YAVAPAI-APACHE NATION WORKERS' COMPENSATION CODE

Table of Contents

Adopted on October 8, 2020 by Resolution No. 165-20, as amended on May 5, 2022 by Resolution No. 77-22.

Section 101. Purpose

The purpose of this Code is to:

(A) Reaffirm the existing policies and procedures recognized by the Yavapai-Apache Nation concerning redress of employee work-related injuries, illnesses, or conditions;

(B) Create and maintain a system for addressing workers' compensation claims fairly and in general conformity with accepted workers' compensation practices of the Nation;

(C) Clearly define standards for compensability and available workers' compensation benefits at levels comparable to what is provided for in the State of Arizona; and

(D) Establish a systemic and uniform procedure for the administration of workers' compensation benefits to Employees.

Section 201. Scope

This Code shall apply to all Employees of the Yavapai-Apache Nation or any of its branches, departments, programs, or subordinate economic organizations who sustain injuries, illnesses, or other conditions arising out of and occurring in the course of employment, regardless of whether those injuries are sustained on or off the reservation, and to any Dependents who may be entitled to benefits or recovery under the terms of this Code.

Section 202. Exclusive Remedy

This Code shall be the sole and exclusive method for obtaining compensation from the Nation for any injuries, illnesses, conditions, or death arising out of and occurring in the course of employment. The liability of the Nation is limited to the following compensation, which shall not be expanded, broadened, enhanced, or otherwise increased except by express amendment of this Code by the Tribal Council:

(A) what is provided for under a valid policy of workers' compensation insurance maintained by the Nation, but only up to the available limit therein;

(B) funds specifically set aside or designated by the Nation for payment of such compensation and/or workers' compensation benefits, if any; or

(C) any other proceeds of any applicable insurance policies.

Section 203. Sovereign Immunity

Nothing in this Code shall be considered, construed, or interpreted as a waiver of the sovereign immunity of the Yavapai-Apache Nation or any of its branches, departments, programs, or subordinate economic organizations, or any employees or officers thereof. The State of Arizona's statutory workers' compensation system shall not apply to the Nation or any Employees, nor shall any claims for workers' compensation benefits be subject to the Arizona workers' compensation laws, statutes, or regulations, or the Industrial Commission of Arizona, or to the jurisdiction of any court of law or equity.

Section 301. Definitions

(A) **"Administrator"** means the third party entity responsible for managing the claims under this Code. Managing the claims includes the duties set forth in Section 501 of this Code.

(B) **"Arise out of Employment"** or **"Arising out of Employment"** means that an incident giving rise to occupational injury or illness must be causally related to the conditions and obligations of employment. Risks that are personal to the Claimant, for purposes of determining compensability, will not be construed to arise out of employment.

(C) **"Child"** or **"Children"** means the offspring of an Employee, 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:

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

(2) He or she is under the age of twenty-three (23) and enrolled as a full-time student in an accredited university, college, or vocational school; or

(3) 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 as determined by a licensed physician.

(D) **"Claimant"** means an Employee or Dependent who follows the appropriate protocol to submit a claim for workers' compensation benefits under this Code, and who is determined to have sustained a Compensable Injury.

(E) **"Compensable Injury"** means a specific (resulting from one incident or exposure) or cumulative (result of repetitive or continuous activity or exposure) injury, 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, illness, or condition meets the standards set forth in Section 601 of this Code.

Where the primary injury, illness, or condition meets the standards set forth in Section 601 of this Code, 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 primary injury, and where there is no intervening or superseding event.

(F) **"Course of Employment"** means taking place within the period of employment, at a place where the Employee is reasonably expected to be, and while fulfilling his or her occupational duties or engaged in something incidental thereto. Injuries sustained while going to or coming from work will not be covered unless the journey itself is part of the service to the employer and there was no substantial deviation.

(G) **"Days"** mean calendar days unless otherwise specified.

(H) **"Death Benefits"** means 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.

(I) **"Dependent(s)"** means the Spouse and/or Child or Children of the deceased Employee.

(J) **"Employee"** means a person employed by or in service of the Yavapai-Apache Nation or any of its branches, departments, programs, or subordinate economic organizations under which such individual receives a salary, wages or other compensation for services, including a Tribal Council member and board or committee member. Employee shall not include any person who qualifies as an independent contractor, contractor, outside consultant, or volunteer.

(K) **"Idiopathic Injury"** means 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 (i.e. a report of pain with no explanation, causation or evidence; "I was just walking and heard my knee pop. I was not carrying, pushing or pulling anything.").

(L) **"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 Nation's expense in order to resolve a medical dispute.

(M) **"Intoxication"** means blood alcohol content in excess of .02 percent, or conviction of the offense of driving while intoxicated by any jurisdiction, or loss of the normal use of one's mental/or physical faculties resulting from the introduction into the body of: (1) an alcoholic beverage, (2) a controlled substance, (3) a mind-altering drug and/or hallucinogenic, (4) a glue or aerosol paint, or (5) any similar substance.

(N) **"Maximum Medical Improvement (MMI)"** means the earliest date after which, based on reasonable medical probability, further material recovery or lasting improvement to an injury, illness, or condition can no longer be reasonably anticipated, and where such injury, illness, or condition is unlikely to change substantially over the next year.

(O) **"Nation"** means the Yavapai-Apache Nation and/or any of its branches, departments, programs, or subordinate economic organizations.

(P) **"Permanent Partial Impairment"** means a level of permanent disability at the time Maximum Medical Improvement (MMI) is achieved, as opined by a treating physician or as the result of an Independent Medical Examination using the most recent edition of the *AMA Guides to the Evaluation of Permanent Impairment*, which results in a whole person impairment rating of less than one-hundred percent (100%).

(Q) **"Permanent Total Impairment"** means a level of permanent disability at the time Maximum Medical Improvement (MMI) is achieved, as opined by a treating physician or as the result of an Independent Medical Examination using the most recent edition of the *AMA Guides to the Evaluation of Permanent Impairment*, which results in a whole person impairment rating of one-hundred percent (100%). There shall be no presumptions of Permanent Total Impairment under this Code.

(R) **"Proximate Cause"** means an incident from which an injury results as a natural, direct, uninterrupted consequence and without which the injury would not have occurred.

(S) **"Psychiatric Injury"** means a mental disorder diagnosed pursuant to the most recent edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental* Disorders, which is medically attributable to employment by a preponderance of evidence, and which resulted in its entirety from a specific, traumatic employment event.

(T) **"Spouse"** means the legal husband or wife of the Employee who was married to the Employee at the time of the Compensable Injury and at the time of the death of the Employee which was the direct result of a Compensable Injury.

(U) **"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.

(V) **"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.

(W) **"Written Decision"** means any of the following, when reduced to writing and sent to an Employee or Claimant:

(1) 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

(2) Determination(s) of entitlement by the Administrator of any available workers' compensation benefit; or

(3) Decision(s) made by the Administrator to close the claim.

Section 401. Reporting Obligations

(A) An Employee must report any injury, illness, or condition that is actually or is thought to be potentially related to employment, no matter how slight, to his or her supervisor and the Human Resources Department immediately, but in no event more than 24 hours after the date of the incident or the date which the Employee either knew, or in the exercise of reasonable diligence, should have known that the injury, illness, or condition was related to his or her employment. A failure to adhere to this requirement could subject the Employee to disciplinary action or may affect the compensability of his or her claim.

(B) If an Employee is incapacitated, another person may report the injury on the Employee's behalf as soon as practicable. In no event will a claim for benefits be accepted if filed or submitted after the expiration of the statute of limitations set forth in Section 402 below.

(C) Once the injury, illness, or condition is reported to the supervisor, the requisite claim forms must be completed by the Employee. These claim forms may include, but are not limited to:

(1) A signed statement from the Employee describing how the incident occurred and the specific body parts affected or illness or condition claimed;

(2) A post-accident investigation report (completed with supervisor);

(3) A medical authorization release and a list of past treating physicians (as requested by the Administrator);

(4) An occupational injury questionnaire (as requested by the Administrator); and

(5) Other documents (as requested by the Administrator).

(D) A supervisor receiving a report or notice of an actual or potential work-related injury, illness or condition from the Employee, or on his or her behalf, must promptly report the claim to the Human Resources Department within twenty-four (24) hours of receipt. A failure of the supervisor to report an injury shall toll the statute of limitations when the Employee can verify to the Human Resources Department that the Employee properly reported the injury.

(E) An Employee must cooperate in requests for post-injury or post-accident drug screens in accordance with the Nation's applicable drug-testing policy in order to qualify as a Claimant eligible to receive workers' compensation benefits.

Section 402. Statute of Limitations

(A) **Filing a Claim:** No claim for workers' compensation benefits will be accepted if the claim is not reported pursuant to Section 401 above within thirty (30) days of the incident or the date which the Employee either knew, or in the exercise of reasonable diligence, should have known that the injury, illness, or condition giving rise to the alleged Compensable Injury was related to his or her employment. If the specific date of the incident cannot be determined, or in the case of cumulative injury or trauma, no claim for workers' compensation benefits will be accepted if the claim 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, illness, or condition was related to his or her employment.

(B) **Appealing a Decision:** Should 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 issuance of a final Written Decision, in a manner and form consistent with the requirements set forth in Section 901 below. A failure to submit an appeal within this timeframe will render the decision of the Administrator final and binding, with no further rights to appeal.

(C) **Reopening a Claim:** Once a claim has been closed pursuant to Section 801 below, 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 Nation of any and all further liability associated with that claim, including any Medicare liens.

Section 501. Claims Administrator Duties

(A) The Administrator shall act on behalf of the Nation in receiving, processing, and administering workers' compensation claims, including payment of benefits under this Code. The Administrator's responsibilities include, but are not limited to the following:

(1) Determining the compensability of claims pursuant to Section 601 below;

(2) Making payments to Claimants pursuant to Section 701 below;

(3) Processing and paying bills and reports submitted by medical providers and other vendors;

(4) Making reports to the Human Resources Department regarding the workers' compensation program and individual claims where required or requested;

(5) Providing a mechanism for reporting claims on-line;

(6) Participating in file reviews at the request of or at intervals established by the Nation;

(7) Ensuring compliance with Medicare reporting where required; and

(8) Managing a trust account for the purpose of dispensing the Nation's workers' compensation liabilities in the event the Nation is partially or fully self-funded; and

(9) Making reports to the excess insurance carrier regarding its program and individual claims where required in the event the Nation is partially self-funded.

(B) The responsibility of the Administrator to make determinations and decisions on behalf of the Nation shall also entail the following duties:

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

(2) Administering and sending to the Employee and/or Claimant a Written Decision as to whether to accept, deny, or further investigate a claim within fourteen (14) days from the date the claim was filed. Where the 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. Where the claim is denied, the Administrator shall include the specific basis for the claim denial and how to initiate the dispute resolution process in Section 901 below. Should the Administrator determine, within the specified period, that further investigation is required, a detailed plan of action regarding the purpose of the investigation and what is sought to be discovered should be established, 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.

(3) The Nation through its Administrator shall retain full medical control over workers' compensation claims for their duration. The Administrator shall determine the reasonableness and necessity of medical care and charges and shall determine amounts payable under this Code. 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.

(4) The Administrator shall determine the eligibility and compensation rate payable for Temporary Partial Disability, Temporary Total Disability, Permanent Partial Impairment, Permanent Total Impairment, Vocational Rehabilitation, and/or Death Benefits. In the case of Death Benefits, the Administrator shall determine the eligibility of Dependents and the terms of any benefits payable. 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.

(5) The Administrator shall, on behalf of the Nation, vigorously pursue any cause of action for, or vigorously defend any cause of action or claim against, the Nation under this Code.

(C) 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.

Section 601. Compensability; Exclusions

(A) In order for an Employee or a Claimant to receive any benefits for workers' compensation under this Code, the Employee or Claimant must demonstrate by a preponderance of evidence that he or she sustained a Compensable Injury.

(B) A claim for workers' compensation benefits must be initiated by filing a claim pursuant to Section 401 and Section 402 above.

(C) A Compensable Injury must both Arise out of Employment and occur within the Course of Employment.

(D) A claim for workers' compensation benefits will not be accepted, nor will payment of any workers' compensation benefits be made or continued, nor will any incident be considered or qualify as a Compensable Injury upon the finding or discovery of the following:

(1) Where the Employee fails to adhere to the reporting requirements or reporting statute of limitations as established under Section 401 or Section 402 of this Code;

(2) Where Intoxication was the Proximate Cause of the injury, illness, condition, or death;

(3) Where the injury, illness, condition, or death 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, illness, condition, or death.

(4) Suicide;

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

(6) Where the injury, illness, condition, or death is caused by or during the commission of a criminal act by the injured Employee;

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

(8) Where the claim is filed after notice of termination or layoff, and it is determined by the Administrator that the filing of the claim was retaliatory in nature;

(9) Where the injury, illness, condition, or death is deemed to be Idiopathic in nature;

(10) Where the injury, illness, condition, or death results from participation in an activity deemed to have been horseplay;

(11) Where at the time of injury, illness, condition, or death, 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 Nation if it were discovered, and the injury, illness, condition, or death is caused by such a refusal or failure to wear or use that personal protective equipment or other safety apparatus;

(12) Where the injury, illness, condition, or death qualifies as a Psychiatric Injury, or any other purely emotional or mental injuries, except:

(a) Where such injury, illness, condition, or death is the direct result of a sudden and extraordinary employment event; or

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

(13) Where the injury, illness, condition, or death results from or is attributable to second-hand smoke, which is considered an inherent risk of employment, which an Employee assumes by accepting a position with the Nation;

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

(15) 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;

(16) 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 Nation, 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; or

(17) Where the injury, illness, condition, or death 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.

Section 701. Workers' Compensation Benefits

(A) **Medical Benefits**:

(1) 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.

(2) The Administrator, on behalf of the Nation, shall retain medical control for the life of the claim, subject to the following:

(a) Life-threatening, Serious, or Severe Injury: Where an Employee has sustained a serious or severe injury which requires immediate emergency medical attention, the Employee should go to the nearest emergency room or urgent care facility. All subsequent treatment is subject to the medical control of Nation through its Administrator.

(b) Minor Injury: Where an Employee has sustained a minor injury, the Employee should be directed to go to a health care provider designated by the Human Resources Department. The designated health care provider shall determine the Employee's initial treatment. If an Employee elects not go the designated health care provider, the Nation shall not be financially responsible for any further medical treatment, or any treatment performed by any other health care provider.

(3) Where deemed appropriate by an authorized and approved medical provider, when a condition reaches Maximum Medical Improvement (MMI), and future and/or supportive medical benefits are necessary, such benefits shall be provided for the duration provided for in the report, subject to the requirements set forth in Section 402 and Section 801 of this Code.

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

(5) Neither the Nation nor the Administrator shall be responsible for any bill or amount in excess of what is allowable under the Arizona fee schedule used by the Industrial Commission of Arizona for comparable bills.

(B) **Temporary Disability Benefits**:

(1) The Nation applies 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.

(2) 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 a rate of sixty-six and two-thirds percent (66 2/3%) of the difference between actual weekly wage during the period of modified and/or light duty and the pre-injury average weekly wage, subject to the maximum rates generally recognized by the State of Arizona at the time of injury.

(3) In instances where light duty or modified duty cannot be accommodated by the Nation, or where a Claimant is deemed temporarily totally disabled (TTD) by an

authorized and approved physician, the Claimant will be entitled to Temporary Total Disability benefits at a rate of sixty-six and two-thirds percent (66 2/3%) of the pre-injury average weekly wage, subject to the maximum rates generally recognized by the State of Arizona at the time of injury. Temporary Total Disability benefits shall not be paid during the first seven (7) days of lost earnings unless a Claimant is hospitalized, or is eligible for Temporary Total Disability benefits for fourteen (14) days or more. The maximum duration that Temporary Total Disability benefits will be paid by the Nation or its Administrator is one-hundred four (104) weeks.

(a) If the covered Employee misses more than fourteen (14) days, the first seven (7) days of lost earnings can be considered for benefits if the covered Employee received no other compensation during this time including but not limited to, sick time, vacation time, and personal time off (PTO).

(b) In no event may the Employee's disability benefits, or other income sources supplementing the loss income exceed 100% of the worker's pre-injury average weekly wage.

(4) Enhanced temporary disability benefits are available for police officers and firefighters who are injured in the line of duty as follows:

(a) The police office or firefighter is injured as the result of any of the following:

i. An attack by an offender or arrestee, or animal;

ii. A duty-related accident involving any modes of transportation authorized by the Nation for performance of the police officer or firefighter's duties;

iii. Attempting to affect an arrest, detention or control of a suspect or alleged offender;

iv. Actively responding to or fighting a fire; or

v. Actively providing first-responder, paramedic-level or equivalent assistance to a victim in an accident or incident.

(b) The Temporary Partial Disability benefit described in Section 701(B)(2) is at the rate of one hundred percent (100%) of the difference between the actual weekly wage during the period of modified and/or light duty and the pre-injury average weekly wage and is not subject to the maximum rates generally recognized by the State of Arizona at the time of injury.

(c) The Temporary Total Disability benefit described in Section 701(B)(3) is at the rate of one hundred percent (100%) of the pre-injury average weekly wage and

is not subject to the maximum rates generally recognized by the State of Arizona at the time of injury.

(d) All other provisions of this Section 701(B) apply to the temporary disability benefits for police officers and firefighters who are injured in the line of duty except as specifically provided above in subsections (4)(b) and (4)(c).

(5) No temporary disability benefits, whether Temporary Partial Disability or Temporary Total Disability shall be paid under circumstances where:

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

(b) The Claimant does not have authorization from the medical provider assigned or designated by the Administrator to be off work;

(c) The Claimant is terminated for misconduct, or quits work, or declines a bona fide offer of light or modified duties by the Nation where such a bona fide offer is for work within the physical limitations prescribed by the authorized or approved physician; or

(d) The Claimant receives wages during a period where the Claimant was opined to have been temporarily totally disabled (TTD).

(6) 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 resulting amount by fifty-two (52). 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 weeks 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**:

(1) Permanent Partial Impairment disability benefits will be paid to a Claimant (including police officers and firefighters injured in the line of duty or otherwise) pursuant to the schedule of benefits under Appendix A of this Code, attached hereto.

(2) Permanent Total Impairment disability benefits will be paid to a Claimant (including police officers and firefighters injured in the line of duty or otherwise) at seventy-five percent (75%) of the pre-injury average weekly wage, subject to the maximum rates generally recognized by the State of Arizona at the time of injury,

for 500 weeks, but shall not inure to any Dependent upon death of the injured Claimant.

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

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

(D) **Vocational Rehabilitation**: Vocational rehabilitation benefits or training are not mandatory under this Code, but may, at the discretion of the Administrator, be ordered pursuant to its authority herein. Claimants who fail or refuse to avail themselves of vocational rehabilitation training may have their disability benefits reduced or terminated.

(E) **Death Benefits**:

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

(2) Death Benefits will be paid at levels generally comparable to those provided to similar dependents under Arizona state law.

(3) 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.

Section 801. Claim Closure

(A) A Claimant's claim for workers' compensation benefits shall be closed when any of the following circumstances occur:

(1) 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;

(2) The Administrator has extended all workers' compensation benefits due under this Code to any Claimant or Dependents;

(3) The Claimant or Dependents fails to appeal a Written Decision within the time-frame prescribed in Section 901 below;

(4) 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;

(5) The Claimant has reached MMI and where all other benefits have been exhausted and/or otherwise paid;

(6) Upon the discovery of any issues impacting compensability or continuing benefits as more fully described in Section 601 above;

(7) Pursuant to a final determination of an arbitrator under Section 903 below;

(8) Any other reason set forth in this Code as determined by the Administrator.

(B) Nothing in this Code shall impair the rights of the parties to compromise any liability that is claimed to exist under this Code on account of injury, illness, condition, or death, subject to the provisions herein. No compromise and release settlement shall be paid without a general release signed by both parties.

Section 901. Dispute Resolution

(A) **Administrator's Written Decision**: When a final Written Decision has been made on a claim by the Administrator, the Written Decision shall include the following:

(1) A statement informing the Claimant that it is a final Written Decision;

(2) A statement informing the Claimant of his or her right to a managerial review;

(3) A statement explaining where a managerial review request should be sent; and

(4) A statement explaining that a managerial review request must be received by the Administrator within thirty (30) days of issuance of a final Written Decision.

(B) **First Level of Appeal - Administrator Managerial Review**:

(1) A managerial review request must be made in writing within thirty (30) days of the Administrator's issuance of the final Written Decision.

(2) The managerial review request must state in detail the basis for any disagreement with the Administrator's Written Decision.

(3) Requests for managerial review shall be made directly to the Administrator.

(4) Upon receipt of a timely request for managerial review, the managerial reviewer shall issue a final managerial determination in writing via certified mail within a reasonable time, not to exceed sixty (60) days except as provided in Section 901(B)(5) below.

(5) Where a request for managerial review is based on a dispute surrounding medical evidence, an Independent Medical Examination shall be allowed, provided that a failure by the Claimant to submit for such an examination will render the Administrator's Written Decision final and binding. In the case where an Independent Medical Examination takes place as part of the managerial review, the managerial reviewer shall issue a final managerial determination in writing via certified mail within sixty (60) days of the completion of the Independent Medical Examination.

(6) The final managerial determination shall state whether the Written Decision being appealed is upheld, amended, or overturned and the basis for the same.

(7) The final managerial determination must include the following:

(a) A statement informing the Claimant that it is a final written managerial determination;

(b) A statement informing the Claimant of his or her right to request arbitration;

(c) A statement explaining where an arbitration request should be sent; and

(d) A statement explaining that an arbitration request must be received by the Administrator within thirty (30) days of receipt of a final written managerial determination.

(C) **Final Level of Appeal – Arbitration**:

(1) A Claimant who disagrees with a final written determination made by the managerial reviewer may file a written request for arbitration within thirty (30) days of receiving a final managerial determination.

(2) A Claimant may also file a written request for arbitration:

(a) To address the Administrator's failure to issue a Written Decision if, through no fault of the Claimant, the Administrator does not issue a Written Decision within fourteen (14) days from the date the claim was filed; or, in cases where the Administrator has determined further investigation is required, within ninety (90) days from the date the claim was filed; or

(b) To appeal the Administrator's Written Decision directly to the arbitrator if, through no fault of the Claimant, the managerial reviewer does not issue a final

managerial determination within sixty (60) days of receipt of a timely request for managerial review; or, in cases where an Independent Medical Examination is allowed, within sixty (60) days of the completion of the Independent Medical Examination.

Any request for arbitration made pursuant to Subsection (C)(2)(a) or (b) of this Section must be filed within thirty (30) days of the relevant lapsed deadline with the Nation's Human Resources Department by certified mail or via personal delivery at 2400 W. Datsi Street, Camp Verde, AZ 86322.

(3) Failure by a Claimant to file a written request for arbitration within the timeframe specified in Subsection (C)(1) or (2) of this Section renders the previous decision by the Administrator or the managerial reviewer final.

(4) A Claimant who files a written request for arbitration must include the following in his or her written request:

(a) The name, address and phone number of the Claimant;

(b) A brief summary of the relevant facts;

(c) A brief statement of the disputed issue; and

(d) A brief statement of the relief sought.

(5) A hearing before the arbitrator shall be held within ninety (90) days of receipt of a written request for arbitration. The Claimant may request, in writing, one extension of the hearing date for up to an additional sixty (60) days, which shall be granted by the arbitrator.

Section 902. Appointment of Arbitrator

(A) When a timely written request for arbitration is made pursuant to Section 901 of this Code, an arbitrator shall be appointed by the Nation to review and make a final determination on the claim.

(B) The arbitrator shall be a licensed attorney who has either previous judicial experience or previous experience in the area of workers' compensation.

(C) The arbitrator shall serve in an objective and independent manner.

Section 903. Arbitration Process

(A) **Notice of Hearing**: The arbitrator shall send written notice to each party informing them of the heard date at least thirty (30) days prior to the hearing.

(B) **Discovery**:

(1) All medical reports relating to the claimed injury, illness, condition or death must be filed with the arbitrator and served by U.S. first class mail or hand delivery on all parties at least fifteen (15) days prior to the hearing date, if the reports have not been previously disclosed.

(2) Either party may request, in writing, disclosure of statements from witnesses, if any such statements exist, at least fifteen (15) days prior to the hearing date.

(3) Upon written request by a party, depositions may be ordered by the arbitrator, the cost of which shall be borne by the parting requesting the deposition.

(C) **Conduct of Hearing**: The arbitrator shall regulate all aspects of the hearing including, but not limited to the administering of oaths and affirmations, considering evidence, hearing witnesses and receiving exhibits with the goal of ensuring an equitable, orderly, and expeditious review.

(D) **Standard of Proof; Burden of Proof**:

(1) The arbitrator shall make his or her determination based on the preponderance of the evidence.
(2) The burden of proof shall be on the Claimant.

(E) **Right to Counsel**: The parties may have legal representation during the appeals process and at any hearing before the arbitrator. The parties shall each bear the fees and costs associated with their own legal representation.

(F) **Applicable Law**: Any claim brought under this Code shall be determined in accordance with this Code and the applicable laws of the Nation. The Arizona state workers' compensation laws, including applicable common law authority and regulations, may be used as a nonbinding source of guidance to the extent it is not inconsistent with this Code or the applicable laws of the Nation. Any use of Arizona statutory law for guidance shall be liberally construed in favor of the employer.

(G) **Final Determination**:

(1) Within thirty (30) days of the hearing, the arbitrator shall issue a written determination on the matter with copies of the determination mailed to the parties.

(2) The determination shall generally review the evidence and testimony and may compare the merits of the evidence or testimony of the parties. The determination shall state the final determination of the arbitrator on all issues before him or her.

(3) The liability of the Nation is limited as provided in Section 202 of this Code and the arbitrator shall not have authority to issue any award for attorneys' fees, costs, or punitive damages against the Nation.

(4) The final determination of the arbitrator is final and there shall be no right to judicial review.

Section 1001. Subrogation/Apportionment/Recovery

(A) Without affecting the Nation's ability to invoke the defense of sovereign immunity for any claims brought against it, the Nation, or the Administrator on its behalf, reserves its right to file a subrogation lien in any action or to enter as a plaintiff to pursue any recovery to which the Nation may be entitled.

(B) 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 (1) 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.

(C) Whenever the Administrator has been fraudulently induced to make any benefit payment under this Code, 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.

(D) 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.

Section 1101. Confidentiality

(A) The information in the claims files and records of Employees or Claimants obtained pursuant to the filing of a claim or any provisions of this Code shall be deemed the exclusive property of the Nation, shall be treated as strictly confidential, and shall not be open to public inspection.

(B) A Claimant, or his or her authorized representative upon the presentation of the signed authorization of the Claimant, may review the Claimant's medical file or receive copies of specific information therefrom.

(C) In the event of an arbitration hearing pursuant to Section 903 above, 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 the arbitration hearing.

(D) The Nation, or its duly authorized representatives, may review any files of their own injured Employees in connection with any pending claims.

(E) Physicians treating or examining or giving medical advice to or providing an opinion about Employees claiming benefits under this Code 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 Administrator at any stage of the proceedings on any matter pertaining to administration of this Code.

(F) Notwithstanding the provisions herein, the Administrator and/or the Nation shall have the right to request full and complete medical records or reports from any of Claimant'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 Nation 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 the Nation, the Administrator or the Nation may suspend any applicable workers' compensation benefits, or can deny the claim on the basis of impeding the right to discovery under Section 601 (D)(14) of this Code.

Section 1201. Medicare Set Asides

The Medicare/Medicaid SCHIP Extension Act (MMSEA) sets forth reporting requirements for insurers where criteria established pursuant to the MMSEA have been met. The Nation recognizes those requirements (*see, e.g. Section 7.1 of the NGHP User Guide*), and nothing herein shall prevent the Administrator from protecting Medicare's interests where required to do so by the MMSEA. Where a Claimant is entitled to supportive medical care after Maximum Medical Improvement is achieved pursuant to Section 701(B)(1)(c) of this Code, 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 Nation, its insurer, nor the Administrator shall have any further obligation to pay benefits under this Code, inclusive of any subsequent Medicare liens.

Section 1301. Effective Date

This Code shall be deemed to have taken effect as of October 8, 2020, and shall supersede all prior workers' compensation codes, acts, resolutions, or policies and procedures of the Nation.

Section 1401. Severability

If any part of this Code is held to be invalid, the remainder shall continue to be in full force and effect to the maximum extent possible.

Appendix A – Schedule of Permanent Partial Impairment

(A) Permanent partial disability shall be paid pursuant to the schedule hereunder. Payment of any permanent disability benefits shall be contingent upon the finding of ratable impairment by a physician or Independent Medical Examiner authorized by the Administrator pursuant to Section 701 of this Code.

(1) Upper Extremities:
- (a) Shoulder: 200 Weeks
- (b) Major Arm: 200 Weeks
- (c) Minor Arm: 160 Weeks
- (d) Major Elbow: 160 Weeks
- (e) Minor Elbow: 140 Weeks
- (f) Major Forearm/Wrist: 200 Weeks
- (g) Minor Forearm/Wrist: 160 Weeks
- (h) Major Hand: 200 Weeks
- (i) Minor Hand: 160 Weeks
- (j) Thumb: 60 Weeks
- (k) Index Finger: 36 Weeks
- (l) Middle Finger: 30 Weeks
- (m) Ring Finger: 25 Weeks
- (n) Fourth (Pinky) Finger: 20 Weeks
- (o) Multiple Fingers: 50 Weeks

(2) Lower Extremities:
- (a) Upper Leg (Including Thigh, Quadriceps, Hamstrings): 200 Weeks
- (b) Knee: 200 Weeks
- (c) Lower Leg (Including Calf, Fibula, Tibia, etc.): 200 Weeks
- (d) Ankle: 160 Weeks
- (e) Foot (Including Calcaneus or Achilles Tendon): 160 Weeks
- (f) Big Toe: 36 Weeks
- (g) Other Than Big Toe: 25 Weeks
- (h) Multiple Toes: 30 Weeks

(3) Back/Neck/Head:
- (a) Head/Skull/Brain (Excluding Psyche): 300 Weeks
- (b) Cervical Spine (Including Neck): 400 Weeks
- (c) Thoracic Spine (Including Trapezius): 400 Weeks
- (d) Lumbar Spine (Including Lumbosacral): 400 Weeks
- (e) Sacroiliac: 400 Weeks
- (f) Coccyx: 400 Weeks
- (g) Hip: 300 Weeks

(4) Loss of Senses:

(a) Loss of Sight, One Eye (w/ enucleation): 125 Weeks
(b) Loss of Sight, One Eye (w/o enucleation): 100 Weeks
(c) Loss of Sight, Both Eyes: 400 Weeks
(d) Loss of Hearing, One Ear: 100 Weeks
(e) Loss of Hearing, Both Ears: 400 Weeks
(f) Loss of Smell: 60 Weeks
(g) Loss of Taste: 50 Weeks
(h) Loss of Speech: 100 Weeks

(5) Mental/Psyche/Disfigurement:
(a) Visible Scarring/Visible Disfigurement (Including Teeth): 10 Weeks
(b) Mental or Psychological Impairment: 200 Weeks

(B) Permanent partial disability shall be calculated by multiplying the impairment percentage or rating opined by the authorized physician or Independent Medical Examiner at the time such physician has determined that Maximum Medical Improvement has been achieved by the number of weeks assigned for the applicable body part above, and multiplying that number by the Claimant's pre-injury average weekly wage, subject to the maximum rates generally recognized by the State of Arizona at the time of injury. The resulting amount will then be multiplied by fifty-five percent (55%) where the Claimant is able to return to his or her usual and customary occupational duties or pre-injury job, or a permanent modified or alternate position, or by seventy-five percent (75%) where the Claimant is unable to return to work by reason of inability of the employer to accommodate work restrictions or otherwise facilitate a return-to-work status.

(C) Where a Claimant, at the time Maximum Medical Improvement has been achieved as opined by the authorized physician or Independent Medical Examiner, has sustained ratable Permanent Partial Impairment to multiple body parts, the following shall apply:

(1) Where multiple body parts fall within the same category of impairment above, (e.g. upper extremity), the number of weeks shall be one and one-half (1 ½) times the highest number of weeks available in the category, subject to a maximum of 500 weeks.

(2) Where multiple body parts fall within different categories of impairment above (e.g. upper extremity and lower extremity), the body parts will be rated separately, and the Claimant paid the combined total thereof, subject to a maximum of 500 weeks.

(D) Nothing herein shall extend or be interpreted to alter the maximum amount of compensation allowable as set forth under this Code.