Mille Lacs Band of Ojibwe

Circle of Health Policy & Procedures

Approved by Commissioner
Health and Human Services
Date: 11/30/2022

Mille Lacs Band of Ojibwe
Circle of Health Introduction

Circle of Health is a nonprofit body politic, of the Mille Lacs Band of Ojibwe. Circle of Health began in 1998, and was located in Onamia, MN. In September 2007, the offices moved to the Chiminising Community Center in Isle, MN, and later back to Onamia, MN where the office is currently located. Daily operations are overseen by the Benefits Manager. The Commissioner of Health and Human Services governs program services, budgets, and band statutes.

These policies are intended to provide Mille Lacs Band Members with a general understanding of Circle of Health's policies and procedures.

However, these policies cannot anticipate every situation or answer every question about heath care claims. It is not intended to create obligation of any kind, by Circle of Health.

The Commissioner of Health and Human Services reserves the right to change, revise, or eliminate any policies or benefits described, herein. The Commissioner of Health and Human Services is subject to follow all Band Statutes and provisions.

Mission:

Circle of Health's mission is to promote physical and mental well-being in all of our communities, by assisting Mille Lacs Band Members to acquire health coverage, and eliminating barriers to health care access.

Circle of Health Purpose:

The Commissioner of Health and Human Services oversees Circle of Health, a Mille Lacs Band Program to pay deductibles, copays and insurance premiums for Mille Lacs Band members. Adult Band members are entitled for benefits regardless of income or where they live. A primary insurance must already be in place; this could be through an Employer, Medicare, Medicaid or other programs. To further be eligible there must be a Mille Lacs Band Member on the primary policy. Circle of Health pays for single or family medical/dental premiums. One policy per family.

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Table of Contents

Policy		Revision Date:	Page
101	Confidentiality		5
102	Enrollment		5
103	Consent for Release of Confidential Information		5
104	Eligibility		5
105	Coverage		5
106	Non-Enrolled First Line Descendant	6/21/2021	6
107	Non-Enrolled Family Members	5/1/2008	6
108	One Policy Per Household/Family		6
109	Adoption of Band Member Children	7/1/2007	6/7
110	Divorce		7
111	Legal Separation		7
112	Care of Another Adult		7
113	Multi-Family Setting		8
114	Medicare		8
115	COBRA Coverage	10/1/2007	8
116	Medicaid Spenddown		9
117	Private Coverage	10/1/2007	9
118	Denial Process for Private Insurance		9
119	Monies Owed to Circle of Health		10
120	Additional Services	2/1/2007	10
121	Orthodontia Policy		10
122	Duplications for Lifetime Additional Service Increases		11
123	Treatment Costs		11
124	Auto Accident & Workers Compensation Claims		11
125	Abortion, Cosmetic, Fertility		11
126	Non Band Member carrying Band Member Child		11
127	Processing of Claims		12
128	Copay or Deductible Provider Payments		12
129	Denials		12/13
130	Request for payment and ACT Entry		13
131	Request for more information		13
132	Submission Time Period	6/21/2021	14
133	Payer of Last Resort		14

134	Check Request Process		14/15
135	Appeals Process	6/21/2021	15
136	Payroll Deductions		15
137	Employer Premiums		16
138	Mailing Process		16

List of Appendices

1. Appendix A: Staff Roster and Contact Information

101 CONFIDENTIALITY

In order to protect confidentiality Circle of Health follows HIPAA (Health Insurance Portability and Accountability Act) Security Regulations.

The reason for this policy is to ensure confidentiality, integrity, and to protect against any threats or hazards to the security or integrity of band member information. In an unlikely event that any information is released, or obtained by our office; Circle of Health will follow HIPAA breach notification requirements. Disciplinary action, along with legal action, will follow when applicable.

102 ENROLLMENT

It is the policy of Circle of Health to have all Mille Lacs Band members who submit claims for medical/dental services and additional services to fill out an **enrollment form**.

The purpose is to maintain updated information from the Band members regarding information and who is eligible on their policy. An enrollment form needs to be completed along with a copy of the band member's identification card, and copies of health insurance cards, prior to paying for any claims through the Circle of Health. Information will be recorded into a file on ACT and updated annually. Circle of Health cards will not be issued until all paperwork is obtained.

103 CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

At the time of enrollment or updating information, it is the policy of Circle of Health to have all band members fill out a Consent Form. This will enable Circle of Health staff to process your claim, and directly deal with providers, employers or insurance companies.

104 ELIGIBILITY

Band members should accept and be willing to apply for medical/dental coverage that may be available through an employer or from a governmental program in your state. The Benefit Coordinator will assist Band members in understanding and applying for applicable insurance policies.

The Circle of Health Office reserves the right to individually do pre-determinations for state or private eligibility. Also, the right to deny payment or reimbursement of health premiums due to no prior consultation with the Circle of Health office.

105 COVERAGE

Circle of Health pays for deductibles, copays and insurance premiums for Mille Lacs enrolled Band members.

106 NON-ENROLLED FIRST LINE DESCENDANT

It is the policy of Circle of Health to recognize first line descendant until the age of 18. However, Circle of Health will pay co-pay and deductible amounts for the first line descendants who remain full time students through the age of 23. Documentation will be required in our office, to verify full time status. The descendant must be on an active band member's policy for co-pays and deductibles to be paid, and proof will be required. The Commissioner of HHS reserves the right to review/discontinue co-pays, deductibles, and premium amounts of a non-enrolled descendant. The Commissioner of HHS, Circle of Health Leadership and HHS Finance must review and act on financial matters in relation to cost containment and plan for the future of Circle of Health Program. This includes the nonpayment of monthly premium amounts for children over the age of 18, where their coverage increases the monthly premium amount.

107 NON-ENROLLED FAMILY MEMBERS

It is the policy of Circle of Health to not cover co-pays and deductibles of non-enrolled family members (includes prescriptions). This coverage ended April 30. 2008.

108 ONE POLICY PER HOUSEHOLD/FAMILY

It is the policy of Circle of Health to pay one premium per household or family. If there are band member children who could be on a mother's or father's policy; but they are on a non-band member's policy, and no legal documents can be provided relatively, the non-band member premium can be denied.

109 ADOPTION OF BAND MEMBER CHILDREN

In the event that a band member child has been adopted by a non-band member family, who do not qualify for Circle of Health Benefits, this policy has been put into place to insure that all other resources have been exhausted before Circle of Health will assist with health/dental premium amounts.

Each county in Minnesota has specific requirements to qualify for Adoption Assistance Program, which includes: reimbursement of non-medical items, financial assistance, and provides Medical Assistance as a backup to a families' health insurance.

If an adoptive family fits the counties' requirements, federal law requires states to provide medical assistance for children receiving Adoption Assistance. If the family already has a private plan in place, medical assistance is a supplement.

If your private health insurance requires you to pay an additional premium amount for your adopted child you may be eligible for reimbursement of the premium. A medical assistance worker will have you complete a Cost Effective Review Form. If the premium is determined to be cost effective, then Medical Assistance will require you to enroll your child under your private insurance plan and you will be reimbursed for the premium from the state. If Medical Assistance determines it is not cost effective, they cannot require you to enroll your child in that policy. Medical Assistance will then be your child's primary insurance. Due to the support and services offered; Circle of Health will request a copy of

the acceptance or denial from the Adoption Assistance Program before any determinations are made. If the adopted band member child is added to a private health insurance plan, a premium reimbursement will only be made for the band member portion of the premium. Proof of the increased premium will need to be provided by your insurance. Circle of Health will review all instances on a case by case basis, provided that all other options have been exhausted.

As long as the agreement/adoption is in place the child continues to be eligible for Medical Assistance. A copy of the medical assistance identification card will need to be in our records, this supplement of insurance will cover any co-pays/deductibles, in which case there should be no billings to the Circle of Health office. Circle of Health is the payer of last resort, submission of claims must show that Medical Assistance has already been billed and denied.

110 DIVORCE

It is the policy of Circle of Health, to not become financially responsible for payment of premiums when a divorce proceeding has begun. Circle of Health makes no commitment where marital matters are concerned; this is a Mille Lacs Band of Ojibwe Band Member program.

It is further understood that under state guidelines, that coverage cannot be terminated by either party in the divorce. Circle of Health does not have authority to terminate any policies, and cannot be held responsible for non-payment of the two parties involved.

Circle of Health reserves the right to only reimburse co-pays and deductibles instead of making payments to providers. The Courts may have ordered that both parents have equally been given the financial responsibility of those costs, and should not be obligated to Circle of Health.

Divorce proceeding paperwork should be sent to our office as soon as available, and any dealings with Circle of Health will only continue with the band member or his/her legal representation, if an appropriate consent of release of information has been provided.

111 LEGAL SEPERATION

It is the policy of Circle of Health, to not become financially responsible for payment of premiums when a non-band member parent has non-enrolled band members. First line descendant does not qualify for assistance from the Circle of Health program without a band member on a policy.

112 CARE OF ANOTHER ADULT

It is the policy of the Circle of Health to not pay co-pays or deductibles due to legal guardianship or care of another adult family member if they are not an enrolled Mille Lacs Band tribal member.

Additionally, if an otherwise single policy has been changed to family coverage due to this agreement Circle of Health reserves the right to only reimburse or pay premiums to the lesser coverage amount.

113 MULTI-FAMILY SETTING

Adult Enrolled Mille Lacs Band Members in a temporary multi-family setting and exceeding one policy per household may be subject to household income guidelines, health history review in regards to medical necessity, proof of financial hardship or additional information qualifying determination of need or exhaustion of all other avenues.

114 MEDICARE

It is the policy of Circle of Health to recognize all Band members who are 65 and older, or who are 65 and younger, disabled, and are eligible and enrolled with Medicare.

The purpose, to maintain information from the Band members and ensure that reimbursements are made for the premium amount. Copays and deductibles are also covered, but must never exceed the maximum allowable amount for Medicare. Proof of this insurance is the annual award letter issued from the Social Security Department.

This letter is sent out every November into December. A copy of this letter needs to be provided to Circle of Health, for our records.

Reimbursements are made, to those qualified, on a quarterly basis, they should arrive the second week of each new quarter. For example, the end of the second week in October for the months October, November and December.

Medicare Part D deductions and supplement plans premiums should also be sent to our office. Medicare is an individual policy.

115 COBRA COVERAGE

It is the policy of Circle of Health to encourage all tribal members to apply for health benefits on the health insurance exchanges within their state before accepting COBRA benefits. The health insurance exchanges provide low-cost affordable coverage or be eligible for federal or state subsidized health plans. Circle of Health staff can assist any tribal member with the health benefit enrollment process. COBRA can be expensive. Insurance available through MNSure or other health insurance exchange has a lower monthly premium cost. Health Insurance exchanges are the only place where you can qualify for financial help to lower your premium costs. You may be eligible for a tax credit or qualify for a low-cost or no-cost state or federal plan (Medical Assistance or MNCare)

It is the policy of Circle of Health to deny all COBRA premiums for Band Members whose employment has ended. The Band Member will be responsible for all COBRA payments. Losing job-based insurance coverage qualifies you for a 60 day special enrollment period that allows you to buy insurance outside the regular open enrollment period. You can apply for a plan during the 60 days before loss of coverage to avoid a gap in your coverage.

If you are eligible for Medical Assistance or MNCare, you can enroll at any time.

The Band Member should contact Circle of Health prior to filling out COBRA paperwork or as soon as it is received from the former employer. A copy of the premium notice needs to be provided to Circle of Health.

If you enroll into COBRA coverage, you can switch to a MNSure Plan:

- During an annual open enrollment period (November 1st to January 31st)
- During your 60 day special enrollment period, which is available when you lost-based coverage
- At any time, if you qualify for Medical Assistance or MNCare.

116 MEDICAID SPENDDOWN

It is the policy of Circle of Health to evaluate each case on an individual basis. After information becomes collective, it is then provided to the Circle of Health Board for possible changes.

Medicaid Recipients should be working with their County Case worker to determine the best per capita disbursement. The Office of Management and Budget has agreed to work with the Circle of Health office if changes are needed to eliminate Medicaid spenddowns.

117 PRIVATE COVERAGE

It is the policy of Circle of Health to assist band members with payment of private coverage policies for 1 (one) year. This allows ample time for the band member to attain employer's insurance or apply for applicable state coverage. Also, for band members to research other health coverage policies that are less costly, but does not decrease any current benefits. Ultimately, becoming better consumers of health policies and sustaining the Circle of Health program.

If a private policy is in place, because you are an independent business owner Circle of Health reserves the right to make sure that premiums are being billed or paid only for the Employee portion. It may be necessary to get this information from your insurance administrator, and Circle of Health will request a copy along with the enrollment, and consent forms on an annual basis.

118 DENIAL PROCESS FOR PRIVATE INSURANCE

It is the policy of Circle of Health for the Benefit Coordinator to assist band members with applying for Private Insurance, if denied during this process, a denial letter and refund check are issued to you (the band member). It is important that you return this check to our office as soon as possible. Circle of Health will not process another premium payment and you will no longer be eligible for reimbursement or the additional benefits until this check is brought into our office.

119 MONIES OWED TO CIRCLE OF HEALTH

It is the policy of Circle of Health to inform band members three times (through letters) to collect any monies that are due. If no agreement is made to pay by the last 30 day request, the client is deemed ineligible for Circle of Health benefits.

120 ADDITIONAL SERVICES

Circle of Health will cover additional services for enrolled band members only, with prior authorization with a yearly or lifetime limitation:

Eyewear:	up to $250.00 per fiscal year (increased 7/1/2008)
DME:	up to $1,000.00 per fiscal year (increased 4/16/2008)
Hearing Aids:	up to $1,500.00 every five years (increased 1/1/2023)
Orthodontia:	up to $3,000.00 lifetime benefit (increased 3/1/2007)

Circle of Health fiscal year is Oct. 1 through Sept. 30

These services must be pre-approved, the provider needs to call Circle of Health and a claims processor will authorize the charges as deemed by the allowable amount and time period.

DME (Durable Medical Equipment): This benefit has been increased due to need of medical equipment. This benefit does not cover disposable items, due to incontinence (bandages, irrigation, Depends), etc.

121 ORTHODONTIA POLICY

Orthodontia procedures are typically limited to ages 7-19, but in extreme cases and those determined as a medical necessity can be pre-authorized by Circle of Health. The orthodontic appliances recommended time period should be a minimum of 24 months, or the Orthodontia office certificate of medical necessity should accompany a medical provider's orders.

A band member who voluntarily terminated orthodontic treatment (for whatever reason) before the Orthodontia benefit was increased March 1, 2007 will be acknowledged as already exhausting this benefit. Circle of Health shall be released from any responsibility for all consequences caused by the treatment being terminated against the advice of the orthodontist. Thus; relieving any financial responsibility upon Circle of Health to either authorize or make payment or reimbursement for any future duplicate services.

Dentures now fall under the orthodontia benefit, and some procedures prolonging the certain outcome of dentures can be determined on a case by case basis, and again request a letter of medical necessity. The band member will need to provide in writing that they are agreeing to exhaust their $3,000 benefit towards those procedures, disallowing them any future assistance if dentures are still required in the future.

None of these benefits can be transferred to non-band members within the household

122 DUPLICATIONS FOR LIFETIME ADDITIONAL SERVICE INCREASES

It is the policy of Circle of Health that there will not be any assistance for duplicate services until the band member pays up to the additional services amount available. For example: A band member previously had braces (already used the first $1,500 orthodontia benefit), and for whatever reason discontinued this treatment, later he/she wants to use the additional amount of $1,500 (added to the Orthodontia Benefit 3/1/2007) to start the process over. So if the total is $3,000 (and there is no primary insurance benefits), the band member would pay $1,500 first. At which time, the provider office can contact us for the remaining $1,500 to be billed.

123 TREATMENT COSTS

Effective March 1, 2007 co-pay or deductibles amounts in relation to chemical dependency treatment will only be paid for enrolled Mille Lacs Band Members, with prior authorization.

124 AUTO ACCIDENT & WORKERS COMPENSATION CLAIMS

It is the policy of Circle of Health that no payment will be made in relation to auto accidents or workers compensation. This matter is to be resolved between the insurance companies or employer. If maximum Auto insurance amounts are met, Circle of Health will evaluate on a case by case basis.

125 ABORTION, COSMETIC, FERTILITY

If your primary insurance, does not cover any of these items neither will Circle of Health. In an extraordinary circumstance where the medical condition of the band member life is in jeopardy, due to the unborn child they are carrying; our office should be contacted. Finally, Circle of Health reserves the right to deny any claims that are to be determined extraordinary and of questionable medical necessity.

126 NON BAND MEMBERS CARRYING POSSIBLE BAND MEMBER CHILDREN

It is the policy of Circle of Health, in a case where a couple is not married, and the non-band member is pregnant, and it is believed that a band member fathered the child; no claims will be paid by Circle of Health. When/If the child becomes an enrolled Mille Lacs tribal member or a birth certificate is supplied with band member father's name any paid co-pays and deductibles can be turned in for reimbursement back to when pre-natal care began.

127 PROCESSING OF CLAIMS

It is the policy of the Circle of Health to make certain payments to third parties for the provision of health care benefits to Mille Lacs Band members. These third party providers may include hospitals, physicians and other health professionals, retail medical suppliers and health care insurance providers through either direct or indirect payment of premiums.

The purpose is to improve access to health care services for all Mille Lacs Band members and families where ever they may live. The Circle of Health does not intend to pay false or fraudulent claims. Sufficient proof of a claim will provide Circle of Health with the information to know that a claim is not false. The staff will verify all information on the check request makes the claim eligible for payment. All supporting documentation will be attached to the check request. If all of the information is correct; it will be given to the Benefits Manager for final approval.

Once checks come back from the OMB office, the claims processor will complete the process by creating an Explanation of Benefits (EOB) for services approved.

128 COPAY OR DEDUCTIBLE PROVIDER PAYMENTS

It is the policy of the Circle of Health to be the payer of last resort for copays and deductibles for medical and dental services. As a condition of agreement to pay, all persons insured under benefits contained herein must exhaust all other means of health care insurance or third party payment, before COH benefits and payments will be made available.

The purpose of this policy is to insure that members obtain primary insurance they are eligible for.

In order to assure clean claims the Benefits Manager or designee may use methods including:

- Telephone calls to members
- Written confirmation from requests from employers
- Written confirmation request from members
- Written confirmation from insurance plans
- Copies of members cancelled checks
- Copies of member's certificate of coverage

Circle of Health staff shall use wide discretion in confirming that all other insurance plan coverage has been exhausted.

All complete claims will be entered and maintained into the ACT system.

129 DENIALS

It is the policy of Circle of Health to record all denials whether the claim has all of the required information or if the claim is incomplete. The records will date the denial, and the reason the claim was denied. The denial will be mailed to the provider's office or band member.

Most insurance have a 60 day appeal process, your dispute needs to begin with the primary insurance. Reason for denial included:

- Service(s) were not covered by the primary health insurance.
- Amount was not covered by the primary health insurance.
- Service(s) were not covered by the primary dental insurance.
- Amount was not covered by the primary dental insurance.
- Maximum fiscal year benefits have been reached.
- Maximum lifetime benefits have been reached.
- Primary insurance's maximum benefits have been reached for the benefit period.
- Zero amount due from Circle of Health.
- Claim was received after the Circle of Health's time limit of 6 months, determined by date of service or from the date of primary insurance payment.
- Patient is not eligible for Circle of Health.
- No primary insurance on date of service.
- Other: *will be explained.*

130 REQUEST FOR PAYMENT AND ACT ENTRY

It is the policy of the Circle of Health to record all claims submitted for payment in each band member file. The record will show the type of claim, date of service, provider name, the amount of the claim, and initials by the claims processor. Personal reimbursement will include type of reimbursement, and dates of service or coverage.

Check production is not done in our office, but sent to the Office of Management and Budget following their processing schedule. An actual Health Provider Billing Form and Explanation of Benefits (EOB) will accompany all check requests. Premium Payments Coupons or letters will accompany check requests, on a quarterly or semi-annual basis. Personal reimbursements requests will be sent with copies of payroll check stubs. Copay and Deductible reimbursements must have two forms of backup, proof of payment and a statement from the provider or a copy of the Explanation of Benefits. Prescriptions must have the prescription tag and a receipt. The Claims Processor will verify that the provider office has not already billed Circle of Health.

131 REQUEST FOR MORE INFORMATION

It is the policy of Circle of Health to return Explanation of Benefits (EOB) back to providers requesting a billing (HCFA) form. Additionally, to send back statements or explanation of benefits sent in by itself by band members. See Request for Payment and Act entry, for the two forms that must accompany payment or reimbursement.

132 SUBMISSION TIME PERIOD

It is the policy of Circle of Health to process any provider payments and allow billings to reach our office up to 6 months from the date of service, or in some cases from the date of primary insurance payment.

The Commissioner of Health and Human Services reserves the right to change the personal premium reimbursements to a shorter time period, corresponding more closely to fiscal year expenses.

133 PAYER OF LAST RESORT

It is the policy of the Circle of Health to be the payer of last resort for copays and deductibles for medical and dental services. As a condition of agreement to pay, all persons insured under benefits contained herein must exhaust all other means of health care insurance or third party payment, before COH benefits and payments will be made available.

In order to assure clean claims the Benefits Manager or designee may use methods including:

- Telephone calls to members
- Written confirmation from requests from employers
- Written confirmation request from members
- Written confirmation from insurance plans
- Copies of members cancelled checks
- Copies of member's certificate of coverage

The Benefits Manger shall use wide discretion in confirming that all other insurance plan coverage has been exhausted.

134 CHECK REQUEST PROCESS

It is the policy of Circle of Health to utilize a uniform **check request form** for to request payment from OMB for premiums, copays and deductibles and additional benefits of hearing, DME, Orthodontia, and eyewear.

The purpose of this policy is to assure there are checks and balances with claims being processed. All claims will be thoroughly reviewed for eligibility prior to sending to the Office of Management and Budget (OMB) for processing the check.

All check requests will be filled out completely for all claims submitted. The check request will include:

- Who the check is payable to
- Amount
- Date of Service
- Member name
- Band ID#
- Eligible family member name

1. All check requests will be batched and a report will be attached with the requests when sent to OMB.
2. All claims will be checked for duplicates.
3. All requests will be paid from an EOB and bill.
4. All checks will be generated from the ACT program. There should be no writing on them.
5. All checks will be mailed by Circle of Health staff.
6. Circle of Health staff will post all checks when they are mailed out and close the file.

135 APPEALS PROCESS

It is the policy of the Circle of Health for claims processors not to pay for claims not covered by a primary insurance.

All claims that do not fit within Circle of Health benefits as a co-pay, premium or deductible amount, will be declined and a denial letter will be sent to the band member.

If a band member feels that their claim was improperly denied, they have the right to bring the matter to the Circle of Health Benefits Manager, within 30 days of receipt of the denial letter. If the appeal is further denied by the Benefits Manager, an appeal letter addressed to the Commissioner of Health and Human Services must be created by the band member, and will be submitted for consideration. After a determination has been made, the band member will be informed by letter through the Circle of Health Benefits Manager.

136 PAYROLL DEDUCTIONS

If you work for a Mille Lacs Band of Ojibwe Entity (Government Center, Corporate Commission, Grand Casino Mille Lacs & Grand Casino Hinckley), and there is an eligible band member on the policy, your premium will be deducted from your paycheck. Contact your Human Resource Department as you have an option for the employee premium to be billed directly to our office. This does not happen automatically, our office needs to verify and update your information before authorizing the billing.

137 EMPLOYER PREMIUMS

It is the policy of Circle of Health to reimburse the employee premiums that are deducted from the band member or respective family member's paycheck. A copy of a check stub from an employer showing amount withheld for medical, dental or vision deductions are reimbursed to the individual whose name is on the paycheck. The band member can also discuss the option with their Human Resource Department to allow Circle of Health to pre-pay employee premium amounts a quarterly basis.

If the band member is the owner of the business, the employee portion must be defined from the employer portion from your insurance administrator. The full premium amount, even though a band member is running the business, does not become eligibility to reimburse the full amount.

138 MAILING PROCESS

It is the policy of Circle of Health to make copies of all checks returned from the Office of Management and Budget, attach to the check request, enter mailing date in the ACT system, and finally to the post office. All checks are mailed, no exceptions.

It is the policy of Circle of Health to allow claims for reimbursement a 2-6 week grace period, from the date of submission. The band member can contact the corresponding claims processor, if after 6 weeks they still haven't received a denial or payment. There are times when band holidays, OMB deadlines or staff vacations, require more time to process the claims.

The Circle of Health program is not emergency program, and will not honor emergency requests.

Appendix A

Current Employee Contact List

Circle of Health Staff

Title	Primary Responsibility	Contact Information
Benefits Manager	Supervision/Day-to-Day Operations	(320) 532-7723
CoH Admin. Asst.	CoH Processing	(320) 532-7741
Claims Processor A - G	Manages Claims A-G	(320) 532-8903
Claims Processor H - P	Manages Claims H-P	(320) 532-7724
Claims Processor Q - Z	Manages Claims Q-Z	(320) 532-8904
Benefit Coordinator	Assists Band Members with Insurance	(320) 532-8932
Benefit Coordinator	Assists Band Members with Insurance	(320) 532-8929
Benefit Coordinator	Assists Band Members with Insurance	(320) 532-1759