

ONEIDA INDIAN NATION WORKERS' COMPENSATION REGULATIONS

ARTICLE I – Scope and Purpose

1-1. The Oneida Indian Nation (the “Nation”) has authorized the promulgation of additional regulations, rules and administrative guidelines, each subject to the review and approval by the Nation Representative(s), or such other designee, necessary to carry out the purposes, and implementation, of the Oneida Indian Nation Workers’ Compensation, Ordinance No. O-15-1 (the “Ordinance”). These Regulations are promulgated under the authority of and pursuant to the Ordinance.

1-2. These Regulations are not all-inclusive, but are an adjunct to, and must be read in connection with, the Ordinance.

ARTICLE II – Definitions

For the purposes of these Regulations, the following words and terms shall have the following meanings:

2-1. “Administrator” shall mean the agency or third party responsible for managing the claims under the Oneida Nation Workers’ Compensation Ordinance and these regulations, and shall have the duties set forth in Article IV of these Regulations.

2-2. “Arising out of employment”: an injury or disease shall be deemed to arise out of an employee’s employment if there is apparent to the rational mind, upon consideration of the circumstances, that there is a causal connection between the conditions under which the work is performed and the injury or disease. Risks that are personal to the Claimant, for purposes of determining compensability, will not be construed to arise out of employment.

2-3. “Child” or “Children” means a legal child of an Employee, by blood, adoption, or marriage, and shall also include an unborn child, a child legally adopted prior to the injury, a child toward whom the Employee stands in loco parentis, and a stepchild if such stepchild was, at the time of the injury, a member of the Employee’s family and substantially dependent upon the Employee for support.

A Child will remain eligible for Death Benefits if:

- (a) He or she is under the age of eighteen (18); or

(b) He or she is under the age of twenty-three (23) and enrolled and attending as a full-time student in an accredited university, college, or vocational school and such enrollment and full-time attendance is certified by the accredited educational institution; or

(c) He or she is developmentally disabled and incapable of caring for his or herself and is totally dependent on the Employee for primary support and maintenance.

2-4. "Claimant" means an Employee or Dependent who follows the appropriate protocol to submit a claim for workers' compensation benefits under the Ordinance and these Regulations, and who is determined to have sustained a Compensable Injury.

2-5. "Compensable Injury" means a specific (resulting from one incident or exposure) or cumulative (result of repetitive or continuous activity or exposure) injury, disease illness, or condition, including damage to artificial limbs, dentures hearing aids, eyeglasses, and medical braces of all types (provided that such damage is incidental to an injury), where such injury, disease, illness, or condition meets the standards set forth in Section V of these Regulations.

Where the primary injury, disease, illness, or condition meets the standards set forth in Article V of these Regulations, consequential injuries alleged to be attributed to the Compensable Injury will be compensable only where there is objective medical evidence submitted by a physician or other medical professional approved by the Administrator which directly correlates such a consequence to the original injury, and where there is no intervening or superseding event.

2-6. "Course of Employment" means an injury happening to an Employee or an occupational disease of an employee originating while s/he has been engaged in the line of his/her duty in the business or affairs of the Employer upon the Employer's premises, or while engaged elsewhere upon the Employer's business or affairs by the direction of the Employer, provided that an injury shall not be deemed to occur in the course of Employment if the injury is sustained (1) at the Employee's place of abode, (2) while the Employee is engaged in a preliminary act or acts in preparation for work unless such act or acts are undertaken at the express direction or request of the Employer, or (3) while going to or coming from work unless the journey itself is part of the service to the Employer and there was no substantial deviation.

2-7. "Days" mean calendar days unless otherwise specified.

2-8. "Death Benefits" shall mean funeral expenses and monetary compensation provided to a deceased Employee's Dependents where the death of the Employee is the direct result of a Compensable Injury.

- 2-9. "Dependent(s)" shall mean the Spouse and/or Child or Children of the deceased Employee.
- 2-10. "Employee" means any person, other than an independent contractor or an individual employed by an independent contractor, who is: 1) employed by an employer subject to these Regulations to render personal services and whose primary place of employment for the employer is within the Oneida Reservation; or 2) who is an elected or appointed official of the Oneida Indian Nation. Employee shall not be interpreted to include:
- a. any person whose employment is of a casual nature and who is employed otherwise than for the purposes of the employer's trade or business;
 - b. any persons who are members of a supervised amateur athletic activity operated on a non-profit basis;
 - c. a musician or a person otherwise engaged in the performing arts who performs services, unless, by written contract, such musician or person is stipulated to be an employee of an employer covered by these Regulations. "Engaged in the performing arts" shall mean performing any service in connection with the production of or performance in any artistic endeavor or live performance, which requires artistic or technical skill or expertise.
 - d. a person operating pursuant to an Exhibitor's License issued by the Nation Department of Taxation, or any similar temporary Nation business or performance license, or any person employed by such person.
 - e. a person whose employment is covered under the Federal Employees' Compensation Act (5 U.S.C. § 8101 *et seq.*) or any other United States federal workers' compensation program.
- 2-11. "Employer" means the Oneida Indian Nation and its governmental entities, agencies and instrumentalities.
- 2-12. "His/her" means his or her, as appropriate.
- 2-13. "Idiopathic Injury" shall mean an injury to an Employee that arises spontaneously from an unknown or obscure etiology or cause, or a risk or injury that is peculiar to the Employee, the cause of which is precipitated not by an event that can be causally linked to employment specifically, but rather an activity of daily living.
- 2-14. "Independent Medical Examination" means an evaluation by a physician with Qualified Medical Examiner certification or equivalent qualifications, performed in order to determine causation, extent, medical status, work status,

permanent and stationary status, level of impairment, entitlement to benefits, apportionment, or other similar attribute of an injury, illness, or condition, at the request of the Administrator at the Employer's expense in order to resolve a medical dispute.

- 2-15. "Medical services and devices" means medical, dental, surgical, optometric or other attendance or treatment, nurse and hospital service, medicine, optometric services, crutches, eye-glasses, false teeth, artificial eyes, orthotics, prosthetic devices, functional assistive and adaptive devices and apparatuses.
- 2-16. "Narcotic Drugs" means any illegal or controlled substance, but does not include drugs prescribed, and used according to a prescription, in the course of medical treatment or in a program of research operated under the direction of a physician or pharmacologist
- 2-17. "Permanent Partial Impairment" shall mean a level of permanent disability at the time a permanent and stationary status (P&S) and/or maximum medical improvement (MMI) is achieved, as opined by a treating physician or as the result of an Independent Medical Examination using the edition of AMA Guides to the Evaluation of Permanent Impairment then in effect at the time of injury, which results in a whole person impairment rating of less than eighty percent (80%).
- 2-18. "Permanent Total Impairment" shall mean a level of permanent disability at the time a permanent and stationary status (P&S) and/or maximum medical improvement (MMI) is achieved, as opined by a treating physician or as the result of an Independent Medical Examination using the edition of the AMA Guides to the Evaluation of Permanent Impairment then in effect at the time of injury, which results in a whole person impairment rating of eighty percent (80%) or higher. There shall be no presumptions of Permanent Total Impairment under these Regulations.
- 2-19. "Physician" means any person duly licensed and authorized to practice a healing art, including the practice of medicine, osteopathy, chiropractic, podiatry, naturopathy, and optometry.
- 2-20. "Previous disability" means an employee's preexisting condition caused by the total or partial loss of, or loss of use of, any Member of his/her body, or other permanent physical impairment.
- 2-21. "Psychiatric Injury" means a mental disorder diagnosed pursuant to the edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the injury, which is medically attributable to employment by a preponderance of evidence, and which resulted in its entirety from a specific, traumatic employment event.
- 2-22. S/he" means she or s/he, as appropriate.

- 2-23. “Surviving spouse” means the legal spouse of a deceased person, but shall not include a spouse who has abandoned the deceased, and shall not include a spouse who the deceased had abandoned prior to his/her death. Abandoned means such an abandonment as would be sufficient under applicable domestic relations law to sustain a judgment of separation or divorce on that ground.
- 2-24. “Temporary Partial Disability” means a non-permanent medical status that results in the Employee being able to perform modified or light work duties or reduced hours at the direction of or as opined by a physician approved by the Administrator, that results in diminished earnings when compared with the pre-injury average weekly wage.
- 2-25. “Temporary Total Disability” means a non-permanent medical status that results in the Employee being physically unable to perform any work at the direction of or as opined by a physician approved by the Administrator, that results in a complete loss of earnings.
- 2-26. “Vocational Rehabilitation” shall mean the amount payable to a Claimant who sustains Permanent Partial Impairment as the result of a Compensable Injury, who does not receive a bona fide offer of permanent modified or alternative work from the Employer, to assist Claimant in defraying reasonable costs of vocational retraining or rehabilitation in order to return to gainful employment.
- 2-27. “Workers’ Compensation Ordinance” means the Oneida Indian Nation Workers’ Compensation Ordinance, Ordinance No. O-15-1.
- 2-28. “Written Decision” shall mean any of the following, when reduced to writing and sent to an Employee or Claimant:
- (a) The finding(s) and/or decision(s) of the Administrator to accept or deny, in full or in part, any aspect of a workers’ compensation claim; or
 - (b) Determinations of entitlement by the Administrator of any available workers’ compensation benefit; or
 - (c) Decisions made by the Administrator to close the claim.
- 2-29. **Rules of Construction.** For purposes of interpreting these Regulations:
- (a) Words and phrases shall be read in context and construed according to the rules of grammar and common usage.
 - (b) The single includes the plural, and the plural includes the singular.
 - (c) Words of one gender include the other genders.

(d) Words in the present tense include the future.

ARTICLE III – Report of Injury to Employer; Claim for Compensation; Appeal

- 3-1. **Report of Injury to Employer.** An Employee must report any injury, disease, illness or condition that is actually or is thought to be potentially related to employment, no matter how slight, immediately to his or her supervisor, or to a person representing his/her Employer and designated to receive such reports. If an Employee is incapacitated, another person may report the injury on the Employee's behalf, as soon as practicable. If the Employee fails to report the injury immediately, the Administrator may reduce the award of compensation under these Regulations proportionately to any prejudice that s/he finds the employer has sustained by reason of the failure, provided that the burden of proof with respect to such prejudice shall rest upon the employer.
- 3-2. **Failure to Report Injury to Employer Within 30 Days of Accident or Incident.** No claim for workers' compensation benefits will be accepted if the Employee fails to report any injury, disease, illness or condition pursuant to Section 3-1 of these Regulations within thirty (30) days of the incident or accident giving rise to the alleged Compensable Injury. If the specific date of incident or accident cannot be determined, or in the case of cumulative injury or trauma, no claim for workers' compensation benefits will be accepted if the injury, disease, illness or condition is not reported within thirty (30) days from the date that the Employee either knew, or in the exercise of reasonable diligence, should have known that the injury, disease, illness, or condition was related to his or her employment.
- 3-3. **Filing a Claim.** Once the injury, disease, illness, or condition is reported to the Supervisor, the requisite claim forms must be completed by the Employee. These claim forms include, but are not limited to:
- (a) An Employer's First Report of Injury;
 - (b) A signed statement from the "Employee" as to how the incident occurred and the specific body parts affected or disease, illness or condition claimed;
 - (c) A post-accident investigation report;
 - (d) A HIPPA compliant Medical Authorization Release and a list of past treating physicians; and
 - (e) An occupational injury questionnaire.

An Employee must also cooperate in requests for post-injury or post-accident drug screens in order to qualify as a Claimant eligible to receive workers' compensation benefits.

3-4. **Appealing a Claim Decision.** If an Employee, Claimant, Dependent or any representative thereof disagree with any Written Decision of the Administrator, he or she must appeal that decision in writing within thirty (30) days of the date of the Administrator's correspondence, in a manner and form consistent with the requirements set forth in Section 8.1 of these Regulations. Failure to submit an appeal within this timeframe will render the decision of the Administrator final and binding, with no further rights to appeal.

3-5. **Reopening a Claim.** Once a claim has been closed pursuant to Section 7.1 of these Regulations, after one (1) year has passed from the last date of medical treatment, a claim shall be presumed permanently closed with no opportunity to reopen it unless the Administrator should, in its discretion and with new, additional, or previously undiscovered medical findings, decide otherwise. A claim that has been permanently closed will relieve the Employer of any and all further liability associated with that claim, including any Medicare liens.

ARTICLE IV– Claims Administrator Duties

4-1. The Administrator shall act on behalf of the Employer in receiving, processing, and administering Workers' Compensation claims, including payment of benefits under the Ordinance and these Regulations. The Administrator's responsibilities include, but are not limited to:

- (a) Determining the compensability of claims pursuant to Article V of these Regulations;
- (b) Making payments to Claimants pursuant to Article VI of these Regulations;
- (c) Processing and paying bills and reports submitted by medical providers and other vendors;
- (d) (d) Managing a trust account for the purpose of dispensing the Employer's workers' compensation liabilities;
- (e) Making reports to the Employer regarding its program and individual claims where required;
- (f) Making reports to the excess insurance carrier regarding its program and individual claims where required;
- (g) Providing a mechanism for reporting claims on-line;

- (h) Participate in file reviews at the request of or intervals established by the Employer; and
- (i) Ensuring compliance with Medicare reporting where required.

4-12. The Administrator shall make determinations and decision on behalf of the Employer, which shall include following duties:

(a) Conduct a thorough investigation of each claim filed, and complete initial contacts within seventy-two (72) hours of receipt of the claim;

(b) Administer and send to the Employee a Written Decision accepting, denying, or requiring further investigate a claim within fourteen (14) days of receipt of the claim. When a claim is accepted, the Administrator shall establish a reserve on the file to reflect the anticipated exposure of the claim, with a detailed analysis of how the reserve was calculated, including an estimate of the benefits due and the duration and frequency of those benefits. When a claim is denied, the Administrator shall include in the Written Decision the specific basis for their claim denial and the Employee's right and method by which to initiate the Dispute Resolution Process pursuant to Article VIII of these Regulations. If the Administrator determines, within the specified period, that further investigation is required, the Administrator's Written Decision must contain a detailed description regarding the purpose of the investigation, what the Administrator seeks to discover through the investigation and a plan of action regarding the investigation. The Written Decision requiring further investigation must explain that the Administrator shall use best efforts shall be made to complete the investigation expeditiously and, under such circumstances, a final Written Decision outlining compensability should be made within ninety (90) days from the date the claim was filed.

(c) The Administrator shall determine the reasonableness and necessity of medical care and charges for the purpose of determining amounts payable under the Ordinance and these Regulations. The Administrator shall promptly approve or disapprove any referrals, procedures, surgeries, or other medical requests made by approved and authorized medical providers. Disapproval of such requests shall not be arbitrary, but instead based upon sufficient justification, including but not limited to medical evidence to the contrary, peer review, utilization review, surveillance video, etc.

(d) The Administrator shall determine the eligibility and compensation rate payable for Temporary Total Disability, Temporary Permanent Disability, Permanent Partial Disability, Permanent Total Disability, Vocational Rehabilitation, and/or Death Benefits consistent with the Ordinance and these Regulations. In the case of Death Benefits, the Administrator shall determine the eligibility of Dependents and the terms of any benefits payable consistent with the Ordinance and these Regulations. In the event of the need to allocate dependency benefits between Dependents living in different households, the Administrator shall make the necessary allocation, based on the obligations, legal or otherwise, of the deceased Employee.

4-3. The Administrator shall, only at the direction of, and on behalf of, the Employer, vigorously pursue any cause of action for, or vigorously defend any cause of action or claim against, the Employer under these Regulations.

4-4. The failure or alleged failure of the Administrator to perform any of the duties or responsibilities outlined above will not as a matter of law or operation create any cause of action by a third party, nor will the right to benefits or recovery for any Employee and/or Claimant be expanded or presumed in such an event.

ARTICLE V – Compensability; Exclusions

5-1. In order for an Employee or Claimant to receive any benefits for workers compensation under the Ordinance and these Regulations, the Employee or Claimant must demonstrate by a preponderance of the evidence that he or she sustained a Compensable Injury.

5-2. A Compensable Injury must both Arise Out of Employment and occur within the Course of Employment.

5-3. A claim for workers' compensation benefits will not be accepted, nor will payment of any workers' compensation benefits be continued, nor will any incident or accident be considered or qualify as a Compensable Injury upon the finding or discovery of the following:

(a) Where the Employee fails to adhere to the reporting requirements of Article III of these Regulations;

(b) Where the injury is caused by intoxication, by the injured Employee's use of alcohol or Narcotic Drugs, or by the unlawful use of any other controlled substance;

(b) Where the injury is either intentionally self-inflicted; or an Employee unreasonably refused to obey written or verbal instructions which, if obeyed, would have reasonably prevented or significantly reduced the likelihood of injury or death.

(c) Suicide;

(d) Where the injury results from an altercation in which the injured Employee was the initial aggressor. This shall include instances where injuries are caused by a third person or fellow Employee who intended to harm the injured Employee for personal reasons;

(e) Where the injury is caused by or during the commission by the injured Employee of a felony, crime, or misdemeanor;

(f) Where the injury arises out of voluntary participation in an off-duty recreational, social, or athletic activity that is not part of the Employee's usual and customary duties;

(g) Where the injury is deemed by the Administrator to have been Idiopathic in nature;

(h) Where the injury results from participation in an activity deemed to have been horseplay;

(i) Where at the time of injury, an Employee refuses or fails to utilize or wear personal protective equipment or other safety apparatus that is considered a prerequisite of the job, where such refusal or failure would be formally admonished by the Employer or Nation if it were discovered, and the injury is caused by such a refusal or failure to wear or use that personal protective equipment or other safety apparatus;

(j) Where the injury qualifies as a Psychiatric Injury as defined in this ordinance, or any other purely emotional or mental injuries, except:

(i) Where such injury is the direct result of a sudden and extraordinary employment event; or

(ii) Where such injury is the direct result of a severe, extreme, or abnormal Compensable Injury as determined by a medical provider authorized by the Administrator;

(k) Where the Employee refuses to cooperate in the investigation of the claim, thus impeding the Administrator's right to discovery;

(l) Where causation or compensability of the claim is in issue, the resolution of which depends on a medical determination made pursuant to an Independent Medical Examination and the Employee without good cause shown, fails to present or appear for the scheduled appointment;

(m) Where compensability is based on misrepresentation or willful omission of a material fact, where if such misrepresentation or omission were known by the Administrator or the Employer, the claim would have been denied, or workers' compensation benefits would have been provided at lesser levels than what was actually paid in reliance upon the misrepresentation or willful omission.

(n) Where the injury is determined to have been a flare-up or exacerbation of a pre-existing injury, illness, or condition where no aggravation or worsening of symptoms are attributable to any attribute of employment or where work just served as the stage for the incident to occur without specific industrial causation.

ARTICLE VI– Benefits and Compensation

6-1. Workers' Compensation Benefits payable to any Employee or Claimant under the Ordinance and these Regulations shall be comparable to those mandated for comparable employees under New York State's Workers' Compensation law; provided however that nothing herein is intended to nor shall be construed as an express agreement to be subject to any provision thereof, nor is any waiver of sovereign immunity, express or implied, made.

6-2. Workers' Compensation Benefits shall include the following:

(a) Medical Benefits:

(i) A Claimant shall be entitled to all medical, surgical, hospital, or dental treatment and any therapy, durable medical equipment, medications, diagnostic testing, radiology, and any other medical service related thereto, as requested or prescribed by a provider authorized and approved by the Administrator.

(ii) Where deemed appropriate by an authorized and approved medical provider, when a condition reaches maximum medical improvement (MMI) and/or permanent and stationary (P&S), and future and/or supportive medical benefits is necessary, such benefits shall be provided for the duration provided for in the report, subject to the requirements set forth in Sections 3-1 through 3-3 of these Regulations.

(iii) The algorithms and treatment recommendations proscribed by the American College of Occupational and Environmental Medicine (ACOEM) guidelines may be used to determine the appropriateness of a recommended treatment, but shall have no binding affect upon the Employer.

(iv) The Employer, the Nation and the Administrator shall not be responsible for any bill or amount in excess of what is allowable under the New York State fee schedule for similar bills under New York State's Workers' Compensation law.

(b) Temporary Disability Benefits:

(i) The Employer may establish a Return-to-Work program, such that best efforts will be made to accommodate recommendations for light duty or modified work duty as prescribed by an authorized and approved physician.

(ii) In instances where light duty or modified duty results in diminished wages as compared to the pre-injury average weekly wage of the Claimant, the Claimant will be entitled to Temporary Partial Disability payments at levels generally comparable to those provided pursuant to the New York State's Workers' Compensation law.

(iii) In instances where light duty or modified duty cannot be accommodated by the Employer, or where a Claimant is deemed Temporarily Totally Disabled by an

authorized and approved physician, the Claimant will be entitled to Temporary Total Disability benefits at levels generally comparable to New York State's Workers' Compensation law. Temporary Total Disability benefits shall not be paid during the first seven (7) days of lost earnings unless a Claimant is eligible for Temporary Total Disability benefits for fourteen (14) days or more.

(iv) No Temporary Disability Benefits, whether Temporary Partial Disability or Temporary Total Disability shall be paid under circumstances where:

(aa) The Claimant is incarcerated, provided that such payments will only be withheld during the period of said incarceration; or

(bb) The Claimant does not have a valid medical certification to be off work; or

(cc) The Claimant receives wages during a period where the Claimant was opined to have been Temporarily Totally Disabled.

(v) For purposes of this Section, a Claimant's pre-injury average weekly wage shall be calculated by adding all reported earnings for one year preceding the date of injury, and dividing the number of applicable days worked. In the event the Claimant has been employed for less than a year, the pre-injury average weekly wage shall be calculated by adding all reported earnings for the actual period worked prior to the date of injury, and dividing the resulting amount by the number of applicable days worked. In the event the Claimant has worked for less than a week, the pre-injury average weekly wage will be calculated by multiplying the Claimant's hourly rate by the number of hours he or she is expected to or was hired to work.

(c) Permanent Impairment Benefits:

(i) Permanent Partial Disability benefits will be paid pursuant to the schedule of benefits recognized for similar injuries under comparable New York State's Workers' Compensation law.

(ii) Permanent Total Disability benefits will be paid to a Claimant for life or until a settlement is reached, but shall not inure to any Dependent upon death of the injured Claimant.

(iii) The Employer shall not be responsible for any portion of Permanent Partial Disability or Permanent Total Disability that is attributable to a condition, disease, illness or injury that is deemed pre-existing or non-industrial in nature.

(iv) In no event shall Permanent Partial Disability for any and all injuries combined exceed an aggregate total of 100%.

(c) Death Benefits:

(i) Death Benefits are only payable to Dependents of the deceased Claimant as determined by the Administrator.

(ii) Death Benefits will be paid at levels generally comparable to those provided to similar dependents under New York State's Workers' Compensation law.

(iii) Death Benefits can either be issued on a bi-weekly basis, at a rate commensurate to what would have been paid under Temporary Total Disability benefits but for the death, or can be paid in a lump sum at a reasonable present day value calculation as determined by the Administrator and subject to the acquiescence of the Dependents.

ARTICLE VII– Claim Closure

7-1. A Claimant's claim for workers' compensation benefits shall be closed when any of the following circumstances occur:

- (a) The Administrator has paid a settlement to the Claimant that has been agreed upon by both the Claimant and the Administrator in exchange for a general release of any and all further liability;
- (b) The Administrator has extended all workers' compensation benefits due under the Ordinance and these Regulations to any Claimant or "Dependents";
- (c) The Employee or Dependent fails to appeal a Written Decision within the time-frame prescribed in Article VIII of these Regulations;
- (d) The Claimant has either unreasonably failed to follow-up with medical treatment, or has abandoned medical treatment as evidenced by failure to present for two consecutive medical appointments without good cause shown, or, with respect to supportive medical care, a failure to treat within one year from the last date of authorized medical care under his or her claim;
- (e) The Claimant has reached the point where no further material improvement would reasonably be expected from medical treatment, where all other benefits have been exhausted and/or otherwise paid;
- (f) Upon the discovery of any issues impacting compensability or continuing benefits as more fully described in Article VI of these Regulations; and
- (g) Pursuant to an order following an arbitration hearing under Section 8-2 of these Regulations.

7-2. Nothing in the Ordinance or these Regulations shall impair the rights of the parties to compromise any liability that is claimed to exist under the Ordinance or

these Regulations on account of injury, disease or death, subject to the provisions herein. No Compromise and Release settlement shall be paid without a general release signed by both parties.

ARTICLE VIII– Dispute Resolution

8-1. **Managerial Review.** Whenever a Written Decision has been made on a claim, in the event of any disagreement or dispute arising there from, an Employee or Claimant or Dependent must request a managerial review of such Written Decision at the Administrator level, and the following shall apply:

- (a) Such a request must be submitted in writing to the Administrator and made within thirty (30) days of the Written Decision. The failure to adhere to this requirement shall render the Written Decision of the Administrator final and binding, and shall constitute a waiver to any subsequent appeals or dispute resolution processes set forth under the Ordinance and these Regulations.
- (b) Upon receipt of a timely request for managerial review, the Administrator shall respond in writing via certified mail as to whether the Written Decision being appealed shall be upheld, amended, or overturned and the justification for same, within a reasonable time not to exceed ninety (90) days. If the Administrator fails to respond within the timeframe proscribed herein, the Written Decision shall be deemed upheld by the Administrator and an aggrieved Employee or Claimant or Dependent may initiate Arbitration authorized by the Ordinance and Section 8-2 of these Regulations.
- (c) Where requests for managerial review are based on a dispute surrounding medical evidence, an Independent Medical Examination shall be allowed, provided however that no prior Independent Medical Examination had previously taken place in review of the claim in question, and further provided that a failure by an Employee or Claimant to submit for such an examination will render the Administrator's Written Decision final and binding.

8-2. **Final Arbitration.** Subject to Section 8-1 of these Regulations, if an Employee, Dependent or Claimant has followed the requirements of Section 8-1 of these Regulations and continues to disagree with recommendation of the Administrator, or if the Administrator fails to respond to a timely request within the ninety (90) days, final arbitration, pursuant to Article IV of the Ordinance may be requested. Such arbitration request must be made within thirty (30) days of receipt of a Written Decision pursuant to Section 8-1 of these Regulations, or thirty (30) days from the ninety-first (91st) day should the Administrator fail to respond in the time-frame allotted pursuant to Section 8-1 where a timely request has been made. A failure to make a timely request for arbitration under this Section for any reason will forever bar further appellate remedy and will render the Administrator's Written Decision final and binding.

The arbitrator shall:

- (a) Be bound by the Ordinance and these Regulations, and any other laws, civil procedures, and regulations of the Nation, but may at his or her discretion use statutory law or other applicable workers' compensation law as a non-binding source of reference or information;
- (b) Take all action necessary to ensure an equitable, orderly, and expeditious review; and
- (c) Regulate all aspects of the arbitration conference including, but not limited to, the administering of applicable oaths and affirmations, admissibility of evidence, and admissibility of expert or lay witness testimony.

Both parties agree to abide by the arbitrator's findings. Except as specifically expressed herein, nothing shall be deemed or interpreted as a waiver of the Employer's or Nation's sovereign immunity, nor does the Nation consent to enforcement of this provision by any other court, forum, or venue, except as provided by the Ordinance and this Regulation.

8-3. **Enforcement of Arbitration Award.** The enforcement of an award of compensation and/or workers' compensation benefits by arbitration; provided the arbitrator shall have no authority or jurisdiction to order execution against any assets or revenues of the Employer or the Nation except: (a) what is provided for under a valid policy of workers' compensation insurance, but only up to the available limit therein; (b) funds specifically set aside or designated by the Employer for payment of such compensation and/or workers' compensation benefits; or (c) any other proceeds of any applicable insurance policies. In no instance shall any enforcement of any kind whatsoever be allowed against any assets of the Employer or the Nation other than the limited assets of the Employer as specified in this Section.

ARTICLE IX– Subrogation; Apportionment; Recovery

9-1. **Subrogation.** Although the Nation and the Employer is entitled to invoke the defense of sovereign immunity for any claims brought against it, nothing herein shall impair the rights of the Nation, the Employer or the Administrator, on the Nation or Employer's behalf, to file a subrogation lien in any action or to enter as a plaintiff to pursue any recovery to which the Nation or the Employer may be entitled.

9-2. **Error.** Whenever the Administrator pays any benefits pursuant to a Compensable Injury as a result of clerical error, mistaken identity, innocent misrepresentation, or other mistake or similar circumstance that does not arise to the level of fraud or intentional omission or misrepresentation of a material fact, the Administrator shall request and the recipient of such benefits shall reimburse any monies expended within one year. The Administrator shall have the discretion to waive, in whole or in part, any refund or reimbursement from a recipient where recovery would be futile, against equity, against good conscience, or under other similar circumstances.

9-3. **Fraud.** Whenever the Administrator has been fraudulently induced to make any benefit payment under the Ordinance and these Regulations, either by a willful omission of or intentional misrepresentation of a material fact, the recipient shall repay the payment, along with a penalty of fifty percent (50%) of the payment amount. The Administrator must demand the repayment within one (1) year of discovering the fraud.

9-4. **Apportionment.** For the purpose of settlement for Permanent Partial Impairment or Permanent Total Impairment the amount of benefits due may be reduced or denied in its entirety by the Administrator for pre-existing impairment, whether work related or not, if apportionment is medically documented by a physician or as the result of an Independent Medical Examination approved by the Administrator.

ARTICLE X -- Confidentiality

10-1. The information in the claims files and records of Employees or Claimants obtained pursuant to the filing of a claim or any provisions of these Regulations shall be deemed the exclusive property of the Nation and the Employer and therefore is strictly confidential and shall not be open to public inspection. A Claimant, or his or her authorized representative upon the presentation of the signed HIPPA compliant authorization of the Claimant, may review the Claimant's medical file. In the event of an arbitration hearing, any evidence that either party wishes to submit or have reviewed pursuant to or in consideration of the arbitration hearing, which shall include any medical or non-medical information present in the claim file, must submit true copies thereof to the opposing parties no later than fifteen (15) days prior to the date of any arbitration conference.

10-2. The Employer, or its duly authorized representatives, may review any files of their own injured Employees in connection with any pending claims. Physicians treating or examining or giving medical advice to or providing an opinion about Employees claiming benefits under the Ordinance and these Regulations as approved or authorized by the Administrator may, at the discretion of the Administrator, inspect the claims files and records of the injured Employee, and other persons may make such inspection at the Administrator's discretion when such persons are rendering assistance to the Administration at any stage of the proceedings on any matter pertaining to administration of the Ordinance or these Regulations.

10-3. Notwithstanding the provisions herein, the Administrator and/or Employer shall have the right to request full and complete medical records or reports from any of Employee's physicians or health care providers at any time and in the form and details as deemed necessary and shall have the right to present specific questions required to evaluate the claim. All medical information and records shall be subject to disclosure to the Administrator and the Employer in connection with any claim for workers' compensation benefits in order to properly understand and evaluate the claim. If the Employee asserts his or her privilege to keep such information or records from being disclosed to the Administrator or Employer, the Administrator or the Employer may

suspend any applicable workers' compensation benefits, or can deny the claim on the basis of impeding the right to discovery under these Regulations.

ARTICLE XI – Medicare Set Asides

11-1. The Medicare/Medicaid SCHIP Extension Act (MMSEA) sets forth reporting requirements for insurers where criteria established pursuant to the Act have been met. Nothing herein shall prevent the Administrator from protecting Medicare's interests where required to do so. Where a Claimant is entitled to supportive medical care after maximum medical improvement is achieved pursuant these Regulations, such supportive care will only be provided as specified by a medical provider authorized by the Administrator and only for the duration specified by that medical provider. Where a claim has been closed due to abandonment, award, or settlement, neither the Employer, its insurer or Administrator shall have any further obligation to pay benefits under the Ordinance and these Regulations, inclusive of any subsequent Medicare liens.

ARTICLE XII -- Effective Date

12-1. These Regulations shall be deemed to have taken effect as of April 1, 2015, and shall replace or supersede any prior workers' compensation regulations.



A handwritten signature in cursive script, appearing to read "Ray Anderson", is written over a horizontal dashed line.