member pays balance**	**$125**
Medically necessary	**Paid in full**	**$210**
Laser vision correction – ***Lasik or PRK***	**15% off retail price or 5% off promotional price**	**None**
Frequency – Exams / Lenses or Contact Lenses / Frames	**12/12/24 Months**	

Additional in-network discounts

- **20% discount on items not covered by the Plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses. Retail prices may vary by location.**
- **Members also receive a 40% discount on complete eyeglass purchases and a 15% discount on conventional contact lenses once the funded benefit has been used.**
- **Not all network providers offer Laser Vision correction services. Please contact your provider for availability of these services.**

Plan limitations and exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount).
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the Plan.
- Services provided as a result of any Worker's Compensation law.
- Aniseikonic lenses.
- Services or materials provided by any other group benefit providing for vision care.
- Two pair of glasses in lieu of bifocals.
- Vision benefit allowances are available for a single application toward the cost of vision services and materials covered under this Plan. Any allowance balance remaining may not be applied to any other services.

Coordination of Benefits

Benefits are coordinated when more than one plan provides vision coverage for you and your dependents. If you or your family members have vision benefits under other group plans, the Claims Administrator will coordinate allowable expenses from this Plan with them. An *allowable expense* is a necessary, reasonable and customary charge for an item covered at least partly by one or more plans covering the person making the claim.

When another plan is primary, this Plan is the secondary plan. Depending on the benefit you have already received and what your other plan covers, you may receive up to 100% benefit between the two plans, but not more than 100%.

As the secondary plan, this Plan calculates your benefit as if there were no other plan. Then it subtracts what the other plan paid. The difference between what this Plan pays as the secondary plan and what it would have paid as the primary plan is available to pay for allowable expenses incurred but not paid in a calendar year for the person making the claim.

Determining Which Plan is Primary

When a husband and a wife work for different employers, they may have coverage under two group plans. The plan covering the patient as the employee has responsibility for providing benefits before the plan covering the patient as a dependent.

If the patient is a ***dependent child***, the plan of the parent whose birth date is earlier in the calendar year (month and day only) is primary. If the patient is a dependent child of separated or divorced parents and two or more plans cover the child, the plan of the parent with custody of the child is primary. The plan of a spouse of the parent with custody of the child is secondary, and lastly the plan of the parent not having custody.

If a court decree states that parents have joint custody of a child but does not say which parent is responsible for the child's health care expenses, or if it says that both parents are responsible but gives physical custody to one parent, benefits for the child are determined by the rules just described. But if a court decree states that one parent is responsible for the child's health care expenses, the benefits of that parent's plan are determined first.

The benefits of a plan covering a person as an ***active employee*** (neither laid off nor retired) or as such an employee's dependent are determined before those of a plan covering the person as ***inactive*** (laid off or retired) or as such an employee's dependent. If another plan does not have this rule and this results in a disagreement on which plan is primary, this rule is ignored.

If you have ***continuation coverage*** under federal or state law and are also covered under another plan, the benefits of a plan covering you as an employee, member or subscriber or as a dependent of an employee, member or subscriber are determined first, then the continuation coverage next. If another plan does not have a continuation coverage rule and this results in a disagreement on which plan is primary, this rule is ignored.

How Secondary Benefits are Calculated

If a claim is received from a provider or member for secondary benefit consideration, the Claims Department will process the claim following the benefit determination procedures below:

- Review the Explanation of Benefits statement from the primary carrier.
- Calculate the Plan's liability in the absence of other insurance.
- The amount payable is the lesser of the allowed charges remaining after the primary carrier's payment, and the liability of this Plan. If the remaining patient out of pocket balance after the primary carrier's payment is less than the EyeMed liability, the patient's responsibility will be $0.00.
- If services were excluded by the primary plan, the Plan will reimburse up to the EyeMed allowed amount less any co-pays. The calculation will be the same as if this Plan was considered the primary plan.

12/22/09

III. Claims Procedures

Claims Administrator Liability

Wyssta serves only as the Claims Administrator for this Plan. In no instance is Wyssta, or any subcontractor of Wyssta, liable for any conduct, including but not limited to tortious conduct or wrongful acts or omissions, by any person providing services to subscribers and covered dependents under this Plan, including but not limited to optometrists, ophthalmologists, opticians, hospitals or hospital employees receiving or providing services. In no instance is Wyssta, or any subcontractor of Wyssta, liable for services of facilities that, for any reason, are unavailable to a subscriber or covered dependent.

How to Contest a Claim Denial

Denial of a Claim for Benefits

If you make a claim for benefits under this Plan and your claim is denied in whole or in part, you and your provider, will receive written notification within 30 days after your claim is received, unless special circumstances require an extension of time for processing. The decision will be sent on a form entitled "Explanation of Benefits."

If additional time is necessary for processing a claim for benefits, the Claims Administrator will notify you and your provider of the extension and the reason it is necessary within the initial 30-day period. If an extension is needed because either you or your provider did not submit information necessary to make a benefits determination, the notice of extension will describe the required information. You will have 45 days from receipt of the notice to provide the specified information.

Appealing a Claim Denial (Filing a Grievance)

If you have questions about the denial of your claim for benefits, please contact EyeMed at 866-723-0513. Because most questions about benefits can be answered informally, the Plan encourages you first to try resolving any problem by talking with EyeMed. However, you have the right to file an appeal requesting that the Plan formally review the benefits determination.

To appeal a benefits determination, contact Wyssta's Benefit Services Department at 800-236-3713, or mail your request to Wyssta Insurance Company, Inc. P.O. Box 85 Stevens Point, WI 54481. Provide the reasons why you disagree with the benefits determination and include any documentation you believe supports your claim. Be sure to include the subscriber's name, the covered dependent's name if applicable, and the subscriber's Social Security number on all supporting documents.

You must make your request within 180 days of the date of the initial benefits determination denying your claim for benefits.

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Wyssta will acknowledge your written request for review within 5 days of receiving it. Upon your request, Wyssta will provide you, free of charge, access to and copies of all documents, records, and other information relevant to your claim for benefits.
Within 30 days of receiving your request, Wyssta will send you the Plan's written decision and indicate any action the Plan has taken. (Special circumstances may require 60 days.)

You have the right to appear in person before the Plan's Grievance Committee to present written and oral information and ask questions of the persons responsible for the determination that resulted in the grievance. The Plan's Claims Administrator will provide you with written notice of the meeting place and time at least seven (7) days before the meeting.

The Claims Administrator will provide you or your authorized representative with written notice of the Plan's decision on the appeal. If the appeal is denied in whole or in part, that notice will include the following information.

1. The specific reason(s) for the denial of the appeal;

2. Reference to the specific Plan provision(s) on which the denial is based;

3. 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 claimant's claim;

4. A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;

5. If an internal processing policy or other similar criterion was relied upon in the denial of the appeal, the notice of such denial also will include either the specific processing policy or a statement that such processing policy was relied upon in denying the appeal and that a copy of that processing policy will be provided free of charge to the claimant upon request;

6. If the denial of the appeal was based on a vision necessity, experimental treatment or similar exclusion or limit, the notice of such denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

7. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If you do not exhaust the appeal procedures described above, and if you file a lawsuit against the Plan seeking payment of benefits, the court may not permit you to go forward with your lawsuit because you failed to utilize these claims appeal procedures. Also, no legal action can be brought later than 3 years after the date of the final decision on the review of the benefits determination.

If you have any questions on the claims appeals procedures, please contact:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481
800-236-3713 or 715-344-6087

IV. Statement of ERISA Rights

As a covered person in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all covered persons in the Plan shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each employee or retiree with a copy of this summary annual report.

Prudent Action By Plan Fiduciaries

In addition to creating rights for covered persons under the Plan, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other covered persons and beneficiaries. No one, including the employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have

sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

V. ONEIDA NATION HEALTH CARE BENEFIT PLAN

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

The Plan's Legal Duties

The Plan is required by applicable law to maintain the privacy of your protected health information. The Plan is also required to give you this notice about its privacy practices, its legal duties, and your rights concerning your protected health information. The Plan must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect unless the Plan replaces it.

The Plan reserves the right to change its privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. The Plan reserves the right to make the changes in its privacy practices and the new terms of its notice effective for all protected health information that the Plan maintains, including protected health information the Plan created or received before the Plan made the changes. Before the Plan makes a significant change in its privacy practices, the Plan will change this notice and send the new notice to its then-current participants as required by law.

You may request a copy of this notice at any time. For more information about the Plan's privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

Uses and Disclosures of Protected Health Information

Treatment: The Plan may disclose your protected health information, without your permission, to a physician or other health care provider to treat you.

Payment: The Plan may use and disclose your protected health information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by the Plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the participant of the Plan through whom the participant or beneficiary participates or initially participated, to a person other than yourself (such as your spouse or parent) to assist with claims disputes and the like. The Plan may disclose your protected health information to a health care

provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: The Plan may use and disclose your protected health information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating the Plan's risk for health coverage, and obtaining stop-loss and similar reinsurance for the Plan's health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying protected health information, and creating limited data sets for health care operations, public health activities, and research.

The Plan may disclose your protected health information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the protected health information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention. Disclosures for health care operations can include disclosures to a person other than yourself (such as your spouse or parent).

Your Authorization: You may give the Plan written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give the Plan an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give the Plan a written authorization, the Plan will not use or disclose your protected health information for any purpose other than those described in this notice.

Family, Friends, and Others Involved in Your Care or Payment for Care: The Plan may disclose your protected health information to a family member, friend or any other person you involve in your health care or payment for your health care. The Plan will disclose only the protected health information that is relevant to the person's involvement. The Plan may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as a medical emergency or during disaster relief efforts.

Before the Plan makes such a disclosure, the Plan will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, the Plan will use its professional judgment to determine whether disclosing your protected health information is in your best interest under the circumstances.

Disclosures to the Tribe: The Plan may disclose to the Tribe whether you are enrolled or disenrolled in the Plan. The Plan may disclose summary health information to the Tribe to obtain premium bids for health insurance coverage offered or that will be offered under the Plan or to decide whether to modify, amend or terminate the Plan. Summary health information is

aggregated claims history, claims expenses or types of claims experienced by the enrollees in the Plan. Although summary health information will be stripped of all direct identifiers, it still may be possible to identify your protected health information.

The Plan may disclose your protected health information and the protected health information of others enrolled in the Plan to the Tribe to administer the Plan. Before the Plan may do that, the Tribe must amend the Plan document to establish the limited uses and disclosures the Tribe may make of your protected health information. Please see the Plan document for a full explanation of those limitations.

Health-Related Products and Services: The Plan may use your protected health information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services, that the Plan provides or includes, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in the Plan's network, if any, about replacement of or enhancements to the Plan, and about health-related products or services that are available only to the Plan's enrollees that add value to, although they are not part of, the Plan.

Public Health and Benefit Activities: The Plan may use and disclose your protected health information, without your permission, when required by law, and when authorized by law for the following kinds of public health and interest activities, judicial and administrative proceedings, law enforcement, research, and other public benefit functions:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on the Plan's premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by worker's compensation laws.

Individual Rights

Access: You have the right to examine and to receive a copy of your protected health information, with limited exceptions. You must make a written request to obtain access to your protected health information. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

The Plan may charge you reasonable, cost-based fees for a copy of your protected health information, for mailing the copy to you, and for preparing any summary or explanation of your protected health information you request. Contact the Plan using the information at the end of this notice for information about these fees.

Disclosure Accounting: You have the right to a list of instances after April 13, 2003 in which the Plan disclosed your protected health information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. The Plan will provide you with information about each accountable disclosure that the Plan made during the period for which you request the accounting, except the Plan is not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before April 14, 2003. If you request this accounting more than once in a 12-month period, the Plan may charge you a reasonable, cost-based fee for responding to your additional requests. Contact the Plan using the information at the end of this notice for information about these fees.

Amendment. You have the right to request that the Plan amend your protected health information. Your request must be in writing and it must explain why the information should be amended. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

The Plan may deny your request only for certain reasons. If the Plan denies your request, the Plan will provide you a written explanation. If the Plan accepts your request, the Plan will make your amendment part of your protected health information and use reasonable efforts to inform others of the amendment who the Plan knows may have relied on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that the Plan restrict its use or disclosure of your protected health information for treatment, payment or health care operations, or with family, friends or others you identify. The Plan is not required to agree to your request and often will not agree. If the Plan does agree, the Plan will abide by the agreement, except in an emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. Any agreement the Plan may make to a request for restriction must be in writing signed by a person authorized to bind the Plan to such an agreement.

Confidential Communication: You have the right to request that the Plan communicate with you about your protected health information in confidence by alternative means or to alternative locations that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

The Plan will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication, and continues to permit the Plan to collect premiums and pay claims, including issuance of explanations of benefits to the participant of the Plan through whom coverage is provided or was initially provided. Please note that an explanation of benefits and other information that the Plan issues to the participant about health care that you received for which you did not request confidential communications, or about health care received by the participant or by others covered by the Plan, may contain sufficient information to reveal that you obtained health care for which the Plan paid, even though you requested that the Plan communicate with you about that health care in confidence.

Electronic Notice: If you receive this notice on the Plan's web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact the Plan using the information at the end of this notice to obtain this notice in written form.

State Law: As a condition of Plan participation, the Tribe requires that the privacy rights of you, your spouse and dependents be governed only by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Tribe's law and any applicable laws of the State of Wisconsin (but only to the extent such laws are applicable to federally recognized Indian tribes and are not preempted by the Tribe's law or the Employee Retirement Income Security Act of 1974, as applicable), without regard to whether HIPAA incorporates privacy rights granted under the laws of other states and without regard to the choice of law provisions of Wisconsin or Tribal law. Nothing contained in this Privacy Practices Notice shall be deemed or construed as a waiver of the sovereign immunity of the Oneida Tribe of Indians of Wisconsin

Questions and Complaints

If you want more information about the Plan's privacy practices or have questions or concerns, please contact the Plan using the information at the end of this notice.

If you are concerned that the Plan may have violated your privacy rights, or you disagree with a decision the Plan made about access to your protected health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your protected health information, you may complain to the Plan using the contact information at the end of this notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019.

The Plan supports your right to the privacy of your protected health information. The Plan will not retaliate in any way if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Contact Person:

Health Plan Privacy Official
C/O Oneida Risk Management Department
P.O. Box 365
Oneida, WI 54155
Telephone: (920) 490-1100
Fax: (920) 490-3600