PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

BILLINGS PUBLIC SCHOOLS EMPLOYEE HEALTH PLAN

RESTATED: JULY 1, 2022

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INTRODUCTION

This document is a description of **Billings Public Schools Employee Health Plan** (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

The District fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time or for any reason, in compliance with the following provisions:

- The District shall have the right to amend this Plan in whole or in part. Amendments shall be by a resolution of the Board of Directors or other similar governing body of the District by the written approval of an authorized officer of the District.

- The District reserves the right at any time to terminate the Plan by a written resolution of the Board of Directors or other similar governing body of the District or by the written approval of an authorized officer of the District.

No assignment of the insured's interest hereunder shall be binding on the District. The terms of this Plan shall not be waived or changed except as provided above.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility, and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

A Plan Participant may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties, or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to an assignment of a Plan Participant's rights to the Plan or the Plan Administrator, or (2) to the extent required under Medicaid laws.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within two years of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

The Claims Administrator utilizes Aetna's Clinical Policy Bulletins (CPBs) to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The CPBs are based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals, and guidelines from nationally recognized health care organizations. These CPBs are reviewed on a regular basis based upon a review of currently available clinical information.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Charges incurred before termination, amendment, or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan, and when the coverage takes effect and terminates.

Medical Benefits. Explains when the benefit applies and the types of charges covered.

Care Management Services. Explains the methods used to curb unnecessary and excessive charges.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

How to Submit a Claim. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a Plan Participant is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person because of Injuries sustained.

COBRA Continuation Coverage. Explains when a Plan Participant's coverage under the Plan ceases and the continuation options which are available.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Section are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are reasonable and customary (as defined as an Allowable Charge); and services, supplies, and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all Covered Charges and/or exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments, or procedures.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services, and/or supplies. *A benefit determination on a claim will be made only after the claim has been submitted. A pre-notification of services is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures section.*

PROVIDER INFORMATION

This Plan has entered into an agreement with certain Hospitals, Physicians, and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Plan Participant uses a Network Provider, that Plan Participant will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Plan Participant's choice as to which provider to use.

To access a list of Network Providers, please refer to the Network Provider website and/or toll free number listed on the **Billings Public Schools Employee Health Plan identification card**. Prior to receiving medical care services, the Plan Participant should confirm with the provider that the provider is a participant in this network.

The Plan Participant may be balance billed by the Non-Network Provider for any amount over the Allowable Charge.

NO SURPRISES ACT (NSA)

For Non-Network Provider charges subject to the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), the Plan Participant cost-sharing will be calculated as if the Allowable Charge was the Recognized Amount. The NSA prohibits Non-Network Providers from pursuing payment from the Plan Participant for the difference between the Allowable Charge and the Non-Network Provider's billed charge for services, except for any applicable cost-sharing.

Non-Network Provider charges subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Network Facility:
  - Provided the Plan Participant has not provided Notice and Consent (as explained below) to waive the applicability of the NSA;
  - Including the furnishing of equipment/devices, labs, imaging, telehealth, pre-operative, and post-operative services regardless of being physically located at the Network Facility; and
- Covered Charges for air ambulance services.

Benefit determinations for Non-Network Provider claims subject to the NSA will be made within 30 days of the Claims Administrator's receipt of the claim and if applicable reimbursement will be submitted directly to the Non-Network Provider.

Notice and Consent. Exceptions to the NSA balance billing protections may apply when the Plan Participant receives non-emergency services (other than ancillary services) from a Non-Network Provider and gives written consent to receive those services as Non-Network Provider benefits. Ancillary services include anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and items and services related to emergency medicine.

CONTINUING CARE PROVISION

In accordance with the Consolidated Appropriations Act of 2021, when a Plan Participant is a receiving treatment from a Network Provider, and that provider's relationship with the Plan is terminated, not renewed, or otherwise ends for any reason (other than the provider's failure to meet applicable quality standards or for fraud), the Plan Participant has rights to elect Continuing Care from the former Network Provider.

The Plan shall notify the Plan Participant in a timely manner that the Network Provider's contractual relationship with the Plan has terminated. If the Plan Participant **elects in writing** to receive Continuing Care, benefits will apply under the same terms and conditions as would have applied had the termination not occurred. This Continuing Care Provision becomes available as of the date of the letter received by the Plan Participant that the former Network Provider is no longer associated with the Plan. The Continuing Care Provision will cease 90 days after that date or when the Plan Participant ceases to receive Continuing Care, whichever occurs first.

Under the Continuing Care Provision, the former Network Provider or former Network Facility must: (i) accept reimbursement from the Plan and any applicable cost sharing from the Plan Participant as payment in full; and (ii) continue to adhere to all policies, procedures, and standards of care imposed by the Plan in the same manner as if the Network Provider termination had not occurred.

For purposes of this provision, a "Continuing Care" Plan Participant is:

(1) undergoing a course of treatment for a serious and complex condition from a specific Network Provider;

(2) undergoing a course of institutional or inpatient care from a specific Network Provider;

(3) scheduled to undergo non-elective surgery from a specific Network Provider, including postoperative care;

(4) pregnant and undergoing a course of treatment for the Pregnancy from a specific Network Provider; or

(5) terminally ill and receiving treatment for such Illness from a specific Network Provider.

DEDUCTIBLES/COPAYMENTS/COINSURANCE PAYABLE BY PLAN PARTICIPANTS

Deductibles/Copayments are dollar amounts that the Plan Participant must pay before the Plan pays.

A **deductible** is an amount of money that is paid once a Plan Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges (except for Covered Charges that are not subject to the deductible).

Each **July 1st**, a new deductible amount is required. The deductible *will apply* to the maximum out-of-pocket amount. *However, Covered Charges incurred in and applied toward the deductible in the last three months of the Plan Year (April, May, and June) will be applied to the deductible in the next Plan Year as well as the current Plan Year.*

Family Unit Deductible. When the maximum amount shown in the Medical Benefits – Schedule of Benefits has been incurred by members of a Family Unit toward their Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that Plan Year.

Deductible For a Common Accident. This provision applies when two or more Plan Participants in a Family Unit are injured in the same accident.

These Plan Participants need not meet separate deductibles for treatment of Injuries incurred in this accident; instead, only one deductible for the Plan Year in which the accident occurred will be required for them as a unit for expenses arising from this accident. **Note:** This combined deductible will also apply to all future reapplications of the deductible resulting from this same accident.

A **copayment** is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Copayments, including Prescription Drug copayments, *do not apply* toward the deductible.

Copayments, including Prescription Drug copayments, *will apply* to the maximum out-of-pocket amount.

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Medical Benefits – Schedule of Benefits and is the Plan Participant's responsibility until the maximum out-of-pocket amount is reached. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts. Coinsurance *will apply* to the maximum out-of-pocket amount.

Benefit payment made by the Plan will be at the percentage rate shown in the Medical Benefits – Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

Once the Plan has made the applicable benefit payment, the remaining percentage owed is the Plan Participant's "coinsurance" responsibility. For example, if the Plan's reimbursement rate is 70%, the Plan Participant's responsibility (or coinsurance) is 30%.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable by the Plan at the percentages shown each Plan Year until the maximum out-of-pocket amount shown in the Medical Benefits – Schedule of Benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Plan Year.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Plan Year.

NOTE: ALL BENEFITS WILL BE PAYABLE ON A PLAN YEAR BASIS.
THE PLAN YEAR IS THE 12-MONTH PERIOD BEGINNING JULY 1ST AND ENDING JUNE 30TH.

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

Sutter Health System Network Providers will be given additional consideration if this Plan is secondary. In this case, the Claims Administrator will also consider a claim received from a Sutter Health System Network Provider within one year from the date of issuance of the primary Explanation of Benefits. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

MEDICAL BENEFITS – SCHEDULE OF BENEFITS

Deductibles, per Plan Year

Per Plan Participant	$1,000
Per Family Unit	$2,000

Maximum Out-of-Pocket Amount, per Plan Year

Per Plan Participant	$3,000
Per Family Unit	$6,000

The following charges do not apply to the 100% maximum out-of-pocket amount and are never aid at 100%:

(1) Amounts over the Allowable Charge;

(2) Discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers, or Pharmacies.

Hospital Room and Board --

Daily limit	the average semiprivate room rate
Reimbursement rate	70% after deductible and $300 copayment per inpatient admission

Intensive Care Unit --

Daily limit	Hospital's ICU Charge
Reimbursement rate	70% after deductible and $300 copayment per inpatient admission

Skilled Nursing Facility --

Daily limit	the Facility's average semiprivate room rate
Reimbursement rate	70% after deductible and $300 copayment per inpatient admission
Maximum number of days payable	120 days maximum per Plan Year

Outpatient Hospital Services / Outpatient Surgical Center --

Reimbursement rate	70% after deductible

Outpatient Surgical Services --

Reimbursement rate	100% after deductible

Note: Refer to the Outpatient Surgical Services benefit listed in the COVERED CHARGES section for more information regarding this benefit.

Second Surgical Opinion --

Reimbursement rate.......... 80% after deductible

Emergency Room Visits (through a Hospital emergency room) **--**

Reimbursement rate.......... 70% after deductible

Physician Services --

Inpatient visits:

Reimbursement rate .... 70% after deductible

Primary Care Physician (PCP) Office visits:

Reimbursement rate .... $25 copayment per visit, no deductible applies

"Primary Care Physician (PCP)" shall mean a general practitioner, family practitioner, general internist, obstetrician/gynecologist, pediatrician, dermatologist, immediate care or urgent care center PCP, Nurse Practitioner (N.P.), Physician Assistant (P.A.), Mental Disorder provider, and Substance Abuse provider.

Primary Care Physician services will only apply to the following established CPT codes (with those qualified Primary Care Physicians as listed above):

New Patient:	Established Patient:
99201 L1	99211 L1
99202 L2	99212 L2
99203 L3	99213 L3
99204 L4	99214 L4
99205 L5	99215 L5

Note: The Primary Care Physician office visit copayment will apply to the PCP's office visit. All other charges rendered during the office visit, including laboratory services, x-rays, and other diagnostic treatment, will be payable per normal Plan provisions (i.e., subject to applicable deductible and coinsurance).

Specialist Office visits:

Reimbursement rate .... 70% after deductible

Allergy Testing, Injections and Serum:

Reimbursement rate .... 70% after deductible

Surgery (not otherwise payable under the separate Outpatient Surgical Services benefit under this Plan):

Reimbursement rate .... 70% after deductible

Ambulance Service --

Reimbursement rate.......... 70% after deductible

Chemotherapy and Radiation Treatment --

Reimbursement rate.......... 70% after deductible

Diagnostic Testing (X-ray & Lab) --

Reimbursement rate........ 70% after deductible

Employee Assistance Program through Billings Clinic Occupational Health and St. Vincent Occupational Health Services --

Reimbursement rate........ 100%, no deductible applies

Benefit maximum........ 20 visits maximum per Plan Year

Imaging Services (MRI, CT Scans, etc.) --

Reimbursement rate........ 70% after deductible

Durable Medical Equipment, Orthotics and Prosthetics --

Reimbursement rate........ 70% after deductible

Hearing Exams and Hearing Aids (birth through age 18) **--**

Reimbursement rate........ 70% after deductible

Benefit maximum........ 1 hearing aid per ear every 3 Plan Years

Home Health Care --

Reimbursement rate........ 70% after deductible

Benefit maximum........ 40 visits maximum per Plan Year

Home Infusion Therapy --

Reimbursement rate........ 70% after deductible

Hospice Care --

Inpatient services:

Reimbursement rate .... 70% after deductible and $300 copayment per inpatient admission

Outpatient services:

Reimbursement rate .... 70% after deductible

Mental Disorders Treatment --

Inpatient Services:

Reimbursement rate .... 70% after deductible and $300 copayment per inpatient admission

Outpatient Services:

Reimbursement rate .... 70% after deductible

Office Visits:

Reimbursement rate .... Refer to the Physician Office Visit benefit

Organ Transplant Coverage --

Reimbursement rate.......... Payable per normal Plan provisions

Note: Refer to the Organ Transplant benefit listed in the COVERED CHARGES section for more information regarding this benefit.

Pregnancy Benefits --

Reimbursement rate.......... 70% after deductible and $300 copayment per admission

Routine prenatal office visits .... 40% of Covered Charges of the global maternity fee will be payable at 100%, no deductible applies; thereafter, subject to 70% after deductible; ***OR***,

If billed separately, 100% of the routine prenatal office visits will be payable at 100%, no deductible applies

Note: Refer to the Coverage of Pregnancy benefit listed in the COVERED CHARGES section for more information regarding routine prenatal office visits.

Maternity Bonus - $100 bonus shall be paid to a female Plan Participant when the length of the Hospital stay is three days or less when the services of a Hospital or a Birthing Center are utilized for delivery.

Routine Well Newborn Nursery (while Hospital confined at birth) **--**

Reimbursement rate.......... 70% after deductible

Preventive Care Services --

Routine Well Care (birth through adult) --

Reimbursement rate .... 100%, no deductible applies

Routine Well Care Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF), *unless otherwise specifically stated in this Medical Benefits – Schedule of Benefits*, and which can be located using the following website:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results

Routine Well Care Services will include, but will not be limited to, the following routine services:
Office visits, routine physical exams, prostate screening, routine lab and x-ray services, all immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations.

Note: If applicable, this Plan may comply with a state vaccine assessment program.

Women's Preventive Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Medical Benefits – Schedule of Benefits*, and which can be located using the following website:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; and
https://www.hrsa.gov/womens-guidelines

Women's Preventive Services, will include, but will not be limited to, the following routine services:
Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

Diabetic Education --

Reimbursement rate .... 100%, no deductible applies

Benefit Maximum .... 3 visits maximum per Plan Year

Nutritional Education Counseling --

Reimbursement rate .... 100%, no deductible applies

Benefit Maximum .... 3 visits maximum per Plan Year

Obesity Interventions (for Plan Participants age 18 years and older with a body mass index (BMI) or 30 kg/m2 or higher) **--**

Reimbursement rate .... 100%, no deductible applies

Benefit Maximum .... 26 visits maximum per Plan Year

Note: Refer to the Obesity Interventions benefit in the COVERED CHARGES section for more information on Obesity Interventions.

Tobacco / Nicotine Cessation Counseling --

Reimbursement rate .... 100%, no deductible applies

Benefit Maximum .... 3 visits maximum per Plan Year

Rehabilitation Services --

Inpatient Services:

Reimbursement rate .... 70% after deductible and $300 copayment per inpatient admission

Outpatient Services (Occupational, Physical and Speech Therapy):

Reimbursement rate .... 70% after deductible

Applied Behavioral Analysis:

Reimbursement rate .... 70% after deductible

Down Syndrome Therapies:

Reimbursement rate .... 70% after deductible

Renal Dialysis Services --

Reimbursement rate.. 70% after deductible

Note: Please see the COVERED CHARGES section for additional information regarding this benefit.

Spinal Manipulation/Chiropractic Services --

Reimbursement rate.. 70% after deductible

Benefit Maximum per visit $25

Benefit Maximum .... 20 visits maximum per Plan Year

Note: Diagnostic x-rays rendered in connection with Chiropractic Services will not be subject to the Plan Year Maximum or Benefit Maximum per visit as listed above.

Substance Abuse Treatment --

Inpatient and Outpatient Services:

Reimbursement rate .... 70%, no deductible applies

Office Visits:

Reimbursement rate .... Refer to the Physician Office Visit benefit

All Other Covered Charges --

Reimbursement rate.. 70% after deductible

RETAIL AND MAIL ORDER PHARMACY
PRESCRIPTION DRUG OPTION

COVERED CHARGES	PLAN PARTICIPANT PAYS		
	***mi*Rx Retail Pharmacy Up to a 30-day supply**	***mi*Rx Mail Order Up to a 90-day supply**	**All Other Pharmacies Up to a 90-day supply***
Generic drugs	$0, deductible waived	$0, deductible waived	30% after medical deductible
Brand Name drugs	30% after medical deductible	30% after medical deductible	30% after medical deductible

* Certain Prescription Drugs may be available at no cost to the Plan Participant. Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact Navitus Health Solutions toll-free at (866) 333-2757 for more information regarding which medications are available. **Note:** Age and/or quantity limitations may apply:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results

Prescription Drug Copayments. The Prescription Drug copayment is applied to each covered pharmacy drug or mail order drug charge as shown above.

Any one miRx Retail Pharmacy prescription is limited to a 30-day supply. Any one miRx Mail Order prescription is available up to a 90-day supply.

Note: The *mi*Rx Mail Order Pharmacy Prescription Drug Option is only available in certain states. Please contact the Claims Administrator toll free at (866) 894-1504 for more information regarding this benefit.

If applicable, this Plan will make a retroactive adjustment to a claim based on a discount, coupon, Pharmacy discount program, or similar arrangement provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.

DENTAL BENEFITS – SCHEDULE OF BENEFITS

Note: Participation in the Dental Benefits under this Plan may require a separate enrollment election. Please contact the Claims Administrator to confirm if a separate enrollment election is required.

Plan Year Dental Deductible:

per Plan Participant $50

per Family Unit.......... $100

The dental deductible applies to the following services:

Class B Services – Basic

Class C Services – Major Restorative

Class D Services – Orthodontia

Dental Percentage Payable

Class A Services – Preventive .... 100%, no deductible applies

Class B Services – Basic .... 80% after deductible

Class C Services – Major Restorative.......... 50% after deductible

Class D Services – Orthodontia .... 50% after deductible

Maximum Benefit Amounts

For Tooth Implants:

per Plan Participant .... $2,000 maximum per Lifetime

For Class A Services:

per Plan Participant .... No maximum

For Class B, C and D Services, Periodontal Services and Temporomandibular Joint Services:

per Plan Participant .... $2,000* maximum per Plan Year

* Class D – Orthodontia and Temporomandibular Joint Services will apply to both the Plan Year maximum and to the following Lifetime benefit maximums:

For Class D-Orthodontia:

per Plan Participant .... $2,000 maximum per Lifetime

For Temporomandibular Joint Services:

per Plan Participant .... $2,000 maximum per Lifetime

Additional information on Dental Care can be found in the Dental Benefits section of this document.

miCARE HEALTH CENTER BENEFITS

*mi*Care Health Center benefits apply when care, treatment, or service is provided by a contracted *mi*Care Health Center provider to a Plan Participant for services that are recommended and approved by a Physician, Nurse Practitioner, Physician Assistant, or Medical Assistants (RNs or LPNs) at the Employer's sponsored *mi*Care Health Center.

The Coordination of Benefits provisions ***will not*** *apply to services provided at miCare Health Center.*

***mi*Care Health Center Eligibility**

A person's eligibility for *mi*Care Health Center benefits (including enrollment, terminations, and COBRA Continuation Coverage rights) is subject to the terms and conditions as stated within the *Eligibility, Funding, Effective Date and Termination Provisions* of this Plan.

Benefit

Benefits for a Plan Participant will be as described in the following *mi*Care Health Center Benefits Schedule.

***mi*CARE HEALTH CENTER BENEFITS SCHEDULE**

Maximum Benefit Amount Per Plan Year	Unlimited
DEDUCTIBLE, PER PLAN YEAR	
Per Plan Participant	None
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR	
Per Plan Participant	None
COVERED CHARGES	**PLAN PARTICIPANT PAYS**
Routine Well Care	$0
Office Visits / Minor Office Visit Procedures	$0
Laboratory Services	$0
***WellVia* Telehealth Benefit**	$0
All Other Covered *mi*Care Clinic Services	$0

***WellVia* Telehealth Benefit**

The *WellVia* Telehealth benefit offers Plan Participants telephone access to experienced board-certified licensed Physicians as a convenient alternative to receive immediate health care for common medical issues. *WellVia* Telehealth Physicians are available 24 hours a day, including weekends and holidays, and are able to provide diagnoses, medical advice, and treatment recommendations, including prescription medications. Telehealth services not incurred through *WellVia* Telehealth will be a Covered Charge subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.

Covered Charges will be payable as stated in this *mi*Care Health Center Benefits Schedule.

To contact a *WellVia* Physician, call the *WellVia* Patient Care Center toll-free at (855) 935-5842 or access their webpage at www.WellViaSolutions.com for additional information.

***mi*CARE HEALTH CENTER GENERAL LIMITATIONS AND EXCLUSIONS**

The following services **are not** available at the *mi*Care Health Center:

(1) **Before covered.** Care, treatment, or supplies incurred before a person was covered under this Plan.

(2) **Chronic pain management services**, for pain that lasts beyond the term of an Injury or painful stimulus including, but not limited to, pain from a chronic or degenerative disease and pain from an unidentified cause.

(3) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(4) **Excluded under medical.** Services that are excluded under medical Plan Exclusions.

(5) **Immunizations and allergy injections** except for influenza, whooping cough, and tetanus.

(6) **Obstetrics**, to include all services typically provided during Pregnancy (prenatal period), childbirth, and the postnatal period.

(7) **Occupational Illness or Injury.** Services related to the management of work related Injuries or conditions, including an independent medical evaluation, a return to work status determination, or a determination of whether an Injury or condition relates to or arose from the individual's employment. This exclusion will not apply to the initial treatment for minor Injuries or occupational diseases that may have occurred or arisen in the workplace.

(8) **Radiology procedures.**

(9) **Services outside the scope of the license** for a family practice Physician, general practitioner, or mid-level provider, as determined by the laws of the state in which the services are provided.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees and Retired Employees, who qualify under one of the classes below.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

Note: If coverage classifications (as noted below) are designated in the Schedule of Benefits section, any change in the amount of coverage available to a Plan Participant occasioned by a change in the covered Employee's classification shall become effective automatically on the classification date.

(1) Is employed by the Employer on a contract or regular basis; and

(a) For all Billings Education Association bargaining unit members and Administrators;

(b) For the Billings Classified Employees Association working 17 to 20 hours per week in one position on a self-pay basis, and Employees working more than 20 hours per week in one or more positions;

(c) For the Billings Classified Employees Association temporary Employees working more than 20 hours per week and who have been employed for 90 consecutive days;

(d) For the Montana Public Employees Association Employees working 17 to 20 hours per week on a self-pay basis; and

(e) For all others more than 20 hours per week.

(2) Completes the employment Waiting Period as follows:

Note: A "Waiting Period", if applicable under this Plan, is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

- Billings Education Association bargaining unit members: Coverage shall become effective on the first contracted day of work;

- Administrators under contract with the District: Coverage shall become effective on his/her contract date with the District;

- All other eligible Employees: Coverage under the Plan shall become effective the first working day of the calendar month, coinciding with or next following the date of the status change, provided enrollment in this Plan is made on a timely basis, as defined in the section "Timely Enrollment".

In the event a covered Employee is moving from full-time to a part-time status or from a part-time to a full-time status, a covered Employee may make a change in coverage as a result of the change in status. The effective date of such coverage change shall become effective on the first working day of the calendar month coinciding with or next following the date of the status change, provided enrollment in this Plan is made on a timely basis, as defined in the section "Timely Enrollment".

(3) Retired Employees. Covered Employees retired with the District in accordance with the rules established by the Employer will be eligible under this Plan.

Note: Upon retirement, an Employee can choose between COBRA Continuation Coverage or continuing coverage under the terms of the Plan as a Retired Employee, if the Retired Employee satisfies the criteria as set forth with the rules established by the District.

In the event the Employee chooses to continue under the terms of the Plan as a Retired Employee, the Employee, and his or her Spouse and Dependent children who are active Plan Participants at the time of the Employee's retirement with the Employer, may remain eligible for coverage up to the limitations as stated under the Plan providing enrollment is made on a timely basis as defined in the section "Timely Enrollment" in the Enrollment section of this Plan, and will forfeit any right to elect COBRA Continuation Coverage at a later date.

If the Employee, and his or her Spouse and Dependent children who are active Plan Participants at the time of the Employee's retirement with the Employer, choose to continue coverage under COBRA Continuation Coverage, they will forfeit any right to continue coverage under this Plan under the terms of any Retiree coverage as stated under this Plan at a later date.

(4) Is in an eligible class.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered **Employee's or Retired Employee's Spouse** and **children** from birth to the limiting age of 26 years. When a child reaches the limiting age, coverage will end on the last day of the child's birthday month.

The term "**Spouse**" must be a resident of the same country in which the covered Employee or Retired Employee lives and shall mean an individual of the ***opposite sex or same sex***, recognized as the covered Employee's husband or wife by the laws of the state in which the marriage was formalized. *This definition does not include common-law marriage, domestic partners, or civil unions.*

The Plan Administrator may require documentation proving a legal marital relationship.

The term "**children**" must be a citizen or a resident of the United States and shall include the covered Employee or Retired Employee's natural children, adopted children, children placed with a covered Employee in anticipation of adoption, or step-children.

If a covered Employee or Retired Employee is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "**child placed with a covered Employee in anticipation of adoption**" refers to a child whom the Employee or Retired Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee or Retired Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

(2) A **covered Dependent child who reaches the limiting age** and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee or Retired Employee for support and maintenance and is unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: Other individuals living in the covered Employee or Retired Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; foster child; or any person who is covered under the Plan as an Employee or as a Retired Employee.

If a person covered under this Plan changes status from Employee or Retired Employee to Dependent or Dependent to Employee or Retired Employee, and the person is covered continuously under this Plan before, during, and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees or Retired Employees, their children will be covered as Dependents of one of the parents, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Dependent child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The Plan Administrator may require a contribution from the covered Employee or Retired Employee in order to maintain coverage for the covered Employee or Retired Employee and any covered Dependents under this Plan.

Eligible Employees will be advised of any required contributions at the time they apply for enrollment in this Plan.

Employer premium contribution is governed by the individual employment contracts. The Plan Administrator reserves the right to change the level of Employee and Retired Employee contributions.

Covered Employees and Retired Employees under this Plan will be notified by the Plan Administrator prior to an increase in the required contribution amount. Covered Employees or Retired Employees in a Plan that does not require Employee or Retiree contributions at the time they enrolled will be notified by the Plan Administrator prior to the date a contribution requirement is made effective.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If Dependent coverage is desired, the covered Employee is also required to enroll for Dependent coverage.

Enrollment Requirements for Newborn Children. A Newborn child of a covered Employee **is not** automatically enrolled in this Plan from the date of birth. The Newborn child must be enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section. If the Newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the parents will be responsible for all costs.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** – The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 60 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees who are covered under the Plan are the parents of children who are covered under the Plan, and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period, if applicable under this Plan, as long as coverage has been continuous.

(2) **Late Enrollment** – An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins as stated in the Open Enrollment section below.

(i) **Open Enrollment** – Each year there is an annual open enrollment period designated by the Employer during which covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them, or eligible Employees and their eligible Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective **July 1st** and remain in effect until the next July 1st unless there is a Special Enrollment event or a change in family status during the year (e.g., birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

(3) **Late Enrollment with respect to Dental Benefits.** If the Employee fails to enroll himself/herself and/or any eligible Dependents within 60 days of their eligibility date, no coverage will be provided for installation, replacement, or alteration of, or addition to, dentures or fixed bridgework, periodontal treatment, or orthodontic diagnosis, evaluation, and pre-orthodontic care, if the expenses are incurred during the first 90 days following the effective date of this coverage.

This same provision will apply if a Plan Participant terminates coverage while remaining in an eligible class, and later wishes to re-enroll.

However, in the event a part-time Certified Employee, who has previously declined coverage, elects to enroll for coverage within 60 days of becoming a full-time Employee, such restriction shall not apply.

(4) **Enrollment Following Benefit Measurement Period** – Employees who were determined to be full-time Active Employees during the applicable measurement period (and their eligible Dependents) may enroll in the Plan the first day of the first full calendar month of the following stability period. Employees will be credited for time previously satisfied toward the employment Waiting Period, if applicable under this Plan.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. ***Special Enrollment Rights may not apply to Retired Employees.*** If an Employee is declining enrollment for himself or herself or his or her Dependents (including his or her Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 60 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. **To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.**

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. *(**Note:** A Retired Employee who declines coverage at retirement and later loses other coverage will not be entitled to special enrollment, nor will the Retired Employee's eligible Spouse or Dependent children.)*

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions: (***Note:*** *The following provisions will not be applicable to a Retired Employee and/or their Spouse or Dependent children.)*

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was COBRA coverage, and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date of loss.

(d) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date of loss.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example, part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption,

then the Dependent may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. *In the case of marriage, birth, adoption or placement for adoption, the Spouse or Dependent of a covered Retired Employee may be enrolled as a Spouse or Dependent of the covered Retired Employee if the Spouse or Dependent is otherwise eligible for coverage under the Plan.*

If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. ***If the Retired Employee is not enrolled at the time of the event, this Special Enrollment right will not be applicable.***

The Special Enrollment Period for newly eligible Dependents is a period of 60 days that begins after the date of the marriage, birth, adoption, or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee or Retired Employee must request enrollment during this 60-day period.

The coverage of the Dependent, including the Spouse or Dependent child of a Retired Employee, and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, as of the date of marriage;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Medicaid or Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan, but who are not enrolled, can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility if:

(a) The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or

(b) The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, he or she must enroll under this Special Enrollment Period in order for their eligible Dependent to enroll.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. The effective date of coverage will be the first day of the first month following the date of loss of coverage or gain in eligibility.

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the District, and its Employees.

For more information regarding your special enrollment rights, contact the Plan Administrator.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month *following or coinciding* with the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

Coverage Status Change. If a covered Dependent is eligible to be enrolled as a covered Employee, enrollment may be effective on the first day of the calendar month.

If a covered Employee is eligible to be enrolled as a Dependent, enrollment may be effective on the first day of *any* calendar month.

Any changes in coverage status do not interrupt participation in the Plan and do not change a Plan Participant’s effective date of coverage.

MEDICARE

Active Employees and Dependent Spouses Age 65 or Over

An active Employee, age 65 or over, and a covered Dependent Spouse, age 65 or over, of an active Employee, will have the option, upon becoming covered by Medicare, to elect one of the following:

(1) Primary Coverage with this Plan: The regular plan of benefits provided under this Plan will be paid without regard of Medicare.

(2) Sole Coverage provided under Medicare: Coverage with this Plan terminates.

All Others Eligible for Medicare

When the covered Employee or Dependent become eligible for Medicare, the benefits ordinarily provided by this Plan will be coordinated with the amount Medicare pays for any Covered Charge, so that total benefits received never exceed the actual amount charged.

Benefits will be calculated in this manner from the date the covered Employee or covered Dependent are first eligible for Medicare, regardless of whether he or she has actually enrolled in coverage under this Plan, are in fact participating or receiving Medicare payments. Therefore, the covered Employee or Dependent should enroll in Medicare promptly as soon as eligible to assure complete health care protection.

Retirees and Their Dependents Eligible for Medicare

Special Medicare Supplementary Benefits are available to the Retired Employee. Please contact the District Office when the Retired Employee becomes ELIGIBLE for Medicare.

"Medicare" means the plan of benefits provided through Title 18 of the United States Social Security act of 1965 as amended from time to time.

TERMINATION OF COVERAGE

The District or the Plan has the right to rescind any coverage of the Employees, Retirees and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The District or the Plan may either void coverage for the Employees, Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. **If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.** The District or the Plan will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The District or the Plan reserves the right to collect additional monies if claims are paid in excess of the Employee's, Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated or, with respect to any benefit under this Plan, the date of termination of such benefit;

(2) The last day of the calendar month in which the covered Employee's employment terminates, except Certified Long-Term Assignment Participants who leave employment prior to the end of the school year, coverage will end on the last contracted day of work;

(3) The last day of the calendar month in which the covered Employee ceases to be in a classification (if any) as shown in the Eligible Classes provision under the Eligibility section under this Plan or, if applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence, or other leave of absence, unless a collectively bargained agreement specifically provides for continuation during these periods;

(4) The last day of the calendar month in which the covered Employee fails to make any required contribution for coverage;

(5) For Billings Education Association bargaining unit members, as well as Certified Long-Term Assignment Participants, who leave employment as of the end of the school year, coverage will end as of August 31st of that year;

(6) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

(7) As otherwise stated in the Eligibility section.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled COBRA Continuation Coverage.

Leave of Absence. An extension of benefits while a covered Employee is on an approved leave of absence will be governed by the varied negotiated agreements between the covered Employee and the Employer.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations. This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A covered Employee whose coverage terminates by reason of termination of employment, and who resumes employment with the Employer within a 26 week period immediately following the date of such termination, shall become eligible for reinstatement of coverage on the date the Employee resumes employment with the Employer. Coverage will become effective on the first day of the calendar month *following or coinciding* with the date the Employee resumes employment with the Employer.

A terminated Employee who is rehired following a 26 week period from the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by the terms of the Plan and applicable law.

However, if the Employee is returning to work directly from COBRA Continuation Coverage, this Employee will be credited with time met towards the employment Waiting Period, if applicable under this Plan, as of the date the Employee elected COBRA Continuation Coverage.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:

  (a) The 24-month period beginning on the date on which the person's absence begins; or

  (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Montana National Guard Members. Employees performing State active duty as a Montana National Guard member may elect to continue Plan coverage subject to the terms of the Montana Military Service Employment Rights Act (MMSERA) under the following circumstances:

(1) The period of coverage of a person under such an election shall be the period of time beginning on the date on which the person's absence for State active duty begins, and ending:

(a) The next regularly scheduled day of employment following travel time plus eight hours, if State active duty is 30 days or less; or

(b) The next regularly scheduled day of employment following 14 days after termination of State active duty, if State active duty is not more than 180 days; or

(c) The next regularly scheduled day of employment following 90 days after termination of State active duty, if State active duty is more than 180 days.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except that a person on State active duty for less than 180 days may not be required to pay more than the regular Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State active duty.

When Retired Employee Coverage Terminates. A Retired Employee's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Retiree coverage is terminated or, with respect to any benefit under this Plan, the date of termination of such benefit;

(2) The date the Retired Employee's coverage under the Plan terminates due to death;

(3) The last day of the calendar month in which the covered Retired Employee fails to make any required contribution for Dependent coverage;

(4) If a Retired Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Retired Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

(5) As otherwise stated as in the Eligibility section.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage is terminated or, with respect to any benefit under this Plan, the date of termination of such benefit;

(2) The date that the Employee's coverage under the Plan terminates for any reason, including death, in which the Employee ceases to be in a classification (if any) as shown in the Eligible Classes provision under the Eligibility section under this Plan. (See the section entitled COBRA Continuation Coverage.);

(3) The last day of the calendar month in which a covered Spouse loses coverage due to loss of eligibility or dependency status. (See the section entitled COBRA Continuation Coverage.);

(4) The last day of the calendar month in which the Dependent child ceases to meet the applicable eligibility requirements. (See the section entitled COBRA Continuation Coverage.);

(5) The last day of the calendar month in which the covered Employee fails to make any required contribution for Dependent coverage;

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

(7) As otherwise stated as in the Eligibility section.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply, and how to select it, see the section entitled COBRA Continuation Coverage.

EXTENDED BENEFITS

EXTENSION OF BENEFITS FOR SURVIVORS. In the event of the death of a covered Employee or an eligible Retired Employee, the covered Dependent survivors will be allowed to continue coverage under this Plan until the surviving covered Spouse remarries or the Dependents obtain other coverage, by paying any required contribution.

MEDICAL BENEFITS. If individual coverage with this Plan should terminate at a time when a Plan Participant is Totally Disabled as a result of Illness or Injury, benefits will be extended solely with respect to Covered Charges incurred to treat the disabling condition until the Plan Participant ceases to be Totally Disabled, or to the end of the 24 month period from the date the Plan Participant became Totally Disabled, or at which time the disabled person becomes eligible for other coverage.

If coverage terminates as the result of termination of the Master Plan Document, at a time the Plan Participant is Totally Disabled, coverage for that Plan Participant will be continued, solely with respect to Covered Charges incurred to treat the disabling condition, for a period of up to three consecutive months following the termination date.

DENTAL BENEFITS. If individual coverage terminates for reasons other than the termination of the Master Plan Document, or its amendment to terminate an eligibility class, before the completion of a course of orthodontic work or other dental treatment which began prior to termination, then dental benefits will be extended for such unfinished dental work, as though coverage had not terminated.

In no event will benefits be payable for eligible dental expenses incurred more than three months after the termination of dental coverage.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Illness and while the Plan Participant is covered for these benefits under the Plan.

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

Sutter Health System Network Providers will be given additional consideration if this Plan is secondary. In this case, the Claims Administrator will also consider a claim received from a Sutter Health System Network Provider within one year from the date of issuance of the primary Explanation of Benefits. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within two years of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions, and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital, Outpatient Surgical Center, or Birthing Center. Covered Charges for room and board will be payable as shown in the Medical Benefits – Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be payable at the average private room rate of that Facility.

Charges for an Intensive Care Unit stay are payable as shown in the Medical Benefits – Schedule of Benefits.

(2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Illness and will be payable as shown in the Medical Benefits – Schedule of Benefits.

Covered Charges will also include amniocentesis, only when deemed Medically Necessary in conjunction with a Pregnancy for a female Plan Participant ages 35 years and over.

Note: Routine prenatal office visits will be payable as shown under the Pregnancy benefit in the Medical Benefits – Schedule of Benefits. The following services will continue to be payable per normal Plan provisions:

> Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of Pregnancy (as defined under this Plan), delivery, and post-partum care.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the Plan Participant is confined as a bed patient in the Facility; and

(b) the attending Physician certifies that the confinement is Medically Necessary; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Plan Participant's care in these Facilities are payable as shown in the Medical Benefits – Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for multiple surgical procedures are subject to the following provisions in the absence of a negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement:

(a) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge for the primary procedure; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed **25%** of the surgeon's Allowable Charge.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Fees of a licensed nurse (R.N., LPN or LVN) for private duty nursing.

(6) **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Illness. The diagnosis, care, and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide, and therapy services is subject to the Home Health Care limit shown in the Medical Benefits – Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the person is not expected to live more than six months, and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as shown in the Medical Benefits – Schedule of Benefits.

(8) Other Medical Services and Supplies. These services and supplies not otherwise included in the items above are covered as follows:

(a) Acupuncture. Charges for acupuncture when deemed Medically Necessary and when rendered by a licensed acupuncturist.

(b) Allergy. Care, supplies, services, and treatment in connection with allergy testing, serum, and injections.

(c) Ambulance. Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(d) Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) Applied Behavioral Analysis or other similar services when provided by an individual licensed by the behavioral analyst certification board or certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

Note: *Benefits are limited to treatment that is prescribed by a Physician and documented by a written Plan of Care provided by the treating Physician. The Plan Administrator may request periodic documentation of continued progress to goals identified in the Plan of Care.*

(f) Breast Pump, Breast Pump Supplies, Lactation Support and Counseling.

<u>Breast pump, breast pump supplies</u>

A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a Newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.
- For female Plan Participants using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.
- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered every three Plan Years following a subsequent Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Medical Benefits – Schedule of Benefits.

Note: *Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be payable under the Women's Preventive Services benefit (as shown in the Medical Benefits – Schedule of Benefits) for the purposes of this benefit.*

The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.

Lactation support and counseling

Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Plan Participants for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

Note: *Payment will be made for Covered Charges for lactation support and counseling under the Women's Preventive Services benefit (as shown in the Medical Benefits – Schedule of Benefits).*

(g) **Cardiac Rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery, or other cardiac condition; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(h) **Chemotherapy or Radiation Treatment** with radioactive substances. The materials and services of technicians are included.

Pre-notification of services, by the Plan Participant, for cancer treatment services is strongly recommended. The pre-notification request to CareLink should include the Plan Participant's Plan of Care and treatment protocol. Pre-notification of services should occur at least seven days prior to the initiation of treatment.

For pre-notification of services, call CareLink at the following numbers:

Toll Free in the United States:	(866) 894-1505
Local Call in Billings, Montana:	(406) 245-3575

A pre-notification of services by CareLink is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan, including but not limited to Medical Necessity, exclusions, and limitations in effect when services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.

(i) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained website www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial.
- The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
- The Plan Participant has signed an Informed Consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent.
- The trial is approved by the Institutional Review Board of the institution administering the treatment.
- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

Routine patient services do not include, and reimbursement will not be provided for:

- The Investigational service, supply, or drug itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant (e.g., monthly CT scans for a condition usually requiring only a single scan); and
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item, or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

(j) Initial **Contact Lenses** or **Glasses** required following cataract surgery.

(k) **Contraceptives.** All Food and Drug Administration (FDA) approved contraceptive methods when prescribed by a Physician, including but not limited to intrauterine devices (IUDs) and implants (including insertion and removal when applicable), injections, and any related Physician and Facility charges including complications. Services will be payable subject to the Preventive Care benefit in the Medical Benefits – Schedule of Benefits.

Oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Plan Participants will be payable under the separate Prescription Drug benefits of this Plan.

(l) **Diabetic Education.** Inpatient and outpatient self-management training and education for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, will be payable up to the limits as shown in the Medical Benefits – Schedule of Benefits.

(m) **Down Syndrome Therapies.** Covered Charges will be payable for professional, counseling, guidance services and treatment programs deemed Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered Dependent child(ren).

Note: *Benefits are limited to treatment that is prescribed by a Physician and documented by a written Plan of Care provided by the treating Physician. The Plan Administrator may request periodic documentation of continued progress to goals identified in the Plan of Care.*

(n) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Plan Participant; and
- Does NOT have significant non-medical uses (i.e., air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Plan Participant's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Plan Participant.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Plan Participant if the Plan Participant were to purchase the item directly. The acquisition cost of the item may be prorated over a six-month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every four Plan Years.

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Plan Participant's medical condition occurs sooner than the four Plan Year period.

- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Plan Participant's medical condition occurs sooner than the four Plan Year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the four Plan Year limit.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

(o) **Hearing Exams and Hearing Aids.** Coverage for hearing exams, exams for the fitting of hearing aids, and hearing aids up to the limits shown in the Medical Benefits – Schedule of Benefits.

(p) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and are required for the administration of a home infusion therapy regimen when ordered by and part of a formal written plan prescribed by a Physician. The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, Prescription Drugs, administration of therapy, and the collection, analysis, and reporting of the results of laboratory testing services required to monitor a response to therapy.

(q) **Impotence.** Office visit charges in connection with impotence / sexual dysfunction when deemed Medically Necessary. Additional testing and treatment will not be a Covered Charge.

(r) **Laboratory Studies.** Covered Charges for diagnostic lab testing and services.

(s) **Mental Disorders and Substance Abuse.** Covered Charges will be payable for care, supplies, and treatment of Mental Disorders and Substance Abuse.

(t) **Morbid Obesity.** Charges for the treatment of obesity ONLY IF it is Morbid Obesity (as defined under this Plan) as a Body Mass Index (BMI) of 40+ **or** as a BMI of 35 or greater with any co-morbid conditions that are expected to improve, reverse, or be limited by any surgical treatment covered under this Plan, and which must be documented in a record or letter of Medical Necessity. Dietary supplements of any kind are excluded, regardless if prescribed.

(u) Injury to or care of **Mouth, Teeth, and Gums.** Charges for Injury to or care of the mouth, teeth, gums, and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Emergency repair due to accidental Injury to sound natural teeth (excluding dentures). Treatment must be incurred within six months from the date of the accidental Injury.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands, or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, and preparing the mouth for the fitting of or continued use of dentures.

Dental Care. The following oral surgery procedures rendered by a Doctor of Dental Surgery (DDS) will be payable under the Medical Benefits section under this Plan:

- Cutting procedures for the treatment of disease or Injury of the jaw; or
- Extraction of impacted teeth, if performed while the Plan Participant is confined to a Hospital for at least 18 hours.

Medically Necessary Hospital confinements incurred in conjunction with dental are considered eligible for payment, regardless of whether the professional fees are covered under this provision.

Medically Necessary Orthodontia Services. This Plan will cover comprehensive Medically Necessary orthodontic services for **Plan Participants up to age 19** that have a severe handicapping malocclusion related to a medical condition such as:

- Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;
- Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services; or
- Skeletal anomaly involving maxillary and/or mandibular structures.

Orthodontic treatment for dental conditions that do not meet the criteria as stated above **will not** be a Covered Charge under this benefit.

Pre-notification of services, by the Plan Participant, for Medically Necessary orthodontic services is strongly recommended. The pre-notification request to the Claims Administrator should include a completed Salzmann assessment form and a written report from the attending Physician, treating the deformity/anomaly. Progress notes, photographs, and other relevant supporting documentation may be included as appropriate. Pre-notification of services should occur at least seven days prior to the initiation of treatment.

A pre-notification of services by the Claims Administrator is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan, including but not limited to Medical Necessity, exclusions, and limitations in effect when services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.

(v) **Naturopath.** Office visit charges by a Naturopathic Doctor (N.D.) Nutritional supplements will not be a Covered Charge.

(w) **Nutritional Education Counseling.** Care, treatment, and services when provided by a health care provider acting within the scope of his or her license, will be payable up to the limits as shown in the Medical Benefits – Schedule of Benefits. *This benefit will not include weight loss medications or nutritional supplements whether or not prescribed by a Physician.*

(x) **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act preventive services requirement. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher.

Intensive, multicomponent behavioral interventions for weight management will include group and individual sessions of high intensity (up to 26 visits per Plan Year) encompassing the following:

- Behavioral management activities such as setting weight loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes

Non-surgical care and treatment and Physician prescribed weight loss medications **will not** be a covered benefit except as may be specifically described as a benefit by this Plan.

This Plan **will not** cover nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

(y) **Occupational Therapy** by a health care provider acting within the scope of his or her license, subject to Medical Necessity. Therapy must be ordered by a Physician, result from an Injury or Illness including autism spectrum disorders, and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short-term and long-term goals, specific treatment techniques, anticipated frequency, and duration of treatment and/or treatment protocol for the Plan Participant's specific condition.

(z) **Organ Transplants.** Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant, which are not considered Experimental or Investigational, are subject to the following criteria:

- The transplant must be performed to replace an organ or tissue.

- A **second surgical opinion** must be obtained prior to undergoing any transplant procedure. The second (or third) opinion must concur with the first Physician's findings that the transplant procedure is Medically Necessary.

  The Physician rendering the second (or third) opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery. The Plan Administrator may require additional information from the Physician providing the surgical opinion to determine if benefits are excluded due to the Experimental/Investigational nature of some transplant procedures.

- **Organ transplant benefit period.** A period of 365 continuous days beginning five days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.

- **Organ procurement limits.** Charges for obtaining donor organs or tissues are Covered Charges under the Plan.

  – If the donor is a Plan Participant under this Plan, his/her Covered Charges will be payable under this Plan;

  – If the recipient is a Plan Participant under this Plan, his/her Covered Charges will be payable under this Plan;

  – If the donor ***is not*** a Plan Participant under this Plan but the recipient is, the donor's expenses will be covered under this Plan if:

    o The donor's expenses would not be covered by any plan in the absence of this Plan; and

    o The expenses would be Covered Charges (had they been Covered Charges incurred by a Plan Participant).

    o Benefits paid to the donor will be treated as though they were paid to the recipient for the purposes of deductible, copayment percentages, Plan benefit maximums, etc.

  – When the donor has medical coverage, his or her plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's plan.

  Donor charges include those for:

  (i) Evaluating the organ or tissue;

  (ii) Removing the organ or tissue from the donor (including the cost of securing an organ from a cadaver or tissue bank, and the surgeon's charges for such removal of the organ);

  (iii) Transportation of the organ or tissue from within the United States or Canada to the Facility where the transplant is to be performed.

Note: *Expenses related to the purchase of any organ will not be covered.*

As soon as reasonably possible, but in no event more than 10 days after a Plan Participant's attending Physician has indicated that the Plan Participant is a potential candidate for a transplant, the Plan Participant or his or her Physician must contact CareLink at (866) 894-1505.

There is no obligation to the Plan Participant to use a Center of Excellence Facility; however, benefits for the transplant and related expenses may vary depending upon whether or not a Center of Excellence Facility is utilized.

A **Center of Excellence** is a licensed healthcare Facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Plan Participant may contact CareLink to determine whether or not a Facility is considered a Center of Excellence.

Special Transplant Benefits

Under certain circumstances, there may be special transplant benefits available when the group health plan and/or a Plan Participant participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact CareLink at (866) 894-1505 as soon as reasonably possible so that the Plan can advise the Plan Participant or his or her Physician of the transplant benefits that may be available.

Transplant Exclusions

Coverage for the following procedures, when Medically Necessary, may be provided under the regular medical benefits provision under this Plan, subject to all Plan provisions and applicable benefit limitations as stated under this Plan:

- Cornea transplantation
- Skin grafts
- Artery
- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

(a1) **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness. *Dental braces or corrective shoes are not Covered Charges under this benefit.*

(b1) **Outpatient Surgery.** The following surgical procedures, when Medically Necessary and performed in an Outpatient Surgical Center, Physician's office or clinic, or on an outpatient basis in a Hospital, will be payable as shown in the Medical Benefits – Schedule of Benefits:

- Arthroscopy (internal exam of joint);
- Bronchoscopy (internal exam of lung), adult, with or without biopsy;
- Cardiac catheterization;
- Cataract removal;
- Cystourethroscopy (internal exam of urinary bladder and urethra);
- Digestive tract endoscopy (internal exam of esophagus, stomach, colon, or rectum);
- Excision of pilonidal cyst, simple;
- Laparoscopy (internal exam of abdomen)
- Morton's neuroma (of foot);
- Myringotomy (puncture of membrane in ear), with or without insertion of tubes;
- Prostate biopsy;
- Reduction of nasal fracture, open or closed;
- Release of carpal tunnel (in wrist);
- Tonsillectomy and/or Adenoidectomy;
- Tympanoplasty;
- Vasectomy (male sterilization).

Covered Charges will include Hospital (Facility) charges, surgeon's charges, assistant surgeon, and anesthesia services, received on the day of surgery. All other services and supplies will be payable per normal Plan provisions.

The Plan **will not** pay for any expense which is: a) paid under any other provision under this Plan; or b) excluded under the Plan Exclusions section under this Plan or is not otherwise a Covered Charge under this Plan.

Inpatient surgery benefit limitation. If a Plan Participant undergoes any of the surgical procedures listed above while confined on an inpatient basis in a Hospital, then:

Covered Charges will be payable subject to all Plan limitations; however,

<u>This limitation will not apply to a surgical procedure listed above when:</u>

(A) Hospital confinement on an inpatient basis is Medically Necessary:

- **(i)** Because the Plan Participant's medical condition will require prolonged postoperative observation by a nurse or other skilled medical staff;
- **(ii)** Because of the Plan Participant's anesthesia status; or
- **(iii)** Because of technical problems shown by the Plan Participant's admission notes or operative report; or

(B) Another surgical procedure which requires Hospital confinement:

- **(i)** Will be performed at the same time; or
- **(ii)** May follow the first procedure (such as when a mastectomy may follow a breast biopsy).

(c1) **Physical Therapy** by a health care provider acting within the scope of his or her license, subject to Medical Necessity. The therapy must be in accordance with a Physician's exact orders as to type, frequency, and duration for conditions mnnnnwhich are subject to significant improvement through short-term therapy. Covered Charges will also include treatment of autism spectrum disorders.

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short-term and long-term goals, specific treatment techniques, anticipated frequency, and duration of treatment and/or treatment protocol for the Plan Participant's specific condition.

(d1) **Poly Vi Flor Vitamins.** Charges for Poly Vi Flor vitamins, including estrogen pellets (including cost and insertion).

(e1) **Prescription Drugs** (as defined**).** Charges for Prescription Drugs, including injectable drugs, when prescribed by a Physician, dispensed by a licensed pharmacist or a Physician, and are Medically Necessary treatment for an Illness or Injury.

The Retail and Mail Order Pharmacy Prescription Drug Option is available for acute conditions (i.e., sudden onset of an Illness, such as antibiotics) in addition to chronic or maintenance medications (i.e., those that are taken for long periods of time, such as drugs prescribed for heart disease, high blood pressure, asthma, etc.)

Prescription Drugs purchased through the *mi*Rx Pharmacy and *mi*Rx Mail Order Pharmacy will be payable as shown in the Retail and Mail Order Pharmacy Prescription Drug Option section.

If a Prescription Drug is purchased from a Non-Participating Pharmacy or a Participating Pharmacy when the Plan Participant's ID isn't used, the Plan Participant will be required to pay 100% of the total cost at the point of sale, no Participating Pharmacy discount will be given, and the Plan Participant will be required to submit the prescription receipt to Navitus Health Solutions for reimbursement (minus any applicable copayment amount as shown in the Retail and Mail Order Pharmacy Prescription Drug Option).

For prescription claims questions or to obtain a claim form, please call:

Navitus Health Solutions toll-free (866) 333-2757 or visit www.ebms.com.

The following will be covered at 100%, no copayment required for Formulary drugs.

Benefits may be subject to prescription Formulary and/or quantity limitations. Non-formulary prescriptions may be payable subject to the applicable prescription copayment as shown in the Retail and Mail Order Pharmacy Prescription Drug Option. ***Contact Navitus Health Solutions toll-free at (866) 333-2757 to request coverage of the medication as a non-formulary medical exception.***

(1) Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Plan Participants with reproductive capacity.

Refer to Contraceptives in this section regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.

(2) Physician-prescribed tobacco/nicotine cessation products. Physician-prescribed tobacco/ nicotine replacement products (nicotine patch, gum, lozenges) and Physician-prescribed medications (such as Zyban, Chantix (and subject to change)).

(3) Certain vaccinations/immunizations as recommended by applicable federal law will be covered only when rendered through a Participating Pharmacy. Please note: Not all Participating Pharmacies may be providing vaccinations/immunizations or may vary in what they offer. It is important to check with the Participating Pharmacy to determine availability, age restrictions, any prescription requirements, or hours of service.

(4) Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance, or deductible will be required, and will only be available when utilizing a Participating Pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact Navitus Health Solutions for more information regarding which medications are available. **Note:** Age and/or quantity limitations may apply:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results

(f1) **Preventive Care/Routine Well Care.** Covered Charges under Medical Benefits are payable for Preventive Care/Routine Well Care as shown in the Medical Benefits – Schedule of Benefits.

Preventive Care/Routine Well Care is care by a Physician that is not for an Injury or Illness and will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.

Consult with your Physician at the time services are rendered as to whether or not the services provided will be considered Preventive Care/Routine Well Care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations or the Women's Preventive Services as required by the Health Resources and Services Administration (HRSA).

Otherwise, services rendered which are not considered or billed by the Physician as Preventive Care/Routine Well Care (as stated above) will be subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided.

(g1) **Prosthetic Devices.** The initial purchase, fitting, and repair of fitted prosthetic devices which replace body parts.

(h1) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

Mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the Plan Participant.

(i1) **Rehabilitation Services.** Charges for inpatient rehabilitation services are payable as shown in the Medical Benefits – Schedule of Benefits. Services must be Medically Necessary to restore and improve a bodily function that was previously normal but was lost as a result of an accidental Injury, Illness, surgery, or as related to an autism spectrum disorder or cognitive function.

Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Plan Participant received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

(j1) **Renal Dialysis.** Renal dialysis services shall include dialysis, Facility services, supplies, and medications provided during treatment. Laboratory testing and Physician visits will be payable per normal Plan provisions.

(k1) **Second Surgical Opinion.** If a Plan Participant is advised by a Physician to have a surgical procedure performed, charges in connection with a second surgical opinion, including laboratory and x-ray services, will be payable as shown in the Medical Benefits – Schedule of Benefits providing:

The second surgical opinion is provided by a specialist who: a) is certified by the American Board of Medication Specialties in a field related to the proposed surgery; b) is independent of the Physician who first advised the Plan Participant to have the surgical procedure; and c) does not perform the surgical procedure for the Plan Participant.

In the event the second surgical opinion does not confirm that the proposed surgery is medically advisable, the Plan will pay benefits in the same manner for a third surgical opinion.

The Plan will not pay for any expense which: a) is paid under any other provision under this Plan; or b) is excluded under the Plan Exclusions section under this Plan or is not otherwise a Covered Charge under this Plan.

(l1) **Speech Therapy** by a health care provider acting within the scope of his or her license, subject to Medical Necessity. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy); (ii) an Injury; (iii) an Illness; or (iv) a diagnosis of autism spectrum disorder.

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short-term and long-term goals, specific treatment techniques, anticipated frequency, and duration of treatment and/or treatment protocol for the Plan Participant's specific condition.

(m1) **Spinal Manipulation/Chiropractic Services** by a health care provider acting within the scope of his or her license, payable up to the limits as shown in the Medical Benefits – Schedule of Benefits.

(n1) **Sterilization Procedures.** Sterilization procedures for female Plan Participants will be payable under the Preventive Care benefit as shown in the Medical Benefits – Schedule of Benefits.

The following charges will be payable per normal Plan provisions: Hysterectomies.

Note: *Sterilization procedures (vasectomy) for male Plan Participants will be payable subject to the separate Outpatient Surgical Benefits listed under this Plan.*

(o1) **Surgical Dressings**, splints, casts, and other devices used in the reduction of fractures and dislocations, and other Medically Necessary medical supplies.

(p1) **Tobacco/Nicotine Cessation Counseling.** Care and treatment for tobacco/nicotine cessation counseling will be payable up to the limits as shown in the Medical Benefits – Schedule of Benefits. Tobacco/nicotine cessation medications and products, when prescribed by a Physician, will be payable under the Prescription Drug benefits under this Plan.

(q1) **Well Newborn Nursery/Physician Care.**

Charges for Routine Well Newborn Nursery Care. Routine well Newborn nursery care is care while the Newborn is Hospital-confined after birth and includes room, board, and other normal well-baby care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the Newborn child is an **eligible and enrolled** Dependent, *who is neither injured nor ill*, and a parent (1) is a Plan Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the Newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for routine well-baby nursery care for the Newborn child while Hospital confined as a result of the child's birth. ***Covered Charges for routine nursery care will be applied toward the Plan of the covered parent, provided the Newborn child is enrolled on a timely basis.***

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Well Newborn Physician Care. This benefit is limited to the Allowable Charges for routine well-baby care made by a Physician for pediatric visits to the Newborn child while Hospital confined as a result of the child's birth.

Covered Charges for routine well Newborn Physician care, including all Physician's charges in connection with circumcision, will be applied toward the Plan of the covered Newborn child, provided the Newborn child is enrolled on a timely basis.

Note: In the event a covered Newborn child has an Illness or suffers an Injury or requires other than routine well Newborn nursery care, Covered Charges will be payable on the same basis as any other medical claim, provided Dependent coverage is in force at the time such Covered Charges are incurred to treat such a condition for the covered Newborn child.

(r1) **X-rays.** Covered Charges for diagnostic x-rays and imaging services.

SELF-AUDIT BILLING CREDIT

The Plan offers an incentive credit to all Plan Participants to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by the provider or service accurately reflect the services and supplies received by the Plan Participant. The Plan Participant is voluntarily asked to review all Hospital and doctor bills and verify that he or she has received each itemized service and the bill does not represent either an overcharge, or a charge for services never received, regardless of the reason. The Claims Administrator agrees to assist the Plan Participant (at his or her request) in determination of errors, and recovery attempts.

In the event a Plan Participant's self-audit results in elimination or reduction of charges, 50 percent of the amount eliminated or reduced will be paid directly to the Plan Participant (subject to a $10 minimum savings), provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Claims Administrator (e.g., a copy of the incorrect bill and a copy of the corrected billing).

This self-audit credit is in addition to the payment of all other applicable Plan benefits for legitimate medical expenses.

Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Plan Participant, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the Plan Participant's liability) on an incorrect billing.

This credit will not be payable for charges in excess of the Allowable Charge regardless of whether the charge is or is not reduced.

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Plan Participants in understanding and becoming involved with their diagnosis and medical Plan of Care, and advocates patient involvement in choosing a medical Plan of Care. Utilization Management begins with the pre-notification process.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services, and/or supplies. A benefit determination on a claim will be made only after the claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in this section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures section.

Examples of when the Physician and Plan Participant should contact CareLink prior to treatment include:

- Inpatient admissions to a Hospital or Skilled Nursing Facility;
- Inpatient admissions to free-standing chemical dependency, mental health, and rehabilitation facilities;
- Cancer treatment Plan of Care, administered on an inpatient or outpatient basis;
- Inpatient or outpatient surgeries relating to hysterectomies, back surgery, or bariatric surgery; and
- Outpatient services as follows:
    - Dialysis
    - Genetic testing
    - Injectables (administered under the Medical Benefits Plan, not those received through the Prescription Drug Benefits of this Plan)
    - Home Health Care
    - Hospice Care
    - Durable Medical Equipment (DME) over $2,000

All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided.

The Physician or Plan Participant should notify CareLink at least seven days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number, and address of the Plan Participant
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The Plan of Care, treatment protocol and/or informed consent, if applicable

If there is an emergency admission to the Hospital, the Plan Participant, Plan Participant's family member, Hospital, or attending Physician should notify CareLink within two business days after the admission.

Hospital observation room stays in excess of 23 hours are considered an admission for purposes of this program, therefore CareLink should be notified.

Contact the Care Management administrator at:

CareLink (406) 245-3575 or (866) 894-1505

PRE-ADMISSION AND POST DISCHARGE CARE CALLS

A CareLink nurse will contact the Plan Participant to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan, and post-discharge follow-up.

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

The Plan Administrator or its designee, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within 15 days of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Plan Administrator or its designee will notify the Plan Participant or the Physician. The time for making a determination on the request will be deferred from the date that the additional information is requested until the date that the information is received.

The Physician and Plan Participant will be provided notice of the Plan's determination. If the pre-notification request is denied, written notice will provide the reason for the adverse pre-notification determination.

As a reminder, a pre-notification of services by CareLink is not a determination by the Plan that a claim will be paid.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within 30 days of the receipt of the adverse pre-notification determination and include a statement as to why the Plan Participant disagrees with the adverse pre-notification determination. The Plan Participant may include any additional documentation, medical records, and/or letters from the Plan Participant's treating Physician(s). The request for reconsideration should be addressed to:

CareLink
Attn: Appeals
7400 West Campus Rd.
New Albany, OH 43054

The Plan Administrator or its designee will perform the reconsideration review. The Plan Administrator or its designee will review the information initially received and any additional information provided by the Plan Participant and determine if the pre-notification determination was appropriate. If the adverse pre-notification determination was based upon the Medical Necessity, the Experimental/Investigational nature of the treatment, service, or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. 3.Written or electronic notice of the determination upon reconsideration will be provided within 30 days of the receipt of the request for reconsideration.

CASE MANAGEMENT

If a Plan Participant has an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor this Plan Participant, and to work with the attending Physician and Plan Participant to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Plan Participant, the family, and the attending Physician in order to assist in coordinating the Plan of Care approved by the Plan Participant's attending Physician and the Plan Participant.

This Plan of Care may include some or all of the following:

- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

Case Management is not a requirement of the Plan. There are no reductions of benefits or penalties if the Plan Participant and family choose not to participate.

Each treatment plan is individualized to a specific Plan Participant and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Plan Participant and the attending Physician.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowable Charge means the amount for a treatment, service, or supply that is the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement.

For Covered Charges rendered by a Physician, Hospital, or ancillary provider in a geographic area where applicable law or a governmental authority directs the amount to be paid, the Allowable Charge will mean the amount established by applicable law or governmental authority for the Covered Charge.

In the absence of such network arrangement, negotiated arrangement, controlling law, or governmental directive that establishes the amount to be paid, the Allowable Charge will mean: (i) an amount that does not exceed billed charges for the same treatment, service, or supply furnished in the same geographic area by a provider of like services; and (ii) a reasonable amount established solely and exclusively by the Plan Administrator or its designee; (iii) for out-of-network air ambulance claims, an amount equivalent to 250% of the Medicare reimbursement for transportation provided; and (iv) (except in circumstances where a provider network arrangement, other discounting or negotiated arrangement is established), an amount that does not exceed 200% of the Medicare allowed amount, if any.

In the event the Non-Network Provider disputes the Plan's Allowable Charge for any claim subject to the No Surprises Act (NSA) through the Independent Dispute Resolution (IDR) process, the Allowable Charge may be determined by a Certified IDR Entity.

Applied Behavioral Analysis, also known as Lovaas therapy, must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

Birthing Center means any freestanding health Facility, place, professional office, or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This Facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the Facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name drug means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complications of Pregnancy are determined as follows:

- These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.
- Other Pregnancy related conditions will be covered that are as medically severe as those listed.
- These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, or feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

District means Billings Public Schools.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury, and (d) is appropriate for use in the home.

Emergency Services mean the following:

(1) An appropriate medical screening examination (as required under section 1867 of the Social Security Act 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency; and

(2) Within the capabilities of the staff and facilities available at the Hospital (including a Hospital outpatient department that provides Emergency Services) or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment (as required under section 1867 of the Social Security Act 42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to a Medical Emergency, Emergency Services shall also include an item or service provided by a Non-Network Provider (regardless of the department of the Hospital in which items or services are furnished) after the Plan Participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Plan Participant is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Network Provider.

Employee means a person who is classified by his Employer as an active, common law employee and who is directly employed and compensated for services by the District, who meets the eligibility requirements and who is properly enrolled in the Plan.

Employer is Billings Public Schools.

Experimental and/or Investigational means services, supplies, care, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure was reviewed and approved by the treating Facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) except as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Charges section, if Reliable Evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going Phase I or Phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating Facility or by another Facility studying substantially the same drug, device, medical treatment, or procedure.

For purposes of this Plan, Phase III and Phase IV clinical trials will not be considered Experimental and/or Investigational. However, the Plan will not pay for any expenses associated with a Phase III or Phase IV clinical trial that should be funded by the clinical trial sponsor, pharmaceutical company, or some other source (other than the Plan Participant and/or the Plan).

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Facility means a healthcare institution which meets all applicable state or local licensure requirements.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being Generic.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed Facility, home care, and family counseling during the bereavement period.

Hospice Unit is a Facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A Facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the state in which the Facility operates.

- A Facility operating primarily for the treatment of Substance Abuse if it has received accreditation from the Commission of Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) or if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness, or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage, or complications of Pregnancy.

Independent Freestanding Emergency Department means a health care Facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Centers or Clinics.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 60-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

Medical Care Facility means a Hospital, a Facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

Medically or Dentally Necessary (Medical or Dental Necessity) care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically or Dentally Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically or Dentally Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a Body Mass Index (BMI) of 40+. The BMI is a factor produced by dividing a person's weight (in kilograms) by his or her height squared (in meters).

Network Provider/Network Facility means a healthcare institution or healthcare provider who have by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Newborn means an infant from the date of birth until the initial Hospital discharge or until the infant is 14 days old, whichever occurs first.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network Provider/Non-Network Facility means a healthcare institution or healthcare provider who do not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

Outpatient Care and/or Services is treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray Facility, an Outpatient Surgical Center, or the Plan Participant's home.

Outpatient Surgical Center is a licensed Facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Certified Nurse Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (PhD), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Billings Public Schools Employee Health Plan, which is a benefits plan for certain Employees of Billings Public Schools and is described in this document.

Plan Administrator means the District, which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-related services.

Plan of Care means a written plan that describes the services being provided and any applicable short-term and long-term goals, specific treatment techniques, anticipated frequency, and duration of treatment and/or treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

Plan Participant is any Employee, Retired Employee, or Dependent (as defined under this Plan) who is covered under this Plan.

Plan Year is the 12-month period beginning on July 1st and ending on the following June 30th.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

Qualifying Payment Amount (QPA) means the median of the contracted rates recognized by the Plan or recognized by all Plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a QPA, said amount will be determined by referencing an applicable state all-payer claims database or any eligible third-party database in accordance with applicable law.

Recognized Amount, except for Non-Network Provider air ambulance services, means an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable, and for Non-Network Provider air ambulance services, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

Retired Employee (Retiree) means a former active Employee of the District who was retired while employed by the District and elects to contribute to the Plan the contribution amount required from the Retired Employee.

Skilled Nursing Facility is a Facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial Care, or educational care.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a Facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility, or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco/nicotine and ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an Illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

PLAN EXCLUSIONS

Note: All exclusions related to Dental are shown in the Dental Benefits section.

The following are not covered under this Plan:

(1) **Abortion.** Services, supplies, care, or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy, or the Pregnancy is the result of rape or incest.

In the event complications arise after the performance of an elective induced abortion, any eligible expenses incurred to treat those complications will be considered by the Plan; however, the initial costs relating to an elective induced abortion *will not* be a Covered Charge, except for such abortions performed due to the life of the mother being endangered by the continued Pregnancy or when the Pregnancy is the result of rape or incest.

(2) **Coding guidelines.** Charges for inappropriate coding in accordance with the industry standard guidelines in effect at the time services were received.

(3) **Complications of non-covered treatments.** Care, services, or treatment required as a result of complications from a treatment not covered under the Plan, except as specifically stated as a benefit under the Abortion exclusion noted above.

(4) **Cosmetic procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and otoplasties.

This exclusion does not apply to breast reduction or augmentation for any reason, or for surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental anomalies, is deemed Medically Necessary, or as otherwise specifically stated as a benefit under this Plan.

(5) **Counseling.** Charges for hypnotism, marriage counseling, and any goal oriented behavior modification type therapy.

(6) **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care, or domiciliary care consisting chiefly of room and board, except as specifically stated as a benefit under this Plan.

(7) **Dental services.** Care, services, supplies, and treatment in connection with dental services / treatment, the nerves or roots of the teeth, gingival tissue or any other dental, orthodontic, or oral surgical charges, except as specifically stated as a benefit under this Plan.

(8) **Educational or vocational testing.** Services for educational or vocational testing or training, except as specifically stated as a benefit under this Plan.

(9) **Excess charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Allowable Charge.

(10) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational therapy, or physical therapy if covered by this Plan.

(11) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(12) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes, and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(13) **Foreign travel.** Care, treatment, or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(14) **Genetic counseling.** Charges for genetic counseling, except when there has been a family history of disorder.

(15) **Government coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(16) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician.

(17) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as specifically stated as a benefit under this Plan.

(18) **Homeopathy.** Care, treatment, services, and supplies in connection with homeopathy.

(19) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or Facility for the service.

(20) **Illegal acts.** Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of the Plan Participant engaging in, or attempting to engage in a felony, a riot, or public disturbance; and for which the Plan Participant is convicted, pleads guilty, enters an Alford plea, or enters a plea bargain agreement, including but not limited to a suspended sentence or deferred prosecution. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(21) **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for impotence or sexual dysfunction, except as specifically stated as a benefit under this Plan.

(22) **Infertility.** Care, supplies, services, and treatment for infertility or sterility, including but not limited to, artificial insemination or in vitro fertilization.

(23) **Learning disabilities**, behavioral modifications, or developmental delay services or treatment, except when provided as treatment for an autism spectrum disorder.

(24) **Mailing or sales tax.** Charges for mailing, shipping, handling, postage, conveyance, and sales tax.

(25) **Massage therapy.** Care, treatment, services, and supplies in connection with massage therapy.

(26) **Missed or canceled appointments** or the completion of claim forms.

(27) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(28) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

(29) **No Physician recommendation.** Care, treatment, services, or supplies not recommended and approved by a Physician; or treatment, services, or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

(30) **Non-compliance.** All charges in connection with treatments or medications where the Plan Participant either is in non-compliance with medical orders issued while an inpatient at or is discharged against medical advice from a Hospital or Skilled Nursing Facility.

(31) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-medical emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(32) **Non-traditional medical services.** Non-traditional medical services, treatments, and supplies which are not specified as covered under this Plan.

(33) **Obesity.** Care and treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness, except for treatment of Morbid Obesity or as provided consistent with the Affordable Care Act preventive services requirements.

(34) **Occupational Injury.** Care and treatment of an Injury or Illness that is occupational -- that is, arises from any employment or work for wage or profit, or for which the Plan Participant is entitled to benefits under any worker's compensation or occupational disease law, or any such similar law.

(35) **Personal comfort items.** Personal comfort items, patient convenience items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, first-aid supplies, and non-hospital adjustable beds.

(36) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document or that exceed the limits as shown under this Plan.

(37) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.

(38) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

(39) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness or Pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Medical Benefits – Schedule of Benefits or required by applicable law.

(40) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(41) **Services before or after coverage.** Care, treatment, or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(42) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization for men and women.

(43) **Temporomandibular joint syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome. Refer to the separate Dental Benefits section regarding coverage of temporomandibular joint syndrome.

(44) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit under this Plan.

(45) **War.** Any loss that is due to a declared or undeclared act of war or caused during the service in the armed forces of any country.

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

Sutter Health System Network Providers will be given additional consideration if this Plan is secondary. In this case, the Claims Administrator will also consider a claim received from a Sutter Health System Network Provider within one year from the date of issuance of the primary Explanation of Benefits. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within two years of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

DENTAL BENEFITS

Note: Participation in the Dental Benefits under this Plan may require a separate enrollment election. Please contact the Claims Administrator to confirm if a separate enrollment election is required.

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Plan Year, a Plan Participant must meet the deductible shown in the Dental Benefits – Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Dental Benefits – Schedule of Benefits has been incurred by members of a Family Unit toward their Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year benefits will be payable for a Plan Participant for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Dental Benefits – Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Dental Benefits – Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Allowable Charges made by a Dentist or other Physician for necessary care, appliances, or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams, including prophylaxis. Limit of two routine examinations per Plan Participant per Plan Year.

(2) Dental x-rays. Bitewing x-rays will be limited to two series per Plan Year.

(3) Fluoride treatments.

(4) Space maintainers.

(5) Sealants.

(6) Emergency palliative treatment for dental pain (includes x-rays).

Class B Services:
Basic Dental Procedures

(1) Oral surgery.

(2) Tooth extractions. This service includes local anesthesia and routine post-operative care.

(3) Endodontics (root canals).

(4) Periodontal services. Periodontic treatment, including appliances (bruxism), and will be payable up to the limits as stated in the Dental Benefits – Schedule of Benefits.

(5) Fillings.

(6) General anesthetics and the administration of such in conjunction with a covered dental procedure, including local infiltration anesthetics (novocaine) and nitrous oxide.

(7) Antibiotic drugs (when prescribed by a Dentist or Physician).

(8) Temporomandibular Joint (TMJ) Syndrome. Manipulative treatment of the jaw through splint therapy only for the treatment of Temporomandibular Joint (TMJ) Syndrome, will be payable up to the limits as stated in the Dental Benefits – Schedule of Benefits.

"Temporomandibular Joint (TMJ) Syndrome" is defined as the disorder of the temporomandibular joint (the joint which connects the mandible or jawbone to the temporal bone), and which is characterized as follows:

(a) Pain or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat, or shoulder;
(b) Popping or clicking of the jaw;
(c) Limited jaw movement or locking;
(d) Malocclusions, overbite, or underbite; and/or
(e) Mastication (chewing) difficulties.

Class C Services:
Major Dental Procedures

(1) Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain, or plastic materials will be included only when the teeth must be restored with gold.

(2) Installation of crowns.

(3) Installment of or addition to partial, full, or removable dentures or fixed bridgework to replace one or more natural teeth if such installation or addition is required due to the extraction, occurring on or after the Plan Participant's effective date of dental coverage under this Plan, of one or more natural teeth due to Injury or disease, and the new dentures or bridgework include the replacement of such extracted teeth and is completed within 24 months from the date of the extraction.

(4) Replacement or alteration of full or partial dentures or fixed bridgework, if such change is required due to one of the following, and is completed within 24 months after the date of such event as follows:

(a) an accidental Injury requiring oral surgery; or
(b) oral surgery treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus, or redundant tissue.

(5) Recementing bridges, crowns, or inlays.

(6) Installing precision attachments for removable dentures.

(7) Addition of clasp or rest to existing partial removable dentures.

(8) Repair of crowns, bridgework, and dentures.

(9) Rebasing or relining of removable dentures.

(10) Tooth implants. Charges in connection with tooth implants will be payable up to the limits as stated in the Dental Benefits – Schedule of Benefits.

(11) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if:

(a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable, but in no event for a replacement made less than two years after the effective date of dental coverage under this Plan.

(b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

Class D Services:
Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

Orthodontic appliances and treatment, *incurred during the course of orthodontic treatment which begins only when the individual is covered by this Plan*, are available for Plan Participants and will include preliminary study, x-rays, diagnostic casts and treatment plan, active treatments, and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments.** Charges for broken or missed dental appointments.

(3) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.

(4) **Duplicate services.** Any duplicate services rendered prior to the end of any specified time interval.

(5) **Employer.** Any services and supplies furnished by or through an employer, mutual benefit association, labor union, trustee, or similar type group.

(6) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(7) **Hygiene.** Oral hygiene, plaque control programs, or dietary instructions.

(8) **Installation.** Replacement, installation, alteration of, or additions to, dentures or fixed bridgework, except as specifically stated as a benefit under this Plan.

(9) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(10) **No listing.** Services which are not included in the list of covered dental services.

(11) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.

(12) **Personalization.** Personalization of dentures.

(13) **Prescribed.** Any services and supplies unless prescribed as Medically or Dentally Necessary by a Dentist or Physician (acting within the scope of his or her license).

(14) **Replacement.** Replacement of lost, misplaced, or stolen dental appliances.

(15) **Splinting.** Crowns, fillings, or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion), or is considered Cosmetic Dentistry.

(16) **Sport.** Items intended for sport or home use, including but not limited to, athletic mouth guards, toothbrushes, toothpaste.

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show his or her **EBMS/Billings Public Schools Employee Health Plan** identification card to the provider. Providers may submit claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from his or her health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number (**Billings Public Schools, Group #00600**)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at http://www.ebms.com.

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the Claims Administrator at the address below:

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within ***365 days*** from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred, unless the claimant is legally incapacitated. Claims received later than that date will be denied.

Sutter Health System Network Providers will be given additional consideration if this Plan is secondary. In this case, the Claims Administrator will also consider a claim received from a Sutter Health System Network Provider within one year from the date of issuance of the primary Explanation of Benefits. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A "Claim" means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain services is strongly recommended, but not required by the Plan. A pre-notification of services is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits and cannot be appealed under this section. Please refer to the Care Management Services section.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are two types of Claims:

Concurrent Care Determination

A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan Participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services section.*

Post-Service Claim

A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

Initial Benefit Determination

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.** If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45 day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information. Under the No Surprises Act, the Plan will have up to 30 calendar days to send a notice of denial of payment or an initial payment to the Non-Network Provider from the time the Claim is resubmitted with additional information.

Notice of Adverse Benefit Determination

If a Claim is denied in whole or in part, the Plan shall provide written or electronic notice of the determination that will include the following:

(1) Information to identify the Claim involved.

(2) Specific reason(s) for the denial, including the denial code and its meaning.

(3) Reference to the specific Plan provisions on which the denial was based.

(4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

(5) Description of the Plan's Internal Appeal Procedures and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once the Claimant has exhausted all available internal and external review procedures.

(6) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

(7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

(9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan Participant's failure to timely pay required premiums.

Claims Review Procedure – General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records, and other information submitted by the Claimant related to the Claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Note: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Non-Network Provider, and the provider has no recourse against the Plan Participant under the No Surprises Act, the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with a Non-Network Provider's payment dispute through the IDR process.

Internal Appeal Procedure

First Level of Internal Review

The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). For Sutter Health System Network Provider Claims, the written request must be submitted within 24 months of the date of the Initial Benefit Determination on a Post Service Claim. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
c/o Employee Benefit Management Services, LLC (EBMS)
Attn: Claims Appeals
P.O. Box 21367
Billings, MT 59104

An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The First Level of Internal Review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

Second Level of Internal Review

If the Claimant does not agree with the Claims Administrator's determination from the First Level of Internal Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review (or 15 days for an appeal of a Concurrent Care Determination), along with any additional supporting information to:

Billings Public Schools
Insurance Office
Attn: Claims Appeals
415 N. 30th
Billings, MT 59101

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the Second Level of Internal Review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The Claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review, unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the first level of review.

External Review Procedure

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within four months from the date of receipt of the notice of the final internal adverse benefit determination or the first day of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or service is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.
- Violation of surprise billing protections as identified within the NSA.
- Application of treatment limits to a Claim for a Mental Disorder.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within six business days as to whether the Claimant's request is eligible for external review and if additional information is necessary to process the Claimant's request. If the Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process the Claimant's request, the Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

The Claimant should receive written notice from the assigned IRO of the Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives the Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. ***Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within two years of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.***

EXAMINATION. The Plan Administrator shall have the right and opportunity to have a Plan Participant examined, whose Injury or Illness is the basis of a Claim hereunder, when and as often as it may reasonably require during pendency of a Claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

FACILITY OF PAYMENT. Whenever a Plan Participant or provider to whom payments are directed to be made shall be mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the District nor the fiduciary(ies) shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, Claims Administrator, or any fiduciary shall not be liable to any person as a result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges. However, this Plan does not adopt the definition for "Allowable Expenses" set forth in the NAIC Model COB Regulations, as amended. If there is a difference between the contracted rates of the primary plan and this Plan, this Plan will base its payment on the lower of the two contracted rates.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or non-group insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and non-group coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical components of long-term care contracts, such as skilled nursing care;

(6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan; or

(7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident, or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See the definition of "Allowable Charge" in the Defined Terms section.)

In the case of Health Maintenance Organization (HMO) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or Network Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Plan Participant does not use an HMO or Network Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Plan Participant used the services of an HMO or Network Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:

(a) The benefits of the plan which covers the person directly (that is, as an Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B"). For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is Retired), THEN Plan B will pay first.

(b) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated, or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's spouse does, the plan of that parent's spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree;
- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

1st The plan covering the custodial parent,
2nd The plan covering the spouse of the custodial parent,
3rd The plan covering the non-custodial parent, and
4th The plan covering the spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (e) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor Retired or as a Dependent of an Employee who is neither laid off nor Retired are determined before those of a plan which covers that person as a laid-off or Retired Employee. This rule does not apply if Rule (a) can be used to determine the order of benefits. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(d) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor Retired or a Dependent of an Employee who is neither laid off nor Retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (a) can be used to determine the order of benefits.

(e) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan.

THIRD PARTY RECOVERY PROVISION

Defined Terms

"Plan Participant" means anyone covered under the Plan, including but not limited to minor dependents and deceased Plan Participants. Plan Participant shall include the parents, trustee, guardian, heir, personal representative, or other representative of a Plan Participant, regardless of applicable law and whether or not such representative has access or control of the Recovery.

"Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise to compensate for any loss related to any Injury, Illness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages, and/or any other recovery of any form of damages or compensation whatsoever.

"Third Party" means any third party including but not limited to another person, any business entity, insurance policy or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), umbrella policy.

Subrogation Provisions

To the extent that the Plan has paid benefits to or on behalf of a Plan Participant, the Plan has a right of reimbursement of such benefits and is entitled to subrogation as provided herein, against a judgment or recovery received by the Plan Participant from a Third Party found liable for a wrongful act or omission that caused the Injury or Illness necessitating benefit payments.

If a Plan Participant intends to institute an action for damages against a Third Party, the Plan Participant shall give the Plan reasonable notice of the Plan Participant's intention to institute the action. Reasonable notice shall include information reasonably calculated to inform the Plan of the facts giving rise to the Third Party action and of any potential Recovery.

The Plan Participant may request that the Plan pay a proportionate share of the reasonable costs of the Third Party action, including attorney fees.

The Plan may elect not to participate in the costs of the action. If such an election is made, the Plan waives 50% of any subrogation rights granted to the Plan through this provision.

The Plan Participant shall take no action through settlement or otherwise which prejudices the rights and interests of the Plan, and shall cooperate fully with the Plan and its agents, regarding the Plan's rights under this section.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept Late Enrollees.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA. **A domestic partner is not a Qualified Beneficiary.**

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the Plan as a "Dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee's Spouse, surviving spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

<u>When is COBRA Continuation Coverage available?</u>

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator:
Billings Public Schools
Insurance Office
415 N. 30th
Billings, MT 59101

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

<u>How is COBRA Continuation Coverage provided?</u>

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

<u>How long does COBRA Continuation Coverage last?</u>

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18-month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination of employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18-month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator:
Billings Public Schools
Insurance Office
415 N. 30th
Billings, MT 59101

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator:
Billings Public Schools
Insurance Office
415 N. 30th
Billings, MT 59101

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

Plan Administrator:
Billings Public Schools
Insurance Office
415 N. 30th
Billings, MT 59101
(406) 281-5045

COBRA Administrator:
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

For more information about your rights under the Public Health Services Act, COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA CONTINUATION COVERAGE
FOR RETIREES' DEPENDENTS

COBRA Continuation Coverage will not be available to those Retired Employees that elected, at the time of retirement, to continue coverage under the terms of the Plan as a Retiree. However, the following COBRA Continuation Coverage may apply to a Retired Employee's Qualified Beneficiaries.

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to certain Plan Participants when group health coverage would otherwise end.

The Retired Employee's family members may have other options available when they lose group health coverage. For example, they may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, an individual may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which the individual is eligible (such as a Spouse's plan), even if that plan generally doesn't accept Late Enrollees.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." Certain covered family members could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA. ***A domestic partner is not a Qualified Beneficiary.***

If you are the Spouse of a covered Retired Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies; or
- You become divorced or legally separated from your Spouse.

Dependent children of the covered Retired Employee will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-covered Retired Employee dies;
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the Plan as a "Dependent child."

Filing a proceeding in bankruptcy with respect to the Employer under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is death of the covered Retiree, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other Qualifying Events (divorce or legal separation of the Retired Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator:
Billings Public Schools
Insurance Office
415 N. 30th
Billings, MT 59101

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

<u>How is COBRA Continuation Coverage provided?</u>

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Retirees may elect COBRA Continuation Coverage on behalf of their Spouse and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

<u>How long does COBRA Continuation Coverage last?</u>

COBRA Continuation Coverage is a temporary continuation of coverage that generally lasts for 18 months. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

If the Qualifying Event is the death of the covered Retiree (or former Retiree), divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Retiree dies, gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator:
Billings Public Schools
Insurance Office
415 N. 30th
Billings, MT 59101

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your former Employer ceases to provide a group health plan to any Retired Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

Plan Administrator:
Billings Public Schools
Insurance Office
415 N. 30th
Billings, MT 59101
(406) 281-5045

COBRA Administrator:
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

For more information about your rights under the Public Health Services Act, COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Billings Public Schools Employee Health Plan is the benefit plan of Billings Public Schools, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Billings Public Schools to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies, or is otherwise removed from the position, Billings Public Schools shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator has the authority to, and does so allocate limited fiduciary duties to American Health Holdings, Inc. Those duties are limited to a review of and determination on a Plan Participant's request (or a request by the Plan Participant's treating provider) for a pre-determination of benefits prior to the occurrence of treatment or services. As part of those limited duties, American Health Holdings shall have the discretionary authority and ultimate decision-making authority to review the request and any submitted documentation, make a decision, respond to an appeal if the decision is to deny the request, and to maintain records related to its activities related to this decision. See the Care Management Services section for additional information.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

FUNDING PROVISION

The coverage afforded to a covered Employee by the Plan Document / Summary Plan Description shall be at least partially funded by the District. If a covered Employee elects to enroll his/her eligible Dependent(s) under the Plan Document / Summary Plan Description, the covered Employee may be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment. For active Employees, the District shall deduct such costs on a regular basis from the covered Employee's wages or salary.

FAILURE TO ENFORCE

Failure to enforce any provisions of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

STATEMENTS

In the absence of fraud, all statements made by a Plan Participant will be deemed representations and not warranties. No such representations will void the Plan benefits. No such representations may be used in defense to a claim under the Plan unless a copy of the instrument containing such representation is or has been furnished to the Plan Participant.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending, or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses, or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium. In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Executive Director of Human Resources
Chief Financial Officer (CFO)
Director of Business Services
Benefits Manager

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers, or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "SECURITY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

(4) Report to the Plan any security incident of which it becomes aware.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan, and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME: Billings Public Schools Employee Health Plan

TAX ID NUMBER: 81-6001088

PLAN EFFECTIVE DATE: July 1, 1994

PLAN YEAR ENDS: June 30th

EMPLOYER INFORMATION

Billings Public Schools
415 N. 30th
Billings, MT 59101
(406) 281-5045

PLAN ADMINISTRATOR

Board of Trustees
415 N. 30th
Billings, MT 59101
(406) 281-5045

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

Plan Name: **Billings Public Schools Employee Health Plan**

Effective: **July 1, 1994**

Restated: **July 1, 2022**

I, ___________________________________ , certify that I am the ________________________________
Name Title

of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms stated herein and am hereby authorizing the implementation of the Plan as of the effective date stated above.

Signature: ____

Print Name: _______________________________________

Date: ____