# *Summary Plan Description*

**Delta Dental PPO**

**for**

**ONEIDA NATION**

**94251-00001**

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# *I. Plan Description Information*

1. Plan Name: Oneida Nation Group Dental Plan

2. Plan Sponsor: Oneida Nation
PO Box 365
Oneida, WI 54155

3. Plan Administrator and Named Fiduciary:

Oneida Nation
PO Box 365
Oneida, WI 54155
920-490-3514

4. Plan Sponsor's Employer Identification Number (EIN): 39-6081138.
The Plan number assigned for government reporting purposes is 502. This dental component of the health and welfare benefit Plan is part of wrap-around Plan 501.

5. The Plan provides dental 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 January 1, 2025.

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

8. Agent for service of legal process:

Lisa Moore
Oneida Nation
PO Box 365
Oneida, WI 54155

9. The Claims Administrator is responsible for performing certain delegated administrative duties, including the processing of claims. The Claims Administrator is:

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
Telephone: 715-344-6087
Toll Free: 800-236-3712

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.

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*

**General Information**

**ELIGIBILITY AND ENROLLMENT**

**Effective: 01-01-2020**

**ELIGIBILITY AND ENROLLMENT PROCEDURES**

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

**COVERAGE APPLICATION DUE**

For newly hired employees, applications for Plan coverage are due by no later than 75 days from date of hire.

Applications for coverage due to a change in status or due to a qualifying event must be received within 30 days from the change of status or qualifying event.

**WAITING PERIOD**

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 90 calendar days of regular employment in a covered position. Voluntary loss of benefits (such as leaving a job or job change) for spouse/Dependent would require a 90-day waiting period, with coverage effective on the date listed below under the Effective Date section.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

**ELIGIBILITY REQUIREMENTS**

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased, emergency temporary, part-time (under 30 hours), substitute relief, seasonal and retired employees.

- Employees working more than one non full-time position are not eligible for medical coverage.
- An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as defined in this document.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

An **eligible Dependent** includes:

- Your legally married spouse, as defined by the state in which You reside, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. Documentation to determine Dependent eligibility will be required by the Plan Administrator. Primary coverage under this Plan is not available to the spouse of an eligible Employee if the spouse is eligible for health coverage through his or her own employer. Secondary coverage may be available to the spouse of an Eligible employee after primary coverage is provided by a spouse's employer.

- A Dependent Child that resides in the United States until the Child reaches his or her 26$^{th}$ birthday.

The term "**Child**" includes the following Dependents:

- A natural biological Child;
- A step Child;
- A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
- A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).
- Legal Guardianship Dependent Eligibility:
  - A Child under Your (or Your spouse's) permanent Legal Guardianship pursuant to an order by a court of competent jurisdiction, as of the date of the court order, up to the age of 18 (refer to EXTENDED COVERAGE FOR DEPENDENT CHILDREN section regarding eligibility past age 18);

- A Dependent does not include the following:

  - A foster Child;
  - A Child of a Domestic Partner or under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - Domestic Partners;
  - An individual from whom You have obtained a legal separation or divorce – coverage terminates as of the date of legal separation;
  - Niece or Nephew;
  - Dependent placed for adoption – once Child placed, coverage terminates;
  - Spouse from whom You are separated for 180 days.
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company.
  - A child under the age of 26 for whom you have voluntarily terminated your parental rights, as of the date of termination, or a child under the age of 26 for whom you have had your parental rights terminated involuntarily, as of the date of the termination; or a child under the age of 26 for whom you have voluntarily relinquished your parental rights pursuant to state law, as of the date of the relinquishment.

Employees have the right to choose which eligible Dependents are covered under the Plan provided they meet the definition of an eligible Dependent and all Plan eligibility requirements.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

**NON-DUPLICATION OF COVERAGE:** Any person who is covered as an eligible Employee shall not also be considered an eligible Dependent under this Plan.

**RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS:** The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You are required to notify Your Employee Benefits Department regarding status changes that do affect or may affect eligibility status. You and Your Dependent have a notice obligation to notify the Plan within 30 days should the Dependent's eligibility status change throughout the Plan year.

**DEPENDENT ELIGIBILITY PROOF DOCUMENTS**

The Plan requires proof documents for all dependents You request coverage for. Proof documents include, but are not limited to:

Marriage
Certificate; Birth
Certificate;
Proof of Legal Adoption;
Proof of Legal Guardianship (up to age 18 unless disabled);
Qualified Medical Support Court Order;
Proof of Disablement;
Proof of Child Placed for Adoption;
Proof of Loss of Health Coverage from an Employer (other than the Tribe).
Proof of federal tax dependency status as issued by the IRS.

Newly Hired Employees Dependents: Proof documents must be received and approved by the Tribe by no later than 75 days from the date of hire. Dependents will not be added for coverage if proof documents are not received and approved.

Proof documents for all other dependents You request Plan coverage for must be received by the Tribe by no later than 30 days from the date of the application for coverage. Dependents will not be added for coverage if proof documents are not received and approved.

**EXTENDED COVERAGE FOR DEPENDENT CHILDREN**

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

**and** the Dependent Child fits the following category:

- If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

    - The Dependent must not be able to hold a self-sustaining job due to the disability; and
    - Proof must be submitted as required; and
    - The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re- enroll in the Plan under any circumstances.

- A Dependent Child over 18 who was under the Legal Guardianship of a Plan subscriber may be eligible for extended Dependent coverage up to 26 under this plan under the following circumstances:

    - The Dependent Child was covered by this Plan on the day before the Child's 18th birthday;
    - The Dependent Child is a federal tax dependent for You or Your Spouse according to the IRS and proof of tax dependency is provided to Plan Administrator by You at least annually;
    - *The Dependent Child is not eligible for health care benefits under the Child's employer plan.*

A Dependent Child provided extended coverage past 18 due to a Guardianship, who at any time does not meet the above requirements, will be removed from the Plan and may not re-enroll.

**IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 30days if Your Dependent no**

**longer meets the criteria listed in this section. If, at any time, the Dependent does not meet the qualifications of Dependent eligibility, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for coverage. Please refer to the COBRA Section in this document.**

**EFFECTIVE DATE OF EMPLOYEE'S COVERAGE**

Your coverage will begin:

- If You apply within Your Waiting Period, Your coverage will become effective the first day following the date You complete Your Waiting Period.

- You must apply for enrollment within 75 calendar days from your hire date or be considered a late enrollee. Late enrollees are not allowed to enroll until an Offer of Coverage is made during an annual enrollment period. Under no circumstances will Your Waiting Period for coverage be less than 90 days from Your hire date. If applying for enrollment was not facilitated by the Plan within 30 days from Your hire date, You may not be considered a Late Enrollee.

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

**EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS**

Your Dependent's coverage will be effective:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent; or

- The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 75 days after Your hire date, or more than 30 days following the date You acquire the Dependent. You may apply for enrollment for a Dependent considered a Late Enrollee during an Offer of Coverage during an enrollment period; or

- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or

- The later of the date specified in a Qualified Medical Child Support Order or the date the plan administrator determines that the order is a QMCSO.

- If Dependent coverage is requested due to a voluntary loss of benefits, coverage for the Dependent will become effective the first day following a 90-day waiting period.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

**TRANSFER OF COVERAGE HOLDER FROM ONE SPOUSE TO THE OTHER IN DUAL EMPLOYMENT SITUATIONS**

In situations where both husband and wife (or both spouses) are employed by the Tribe and either may be the coverage holder or dependent: Changing coverage from the spouse as the coverage holder to the dependent spouse with the former dependent spouse becoming the coverage holder and the former coverage holder spouse becoming the dependent, is not allowed unless there is a qualifying event.

**SPECIAL ENROLLMENT PROVISION**

Under the Health Insurance Portability and Accountability Act

**Effective: 01-01-2014**

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. Special enrollment rights are triggered by a "Qualifying Event." The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

**LOSS OF HEALTH COVERAGE**

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage.

If the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage is offered; or
  - Exhausted due to an individual meeting or exceeding the applicable maximum benefits on the plan; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and You or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

**CHANGE IN FAMILY STATUS**

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 30 calendar days of marriage, birth, adoption or Placement for Adoption.

**NEWLY ELIGIBLE FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM**

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

**EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION**

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage (Note: Eligible individuals must submit their enrollment forms prior to the Effective Date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or

- In the case of a Dependent's birth, on the date of such birth; or

- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or

- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or

- In the case of loss of coverage, on the date following loss of coverage.

**RELATION TO SECTION 125 CAFETERIA PLAN**

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

Once enrolled with effective Plan coverage, Employees may not terminate Plan coverage for themselves or dependents without a qualifying event. Qualifying events as determined under Section 125 of the Code or by the Plan sponsor. Examples of qualifying events may include, but not be limited to:

- Birth
- Adoption
- Marriage
- Death
- Divorce or Annulment
- Change in eligibility
- Change in employment status of employee, spouse or dependent that affects eligibility
- Change in coverage under other employer's Plan

## TERMINATION

For information about continuing coverage, refer to the COBRA section of this SPD.

### EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or

- The date this Plan is canceled; or

- The date coverage for Your benefit class is canceled; or

- The day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment; or

- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:

    - If You are temporarily absent from work due to an approved leave of absence for medical reasons, Your coverage under this Plan will continue during that leave for a maximum of 180 consecutive days.
    - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section.
    - If You are temporarily absent from work due to non-medical or military duty reasons, You may continue Plan coverage through COBRA; or

- The day of the month in which Your employment ends; or

- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

**YOUR DEPENDENT'S COVERAGE**

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or

- The day of the month in which Your coverage ends except in the event that the Employee dies, coverage for the Dependent will continue for 90 days following the death of the Employee, after which time COBRA coverage will be offered, or, if employed by the Tribe, plan coverage; or

- The day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides. Failure to notify within 30 days will result in charges to the Employee for expenses paid on an ineligible member; or

- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section; or

- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The date Dependent coverage is no longer offered under this Plan; or

- The day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment; or

- Legal guardianship must be pursuant to an order by a court of competent jurisdiction and Plan coverage will terminate at age 18 unless Totally Disabled.

- The day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

**RESCISSION OF COVERAGE**

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions.

**REINSTATEMENT OF COVERAGE**

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all of the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Employee Benefits department for assistance with re-enrolling.

**Definitions**

The following terms shall apply to the plan:

**Active Work/Actively at Work:** when an employee is performing 'all of the fulltime duties of his/her job with the employer. These duties must be performed at the employer's place of business, except to the extent that he/she must travel to perform his/her duties. The employee shall be deemed to be actively at work on: (1) each day of a paid vacation; or (2) a regularly scheduled non-working day, provided that, in either case, he/she was at work on his/her last regular working day prior to such date.

**Alternate Treatment:** if, based on the generally-accepted national standards of dental practice as determined by the Claim Administrator, there are other procedures or materials that will provide suitable treatment, covered dental expenses will be limited to those which are customarily employed and recognized by the dental profession in the United States to be appropriate methods of treatment for the participant's illness or injury covered under the plan, taking into account the total current oral condition of the participant who is the patient.
**Calendar Year:** the period that starts with a participant's effective date in the plan and ends on December 31 of such year. Each following calendar year shall start on January 1st of any year and end on December 31st of that year.

**Charge:** an amount for a treatment, service or supply provided by a dental care provider that is reasonable, as determined by the Claim Administrator, when taking into consideration, among other factors determined by the Claim Administrator, amounts charged by dental care providers for similar treatment, services and supplies when provided in the same geographic area and amounts accepted by the dental care provider as full payment for similar treatment, services and supplies. The term" area" in this definition means a county or other such area the Claim Administrator determines is necessary to obtain a representative cross section of such amounts. In some cases the amount the Claim Administrator determines as reasonable may be less than the amount billed. Charges are incurred: (1) on the date of insertion for a crown, inlay, onlay, bridge or partial or complete dentures; (2) on the date the root canal is completed for root canal treatment; and (3) on the date a participant receives the dental service or supply for all other dental services or supplies.

**Claim Administrator:** Delta Dental of Wisconsin acting as the dental claim administrator.

**Dental Services:** dental treatment or services provided by one of the following to treat the participant's illness or injury: (1) a provider of a participant's choice; (2) a provider of a participant's choice and is acting within the lawful scope of practice of a provider; and (3) a licensed dental professional performing related services requested by a provider or physician acting within the lawful scope of practice of a provider.

**Dentally Necessary:** the dental service or supply provided by a provider, physician, licensed dental professional or health care provider that is required to identify or treat a participant's illness or injury and which is, as determined by the Claim Administrator: (1) consistent with the symptom(s) or diagnosis and treatment of the participant's illness or injury; (2) appropriate under the standards of generally accepted national standards of dental practice to treat that illness or injury; (3) not solely for the convenience of a participant, provider, physician, licensed dental professional, or health care provider; and (4) the most appropriate dental service or supply which can be safely provided to the participant and accomplishes the desired end result in the most economical manner.

**Provider**: a person who has received a degree in dentistry and is licensed to practice dentistry in the state in which he/she is located and provides dental services while he/she is acting within the lawful scope of his/her license.

## Delta Dental PPO Providers

Delta Dental PPO Providers have signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, agreeing to accept reduced fees for the dental procedures they provide. This reduces your out-of-pocket costs because you will be responsible only for applicable deductible amounts, copayments and coinsurance for benefits. And because these providers agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.

## Providers Outside the Delta Dental PPO Network

### *Delta Dental Premier Providers*

Delta Dental Premier Providers have signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, agreeing to accept direct payment from Delta Dental. They have also agreed not to charge you any amount that exceeds the Maximum Plan Allowance (MPA); however, you are still responsible for deductibles, copayments, coinsurance, and fees for services that are not benefits under this dental Plan.

The Maximum Plan Allowance is the total dollar amount allowed for a specific benefit. The Maximum Plan Allowance will be reduced by any deductible and coinsurance you are required to pay.

### *Noncontracted Providers*

If your provider has not signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, claim payments will still be calculated based on the MPA, but they will be sent directly to you rather than to the provider. You will then reimburse your provider through his or her usual billing procedure. You will be responsible for any amount in excess of the Maximum Plan Allowance, as well as any deductible, copayment, coinsurance, and fees for services that are not benefits under this dental Plan.

Please note that if the fee charged by a noncontracted dentist is not allowed in full, Delta Dental is not implying that the provider is overcharging. Dental fees vary and are based on each provider's overhead, skill, and experience. Therefore, not every provider will have fees that fall within the MPA.

For information on Delta Dental PPO or Delta Dental Premier providers, call 800-236-3712, or visit Delta Dental's website at www.deltadentalwi.com.

**Dependent:** (1) your spouse; (2) your natural child, adopted child, child placed for adoption with you, step-child or legal ward under age 26. A person is not an eligible dependent if he/she is: (1) covered under the plan as an employee; (2) on active duty with the military service, including national guard or reserves, other than for military duty of less than 30 days; or (3) in the case of a child: (a) if such child provides 50% or more of his/her own support, as defined by the Claim Administrator; or (b) such child is no longer eligible if adopted or placed for adoption and insured under the adopting person's coverage in accordance with Section 632.896, Wisconsin Statutes, as amended. No person shall be considered as an eligible dependent of more than one employee covered as a participant under the plan.

**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.

**Employer:** Oneida Nation.

**Experimental or Investigative:** as determined by the claim administrator, the use of any treatment, service or supply for a participant's illness or injury that, at the time it is used, meets one or more of the following:

1. Requires approval that has not been granted by the appropriate federal or other governmental agency, such as, but not limited to, the federal Food and Drug Administration (FDA); or
2. Isn't yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or
3. Is the subject of either: (a) a written investigational or research protocol; or (b) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (c) an ongoing phase I, II or III clinical trial; or (d) an ongoing review by an Institutional Review Board (IRB); or
4. Doesn't have either: (a) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (b) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (A.M.A.) concerning such treatment, service or supply and reflecting its recognition and reproducibility by non-affiliated sources the Claim Administrator determines to be authoritative.

Additional criteria that the Claim Administrator uses for determining whether a treatment, service or supply is considered to be experimental or investigative and, therefore, not covered for a particular illness or injury include, but are not limited to:

1. What are its failure rate and side effects;
2. Whether other more conventional methods of treatment have been first exhausted;
3. Whether it is medically necessary for the treatment of that illness or injury;
4. Whether it is universally recognized as not experimental or investigative by Medicare, Medicaid and other third party payors (including insurers and self funded plans); or
5. Whether any documentation refers to the treatment, service or supply as posing an uncertain outcome or having an unusual risk.

To question whether a particular treatment, service or supply is considered experimental or investigative, see section "Preauthorization Procedure".

The determination of whether a treatment, service or supply is experimental or investigative under the definition set out above and our criteria shall be made by the Claim Administrator in its sole and absolute discretion. In any dispute arising as a result of the Claim Administrator's determination, such determination shall be upheld if the decision is based on any credible evidence. In any event, if the decision is reversed, the limit of the plan's liability under the plan or on any other basis shall be to provide plan benefits only and neither compensatory nor punitive damages, nor attorney's fees, nor other costs of any kind shall be awarded in connection therewith or as a consequence thereof.

**Family Coverage:** means coverage applies to you and your eligible spouse and your eligible dependent children. To be covered, a dependent must be properly enrolled and approved by the Claim Administrator for coverage under the plan.

**Health Care Provider:** any person, institution or other entity licensed by the state in which he/she or it is located to provide treatment, services or supplies covered by the plan to a participant, within the scope of his/her or its license.

**Illness:** a physical illness or a behavioral health disorder.

**Immediate Family:** your spouse and children.

**Injury:** bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes. An accident caused by chewing resulting in damage to a participant's teeth is not considered an injury.

**Licensed Dental Professional:** a person licensed by the state in which he/she resides and provides dental services requested by a provider or physician while he/she is acting within the lawful scope of his/her license.

**Limited Family Coverage:** means coverage applies to the employee and one of his/her eligible dependents (for example, employee and spouse or employee and one child). To be covered, a dependent must be properly enrolled and approved by the Claim Administrator for coverage under the plan. When referred to in the plan, family coverage also includes limited family coverage.

**Maximum Plan Allowance (MPA):** means the total dollar amount allowed under the contract for a specific benefit.

**Medicaid/Medical Assistance:** benefits available under state plans pursuant to Title XIX of the Social Security Act of 1965, as amended.

**Medicare:** benefits available under Title XVIII of the Social Security Act of 1965, as amended.

**Participant:** you or one of your eligible dependents who has been enrolled and approved by the Claim Administrator for coverage under the plan.

**Physician:** a person who received a degree in medicine and is a medical doctor or surgeon licensed by the state in which he/she is located and provides services while he/she is acting within the lawful scope of his/her license. A physician includes the following:

1. M.D. - Doctor of Medicine;
2. D.O. - Doctor of Osteopathy;
3. D.D.S. - Doctor of Dental Surgery;
4. D.D.M. - Doctor of Dental Medicine;
5. D.S.C. - Doctor of Surgical Chiropody;
6. D.P.M. - Doctor of Podiatric Medicine; and
7. O.D. - Doctor of Optometry.

A physician does not include a Doctor of Chiropractic (D.C.).

**Single Coverage:** means coverage applies only to you. To be covered, you must be properly enrolled and approved by the Claim Administrator for coverage under the Plan.

**Totally Disabled/Total Disability:** an employee's inability due to illness or injury to perform all of the full-time duties of any job with the Employer. The employee also cannot be working for wage or profit for anyone, including himself/herself. For dependents, it means the inability due to illness of injury to carryon all of the normal activities of a healthy person of the same age and sex.

**Treatment:** management and care provided by a physician or other health care provider for the diagnosis, remedy, therapy, combating or the combination thereof, of an illness or injury.

**Treatment Plan:** a dentist's or physician's report on a form acceptable to the Claim Administrator which: (1) itemizes the dental services and supplies recommended by the provider or physician as being dentally necessary for a participant; (2) shows the provider’s or physician's billed amount for each dental service and supply; and (3) is accompanied by supporting pre-operative x-rays or other diagnostic records when required or requested by the Claim Administrator.

**You, Your:** an eligible employee covered under the Plan.

## Annual Deductible Amount

The annual deductible amount is $25 per participant, not to exceed $75 per family. The appropriate deductible amount applies each calendar year. Charges for covered expenses must add up to the appropriate deductible amount before benefits are payable for other charges for covered expenses. No benefits are payable for charges used to satisfy the appropriate annual deductible amount and coinsurance amounts. You are responsible for paying the charges used to satisfy the appropriate deductible and coinsurance amounts. After the deductible amount for that coverage is satisfied, benefits are payable at the coinsurance percentage shown in subsection 7.4 for charges for the covered expenses incurred by that participant, subject to the maximum benefit limits. The annual deductible amount does not apply to Type I Services and Supplies - Preventive and Type IV Services and Supplies - Orthodontia.

## Maximum Benefit Limits

1. The maximum benefit limit for Type I, Type II, and Type III services and supplies is $2,000 per calendar year per participant. *
2. The orthodontia lifetime maximum benefit limit for Type IV services and supplies is $2,000 for employee, spouse and dependent children to age 26. The orthodontia lifetime maximum benefit limit applies to those dental services incurred by each participant for the life of the Plan, including renewals, while the participant is covered under the Plan.

* Diagnostic & Preventive Procedures (Type I services) are not subject to the maximum benefit.

## Benefit Provisions

**Payment of Benefits**

1. Subject to the applicable annual deductible amount, benefits are payable at the applicable coinsurance percentage for charges for covered expenses described in subsection "Covered Expenses" for dental services and supplies provided to a participant up to the applicable maximum benefit limits. All dental services and supplies must be dentally necessary and are subject to all the terms, conditions and provisions of the Plan, including, but not limited to, alternate treatment as stated in paragraph 3. below. The dental services and supplies must be ordered by a provider or physician. Covered dental services and supplies must be provided while the participant is covered under the Plan. The participant is responsible for any amount of the charge for which benefits are not paid and for any amount that exceeds the Claim Administrator's determination of the charge for the dental service or supply. The applicable deductible must be satisfied for the calendar year in which the covered expense is incurred before benefits are payable, unless specifically stated otherwise in the Plan.

2. A participant must submit, or have his/her provider or physician submit, a written treatment plan to the Claim Administrator in advance of treatment when amounts to be billed for a proposed covered dental service and supply or series of proposed covered dental services and supplies would exceed $200. The treatment plan must be submitted prior to a provider or physician performing any such dental services. If a participant does not timely submit a treatment plan to the Claim Administrator, the Claim Administrator may decide that the dental service or supply is not dentally necessary and no benefits will be paid for the dental service or supply or any related dental service or supply.

3. If alternate treatment using other dental services and supplies may be employed to treat a participant's illness or injury, covered expenses shall be limited to alternate treatment consisting of those dental services and supplies which are: (a) customarily employed in the treatment of the participant' illness or injury covered under the Plan and are recognized by the dental profession in the United States to be appropriate methods of treatment for the participant's illness or injury in accordance with generally accepted national standards of dental practice; and (b) accomplish the desired dental result in the most economical manner when taking into account the total current oral condition of the participant who is the patient; as determined by the Claim Administrator.

## Covered Expenses

The following dental services and supplies are covered expenses. All dental services and supplies must be dentally necessary. All dental services and supplies must be ordered by a provider or physician. If the dental service or supply is not listed in this subsection, that dental service or supply is not covered and benefits are not payable under the Plan.

**Evidence-Based Integrated Care Plan (EBICP)**
Delta Dental's Evidence-Based Integrated Care Plan ("EBICP") is an enhancement that provides expanded benefits for persons with diseases and medical conditions that have oral health implications. To participate in EBICP, eligible dental Plan enrollees or their Providers are required to set the appropriate health condition indicator online at www.deltadentalwi.com or a Delta Dental of Wisconsin representative will assist in setting the EBICP indicator by telephone. The EBICP Periodontal Disease health condition indicator will be automatically updated when non-surgical or surgical periodontal procedures are processed by Delta Dental of Wisconsin.

The EBICP benefits are as follows:

**Periodontal Disease**
1. With an indicator of surgical or non-surgical treatment of **Periodontal Disease**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
2. With an indicator of surgical or non-surgical treatment of **Periodontal Disease**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

**Diabetes**
1. With an indicator of a **Diabetes** diagnosis, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

**Pregnancy**
1. With an indicator of **Pregnancy**, a participant is eligible for one additional dental visit for adult prophylaxis or periodontal maintenance during the pregnancy.

**High Risk Cardiac Conditions**
1. With an indicator for **High Risk Cardiac Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis. High risk cardiac condition indicators are:
    - History of infective endocarditis
    - Certain congenital heart defects (such as having one ventricle instead of the normal two)
    - Individuals with artificial heart valves
    - Heart valve defects caused by acquired conditions like rheumatic heart disease
    - Hyper tropic cardiomyopathy which causes abnormal thickening of the heart muscle
    - Individuals with pulmonary shunts or conduits
    - Mitral valve prolapse with regurgitation (blood leakage)

**Suppressed Immune System Conditions**
1. With an indicator for **Suppressed Immune System Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
2. With an indicator of **Suppressed Immune System Conditions**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

**Kidney Failure or Dialysis Conditions**

1. With an indicator for **Kidney Failure or Dialysis Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

**Cancer Related Chemotherapy and/or Radiation**

1. With an indicator for **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
2. With an indicator of **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

**1. Type I Services and Supplies – Preventive and Diagnostic**

Benefits are payable at 80% of the charges for the following dental services and supplies:

a. Oral evaluations, including diagnosis.
b. Prophylaxis, including cleaning, scaling and polishing up to a maximum of two per participant per calendar year.
c. Topical application of fluoride. Coverage is limited to two courses of treatment per calendar year per participant who is a dependent child up to and including age 16.
d. Emergency palliative treatment for the relief of pain.
e. Space maintainers. Coverage is limited to a participant who is a dependent child under the age of 14. Benefits are payable for charges for all adjustments provided to the participant within six consecutive months of the space maintainer's installation.
f. Complete series or Panorex x-rays. Coverage is limited to one complete series or panorex in any 60-consecutive month period per participant.
g. Individual periapical x-rays.
h. Occlusal x-rays.
i. Extraoral x-rays. Coverage is limited to 1 film during each 6-month period per participant.
j. Bitewing x-rays. Coverage is limited to one set per 12-month period for all participants.
k. Sealants. Coverage is limited to one application to a participant's bicuspid and molar teeth every 18 months per participant who is a dependent up to and including age 19.

**2. Type II Services and Supplies - Basic**

Benefits are payable at 80% of the charges for the following dental services and supplies, subject to deductible:

a. Laboratory tests and other diagnostic examinations.
b. Oral surgery.
c. Anesthesia. Benefits are payable for the charge for general anesthesia billed as a separate procedure only when required for extraction of impacted teeth.
d. Routine and surgical extractions.
e. Therapeutic injections.
f. Periodontics. Coverage for periodontic appliances is limited to one appliance per participant at 36 consecutive month intervals.
g. Endodontics.
h. Restorations, including fillings of amalgam or synthetic process for all teeth, but specifically excluding the following: (1) initial placement of full or partial denture and replacements of dentures and fixed bridge units.
i. Alveolectomy.
j. Denture repair and bridgework repair.
k. Prefabricated crowns.

**3. Type III Services and Supplies - Major**

Benefits are payable at 65% of the charges for the following dental services and supplies, subject to deductible:

a. Inlays and onlays only when a tooth cannot be restored by a silver filling.
b. Crowns. Crowns are not covered if placed for the purpose of periodontal splinting.
c. Porcelain veneers on crowns or pontics on all teeth.
d. Prosthetics, including bridges and dentures, limited to the following:
   (1) The initial installation of, or addition to, a full or partial denture or implant or fixed bridgework, provided all of the following are met:
      (a) That such installation or addition is required as a result of an extraction of one or more injured or diseased natural teeth on or after the participant's effective date of coverage under the Plan;
      (b) That such installation or addition referred to in a. above includes the replacement of such an extracted tooth; and
      (c) That such denture or bridgework is completed within 12 months following the date of the extraction, while that participant is covered under the Plan.

      A denture or bridgework shall be considered initially installed only if such denture or bridgework does not replace the participant's existing prosthetic.

   (2) The replacement or alteration of a full or partial denture, implants, fixed bridgework, crown, inlay or onlay, provided the dentally necessary replacement or alteration: (a) occurred on or after the participant's effective date of coverage under the Plan; (b) cannot be satisfactorily repaired and restored to reasonable function, as determined by the Claim Administrator; and (c) is completed within 12 months and while the participant is covered under the Plan at such time after one of the following has occurred:
      (a) An injury which requires surgical treatment; or
      (b) Oral surgical treatment which involves the reposition of muscle attachments, or other removal of a tumor, cyst, torus or redundant tissue.

   (3) The replacement of a full or partial denture, crown, inlay or onlay when the replacement is required as a result of structural change within the mouth, provided all of the following are met, and the participant is covered under the Plan at such time:
      (a) Such replacement is done more than five years after the date of the installation of such denture, crown, inlay or onlay; and
      (b) Any such replacement shall in no event be done less than two years after the participant's effective date of coverage under the Plan.

   (4) The replacement of a full or partial denture, crown, inlay or onlay other than as stated in (2) and (3) above only after five years have passed since the last such service was performed and the participant is covered under the Plan at such time. Such denture, crown, inlay or onlay must not be satisfactorily repairable or restorable to reasonable function, as determined by the Claim Administrator.

Coverage for initial replacement of teeth is not limited to those lost while you are covered under this dental Plan.

4. **Type IV Services and Supplies - Orthodontia**
   Benefits are payable at 50% of the charges for the following dental services and supplies.
   a. Orthodontic appliances, includes furnishing and attachment of any necessary orthodontic appliances.
   b. Orthodontic treatment performed pursuant to a written treatment plan, including any supporting x-rays, submitted to us within 90 days prior to the commencement of such treatment.

Benefits are payable for charges for covered expenses incurred for anyone course of orthodontic treatment, including any orthodontic diagnosis, evaluation and pre-orthodontic treatment. However, benefits for all orthodontia provided to a participant during that participant's lifetime while he/she is covered under the Plan shall not exceed the orthodontia lifetime maximum benefit limit shown in subsection "Maximum Benefit Limits". Orthodontics is covered for employee, spouse and dependent children to age 26.

**Exclusions**

The following aren't covered under the Plan. The Plan provides no benefits for:

1. Treatment, services and supplies for any injury or illness covered by Worker's Compensation or similar laws, even if the participant doesn't choose to claim such benefits.
2. Treatment, services and supplies furnished by the U.S. Veterans Administration, except for such treatment, services and supplies for which under applicable federal law the Plan is the primary payor and the U.S. Veterans Administration is the secondary payor.
3. Treatment, services and supplies furnished by any federal or state agency or a local political subdivision when the participant is not liable for the costs in the absence of insurance, unless coverage is required by any state or federal law.
4. Treatment, services and supplies covered by Medicare, if the participant has or is eligible for Medicare, to the extent benefits are or would be available from Medicare, except for treatment, services and supplies for which under applicable federal law the Plan is the primary payor and Medicare is the secondary payor.
5. Treatment, services and supplies for any injury or illness caused by: (a) atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile.
6. Dental services and supplies for cosmetic purposes, unless necessitated as a result of injuries sustained while the participant is covered under the policy.
7. Dental services and supplies which aren't dentally necessary or which aren't appropriate to the treatment of an illness or injury as determined by the Claim Administrator.
8. Dental services when not provided by a provider, physician or a licensed dental professional performing a related service requested by a provider or physician.
9. Dental services and supplies for replacement of a lost or stolen prosthesis or for a replacement or second prosthesis.
10. Dental services and supplies for oral hygiene, dietary or plaque control instructions and programs.
11. Athletic mouthguards.
12. Any amount billed by a provider, physician or licensed dental professional because of the patient's failure to appear for a scheduled appointment.
13. Dental services and supplies received from the dental or medical department of any employer, union, employee benefit association, trustee, or for services of a provider or clinic contracted for or by any such organization.
14. Dental services and supplies for dentures, crowns, inlays, onlays, bridgework or appliances for altering vertical dimensions.
15. Dental services and supplies for denture or bridgework adjustments provided to a participant within six months of the placement of a denture or bridgework with that participant.

17. Dental services and supplies for a temporary denture or bridge that, when combined with the charge for the permanent denture or bridge, exceeds the reasonable charge for the permanent denture or bridge.
18. Dental services and supplies provided, for or in connection with, implants, precision or semi precision attachments, denture duplication or other customized attachments.
19. Drugs and medicines, other than injectable antibiotics administered by a provider or physician as a result of dental treatment.
20. Dental services and supplies, including, but not limited to, oral surgical services, or that portion thereof, which are covered expenses under the participant's health coverage or any other medical coverage that he/she has, or for which benefits are paid under such other coverage.
21. Dental services and supplies provided in connection with the treatment of the temporomandibular joint, except for oral surgical services.
22. Orthodontia services for other than malocclusion of natural teeth.
23. Crowns for the purpose of periodontal splinting.
24. Treatment, services and supplies provided by members of the participant's immediate family or anyone else living with the participant.
25. Treatment, services and supplies which are experimental or investigative, except for the investigational drugs used to treat the HIV virus as described in Section 632.895(9), Wisconsin Statutes, as amended.
26. Treatment, services and supplies not specifically identified as being covered under the Plan.
27. Treatment, services and supplies provided when the participant's coverage was not effective under the Plan. This includes care provided either prior to the participant's effective date of coverage or after his/her coverage terminated under the Plan.
28. Treatment, services and supplies in connection with any illness or injury caused by a participant's: (a) engaging in an illegal occupation; and (b) commission of or an attempt to commit a felony.
29. That portion of the amount billed for a treatment, service or supply covered under the Plan that exceeds the Claim Administrator's determination of the reasonable charge for such treatment, service or supply.
30. Treatment, services and supplies for which the participant has no obligation to pay.
31. Treatment, services and supplies for which proof of claim isn't provided to the Claim Administrator in accordance with the Plan.

## Preauthorization Procedure

**Experimental, Investigative or Not Dentally Necessary Dental Services or Supplies**
Benefits are not payable for dental services or supplies that are experimental, investigative or not dentally necessary, as determined by the Claim Administrator. The types of dental services or supplies that may fall into this category, but not limited to these are:

1. New dental technology;
2. New surgical methods or techniques;
3. Acupuncture or similar methods;
4. Methods of treatment by diet.

A participant may ask the Claim Administrator whether or not a dental treatment, service or supply will be covered and how much in benefits will be paid. After the Claim Administrator receives a request for preauthorization, the Claim Administrator will make a determination on whether or not to preauthorize benefits for a dental treatment, service or supply based upon the information available to the Claim Administrator at the time of the preauthorization request. However, even if a dental treatment, service or supply is preauthorized in writing by the Claim Administrator, no benefits will be paid unless after receiving the proof of claim, the Claim Administrator determines that benefits are payable for the preauthorized dental treatment, service or supply under the terms, conditions and provisions of the Plan and the participant's coverage is in effect at the time the treatment, service or supply is provided to the participant. However, even if a dental treatment, service or supply is preauthorized by the Claim Administrator under this subsection, benefits are still subject to all terms, conditions and provisions of the Plan. The proof of claim may differ from the preauthorization request. This means that our preauthorization of benefits is not the Claim Administrator's final decision and does not guarantee the payment of benefits later. This means that benefits may not be paid if, after reviewing the proof of claim, the Claim Administrator determines that the dental treatment, service or supply is not covered under the Plan. The Claim Administrator continuously reviews the medical appropriateness, experimental or investigative nature of various procedures. This may also impact the Claim Administrator's determination of the availability of benefits.

**When Amounts to Be Billed For Proposed Dental Services and Supplies Exceed *$200***
If the amounts to be billed for proposed dental services and supplies for the performance of a covered dental service and supply, or a series of covered dental services and supplies can reasonably be expected to exceed $200 the participant or his/her provider or physician must submit a written treatment plan. The Claim Administrator will then inform the participant and his/her provider or physician of the coverage provided for the proposed services. In the event benefits are preauthorized by the Claim Administrator and the proposed course of treatment is not completed
within six months from the date of submission of the treatment plan to the Claim Administrator, a new treatment plan must be submitted to the Claim Administrator within six months of the previous preauthorization from the Claim Administrator.

If a participant does not use the preauthorization process as described above, the Claim Administrator may decide that the dental service or supply is either experimental, investigative or not dentally necessary. No payment can then be made for the dental service or supply or any related dental service or supply.

If a participant or his/her provider or physician disagrees with the Claim Administrator's decision, the participant may appeal that decision by submitting to the Claim Administrator documentation from the treating provider or physician as to the dental value or effectiveness of the dental service or supply. The decision on the appeal made by us at that time will be final.

## Coordination of Benefits

**1. Applicability**

a. This subsection applies to this plan when an employee or the employee's covered dependent has dental care coverage under more than one plan. "Plan" and "this plan" are defined below.
b. If this subsection applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:
   (1) Shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. This reduction is described in paragraph 4. Effect on the Benefits of This Plan.

**2. Definitions**

**Allowable Expense:** an item of expense for dental care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the cash value of each service provided shall be considered both an allowable expense and a benefit paid.

**Claim Determination Period:** a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or a similar provision takes effect.

**Plan:** any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include Medicare and Medicaid. It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
c. Medical expense benefits coverage in group, group-type, and individual automobile "no-fault" contracts; but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis are included.

Each contract or other arrangement for coverage under a., b. or c. is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

**Primary Plan/Secondary Plan:** the Order of Benefits Determination Rules states whether this plan is a primary plan or secondary plan as to another plan covering the person.

When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans and may be a secondary plan as to a different plan or plans.

**This Plan:** the part of the policy that provides benefits for dental care expenses.

**3. Order of Benefit Determination Rules**

a. *General.* When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:
   (1) The other plan is automobile medical expense benefit coverage and has rules coordinating its benefits with those of this plan; and
   (2) Both those rules and this plan's rules described in paragraph 3. b. require that this plan's benefits be determined before those of the other plan.

b. *Rules.* This plan determines its order of benefits using the first of the following rules which applies:
   (1) Non-dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber are determined before those of the plan which covers the person as a dependent of an employee, member or subscriber.
   (2) Dependent Child/Parents Not Separated or Divorced. Except as stated in paragraph 3.b.(3), when this plan and another plan cover the same child as a dependent of different persons, called "parents":
      (a) The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but
      (b) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

      However, if the other plan does not have the rules described in (a) but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits.

   (3) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      (a) First, the plan of the parent with custody of the child;
      (b) Then, the plan of the spouse of the parent with custody of the child; and
      (c) Finally, the plan of the parent not having custody of the child.

   Also, if the specific terms of a court decree state that the parents have joint custody and do not specify that one parent has responsibility for the child's dental care expenses or if the court decree states that both parents shall be responsible for the dental care needs of the child but gives physical custody of the child to one parent, and the entities obligated to payor provide the benefits of respective parent's plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to 3. b. above.

   However, if the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to payor provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired or as that employee's dependent are determined before those of a plan which covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (4) is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this paragraph (4).

(5) Continuation of Coverage.
   (a) If a person has continuation coverage under federal law and is also covered under another plan, the following shall determine the order of benefits: (1) first, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber; (2) second, the benefits under the continuation coverage.

   (b) If the other plan does not have the rule described in (a) above, and if, as a result, the plans do not agree on the order of the benefits, this paragraph (5) is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

**4. Effects on the Benefits of This Plan**

a. When This Paragraph Applies. This paragraph applies when, in accordance with paragraph 3. Order of Benefit Determination Rules, this plan is a secondary plan as to one or more other plans. In that event the benefits of this plan may be reduced under this subsection. Such other plan or plans are referred to as "the other plans" in b. below.

b. Reduction in This Plan's Benefits. The benefits of this plan will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:
   (1) The benefits that would be payable for the allowable expenses under this plan in the absence of this COB provision; and
   (2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

**5. Right to Receive and Release Needed Information**

The Claim Administrator has the right to decide which facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the participant but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under this plan must give the Claim Administrator any facts it needs to pay the claim.

**6. Right of Recovery**

If the amount of the payments made under the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

a. The persons it has paid or for whom it has paid;
b. Insurance companies; or
c. Other organizations.

The "amount of the payments made" includes the cash value of any benefits provided in the form of services.

## Additional Provisions

**Proof of Claim**

A participant, or the physician, hospital or other health care provider on the participant's behalf, must submit written proof of his/her claim for each treatment, service or supply provided to him/her to the Claim Administrator within 120 days of the date on which he/she receives that treatment, service or supply. Written proof of his/her claim includes: (a) the completed claim forms if required by the Claim Administrator; (b) the actual itemized bill for each treatment, service or supply; and (c) all other information that the Claim Administrator needs to determine the Employer's liability to pay benefits under the Plan, including, but not limited to, medical records and reports. Late claims may not be reimbursed unless the employee demonstrates to the Claim Administrator that it was not reasonably possible to submit proof of the claim within the prescribed 120-day period. In no event will a claim be accepted beyond one year plus 120 days from the date of the expense.

**Physician, Hospital or Other Health Care Provider Reports**

Physicians, hospitals and other health care providers must give the Claim Administrator their records and reports to help the Claim Administrator determine benefits due to a participant. By accepting coverage under the Plan the covered employee agrees to authorize his/her physicians, hospitals and other health care providers to release all medical records and reports to the Claim Administrator for himself/herself and all his/her dependents. This is a condition of the Plan providing coverage to the covered employee and all his/her dependents. It's also a continuing condition of the Plan paying benefits. The covered employee expressly authorizes and directs the following to release these records and reports to the Claim Administrator: (1) any physician who has diagnosed for, attended, treated, advised or provided professional services to a participant; (2) any hospital in which that participant was treated or diagnosed; and (3) any other health care provider who has diagnosed for, attended, treated, advised or provided treatment, services or supplies to a participant. The covered employee authorizes them to furnish to the Claim Administrator any and all information related to the treatment, services, supplies or facilities provided to or used by a participant, to the extent required by a particular situation and allowed by applicable law. The covered employee also expressly authorizes the Claim Administrator to release to or obtain from any other insurance company or service or benefit plan the information which the Claim Administrator needs to determine the Employer's liability to pay benefits under the Plan.

**Assignment of Benefits**

This coverage is just for the covered employee and his/her dependents. Benefits may be assigned to the extent allowed by applicable laws.

**Limitation on Lawsuits and Legal Proceedings**
No participant shall bring any legal action against the Employer and/or the Claim Administrator regarding benefits, claims submitted, to compel payments of benefits or any other matter concerning the participant's coverage under the Plan until the earlier of: (1) 60 days after the Claim Administrator has received or waived proof of claim described in subsection "Proof of Claim"; or (2) the date the Claim Administrator denies payment of benefits for a claim. Action

can be brought earlier if waiting will result in prejudice against a participant. However, the mere fact that a participant has to wait until the earlier of the above is not considered prejudicial. No action can be brought more than three years after the time the Claim Administrator requires written proof of claim.

**Direct Payments and Recovery**

1. **Direct Payment of Benefits**
   All claim payments will be issued to the provider.

2. **Recovery of Excess Payments**
   If the Claim Administrator pays more benefits than what the Employer is liable to pay for under the Plan, including, but not limited to, benefits paid in error by the Claim Administrator, the Claim Administrator can recover the excess benefit payments from any person, organization, physician, hospital or other health care provider that has received such excess benefit payments. The Claim Administrator can also recover such excess benefit payments from any other insurance company, service plan or benefit plan that has received such excess benefit payments. If the Claim Administrator cannot recover such excess benefit payments from any other source, it can also recover such excess benefits payments from a covered employee.

   When the Claim Administrator requests that the covered employee pay the Claim Administrator an amount of the excess benefit payments, the covered employee agrees to pay the Claim Administrator such amount immediately upon the Claim Administrator's notification to the covered employee. The Claim Administrator may, at its option, reduce any future benefit payments for which the employer is liable under the Plan on other claims by the amount of the excess benefits payments, in order to recover such payments. The Claim Administrator will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by the Claim Administrator.

**Subrogation**
Each participant agrees that, to the extent of benefits provided under the Plan: (1) the Employer shall be subrogated to a participant's rights of recovery from any third party for illness or injury for which the third party may be liable; and (2) those rights, including costs of collection, are assigned to the Employer to such extent. Except as provided by law, the Employer has a first lien on the proceeds of any recovery from the third party. Each participant agrees to help the Employer and the Claim Administrator obtain its recovery and agrees to do nothing to hinder the Employer's or the Claim Administrator's recovery rights, by settlement or otherwise. No settlement, compromise or waiver of rights shall be entered into without the Employer's or the Claim Administrator's advance written consent. The Employer or the Claim Administrator has the option to take appropriate action to protect its rights, including bringing suit in the participant's name or its name. The proceeds of any settlement or judgment a participant receives shall be held in trust for the Employer's or the claim Administrator's benefit under this provision. The Employer or the Claim Administrator is entitled to recover any reasonable attorney's fees it incurs in collecting from such proceeds held by the participant. A participant must cooperate at every stage of the Plan, including claims investigation, recovery of overpayments and subrogation. Failure to cooperate or prejudicing a right of the Plan may result in loss of benefits.

# *III. Claims Procedures*

## Prior Approval of Benefits

Your group dental plan does not require prior approval of dental procedures. However, you or your provider may request a Predetermination of Benefits to obtain advance information on your group dental plan's possible coverage of dental procedures before they are rendered. Payment, however, is limited to the benefits that are covered under your plan and is subject to any applicable deductibles, copayments, coinsurance, waiting periods, and annual and lifetime benefit maximums.

## How to Contest a Claim Denial

### Denial of a Claim for Benefits

If you make a claim for benefits under this group dental 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, Delta Dental 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 Delta Dental at 800-236-3712. Because most questions about benefits can be answered informally, Delta Dental encourages you first to try resolving any problem by talking with them. However, you have the right to file an appeal requesting a formal review of the benefits determination.

To file a grievance or appeal a benefits determination, contact Delta Dental's Benefit Services Department at 800-236-3712, fax your request to 715-343-7616, or mail your request to Delta Dental, P.O. Box 828, 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 member number on all supporting documents.

Delta Dental will acknowledge your written request for review within 5 days of receiving it. Upon your request, you will be provided, 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, Delta Dental will send you the written decision and indicate any action taken. (Special circumstances may require 60 days.)

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

Delta Dental will provide you or your authorized representative with written notice of the 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 dental 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 seeking payment of benefits, the court may not permit you to go forward with your lawsuit because you failed to utilize Delta Dental's grievance/claims appeal procedures. Also, no legal action can be brought against Delta Dental later than 3 years after the date of the Grievance Committee's final decision on the review of the benefits determination.

If you have any questions, please contact:
Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
800-236-3712 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 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 the Summary Annual Report.

**Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the sections of this Plan and Summary Plan Description governing your COBRA continuation coverage rights.

**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.

# *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 Nation.

**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