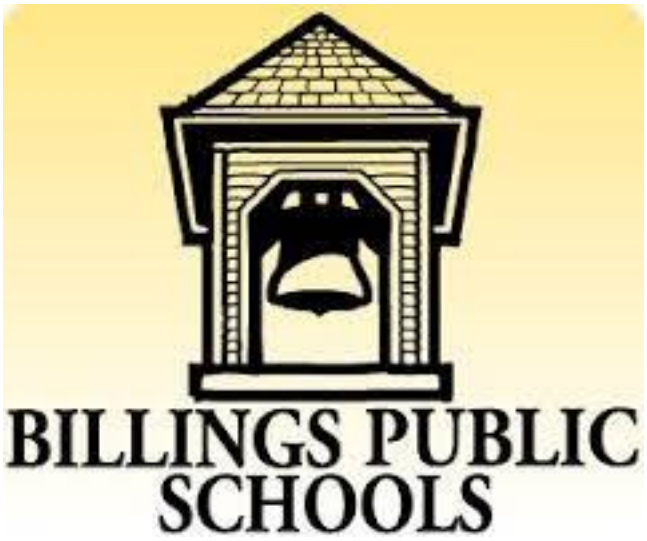

BILLINGS PUBLIC SCHOOLS

PRIMARY CARE PLAN

PLAN DOCUMENT

EFFECTIVE: JULY 1, 1994

RESTATED: JULY 1, 2017

HOW TO OBTAIN BENEFITS

Once you become eligible, this Plan has the responsibility for seeing that you receive all the benefits to which you are entitled. To receive these benefits as quickly as possible, complete clearly and accurately any forms required.

To assist Employee Benefit Management Services ("EBMS") in processing your claim, please follow the steps listed below.

WHEN YOU HAVE A CLAIM:

Step 1. **If the claim is caused from an accident**, secure the proper claim form from EBMS. You should familiarize yourself with these forms and make sure that you have the correct form when filing a claim.

Step 2. Fill out your portion of the claim form.

Step 3. Have your doctor fill out his or her portion of the form. Please make sure the doctor completes all the information requested, INCLUDING DIAGNOSIS AND PROCEDURE CODES.

Step 4. In the case of Hospital confinements, a form provided by the Hospital must be completed in detail by the Hospital and submitted to EBMS.

Step 5. Attach all bills or receipts relating to the health service provided. Make sure the bill clearly identifies what services were performed and what the charge for each service was. All itemized bills must show the following:

(a) The Participant's name;
(b) The patient's name;
(c) The Physician's name;
(d) The type of service rendered;
(e) An itemization of the charges;
(f) The condition for which the expense was incurred; and
(g) The date of service.

A receipt for a prescription drug must show the following:

(a) The Participant's name;
(b) The patient's name;
(c) The prescribing Physician;
(d) The prescription number;
(e) An itemization for each separate prescription item; and
(f) The date of purchase.

Step 6. If you have any questions regarding Steps 1-5, contact EBMS.

Step 7. If a claim is for a Dependent, follow the first five steps above and be sure to complete that portion of the claim form referring to your Dependent; and

Step 8. Forward complete claim form and all related bills to:

EMPLOYEE BENEFIT MANAGEMENT SERVICES, INC.
P. O. Box 21367
Billings, MT 59104-1367

Questions on Claims - Call:
(406) 245-3575

Outside Billings:
1 (800) 872-3200 or
1 (800) 777-3575 (Outside Montana)

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ARTICLE I

INTRODUCTION AND PLAN INFORMATION

NAME OF PLAN
The name of the Plan is Billings Public Schools Employee Health Plan.

PURPOSE OF THE PLAN
Billings Public Schools executes this document, including any addenda, to establish a health benefit Plan for the exclusive benefit of its Participating Participants and their Dependents and to grant them legally enforceable rights under this Plan.

EFFECTIVE DATE
The effective date of the Plan Document is July 1, 1994.

PLAN ADMINISTRATOR TAX ID NUMBER (EIN)
81-6001088

PLAN NUMBER
501

PLAN YEAR
The Plan Year is a period beginning on July 1 and ending on the last day of June.

PLAN FIDUCIARIES, TITLES, ADDRESSES
The Named Plan Fiduciaries, their titles and principal place of business are:

Board of Trustees
415 N. 30th
Billings, MT 59101

Grandfathered Health Plan. This Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or the U.S. Department of Health and Human Services at www.HealthCare.gov. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ARTICLE II

SCHEDULE OF BENEFITS

Medical Plan B

Individual Deductible per Plan Year	$500
Aggregate Family Deductible per Plan Year	$1,000
Benefit Percentage	80%
Individual Out-of-Pocket per Plan Year	$2,500
Aggregate Family Out-of-Pocket per Plan Year	$5,000
Primary Care Office Visit Copayment – No Deductible will apply	$10
Prescription Drug Benefit – Deductible will apply	80%
Chemical Dependency, Alcoholism – No Deductible will apply	70%
Routine Office Visit Copayment – No Deductible will apply	$10
Routine Well Care – No Deductible will apply	70%
Routine Well Child Care – No Deductible will apply	Payable as any other Illness
Women's Preventive Services – No Deductible will apply	100%
Hepatitis B Immunizations – No Deductible will apply	100%
Immunizations – No Deductible will apply	100%

miRx Pharmacy Prescription Drug Benefit – Medical Plan B:

Generic Prescription Drugs – No Deductible will apply	100%
Brand Name Prescription Drugs – Deductible will apply	80%

Medical Plan C

Individual Deductible per Plan Year	$1,000
Aggregate Family Deductible per Plan Year	$2,000
Benefit Percentage	70%
Inpatient Hospital Admission Copayment per Admission	$300
Individual Out-of-Pocket per Plan Year	$3,000
Aggregate Family Out-of-Pocket per Plan Year	$6,000
Primary Care Office Visit Copayment – No Deductible will apply	$25
Prescription Drug Benefit – Deductible will apply	70%
Chemical Dependency, Alcoholism – No Deductible will apply	70%
Routine Office Visit Copayment – No Deductible will apply	$25
Routine Well Care – No Deductible will apply	70%
Routine Well Child Care – No Deductible will apply	Payable as any other Illness
Women's Preventive Services – No Deductible will apply	100%
Hepatitis B Immunizations – No Deductible will apply	100%
Immunizations - No Deductible will apply	100%

miRx Pharmacy Prescription Drug Benefit – Medical Plan C:

Generic Prescription Drugs – No Deductible will apply	100%
Brand Name Prescription Drugs – Deductible will apply	70%

Medical Plan B and Medical Plan C:

The Out-of-Pocket maximum will include the co-insurance and the Deductible combined. The following will not apply to the Out-of-Pocket maximum and are never paid at 100%:

- Copayments
- Routine Well Care services
- Inpatient or outpatient Chemical Dependency/Alcoholism treatment

ALL PLANS WILL INCLUDE THE FOLLOWING BENEFITS:

Plan Year Benefit Maximum.....Unlimited

Mental Illness or Disorder

Inpatient Services:

Day Maximum per Plan Year.....30 days

Outpatient Services:

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

Two days of partial confinement in a Hospital will be considered as one day of confinement. Partial confinement means treatment for at least 3 hours, but no more than 12 hours, in any 24-hour period.

Alcoholism, Chemical Dependency

Inpatient Services:

Day maximum per Plan Year ..... 30 days

Outpatient Services:

Maximum Benefit per Plan Year..... 24 visits

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

Benefit Percentage..... 100%

NOTE: All charges are subject to the outpatient Maximum Benefit per Plan Year of 20 visits.

Inpatient Hospital Room and Board..... Average Semi-Private room rate

Intensive Care Unit (ICU).....Allowable Charge

Skilled Nursing Facility –

Daily limit — Average Semi-Private room rate

Maximum per Plan Year ..... 120 days

Home Health Care

Maximum per Plan Year..... 40 visits

Chiropractic Services

Plan Year Maximum .....20 Visits

Benefit Maximum Per Visit..... $25

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.

Diabetic Education

Plan Year maximum..... 3 visits

NOTE: All eligible charges are subject to the Plan Year deductible.

MATERNITY EXPENSE PROVISION

Female Plan Members.....	Payable the same as any other Illness
*Routine prenatal office visits	40% of Covered Expenses of the global maternity fee will be payable at 100%, deductible waived; thereaft er, subject to the applicable benefit percentage after deductible; ***OR,*** *if billed separately*, 100% of the routine prenatal office visits will be payable at 100%, deductible waived

Note: **Refer to the Coverage of Pregnancy benefit listed in the Major Medical Expense Benefits section for more information regarding routine prenatal office visits.*

Maternity Bonus - $100 bonus shall be paid to a Plan Member when the length of the Hospital stay is three (3) days or less when the services of a birthing center are utilized for delivery.

NON-EMERGENCY DEDUCTIBLE

Non-Emergency Use of the Emergency Room Deductible..... $25
8:00 a.m. to 5:00 p.m. weekdays

Applied Behavioral Analysis – (for covered Dependent children from birth through 18 years only)

Plan Year maximum ..... 152 visits

Down Syndrome Therapies Benefit – (for covered Dependent children from birth through age 18 years only)

Plan Year maximums:

Speech Therapy .....104 visits

Physical Therapy .....52 visits

Occupational Therapy.....52 visits

ROUTINE SERVICES:

Routine Well Care (Ages 8 years through Adult)**:**

Routine well care will include the following routine services: One Prostate Screening Antigen (PSA) test per Plan Year, routine laboratory and x-ray services, routine colorectal cancer screening services (*) and immunizations.

*Routine colorectal cancer screening services will include the following services: Fecal Occult Blood Test (FOBT), flexible sigmoidoscopy, colonoscopy, barium enema.

Charges for Women's Preventive Services (Ages 13 years through Adult):

Women's Preventive Services will be subject to age and developmentally appropriate frequency limitations as determined by the Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Schedule of Benefits,* and will be payable as stated under the Routine Well Care benefit as stated in the Schedule of Benefits section of this Plan.

Coverage will include but will not be limited to the following routine services that is neither for an Illness nor an Injury and which applicable services can be located using the following website:

http://www.hrsa.gov/womensguidelines

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), 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.

Routine Office Visits. Routine office visits other than those included in the separate Routine Well Care benefit listed above will be payable as stated in the Schedule of Benefits.

Hepatitis B Immunizations:

One series per Plan Member..... Lifetime maximum

Routine Well Child Care*- (Birth through 7 years of age):

* *Refer to ARTICLE V – MAJOR MEDICAL EXPENSES - COVERED EXPENSES section for more information regarding the routine well child care benefit.*

DENTAL SERVICES

SCHEDULE OF BENEFITS

Note: Participation in the Dental Services Benefits will require a separate enrollment election.

There is a separate co-insurance and deductible for dental services.

Individual Deductible $50

Aggregate Family Deductible $100

Preventive & Diagnostic Benefit Percentage 100%

Basic Care Benefit Percentage 80%

Major Restorative Benefit Percentage 50%

Orthodontic Care Benefit Percentage 50%

Maximum Plan Year Benefits

Preventive Services for covered Dependent children ages 19 and under ..... No Maximum

All other Dental services **(including those listed below with a Lifetime Maximum)**, other than Tooth Implants, for covered Dependent children over age 19 and all other Plan Members $2,000

Orthodontic

Lifetime Maximum $2,000

Tooth Implants

Lifetime Maximum $2,000

Benefit Percentage 50%

Temporomandibular Joint

Lifetime Maximum $2,000

Benefit Percentage 80%

Periodontal

Lifetime Maximum $2,000

Benefit Percentage 80%

PRIMARY CARE PLAN

- **PCP: Primary Care Physician:**

  * General Practitioner
  * Family Practitioner
  * General Internist
  * Obstetrician/Gynecologist
  * Pediatrician
  * Immediate Care Center PCP
  * Nurse Practitioner
  * Physician Assistant (P.A.)

  The following specialists are covered according to the normal plan parameters with the Deductible and co-insurance applying.

  * Chiropractor
  * Opticians/Ophthalmologist
  * Mental Health Provider
  * Podiatrist

- **PCP Is Your Choice:**

  * PCP designation is not required.
  * PCP can be any choice of the above listed Physicians practicing in private or group practice, immediate care or urgent care center.
  * PCP can be any combination of the above listed Physicians. Example: Children to pediatrician, parents to internist.
  * PCP can be changed at any time.

- **Your PCP Provides You Access To Required Health Care Services:**

  * PCP Physician charges: 100% of the Allowable Charge after any applicable co-payment (as stated in the Schedule of Benefits). Deductible does not apply. Lab work, x-ray and diagnostic work will apply to the Deductible under the limits of the Plan.
  * Visits to M.D. specialists of your choice are subject to Deductible and co-insurance.

Primary Care Services encompass only these established CPT codes with those qualified PCP Physicians:

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

Emergency Procedures & Coverage

- In case of emergency, **seek most immediate medical attention**.
- Coverage of emergency treatment is based on normal Plan coverage by treatment code.
- Office visit or facility charges for an emergency visit can vary.
    * If in a PCP office, the office visit and related covered services will be covered at 100% of the Allowable Charge after any applicable co-payment (as stated in the Schedule of Benefits). Deductible does not apply.
    * If in an immediate care or urgent care center, the office visit and related Covered Expenses will be covered at 100% of the Allowable Charge after any applicable co-payment (as stated in the Schedule of Benefits). Deductible does not apply.
    * If in a Hospital emergency room, the facility visit will be covered according to the Plan.
- Call CareLink within two business days of emergency admission to the Hospital.

CareLink

- **CareLink: Patient/Physician Assistance Line**
- Please contact CareLink at (406) 245-3575 or toll-free (866) 894-1505.
- **CareLink will assist you with:**
    * Pre-notification
    * Large Case Management

SUMMARY

- Your PCP is your first point of contact for any non-emergency health care service and for an emergency when appropriate.
    * Office visit benefits for non-emergency services will be paid at 100% of the Allowable Charge after any applicable co-payment (as stated in the Schedule of Benefits). Deductible does not apply.

* Emergency care can be rendered by a PCP at his/her office. The office visit and related Covered Expenses will be covered at 100% of the Allowable Charge after any applicable co-payment (as stated in the Schedule of Benefits). Deductible does not apply.

- Emergency care through a Hospital emergency room is covered according to the Plan.

- Pre-notification of Hospital admission is strongly recommended and can be accomplished by contacting CareLink (406) 245-3575 or toll-free 1-(866) 894-1505.

- ***Please refer to the Care Management Services section for more information regarding pre-notification.***

*mi*CARE HEALTH CENTER BENEFITS

*mi*Care Health Center benefits apply when care, treatment, or service is provided by a contracted *mi*Care Health Center provider by a Plan Member 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, conditions and limitations as stated within Article IV, Coverage Under This Plan section under this Plan.

Benefit

Benefits for a Plan Member 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 CALENDAR YEAR	
Per Plan Member	None
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Per Plan Member	None
Covered Expenses	**Plan Member Pays**
Routine Well Care	$0
Office visits / minor office visit procedures	$0
Laboratory Services	$0
***WellVia* Telehealth benefit**	$0
All Other Covered miCare Clinic Services	$0

WellVia Telehealth

The *WellVia* Telehealth benefit offers Plan Members 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.

Covered Expenses 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 1 (877) 872-0370 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.

Pharmacy and Mail Order
Prescription Drug Option

Covered Expenses	Plan Member Pays	
	Retail Pharmacy 34 - day supply	**Mail Order 90-day supply**
Generic drugs Medical Plan B and Medical Plan C	$0, deductible waived	$0, deductible waived
Brand Name drugs		
Medical Plan B	20% after medical deductible	20% after medical deductible
Medical Plan C	30% after medical deductible	30% after medical deductible

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

Any one pharmacy prescription is limited to a 34-day supply. Any one mail order prescription is limited to a 90-day supply.

Note: The miRx Mail Order Prescription Drug Option is available in certain states. Please contact the Claims Administrator, EBMS, Inc., toll free at 1 (866)-894-1504 for more information regarding this benefit.

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Plan Member 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 Member 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 benefit, and can only be appealed under the procedures in this Care Management Services section. A pre-notification cannot be appealed under the Plan's Claims Review Procedures.*

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

- Inpatient admissions to a Hospital
- 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, but not limited to, hysterectomies, back surgery, or bariatric surgery; and
- Outpatient services as follows:
    - Dialysis
    - Genetic testing
    - Injectables
    - Home Health Care
    - Hospice
    - 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 Member should notify CareLink at least seven (7) 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 Member
- 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 Member, the Plan Member's family member, Hospital or attending Physician should notify CareLink within two (2) 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 Member 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 fifteen (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 Member 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 Member will be provided notice of the Plan's determination. If the pre-authorization request is denied, written notice will provide the reason for the adverse pre-notification determination.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within thirty (30) days of the receipt of the adverse pre-notification determination and include a statement as to why the Plan Member disagrees with the adverse pre-notification determination. The Plan Member may include any additional documentation, medical records, and/or letters from the Plan Member'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 Member, 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. Written or electronic notice of the determination upon reconsideration will be provided within thirty (30) days of the receipt of the request for reconsideration.

CASE MANAGEMENT

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

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 Member and family choose not to participate.

Each treatment plan is individualized to a specific Plan Member 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 Member and the attending Physician.

ARTICLE III

DEFINITIONS

ALCOHOLISM, CHEMICAL DEPENDENCY, DRUG ADDICTION OR SUBSTANCE ABUSE
The terms "Alcoholism, Chemical Dependency, Drug Addiction or Substance Abuse" mean the taking of alcohol or other drugs at dosages that place a Plan Member's welfare at risk, cause the Plan Member to endanger the public welfare and which constitute alcohol or drug dependence.

ALLOWABLE CHARGE
The term "Allowable Charge" means the charge for a treatment, service, or supply that is the lesser of: 1) the charge made by the provider that furnished the care, service, or supply; 2) the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement; 3) the reasonable and customary charge for the same treatment, service, or supply furnished in the same geographic area by a provider of like service as further described below; or 4) an amount equivalent to the following:

1. For specialty drugs,130% of the average sales price;
2. For inpatient or outpatient facility claims, an amount equivalent to 200% of the Medicare equivalent allowable.

The reasonable and customary charge shall mean an amount equivalent to the **90th percentile** of a commercially available database, or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan. If there are insufficient charges submitted for a given procedure, the Plan will determine an Allowable Charge based upon charges made for similar services. Determination of the reasonable and customary charge will consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that provider.

For Covered Charges rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charge.

The Plan Administrator or its designee has the ***ultimate discretionary authority*** to determine an Allowable Charge, including establishing the negotiated terms of a provider arrangement (including a PPO agreement if applicable) as the Allowable Charge even if such negotiated terms do not satisfy the lesser of test described above.

In rare instances, Hospital services reimbursed on a Diagnostic Related Grouping (DRG), Ambulatory Payment Classification (APC), or per diem PPO rate, can be repriced to exceed the billed amount. Excess charges are not subject to the Plan Member's deductible or out-of-pocket maximum and will be the Plan's responsibility.

APPLIED BEHAVIORAL ANALYSIS
Applied Behavioral Analysis, also known as Lovaas therapy, is therapy 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.

For purposes of Applied Behavioral Analysis, care shall include Medically Necessary interactive therapies derived from evidence-based research, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

BENEFIT ADMINISTRATOR
The term "Benefit Administrator" means the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the administration, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written administration agreement. If no Benefit Administrator is appointed or retained (as a result of the termination or expiration of the administrative agreement or other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by the Benefit Administrator in writing, the term will mean the Plan Administrator.

The Benefit Administrator of the Plan is:

Employee Benefit Management Services, Inc.
2075 Overland Avenue
P.O. Box 21367
Billings, MT 59104-1367
(406) 245-3575
1-800-777-3575

BENEFIT PERIOD
The term "Benefit Period" means a time period of one (1) year commencing with the effective date of this Plan or the Plan anniversary. This Benefit Period will terminate on the earliest of the following dates:

A. The last day of the one (1) year period;

B. The day the Plan Benefit Maximum applicable to the Plan Member becomes payable; or

C. The day the Plan Member ceases to be covered for benefits under this Plan.

BRAND NAME DRUG
The term means a trade name medication.

CLOSE RELATIVE
The term "Close Relative" means the spouse, parent, brother, sister, child or spouse's parent of a Plan Member.

COBRA
The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended.

COMPLICATIONS OF PREGNANCY
The term “Complications of Pregnancy” is 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 PROCEDURE
The term "Cosmetic Procedure" means a procedure performed solely for the improvement of a Plan Member's appearance rather than for the improvement or restoration of bodily function.

COVERED EXPENSE(S)
The term "Covered Expense(s)" means expenses incurred by a Plan Member for any Medically Necessary treatments, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

CUSTODIAL CARE
The term "Custodial Care" means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Plan Member, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of meals or special diets, housekeeping, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

DEDUCTIBLE
The term "Deductible" means a specified dollar amount of Covered Expenses that must be incurred during a year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and this Plan.

DEPENDENT
The term "Dependent" means:

A. The Participant's legal spouse who is a resident of the same country in which the Participant resides. Such spouse must have met all requirements of a valid marriage contract in the state of marriage of such parties; and

B. The Participant's child who meets all of the following conditions:

1. Is a citizen or a resident of the United States; and

2. Is a natural child, stepchild, legally adopted child or child for whom the Participant becomes legally responsible by reason of placement for adoption, or a child who has been placed under the legal guardianship of the Participant; and

3. Is less than 26 years of age.

   The age requirement is waived for any mentally or physically handicapped child who is incapable of self-sustaining employment and is chiefly dependent upon the Participant for support and maintenance, provided the child suffered such incapacity prior to attaining 26 years of age. Proof of incapacity must be furnished to the Plan Administrator, or its designee, and additional proof may be requested from time to time.

This Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO). Any child of a Plan Member 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 Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

The term "Dependent" excludes these situations:

A spouse who is legally separated or divorced from the Participant. Such spouse must have met all requirements of a valid separation agreement or divorce decree in the state granting such separation or divorce.

DEPENDENT COVERAGE
The term "Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of an Illness or Injury of a Dependent.

DISTRICT
The term "District" means Billings Public Schools.

DURABLE MEDICAL EQUIPMENT
The term "Durable Medical Equipment" means equipment which is:

A. Able to withstand repeated use;

B. Primarily and customarily used to serve a medical purpose; and

C. Not generally useful for a person in the absence of Illness or Injury.

FAMILY
The term "Family" means a covered Participant and his covered Dependents.

FULL-TIME EMPLOYMENT
The term "Full-Time Employment" means a basis whereby a Participant is employed, and is compensated for services, by the District for at least the number of hours per week stated in the eligibility requirements. The work may occur either at the usual place of business of the District or at a location to which the business of the District requires the Participant to travel.

GENERIC DRUG
The term 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.

HABILITATIVE AND REHABILITATIVE CARE
Habilitative and Rehabilitative Care shall include Medically Necessary interactive therapies derived from evidence-based research, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

HOME HEALTH CARE AGENCY
The term "Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

A. It is primarily engaged in providing skilled nursing and other therapeutic services and is duly licensed, if such licensing is required, by the appropriate licensing authority to provide such services;

B. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse;

C. It maintains a complete medical record on each individual; and

D. It has a full-time administrator.

HOSPICE
The term "Hospice" means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Plan Members suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE BENEFIT PERIOD
The term "Hospice Benefit Period" means a specified amount of time during which the Plan Member undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Plan Member certifies a prognosis of terminally ill, and the Plan Member is accepted into a Hospice program.
The period shall end the earliest of six (6) months from this date or at the death of the Plan Member. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof may be required by the Plan Administrator or its designee before a new Hospice Benefit Period can begin.

HOSPITAL
The term "Hospital" means 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
The term "Illness" means a bodily disorder, disease, physical sickness, mental infirmity, or Pregnancy. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

INFERTILITY
The term "Infertility" means incapable of producing offspring.

INJURY
The term "Injury" means a condition caused by accidental means which results in damage to the Plan Member's body from an external force.

INPATIENT
The term "Inpatient" refers to the classification of a Plan Member when that person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Plan Member as a result of such admission.

INTENSIVE CARE UNIT
The term "Intensive Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

A. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

B. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

C. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

LICENSED PRACTICAL NURSE
The term "Licensed Practical Nurse" means an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

MEDICAL EMERGENCY
The term "Medical Emergency" means an illness or injury of sudden, acute onset requiring immediate Physician and Hospital attention. Examples of Medical Emergency are heart attacks or suspected heart attacks, coma, loss of respiration, strokes, broken bones and acute appendicitis.

MEDICALLY NECESSARY
The term "Medically Necessary" means that a service, medicine, or supply is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted current medical practice.

A service, medicine, or supply will not be considered Medically Necessary if:

A. It is provided only as a convenience to the Plan Member or provider;

B. It is not appropriate treatment for the Plan Member's diagnosis or symptoms;

C. It exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;

D. It is part of a plan of treatment that is considered to be investigational, experimental or for research purposes in the diagnosis or treatment of an Illness or Injury. "Investigational, experimental or for research purposes" means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or

E It involves the use of a drug or substance not formally approved by the United States Food and Drug Administration, even if approval is not required. The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not of itself, make the service or supply Medically Necessary.

MEDICARE
The term "Medicare" means the programs established by Title I of Public Law 89-98 as amended entitled "Health Insurance for the Aged Act," and which includes parts A and B of Subchapter XVII of the Social Security Act as amended from time to time.

MENTAL ILLNESS OR DISORDER
The term "Mental Illness or 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.

MINOR EMERGENCY MEDICAL CLINIC
The term "Minor Emergency Medical Clinic" means a free-standing facility, regardless of its name, including an ambulatory surgical center that is engaged primarily in providing minor emergency and episodic medical care to a Plan Member. A Physician, a Registered Nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system.

MORBID OBESITY
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).

NEWBORN
The term "Newborn" means an infant from the date of birth until the initial Hospital discharge or until the infant is fourteen (14) days old, whichever occurs first.

ORTHOTIC APPLIANCE
The term "Orthotic Appliance" means an external device intended to correct any defect in form or function of the human body.

OUTPATIENT
The term "Outpatient" refers to the classification of a Plan Member when that Plan Member receives medical care, treatment, services or supplies at a clinic, a Physician's office, or at a Hospital, if not a registered bed patient at that Hospital, an Outpatient Psychiatric Facility or an Outpatient Alcoholism Treatment Facility.

OUTPATIENT ALCOHOLISM TREATMENT FACILITY
The term "Outpatient Alcoholism Treatment Facility" means an institution which provides a program for diagnosis, evaluation, and effective treatment of Alcoholism; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services or arrangements at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse; prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards.

OUTPATIENT PSYCHIATRIC FACILITY
The term "Outpatient Psychiatric Facility" means an administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PARTICIPANT
The term "Participant" means a person who is directly employed and compensated for services by the District, who meets the eligibility requirements and who is properly enrolled in the Plan.

PHYSICIAN
The term "Physician" means a medical practitioner who:

A. Is a legally qualified Physician or surgeon (or is a professional person deemed by state law to be the same as a legally qualified Physician); and

B. Is acting within the lawful scope of his or her license.

Physician DOES NOT include a person who:

A. Is the Plan Member receiving treatment; or

B. Is a relative of the Plan Member receiving treatment.

PLAN
The term "Plan" means without qualification this Plan Document.

PLAN ADMINISTRATOR
The term "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 MEMBER
The term "Plan Member" shall mean a Participant, Retiree, or Dependent (as defined under this Plan) who is covered under this Plan.

PLAN OF CARE
The term "Plan of Care" is 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 Member's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Member's condition changes.

PLAN YEAR
The term "Plan Year" means a period of time beginning with the effective date of this Plan or the anniversary of this date and ending on the day before the next anniversary of the effective date of this Plan.

PREGNANCY
The term "Pregnancy" means that physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

PRESCRIPTION DRUG
The term shall mean 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. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

PSYCHIATRIC CARE
The term "Psychiatric Care," also known as psychoanalytic care, means treatment for a Mental Illness or Disorder, Alcoholism or Drug Addiction.

PSYCHOLOGIST
The term "Psychologist" means an individual holding the degree of Ph.D., licensed by the jurisdiction in which he practices and acting within the scope of his license.

REGISTERED NURSE
The term "Registered Nurse" means an individual who has received specialized nursing training, is authorized to use the designation of "R.N.", and is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

RETIREE
The term "Retiree" shall mean 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.

ROOM AND BOARD
The term "Room and Board" refers to all charges by whatever name called which are made by a Hospital, Hospice, or Convalescent Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SEMI-PRIVATE
The term "Semi-Private" refers to a class of accommodations in a Hospital or Skilled Nursing Facility.

SKILLED NURSING FACILITY
The term "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 Sickness. 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 per day 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.

TOTAL DISABILITY (TOTALLY DISABLED)
The term "Total Disability" means a physical or mental state of a Plan Member resulting from an Illness or Injury which wholly prevents:

A. In the case of Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and

B. In the case of a Dependent, from performing the normal activities of a person of like age and sex in good health.

ARTICLE IV

COVERAGE UNDER THIS PLAN

Coverage provided under this Plan for Participants and their Dependents shall be in accordance with the Eligibility, Effective Date, Termination, and COBRA Continuation Coverage provisions as stated in this Plan document, including any coverage classification stated on the Schedule of Benefits page.

If coverage classifications are designated on the Schedule of Benefits, any change in the amount of coverage available to a Plan Member occasioned by a change in the Participant's classification shall become effective automatically on the classification change date.

PARTICIPANT ELIGIBILITY
A Participant eligible for coverage under the Plan shall be any Participant who meets all of the following conditions:

A. Is employed by the District on a contract or regular basis and:

1. For all Billings Education Association bargaining unit members and Administrators;

2. For the Billings Classified Employees Association working seventeen (17) to twenty (20) hours per week in one (1) position on a self-pay basis, and Participants working more than twenty (20) hours per week in one (1) or more positions;

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

4. For the Montana Public Employees Association employees working seventeen (17) to twenty (20) hours per week on a self-pay basis; and

5. For all others more than 20 hours per week.

District premium contribution is governed by the individual employment contracts.

A Participant eligible for Dependent coverage shall be any Participant whose Dependents meet the definition of a Dependent. Each Participant will become eligible for Dependent coverage on the latest of the following:

A. The date he becomes eligible for Participant coverage; or

B. The date on which he first acquires a Dependent.

RETIREE ELIGIBILITY
Persons retired in accordance with the rules established by the District will be eligible.

DEPENDENT ELIGIBILITY
A Dependent will be considered eligible for coverage on the date the Participant becomes eligible for Dependent Coverage, subject to all limitations and requirements of this Plan, and in accordance with the following:

A. Newborn children of a covered Participant will be covered from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly

enrolled as a Dependent of the Participant within sixty (60) days of the child's date of birth. This provision shall not apply to or in any way affect the normal maternity provisions applicable to the mother.

B. A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent of the Participant within sixty (60) days of the date of marriage.

C. If a Dependent is acquired other than at the time of his or her birth, adoption, placement for adoption, due to a court order, decree, or marriage, that Dependent will be considered an eligible Dependent from the date of adoption, placement for adoption, such court order, decree, or marriage, provided that this new Dependent is properly enrolled as a Dependent of the Participant within sixty (60) days of adoption, placement for adoption, the court order, decree, or marriage.

The following persons are excluded as Dependents: other individuals living in the Participant's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Participant; any person who is on active duty in any military service or any country; or any person who is covered under the Plan as a Participant.

If both mother and father are Participants, their children will be covered as Dependents of either the mother or the father, but not of both.

EFFECTIVE DATE OF COVERAGE

PARTICIPANT EFFECTIVE DATE

The coverage for Billings Education Association bargaining unit members shall become effective on the first contracted day of work.

Administrators under contract with the District will become effective on his/her contract date with the District.

For all other personnel, coverage under the Plan shall become effective with respect to an eligible person on the first working day of the month, coinciding with or next following the date of the status change, provided written application for such coverage is made within 60 days of such date.

In the event a Participant is moving from a full-time to a part-time status or from a part-time to a full-time status, the Participant may make a change in coverage as a result of the change in status. The effective date of such coverage change shall become effective with respect to an eligible person on the first working day of the month, coinciding with or next following the date of the status change, provided written application for such coverage is made within 60 days of such date.

A Participant may be required to state in writing the reason coverage is being waived, to confirm entitlement to special enrollment, described hereafter, at a later date. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

Special enrollment is allowed for Participants or Dependents who originally declined coverage if they:

1. Had other coverage, which they later lost because of separation/divorce, termination of employment or reduction in hours, death or the cessation of employer contributions for their coverage (unless it was for cause), or

2. Were on COBRA, but their COBRA eligibility has expired.

If a Participant who did not initially enroll later marries or has or adopts a child, the Participant is entitled to special enrollment along with the child.

A person eligible for special enrollment has sixty (60) days from the date of the event within which to enroll. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

DEPENDENT EFFECTIVE DATE

Each Participant who makes written request for Dependent Coverage hereunder, on a form approved by the Plan Administrator, shall, subject to the provisions of this section, become covered for Dependent Coverage as follows:

A. If the Participant makes such written request on or before the date he becomes eligible for Dependent Coverage, or within a sixty (60) day period of such date, he shall become covered, with respect to those persons who are then his Dependents, on the date he becomes covered for Dependent Coverage.

B. If the Participant acquires a Dependent after his effective date of coverage, he must make a written request for coverage within the sixty (60) day period immediately following the first day on which he is eligible for Dependent Coverage.

A Dependent spouse shall become covered on the date of marriage and a Dependent child shall become covered on the date acquired.

Newborn children of a Participant who are born while such Participant is covered under the Plan will be automatically covered from the date of birth for Dependent Coverage, **provided the newborn child is properly enrolled** as a Dependent of the Participant **within sixty (60) days** of the newborn child's date of birth.

Routine Physician charges (or Hospital and Physician charges in the case of Injury or Illness) will be payable under the newborn child, provided the newborn child is enrolled within sixty (60) days from the date of the newborn child's date of birth.

Routine Hospital charges in connection with routine newborn nursery care will be payable under the mother.

C. If the Participant makes such written request after the end of the sixty (60) day period specified in B immediately above, or after previous termination of Dependent Coverage because of his failure to make a contribution when due, the Participant must enroll for Dependent Coverage during the open enrollment period, as determined by the District.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. Special Enrollment Rights may not apply to Retirees. If a Participant is declining enrollment for himself or herself or his or her dependents (including their 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 after 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.**

A Retiree who declines coverage at retirement will not be entitled to Special Enrollment Rights. Likewise, when a Retiree's coverage terminates under the Plan Special Enrollment Rights will not apply.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage creating a Special Enrollment right.** A Participant or Dependent, who is otherwise eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

(a) The Participant 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 Participant stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Participant or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

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

(e) For purposes of these rules, a loss of eligibility occurs if:

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

(ii) The Participant 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 Participant 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 Participant 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 Participant 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 Participant is a participant under this Plan, or has met any required 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 and

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

then the Dependent (and if not otherwise enrolled, the Participant) may be enrolled under this Plan. In the case of the birth or adoption of a child, the spouse of the covered Participant may also be enrolled as a Dependent of the covered Participant if the spouse is otherwise eligible for coverage. If the Participant is not enrolled at the time of the event, the Participant must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 60 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Participant must request enrollment during this 60-day period.

The coverage of the Dependent and/or Participant enrolled in the Special Enrollment Period will be effective:

(a) In the case of marriage, 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.

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

Participants 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 sixty (60) days from the date of the following loss of coverage or gain in eligibility:

(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 Participant) may be enrolled under this Plan.

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 Participant must request enrollment in writing during this 60-day period.

If a State in which the Participant 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 Participants.

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

LATE ENROLLMENT WITH RESPECT TO DENTAL BENEFITS

If you fail to enroll within sixty (60) days of your 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 ninety (90) days following the effective date of this coverage.

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

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

COVERAGE STATUS CHANGE

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

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

PARTICIPANT CONTRIBUTION

The Plan Administrator may require a contribution from Participants in order to maintain Participant participation and the participation of any Dependents in the Plan. Eligible Participants will be advised of any required contributions at the time they apply for enrollment in the Plan. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required contribution amount. Participants in a Plan that does not require Participant contribution at the time they enrolled will be notified by the Plan Administrator prior to the date a contribution requirement is made effective.

MEDICARE

Active Participants and Dependent Spouses Age 65 or Over

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

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

B. Sole Coverage Provided under Medicare: Coverage with this plan terminates.

All Others Eligible for Medicare
When you become Eligible for Medicare, the benefits ordinarily provided by this Plan will be coordinated with the amount Medicare pays for any eligible expense, so that total benefits received never exceed the actual amount charged.

Benefits will be calculated in this manner from the date you are first Eligible for Medicare, regardless of whether you have actually enrolled, are in fact participating or receiving Medicare payments. Therefore, please enroll promptly as soon as you are eligible to assure complete health care protection.

Retirees and Their Dependents Eligible for Medicare
Special Medicare Supplementary Benefits are available to the Plan Member. Please contact the District Office when the Plan Member 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 Participants, 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 Participants, 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 Participant's, Retiree's and/or Dependent's paid contributions.*

PARTICIPANT TERMINATION

Participant coverage terminates immediately upon the earliest of the following dates:

A. The last day of the calendar month in which the Participant's employment terminates, except Certified Long-Term Assignment Participant coverage will end on the last contracted day of work;

B. The last day of the calendar month in which the Participant ceases to be in a classification (if any) shown in the Schedule of Benefits or eligibility section. This includes death or termination of active employment of the Participant. (See the section entitled COBRA Continuation Coverage). It also includes a Participant on disability or leave of absence unless a collectively bargained agreement specifically provides for continuation during these periods;

C. The last day of the calendar month in which the Participant fails to make any required contribution for coverage;

D. Date the Plan is terminated or, with respect to any benefit of the Plan, the date of termination of such benefit; or

E. For those Billings Education Association bargaining unit members who leave employment as of the end of the school year, coverage will end as of August 31 of that year.

F. If a Participant commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the District or the Plan may either void coverage for the Participant 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;

Note: Except in certain circumstances, a Participant 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.

REINSTATEMENT

A Participant whose coverage terminates by reason of termination of employment, and who resumes employment with the District within a six (6) month period immediately following the date of such termination, shall become eligible for reinstatement of coverage on the date he resumes employment. Coverage will become effective on the first day of the month following or coinciding with the date the Participant resumes employment with the District.

DEPENDENT TERMINATION

Dependent Coverage terminates immediately upon the earliest of the following dates:

A. The last day of the calendar month in which the Dependent ceases to be a Dependent as defined in the Plan.

B. The last day of the calendar month in which the Participant's coverage terminates under the Plan.

C. The last day of the calendar month in which the Participant ceases to be in a classification (if any) shown in the Schedule of Benefits or eligibility section.

D. The last day of the calendar month in which the Participant fails to make any required contribution for Dependent Coverage.

E. Date the Plan is terminated or, with respect to any benefit of the Plan, the date of termination of such benefit.

F. The last day of the calendar month in which a covered spouse loses coverage due to loss of dependency status. (See the section entitled COBRA Continuation Coverage.)

G. If a Dependent commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, 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;

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.

PARTICIPANTS ON MILITARY LEAVE.
Participants 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 Participants and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person 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 Participant'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 Participant wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Participant may also have continuation rights under USERRA. In general, the Participant 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 Participant may elect USERRA continuation coverage for the Employee and their Dependents. Only the Participant has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Montana National Guard Members. Participants 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 8 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 Participant’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.

EXTENDED BENEFITS

MEDICAL BENEFITS

If individual coverage with this plan should terminate at a time a Plan Member is Totally Disabled as a result of Illness or Injury, benefits will be extended solely with respect to Covered Expenses incurred to treat the disabling condition until the individual ceases to be Totally Disabled, or to the end of the 24 month period from the date the person 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 Member is Totally Disabled, coverage for that individual will be continued, solely with respect to eligible expenses incurred to treat the disabling condition, for a period of up to three (3) 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 (3) months after the termination of dental coverage.

EXTENSION OF BENEFITS FOR SURVIVORS

In the event of the death of a Participant or eligible retiree, the covered dependent survivors will be allowed to continue coverage until the surviving spouse remarries or the Dependents obtain other coverage, by paying any required contribution.

LEAVE OF ABSENCE

An extension of benefits while a Participant is on an approved leave of absence will be governed by the varied negotiated agreements between the Participant and the District.

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 Participant, 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 Participant, 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 Participant dies;
- The parent-covered Participant's hours of employment are reduced;
- The parent-covered Participant's employment ends for any reason other than his or her gross misconduct;
- The parent-covered Participant 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 Participant covered under the Plan, the retired Participant will become a Qualified Beneficiary with respect to the bankruptcy. The retired Participant'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 the end of employment, reduction of hours of employment, death of the covered Participant, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Participant'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.

How is COBRA Continuation Coverage provided?

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 Participants may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their 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.

How long does COBRA Continuation Coverage last?

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 Participant (or former Participant), the covered Participant's (or former Participant'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 Participant) 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 or 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 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your spouse and 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 Participant or former Participant 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

COBRA Administrator:
Employee Benefit Management Services, Inc.
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.

ARTICLE V

MAJOR MEDICAL EXPENSE BENEFITS

CO-PAYMENT PERCENTAGE AND DEDUCTIBLE
The Plan will pay the percentage stated in the Schedule of Benefits for the amount listed in the Schedule of Benefits except that the Plan Member, not the Plan, must pay the amounts needed to satisfy the Deductibles listed in the Schedule of Benefits. In no event shall the amount paid exceed the Plan Benefit Maximum stated in the Schedule of Benefits.

The Deductibles apply to Covered Expenses for each Plan Year. An individual Deductible needs to be satisfied only once per Plan Year, regardless of the number of Illnesses, except that once a Family has satisfied the aggregate family Deductible, no further Deductible applies to any member of that Family.

Amounts incurred to satisfy any Deductible during the last three (3) months of a Plan Year will be applied toward the satisfaction of the Deductible requirement for the next Plan Year.

If two (2) or more covered members of a Family are injured in the same accident, only one individual Deductible amount will be subtracted from the total of all eligible expenses incurred among all injured, covered, family members. This combined Deductible will also apply to all future reapplications of the deductible for such accident.

Charges that were used to satisfy the cash Deductible under any prior plan or insurance coverage for the Plan Year in which this Plan originally became effective shall be credited toward satisfying the cash Deductible for this Plan, upon receipt of documented proof of such full or partial satisfaction.

ALLOCATION AND APPORTIONMENT OF BENEFITS
The Plan Administrator may allocate the Deductible amount to any eligible charges and apportion the benefits to the Plan Member and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Plan Member and all assignees.

ANNUAL PLAN BENEFIT MAXIMUM
The total Major Medical Expense Benefits payable for a Plan Member shall not exceed the Annual Plan Benefit Maximum while covered under this Plan, as specified in the Schedule of Benefits, even though the Plan Member may not have been continuously covered.

COVERED EXPENSES
In order to be eligible for benefits under this section, charges actually incurred by a Plan Member must be administered or ordered by a Physician and Medically Necessary for the diagnosis and treatment of an Illness or Injury unless otherwise specifically covered.

Covered charges include the following:

A. Charges made by a **Hospital** for:

1. Inpatient Treatment:

a. Daily Room and Board (charges made by a Hospital having only private rooms will be payable at the average private room rate of that facility) or confinement in an Intensive Care Unit, not to exceed the applicable maximum limits shown in the Schedule of Benefits;

b. General nursing services; and

c. Medically Necessary Inpatient services and supplies furnished by the Hospital, other than Room and Board.

2. Outpatient Treatment:

a. Emergency room use;
b. Treatment for chronic conditions;
c. Physical therapy treatments;
d. Hemodialysis; and
e. X-ray and linear therapy.

B. Charges made by a **Skilled Nursing Facility** must meet the following conditions:

The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

a. the patient is confined as a bed patient in the facility; and

b. the attending Physician certifies that the confinement is deemed 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 Expenses for a Plan Member's care in these facilities are payable as described in the Schedule of Benefits.

C. Charges made by a **Hospice** during a Hospice Benefit Period for:

1. Nursing care by a Registered Nurse, a Licensed Practical Nurse, a vocational nurse, or a public health nurse, all of whom are under the direct supervision of a Registered Nurse;
2. Physical therapy and speech therapy when rendered by a licensed therapist;
3. Medical supplies, including drugs and biologicals, and the use of medical appliances;
4. Physician's services; and
5. Services, supplies, and treatments deemed Medically Necessary and ordered by a Physician.

D. Charges made by a **Home Health Care Agency** for:

1. Registered Nurses or Licensed Practical Nurses;
2. Certified home health aides under the direct supervision of a Registered Nurse;
3. Registered therapist performing physical, occupational, or speech therapy;
4. Physician calls in the office, home, clinic or Outpatient department;
5. Services, drugs and medical supplies Medically Necessary for the treatment of the Plan Member that would have been provided in the Hospital, but not including Custodial Care; and
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

This benefit includes services performed by a Registered Nurse employed by a licensed home infusion company. Services will be limited to those which are performed within the scope of the licensure of the home infusion company.

E. The **services of a Physician** for medical care including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care, and surgical opinion consultations.

F. Office visit charges by a licensed **Naturopath.** Nutritional supplements will not be a Covered Expense.

G. Fees of **Registered Nurses or Licensed Practical Nurses** for private duty nursing.

H. Charges for Medically Necessary transportation by local professional **ambulance** service, and expenses incurred for necessary transportation by licensed air ambulance.

I. Charges for **blood transfusion services**, including the cost of blood and blood plasma to the extent it is not donated or replaced through the operation of a blood bank or otherwise.

J. Charges for **oxygen** and other gases and their administration.

K. Charges for the cost and administration of an **anesthetic**.

L. Charges for **x-rays, microscopic tests, laboratory tests** and other diagnostic tests and procedures.

M. Treatment or services rendered by a licensed **physical therapist** in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

N. **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and meet one of the following criteria:

(i) Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person;

(ii) An Injury;

(iii) A Sickness; or

(iv) A learning or Mental Disorder including, but not limited to, autism, and must be documented with a written Plan of Care. The Plan of Care should include goals, specific treatment techniques and anticipated frequency and duration of treatment. The Plan of Care should be updated as the Plan Member's condition changes and treatment should demonstrate a reasonable explanation of improvements, in addition to documentation of continued progress to the goals.

O. **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

P. Charges for **Rehabilitation therapy**. Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

(i) Inpatient Care. 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 Member 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).

Q. **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.

Benefits will be payable only for covered Dependent child(ren) from birth through age 18 years and will be payable up to the limits as stated in the Schedule of Benefits.

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.

R. **Down Syndrome Therapies.** Down Syndrome therapies will be payable for covered Dependent child(ren) from birth through age 18 years.

Covered Expenses will be payable for Habilitative and Rehabilitative Care including but not limited to 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), and will be payable up to the limits as stated in the Schedule of Benefits.

Note: *Benefits are limited to treatment prescribed by a Physician and documented by written Plan of Care provided by the treating Physician.*

The Claims Administrator may request periodic documentation of continued progress to goals identified in the Plan of Care.

S. Charges for **radiation therapy** and **chemotherapy treatment**.

Pre-notification of services, by the Plan Member, for **cancer treatment** services is strongly recommended. The pre-notification request to CareLink must include the Plan Member's plan of care and treatment protocol. Pre-notification of services should occur at least seven (7) 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 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 Claims Review Procedures section.

T. Charges for **dressings, casts, splints, trusses, braces,** or other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes.

U. Charges for rental of a wheel chair, Hospital bed, iron lung, or other **Durable Medical Equipment** required for temporary therapeutic use or the purchase of this equipment if economically justified, whichever is less.

V. Charges for **Orthotic Appliances**, prosthesis, artificial limbs, eyes or larynx, but not the replacement thereof, unless the current Orthotic Appliance, prosthesis, artificial limb, eye or larynx is not functional.

W. Charges for **FDA-approved contraceptive medications, devices and related supplies** requiring a Physician's written prescription. This benefit will include any associated Physician and facility charges and will be payable under the Women's Preventive Services as listed in the Schedule of Benefits section.

X. Charges for **voluntary sterilization**.

Sterilization procedures for female Plan Members will be payable as shown under the *Women's Preventive Services benefit* as shown in the Schedule of Benefits section.

The following charges will be payable per normal Plan provisions:

- *Hysterectomies; and*
- *Sterilization procedures for male Plan Members.*

Y. Medically Necessary charges incurred for the care and treatment due to an **organ or tissue transplant**, which are not considered Experimental or Investigational and will be subject to the following conditions:

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

2. 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 Physicians giving surgical opinions to determine if benefits are excluded due to the experimental or investigational nature of some transplant procedures.

3. If the donor is a Plan Member under this Plan, his Covered Expenses are covered under this benefit.

4. If the recipient is a Plan Member under this Plan, his Covered Expenses are covered under this benefit.

5. If the donor is not a Plan Member under this Plan but the recipient is, the donor's expenses will be covered if:

a. The donor's expenses would not be covered by any plan (as that term is defined in the Duplication of Benefits section) in the absence of this Plan; and

b. The expenses would be Covered Expenses (assuming that they were incurred by a Plan Member).

Benefits paid to the donor under this paragraph are treated as though they were paid to the recipient for purposes of Deductible, co-payment percentages, Plan Benefit Maximums, etc.

6. Covered Expenses include the cost of securing an organ from a cadaver or tissue ban, the surgeon's charges for removal of the organ and a Hospital's charge for storage or transportation of the organ.

Z. Physician's charges for **obstetrical service** are paid on the same basis as for an Illness, including the mother's prenatal care, for all female Plan Members and will be payable as shown under the Maternity Expense Provision listed in the Schedule of Benefits.

Note: Routine prenatal office visits will be payable as stated under the Maternity Expense Provision as shown in the Schedule of Benefits section. 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.

For more information regarding coverage of maternity expenses, refer to the separate Maternity Expense Provision listed under Article V – Other Benefits, Special Medical Provisions section under this Plan.

This Plan does not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from this Plan for prescribing a length of stay not in excess of the above periods. This Plan does not prohibit the discharge of the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) as applicable) provided the mother and the Physician (nurse midwife, or Physician assistant) are in agreement.

A1. **Breast pump, breast pump supplies and lactation support and counseling**

Breast pump and breast pump supplies

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 Expense under this Plan.

- For female Plan Members 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 (3) Plan Years following a subsequent Pregnancy.

Covered Expenses for the purchase or rental of a breast pump and supplies will be payable subject to the Routine Well Care benefits as shown in the Schedule of Benefits section.

Note: *Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable under the Women's Preventive Services benefits (as shown in the Scheduled of Benefits section) only 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 Expenses include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for all female Plan Members. 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 Expenses for lactation support and counseling under the Women's Preventive Services benefits as shown in the Schedule of Benefits section.*

B1. Charges incurred for the treatment required because of an **accidental bodily Injury to natural teeth** (excluding dentures). Such expenses must be incurred within six (6) months of the date of accident.

C1. Charges for **drugs,** including injectable drugs**,** which are prescribed in writing by a Physician, are dispensed by a licensed pharmacist or Physician, and are Medically Necessary for the treatment of an Illness or Injury.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Plan Member's ID card is not used, the Plan Member will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Member will be required to submit the prescription receipt to **Navitus Health Solutions** for reimbursement (minus any applicable copayment as shown in the Schedule of Benefits).

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

Navitus Health Solutions toll-free 1 (866) 333-2757 or visit www.ebms.com.

Vaccinations / immunizations when rendered only through a Participating Pharmacy and will be payable subject to first dollar coverage (i.e., no deductible or copayment will apply.) ***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 of an in-store immunization program, age restrictions on service, need for prescription or hours of service.

D1. ***miRx* Pharmacy Drug Benefit Option.** The *miRx* drug benefit 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 sometimes prescribed for heart disease, high blood pressure, asthma, etc.). *Please contact the Claims Administrator toll-free at 1 (866) 894-1496 for more information concerning the miRx mail order pharmacy.* **(Note: The *miRx* Mail Order Prescription Drug Option is only available in certain States.)**

E1. Charges for **Mental Illness / Disorder and Alcoholism/Chemical Dependency treatmen**t rendered by a Physician or certified and licensed social worker under the direct supervision of a Physician, subject to the percentages and amounts listed in the Schedule of Benefits.

F1. Charges for **insulin, disposable needles and syringes, and clinitest** required for the treatment of diagnosed diabetes and other diabetic supplies such as blood glucose meters, pen needles, lancet and lancet devices, and disposable blood/urine glucose /acetone testing agents. Custom-made orthopedic shoes may be considered upon demonstration of medical necessity and as a result of a condition directly related to or caused by diabetes.

G1. **Diabetic Education Benefit.** Outpatient self-management training and education for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, up to the limits as stated in the Schedule of Benefits.

H1. Charges for treatment of **obesity** ONLY IF it is Morbid Obesity as defined under this Plan (Article III –DEFINITIONS) 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 of the prescribed treatment.*

I1. Charges for **out of country expenses** subject to the Allowable Charges limitations of the country or area in which expense occurred.

J1. **Poly Vi Flor vitamins;** estrogen pellets (including cost and insertion).

K1. Benefits are payable in accordance with Plan provisions for **reconstructive surgery** following a mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

L1. **Spinal manipulation/chiropractic services** by a licensed M.D., D.O. or D.C., subject to the maximums listed in the Schedule of Benefits.

M1. **Acupuncture services** when deemed Medically Necessary and rendered by a licensed acupuncturist.

N1. **Routine Preventive Care.** The Allowable Charges are payable for the following routine Preventive Care services:

- **Charges for Routine Well Care.** Routine well care is care by a Physician for a Plan Member that is neither for an Illness nor an Injury and will be payable as stated in the Schedule of Benefits section of this Plan.

- **Charges for Routine Office Visit.** Routine office visit is an office visit with a Physician for a Plan Member that is neither for an Illness nor an Injury and will be payable as stated in the Schedule of Benefits section of this Plan.

- **Charges for Women's Preventive Services.** Women's Preventive Services (as referenced under the Health Resources and Services Administration (HRSA) will be payable as stated in the Schedule of Benefits section of this Plan. Coverage will include but will not be limited to the following routine services that is neither for an Illness nor an Injury and which applicable services can be located using the following website:

  http://www.hrsa.gov/womensguidelines

  - 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), 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.

- **Charges for Hepatitis B series.** Charges for the Hepatitis B immunizations and will be payable as stated in the Schedule of Benefits section of this Plan.

- **Charges for Routine Well Child Care.** Routine well child care, **from birth through age 7 years**, means Physician-delivered or Physician-supervised services, that is neither for an Illness nor an Injury, and which will include as the minimum benefit coverage for services delivered at the intervals and scope stated below.

  Benefits will be paid according to the Plan provisions applicable to covered Dependent children, will not be subject to the Deductible amount per Plan Year per Plan Member and will be limited to a benefit maximum of ten (10) visits.

  The services to be included at each visit include:

  1. History;
  2. Physical Examination;
  3. Developmental Assessment;
  4. Anticipatory Guidance;
  5. Routine Immunizations according to the Schedule of Immunizations recommended by the immunization practices advisory committee of the United States Department of Health and Human Services; and
  6. Laboratory Test.

  All in keeping with prevailing medical standards.

Developmental Assessment and Anticipatory Guidance, as used above, means the services described in the guidelines for health supervision II, published by the American Academy of Pediatrics. Such benefits will be limited to one visit payable to one provider for all the services provided at each visit.

O1. Office visit charges in connection with **impotence / sexual dysfunction** only when the cause is related to an organic condition (i.e., not psychological in nature). Additional testing and treatment will not be a Covered Expense.

ELIGIBLE DENTAL EXPENSES

Note: Participation in the Dental Services Benefits will require a separate enrollment election.

The Allowable Charge for the following services and supplies will be considered eligible when they are incurred upon recommendation of a licensed dentist or Physician (acting within the scope of his/her license), but not including any charge which is eligible as a medical expense under the provisions of this Plan:

A. Routine **oral examinations** (including diagnosis, x-rays, and prophylaxis), but not more than two such examinations in a Plan Year;

B. **Fluoride treatments**, space maintainers and sealants;

C. **Emergency exams** for dental pain (includes x-ray);

D. **Tooth extractions**;

E. **Fillings**;

F. **Endodontics** and root canal therapy;

G. **Periodontic** treatment including appliances (bruxism);

H. **Oral surgery**;

I. **Drugs** requiring a dentist's or Physician's written prescriptions;

J. **Inlays and crowns**;

K. **Initial installation of, or addition to, full or partial dentures or fixed bridgework,** if such installation or addition is required due to the extraction, on or after the effective date of this coverage, 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 twenty-four (24) months of the date of the extraction;

L. **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 twenty-four (24) months after such event;

1. An accidental Injury requiring oral surgery;
2. Oral surgery treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus, or redundant tissue.

M. **Replacement of a full upper and lower denture, or partial dentures or fixed bridgework** if required as a result of structural change within the mouth or if made more than five (5) years after the installation of the denture (whether while covered by this plan or not), but in no event for a replacement made less than two (2) years after the effective date of this coverage;

N. Repair of **dentures and bridgework;**

O. **Orthodontic appliances** and treatment, incurred during a course of orthodontic treatment which begins while the individual is covered by this plan;

P. **Anesthetic agents** and the administration of such in conjunction with a covered dental procedure, including local infiltration anesthetics (novocaine), and gas (nitrous oxide);

Q. Manipulative treatment of the jaw through splint therapy only for the treatment of **Temporomandibular Joint (TMJ) Syndrome**. Expenses are subject to the Plan deductible and percentage levels. Benefits are limited to a maximum of $2,000 per lifetime. "Temporomandibular Joint (TMJ) Syndrome" is defined as a disorder of the temporomandibular joint (the joint which connects the mandible or jawbone to the temporal bone) which is generally characterized by:

1. Pain or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat or shoulder;
2. Popping or clicking of the jaw;
3. Limited jaw movement or locking;
4. Malocclusion, overbite or under bite; and/or
5. Mastication (chewing) difficulties;

R. **Tooth implants**, as shown in the Schedule of Benefits.

ARTICLE VI

OTHER BENEFITS

SECOND SURGICAL OPINION
If a Plan Member, while covered under this provision, is advised by a Physician to have a surgical procedure performed, the Plan will pay 80% after satisfaction of the deductible, of the expense incurred for a second opinion on the need for surgery (including x-ray and laboratory services).

If 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 opinion.

Conditions
Benefits will be payable only if:

A. The opinion is given by a specialist who:
   1. Is certified by the American Board of Medical Specialties in a field related to the proposed surgery;
   2. Is independent of the Physician who first advised the surgery;
   3. Does not perform the surgery for the Plan Member.

Exceptions
The Plan will not pay for:

A. Any expense which is paid under any other provision of this Plan; or
B. Anything excluded under the General Exclusions and Limitations.

OUTPATIENT SURGERY BENEFITS
If a Plan Member, while covered under this provision, undergoes any surgical procedure listed below:

Arthroscopy (internal exam of joint)
Bronchoscopy (internal exam of lung), adult, with or without biopsy
Cardiac Catheterization
Cataract removal
Cystourethroscopy (internal exam or urinary bladder and urethra)
Digestive tract endoscopy (internal exam of esophagus, stomach, colon or rectum)
Dilation and curettage of uterus (D&C)
Excision of pilonidal cyst, simple
Laparoscopy (internal exam of abdomen), with or without tubal ligation (female sterilization)
Laryngoscopy and tracheoscopy (internal exam of larynx and windpipe)
Morton's neuroma (of foot)
Myringotomy (puncture of membrane in ear), with or without insertion of tubes
Prostate biopsy
Reduction nasal fracture, open or closed
Release of carpal tunnel (in wrist)
Tonsillectomy and/or Adenoidectomy
Tympanoplasty
Vasectomy (male sterilization)

PROVIDED SERVICES ARE PERFORMED:

A. In an ambulatory surgery facility;
B. In a Physician's office or clinic; or
C. On an out-patient basis in a Hospital;

The Plan will pay 100% of the expense incurred in excess of any deductible shown in the Plan for covered Hospital, medical and surgical services received on the day of surgery. Any coinsurance provisions limit shown in the Schedule will apply.

Exceptions
The Plan will not pay for:

A. Any expense which is paid under any other provision of the policy; or
B. Anything excluded under the General Exclusions and Limitations.

In-patient Surgery Benefit Limitation
If the Plan Member, while covered under this provision, undergoes any of the surgical procedures listed above while confined as a resident patient in a Hospital, then:

A. Benefits will be payable subject to all Plan limitations; but

B. Benefits will not exceed 80% of the expense incurred in excess of any Deductible shown in the Plan for all covered Hospital, medical and surgical services received as a result of that surgical procedure.

If the percentage payable provision shown in the Schedule is subject to a coinsurance limit:

A. Such expense will not apply toward the satisfaction of the coinsurance limit; and

B. The percentage payable will not exceed 80% for such services after the coinsurance limit is reached.

Exceptions
This limitation will not apply to a surgical procedure listed above when:

A. Hospital confinement as a resident patient is Medically Necessary:

1. Because the Plan Member's medical condition will require prolonged postoperative observation by a nurse or other skilled medical staff;

2. Because of the Plan Member's anesthesia status; or

3. Because of technical problems shown by the Plan Member's admission notes or operative report; or

B. Another surgical procedure which requires Hospital confinement:

1. Will be performed at the same time; or

2. May follow the first procedure (as when a mastectomy may follow a breast biopsy.)

SPECIAL MEDICAL PROVISIONS

ELECTIVE STERILIZATIONS PROVISION
Although benefits are not generally provided for procedures which are not Medically Necessary, an exception is made in providing coverage for an elective sterilization procedure and all other eligible expenses incurred as the result of such procedure. Benefits will be payable as stated in the Covered Expenses section.

DENTAL CARE
The following oral surgery procedures rendered by a Doctor of Dental Surgery will be considered medical, rather than dental, eligible expenses: (a) Cutting procedures for the treatment of disease or injury of the jaw, or (b) the extraction of impacted teeth, if performed while the Plan Member is confined to a Hospital for at least eighteen (18) hours.

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

MATERNITY EXPENSE PROVISION
If otherwise eligible expenses are incurred as the result of Pregnancy, benefits will be provided for those charges on the same basis as any other Illness and will be payable as stated under the Maternity Expense Provision as shown in the Schedule of Benefits section.

Amniocentesis will be considered an eligible expense only when Medically Necessary in conjunction with a Pregnancy in a Plan Member age 35 or over.

Benefits are not provided for an elective induced abortion except in the case of rape, incest or if carrying the fetus to full term would seriously endanger the life of the mother. In the event complications arise after the performance of an abortion, any eligible expenses incurred to treat those complications will be considered, but the initial costs relating to the abortion will not be covered.

NEWBORN NURSERY CARE
Routine Hospital expenses for routine nursery care, incurred for care of a newborn will be considered eligible during the time the mother is necessarily confined for the delivery, and will be paid as part of her claim.

Routine Physician charges for routine nursery care, incurred for care of the newborn while the newborn child is Hospital confined as a result of the newborn child's birth and will be payable under the Plan of the newborn child provided Dependent coverage is in force within sixty (60) days from the date of the newborn child's birth. Circumcision is a Covered Expense and will be payable under the Plan of the newborn child.

If the newborn child is ill, suffers an Injury or requires other than routine nursery care, benefits will be available on the same basis as any other medical claim, provided dependent coverage is in force at the time eligible expenses are incurred to treat such a condition.

ARTICLE VIII

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Plan Members and to all benefits provided by this Plan:

A. Charges incurred prior to a Plan Member's effective date of coverage under the Plan, or after coverage is terminated.

B. Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

C. Charges arising out of or in the course of any employment or occupation for wage or profit, or for which the Plan Member is entitled to benefits under any worker's compensation or occupational disease law, or any such similar law.

D. Charges incurred for which the Plan Member is not legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

E. Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of the Plan Member engaging in, or attempting to engage in a felony, a riot or public disturbance; and for which the Plan Member 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.

F. Charges incurred in connection with any self-inflicted Injury or Illness, whether sane or insane. 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.

G. Charges incurred for routine medical examinations or routine health check-ups, nutritional supplements, or immunizations not Medically Necessary for the treatment of an Injury or Illness, except as specifically stated as a benefit under this Plan.

H. Charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use.

I. Charges incurred in connection with Custodial Care, education or training, except as specifically stated as a benefit under this Plan.

J. Charges incurred for cosmetic purposes, except for the correction of defects resulting from traumatic Injuries sustained by the Plan Member; provided, however, that this exclusion shall not apply to services rendered to a Newborn child, which are necessary for treatment or correction of a congenital defect; breast reduction or augmentation for any reason, unless Medically Necessary or as specifically stated as a benefit under this Plan;

K. Charges incurred in connection with services and supplies which are: (1) not Medically Necessary for the treatment of an Injury or Illness; (2) in excess of Allowable Charges; or (3) not recommended and approved by a Physician unless specifically shown as a Covered Expense elsewhere in the Plan.

L. Charges for services, supplies or treatments not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.

M. Charges for services rendered by a Physician, nurse, licensed therapist or Home Health Care Agency Participant if such individual is a Close Relative of the Plan Member, or resides in the same household as the Plan Member.

N. Charges incurred outside the United States if the Plan Member traveled to such a location for the primary purpose of obtaining medical services, drugs, or supplies.

O. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the actual Illness or Injury.

P. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician.

Q. Charges incurred in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices.

R. Charges related to or in connection with treatment of Infertility, sterility, artificial insemination, or in-vitro fertilization.

S. Charges for professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Plan Member's life and unless such care is specifically listed as a Covered Expense elsewhere in the Plan.

T. Care and treatment that is Experimental and/or Investigational:

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 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 consider the treatment to be experimental:

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. 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, or

4. If Reliable Evidence shows that the drug, device, medical treatment or procedure is under study, prior to or in the absence of any clinical trial, 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

5. 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 Member 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.

Unlabeled uses of FDA-approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen for a medically accepted indication are not Experimental and/or Investigational, provided that the use is supported by one or more citations in one of the drug compendia: American Hospital Formulary Service Drug Information (AHFS) or the United States Pharmacopeia Drug Information (USPDI).

U. Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or a molar process and any other dental, orthodontic or oral surgical charges unless expressly included as a benefit of this Plan.

V. Charges for missed appointments or the completion of claim forms.

W. Charges for transportation costs other than ambulance service as specified.

X. Charges for hypnotism, marriage counseling, family counseling, any goal oriented behavior modification type therapy, such as to quit smoking.

Y. Charges for family services, except contraceptives as specified and genetic counseling where there has been a family history of disorder.

Z. Charges for elective abortions, except as specified under the separate Maternity Expense Provision listed in under the Article VI – Other Benefits section of this Plan.

A1. Charges for hot tubs, health club memberships, exercise bicycles or UVL tanning beds, air cleaners, air filters, humidifiers or environmental devices.

B1. Charges for inappropriate coding in accordance to the industry standard guidelines in effect.

C1. Charges for mailing, shipping, handling, conveyance and sales tax.

D1. Personal comfort items, personal or patient convenience, or other equipment, such as, but not limited to, air conditioners, air-purification units, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

E1. Care, treatment, services and supplies in connection with homeopathy.

F1. Care, treatment, services and supplies in connection with massage therapy.

DENTAL CARE LIMITATIONS

In addition to those the "General Plan Exclusions and Limitations" which apply, Dental Care Benefits are not provided for:

A. Any services and supplies, unless prescribed as necessary by a dentist or Physician (acting within the scope of his/her license);

B. Any services and supplies furnished by or through an employer, mutual benefit association, labor union, trustee, or similar type group;

C. Replacement of lost, misplaced or stolen dental appliances;

D. Any cosmetic dentistry, including the alteration or extraction and replacement of sound teeth to change appearance;

E. Any duplicate services rendered prior to the end of any specified time interval;

F. Replacement, installation, alteration of, or additions to, dentures or fixed bridgework, except as specified;

G. Items intended for sport or home use, such as athletic mouth guards, toothbrush, toothpaste, etc.

ARTICLE IX

DUPLICATION 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 Member is covered by this Plan and another plan, or the Plan Member'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.

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 nongroup insurance contracts and subscriber contracts;

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

(3) Group and nongroup 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 Article III – Definitions section.)

In the case of HMO (Health Maintenance Organization) 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 Member 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 Member 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:

(A) 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.

(B) 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:

(1) The benefits of the plan which covers the person directly (that is, as a Member/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.

(2) 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 (5) 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.

(3) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or as a Dependent of a Member/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 Member/Employee. This rule does not apply if Rule (1) 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.

(4) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or a Dependent of a Member/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 (1) can be used to determine the order of benefits.

(5) 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.

(C) 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.

(D) 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.

(E) 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 Member 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 Member. 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 Member under the Plan.

ARTICLE X

CLAIM PROCEDURES

NOTICE AND PROOF OF CLAIM

Written notice and proof of loss (ordinarily a completed claim form) must be given to the Plan Administrator or his designee within ninety (90) days after the occurrence or commencement of any loss covered by this Plan. Failure to give such notice and proof within the time required will neither invalidate nor reduce any claim if it is shown that: (1) it was not reasonably possible for the claimant to give written notice and proof within that time; and (2) written notice and proof are given as soon as reasonably possible, but no later than one (1) year after the loss occurs or commences, unless the claimant is legally incapacitated.

When a Plan Member's coverage terminates for any reason, written proof of claim must be given to the Plan Administrator within ninety (90) days of the date of termination of coverage, if the Plan remains in force. Upon termination of the Plan, final claims must be received within thirty (30) days of termination.

The Plan Administrator shall approve, partially approve or deny a claim within ninety (90) days of its submission. If special circumstances require more than ninety (90) days, the Plan Administrator shall have up to an additional ninety (90) days to complete its review upon notice to the claimant. If a claim is denied (in whole or in part) the Plan Administrator shall provide the Plan Member with a written notice containing: (1) the reasons for the denial including reference to the Plan provisions upon which the denial is based; (2) a description of additional information which would permit payment of the claim; and (3) an explanation of the claim review procedures of the Plan.

CLAIM REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Plan Participant or by an authorized representative of a Plan Member that complies with the Plan's reasonable procedures for filing benefit Claims. A Claim for benefits is not a Claim that has been previously submitted, denied, appealed, and re-denied upon appeal. A "Claim" is a Post-Service Claim under the terms of the Plan. A **Post-Service Claim** means a Claim for covered medical services that have already been received by the Plan Member.

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. The Plan Administrator shall have full responsibility to adjudicate all claims and to provide a full and fair review of the initial claim determination in accordance with the following Claims review procedure.

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

For the purposes of this section, **Claimant** means the Plan Member or the Plan Member's authorized representative. A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives. A Claimant does not include a healthcare provider simply by virtue of an assignment of benefits.

An Adverse Benefit Determination shall mean a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. An inquiry regarding eligibility or benefits without a Claim for benefits is not a Claim and, therefore, cannot be appealed.

Initial Benefit Determination

The Initial Benefit Determination on a Post-Service Claim will be made within 30 days of the Claim Administrator's receipt of the Claim. If the Claims Administrator requires an extension due to circumstances beyond the Plan's control, the Claims Administrator will notify the Claimant of the reason for the delay within the initial 30-day period. A benefit determination on the Claim will be made within 15 days of the date the notice of the delay was provided to the Claimant. If additional information is necessary to process the Claim, the Claims Administrator will request the additional information from the Claimant within the initial 30-day 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**. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Determination

The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant. If a Claim is denied in whole or in part, notice will include the following:

(1) Specific reason(s) for the denial.

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

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

(4) Description of the Plan's Claims review procedures and the time limits applicable to such procedures.

(5) 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:

(6) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and that a copy will be provided free of charge to the Claimant upon request).

(7) 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, or a statement that such explanation will be provided free of charge, upon request.

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

If the Claimant does not understand the reason for the Adverse Benefit Determination, the Claimant should contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

Claims Review Procedure - General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level 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 either an appropriate Plan representative or the Claims Administrator on the Plan's behalf, who is neither the individual who made the Initial Benefit Determination, nor a subordinate of that individual. The review will 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 the Initial Benefit Determination.

If the Adverse Benefit Determination was based in whole or in part upon medical judgment, including determinations on whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary, the Plan Administrator or its designee will consult with a health care professional who has the appropriate training and experience in the applicable field of medicine; was not consulted in the Initial Benefit Determination; and is not the subordinate of the initial decision-maker. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

The Plan Administrator will provide free of charge upon request by the Claimant, reasonable access to and copies of, documents, records, and other information as described in Items 5 through 8 under "Notice of Adverse Benefit Determination".

First Level of Claims Review

The written request for review must be submitted within 180 days of the Claimant's receipt of notice of an Adverse Benefit Determination. 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
℅ Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the initial Adverse Benefit Determination within the 180 day period will render that determination final.

The first level of 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.

Second Level of Claims Review

If the Claimant does not agree with the Claims Administrator's determination from the first level 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 review, along with any additional supporting information to:

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

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the determination from the first level of review within the 60 day period will render that determination final.

The second level of 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 review to the Claimant within a timely manner but not to exceed 120 calendar days of receipt of the appeal. The determination by the Plan Administrator upon review will be final, binding, and conclusive and will be afforded the maximum deference permitted by law.

If upon review, the Adverse Benefit Determination remains the same and the Claimant still does not agree with the determination, the Claimant has the right to bring an action for benefits. ***Before filing a lawsuit, the Claimant must exhaust both levels of review as described in this section. A legal action to obtain benefits must be commenced within two (2) years of the date of the notice of the Plan Administrator's determination on the second level of review.***

EXAMINATION
The Plan Administrator shall have the right and opportunity to have the Plan Member 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 Member 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, Benefit Administrator or any Fiduciary shall not be liable to any person as the result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

SELF-AUDIT BILLING CREDIT
The Plan offers an incentive credit to all 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 Participant or a covered dependent. The 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 Participant (at his or her request) in determination of errors, and recovery attempts.

In the event a 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 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 Member, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the Plan Member'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.

ARTICLE XI

GENERAL PLAN PROVISIONS

PLAN CONSTRUCTION
This Plan shall be construed in accordance with the laws of the state in which the District is located.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

PLAN ADMINISTRATOR RESPONSIBILITIES
The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator's responsibilities include those delegated to the Benefit Administrator as set forth in an administration agreement and any addenda thereto.

NOTE: 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.

PLAN ADMINISTRATOR DISCRETION
The Plan Administrator shall be the sole judge of the standards of proof required in any case. In the application and interpretation of this Plan Document, the decisions of the Plan Administrator shall be final and binding on the Participants, Dependents, and all other persons. Subject to the stated purposes and provisions of this Plan Document, the Plan Administrator shall have the full and exclusive power and authority, in its sole discretion, to determine all questions of coverage and eligibility for benefits, methods of providing or arranging for benefits and all other related matters. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan Document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all of the parties hereto and the beneficiaries thereof.

PARTICIPANT OBLIGATIONS
The coverage afforded to a Participant by the Plan Document shall be at least partially funded by the District. If a Participant elects to enroll Dependent(s) under the Plan Document, the Participant may be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment. For active Participants, the District shall deduct such costs on a regular basis from the Participant'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 Member 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 Member.

PLAN AMENDMENTS AND TERMINATION
The District establishes this Plan with the intention of maintaining it for an indefinite period of time. However, the District reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

A. 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 or by the written approval of an authorized officer of the District.

B. 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.

ASSIGNMENT, CHANGE AND WAIVER
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 in the provision entitled Plan Amendments and Termination.

PLAN IS NOT A CONTRACT
The establishment and maintenance of this Plan shall not be construed as conferring any legal rights on any Participant to be continued in the employ of the District nor shall this Plan interfere in any way with the right of the District to discharge any Participant.

DISCREPANCIES
In the event that there may be a discrepancy between the booklet provided to Participants (the "Summary Plan Description") and the Plan Document, the Plan Document will prevail.

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 mental 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:

A. 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);

B. 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;

C. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Participant benefit Plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

D. 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;

E. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

F. 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);

G. 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);

H. 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 Participant 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*);

I. 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

J. 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:

i. The following Participants, or classes of Participants, 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)
Business / Human Resources Coordinator
Benefits Manager

ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

iii. In the event any of the individuals described in subsection (i) 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 "PRIVACY 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:

- 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;

- 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.

- 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

- Report to the Plan any security incident of which it becomes aware.