

**BILLINGS PUBLIC SCHOOLS**

**PRIMARY CARE PLAN**

**PLAN DOCUMENT**

**EFFECTIVE: JULY 1, 1994**

**RESTATED: JULY 1, 2008**

## 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.

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

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 Well Care – No Deductible will apply .....	70%
Routine Well Child Care – No Deductible will apply.....	Payable as any other Illness
Hepatitis B Immunizations – No Deductible will apply.....	100%

**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 Well Care – No Deductible will apply .....	70%
Routine Well Child Care – No Deductible will apply.....	Payable as any other Illness
Hepatitis B Immunizations – No Deductible will apply.....	100%

**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 Benefit Maximum.....	\$2,000,000
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**Mental Health Care**

**Inpatient Services:**

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

**Chemical Dependency, Alcoholism**

Inpatient Services:

Benefit maximum ..... \$12,000 per inpatient admission

Inpatient and Outpatient Services:

Combined Lifetime maximum..... \$24,000

**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.

**Home Health Care**

Maximum per Plan Year ..... 40 visits

**Room and Board** ..... Average Semi-Private

**Intensive Care** ..... Reasonable & Customary

**Chiropractic Services**

Plan Year Maximum ..... 20 Visits

Benefit Maximum Per Visit ..... \$25.00

**Diabetes Education**

Plan Year maximum..... \$250

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

**MATERNITY EXPENSE PROVISION**

Female Participants & Dependent Spouses ..... Same as any other Illness



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

**Routine Well Care:**

*Routine well care will include the following routine services:* One Gynecological exam, one Pap smear, one mammogram, and one Prostate Screening Antigen (PSA) test per Plan Year.

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

**Hepatitis B Immunizations** (for covered Participants only):

One series per Participant..... 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**

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 Benefit.....	\$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.....	\$2000

## **PRIMARY CARE PLAN**

- **PCP: Personal Care Physician:**

- \* General Practitioner
- \* Family Practitioner
- \* General Internist (Internist whose practice is 70% general medicine)
- \* Obstetrician/Gynecologist
- \* Pediatrician
- \* Immediate Care Center PCP
- \* Nurse Practitioner
- \* Physician Assistant

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 Usual and Customary 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 coinsurance.

## **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 Usual and Customary 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 charges will be covered at 100% of Usual and Customary 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**
  - \* Staffed by a RN, available from 7:00 a.m. to 7:00 p.m., Monday through Thursday, and from 7:00 a.m. to 5:00 p.m. Friday.
- **CareLink will assist you with:**
  - \* Precertification
  - \* Large Case Management

Please contact CareLink at (406) 245-3575.

## **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 Usual and Customary 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 services will be covered at 100% of Usual and Customary 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.

- Precertification of Hospital admission is required and can be accomplished by contacting CareLink.

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

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

**PRECERTIFICATION REQUIREMENTS  
CARELINK UTILIZATION AND  
MEDICAL CASE MANAGEMENT SERVICES**

**OVERVIEW**

The CareLink program is designed to assist Plan Members in obtaining high quality, cost effective medical care that is both appropriate and Medically Necessary.

**TELEPHONE CONSULTATION**

Registered Nurses are available by a toll free line during CareLink's normal working hours to answer Plan Member's health-related questions. Assistance ranges from providing a better understanding of specific medical procedures, to plain English translations of medical terminology and help in locating community support services.

**CERTIFICATION**

Maximum benefits available under the Plan for admissions and/or procedures specified by the Plan are provided only if such admissions/procedures are certified as appropriate/Medically Necessary by CareLink.

**Details on what must be certified and what happens to benefits when certification is not obtained, are provided under the heading "Certification Requirements" in this section.** Note that elective admissions/procedures must be certified in advance (pre-certified).

The certification process encourages communication between all parties in the proposed treatment plan, and often initiates consideration of alternative treatment options. Health and financial risks associated with unnecessary care may be avoided through this program.

In order to obtain certification, the Plan Member should call CareLink in advance of the planned admission/procedure. The CareLink nurse will ask several questions concerning the medical problem and the proposed plan of treatment. If additional medical information is needed, CareLink will contact the Plan Member's Physician. Based on the information provided by the Plan Member and the Plan Member's

Physician, certification may be provided. In either case (certification or non-certification) the Plan Member will be notified.

If a Hospital admission is involved, the certification will be for a specified number of days. After the Plan Member is admitted, an ongoing evaluation of the need for continued stay will occur. A CareLink Physician will contact the Plan Member's healthcare provider if there are any questions regarding the need for additional inpatient days. The Plan Member's Physician will be notified immediately when additional days are not certified, and the Plan Member will receive written confirmation of the decision. The final decision regarding healthcare always remains with the Plan Member and the Plan Member's Physician. A Plan Member or the Attending Physician is entitled to appeal non-certification decisions made by CareLink. This process can be initiated by written request submitted to the CareLink manager, within 45 days after receipt of the non-certification letter.

### **DISCHARGE PLANNING**

CareLink assists the Plan Member and the Plan Member's family to identify potential problems that could delay timely discharge from a Hospital, or interfere with recovery. CareLink nurses work with the Plan Member and the Plan Member's healthcare provider to make the arrangements necessary for timely discharge and to promote full recovery.

### **CASE MANAGEMENT**

If a Plan Member suffers a serious or long term illness or injury, CareLink will help the Plan Member explore the care options that are available, and assist the Plan Member in making arrangements for necessary services. CareLink nurses work with the Plan Member and the Plan Member's healthcare provider and family to coordinate a plan of care that suits the Plan Member's needs and has a positive impact on the quality of patient and family life during a difficult time.

### **CERTIFICATION REQUIREMENTS**

The following **MUST** be certified by CareLink:

All inpatient admissions, including admissions to:

- Hospitals
- Free standing chemical dependency units
- Free standing mental health facilities

Hospital Observation Room stays in excess of 23 hours are considered an emergency admission for purposes of this program and must be certified as such.

Maternity admissions must be called in at the time of admission or within two business days.

Plan Members are required to call CareLink at least 7 days in advance of elective admissions, and within 2 business days of emergency admissions.

### **Outpatient procedures do not require certification.**

The initial admission and each day of the Plan Member's stay must be reviewed for appropriateness of inpatient care. The initial certification, if provided, will be for a specified number of days. Any requests for

an extended certification will be considered based on medical information made available as the initial certified term expires.

A request for certification is initiated when the Plan Member (or a family member or provider on the Plan Member's behalf) contacts a CareLink nurse upon calling the Contract Administrator's toll free number during normal working hours: **1-866-894-1505**. If in Billings, the local number is: **245-3575**. Normal working hours are from 7 a.m. to 7 p.m. Monday through Thursday, and from 7 a.m. through 5 p.m. Friday.

***IF A COVERED PERSON DOES NOT COMPLY WITH THIS CERTIFICATION PROCEDURE, BENEFITS WILL AUTOMATICALLY BE REDUCED BY \$300. THE ADDITIONAL OUT-OF-POCKET EXPENSE TO THE COVERED PERSON RESULTING FROM THIS REDUCTION IS NOT SUBJECT TO THE PLAN'S DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM LIMITATIONS. SUCH CARE WILL FURTHER BE SUBJECT TO RETROSPECTIVE REVIEW FOR CERTIFICATION.***

No benefits are provided for care which is determined to be not Medically Necessary, whether as a result of review through the certification process, retrospective review or subsequent claim review. Further, CareLink certification is not a guarantee of benefits. All charges, even for services certified as appropriate and Medically Necessary, are subject to Plan eligibility and benefit provisions (e.g. pre-existing conditions, time limitations, exclusions, etc.).

## ARTICLE III

### DEFINITIONS

#### **ALCOHOLISM, DRUG ADDICTION OR SUBSTANCE ABUSE**

The terms "Alcoholism, 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.

#### **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.

#### **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.

#### **CONVALESCENT NURSING FACILITY**

The term "Convalescent Nursing Facility" means an institution or distinct part thereof, that is operated pursuant to law and meets all the following conditions:

- A. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a



Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily activities;

- B. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
- C. It maintains a complete medical record on each patient;
- D. It has an effective utilization review plan; and
- E. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled or handicapped, custodial or educational care, or care of Mental Disorders.

The term shall also apply to expenses incurred in an institution referring to itself as a skilled nursing facility, extended care facility, convalescent nursing home, or any other similar designation.

#### **CONVALESCENT PERIOD**

The term "Convalescent Period" means a period of time commencing with the date of confinement by the Plan Member to a Convalescent Nursing Facility. Such confinement must meet both of the following conditions:

- A. The confinement must have been for a period of not less than three (3) consecutive days; and
- B. The convalescent confinement must commence within fourteen (14) days after the Plan Member is discharged from a Hospital and both the Hospital and convalescent confinements must have been for the care and treatment of the same Illness or Injury. Alternatively, the convalescent confinement must be as an alternative to hospitalization. The Plan Administrator may require that a Physician certify whether the convalescent care is rendered as an alternative to hospitalization.

A Convalescent Period will terminate when the Plan Member has been free of confinement in any and all institutions providing Hospital or nursing care for a period of ninety (90) consecutive days. A new Convalescent Period shall not commence until a previous Convalescent Period has terminated.

#### **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.

#### **CREDITABLE COVERAGE**

Includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of special second COBRA election period under the Trade Act, does not count.

**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.
  
- B. The Participant's child who meets all of the following conditions:
  - 1. Is a resident of the same country in which the Participant resides;
  - 2. Is unmarried;
  - 3. 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;
  - 4. Is less than twenty-five (25) 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 twenty-five (25) 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.

The term "Dependent" excludes these situations:

- A. 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;
  
- B. Any Dependent child on active military duty.

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.

***Please Note:** If an otherwise eligible Dependent is not the covered Participant's true tax dependent as defined by the Internal Revenue Service (IRS), benefits for that Dependent will NOT be provided on a tax-free basis and therefore, the Participant may be required to pay the cost of the benefits on an after-tax basis and the Participant may be subject to additional tax consequences.*

#### **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.

#### **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 CARF (Commission of Accreditation of Rehabilitation Facilities) or JCAHO (Joint Commission of Accreditation of Hospital Organizations) 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 of a covered Participant or spouse. 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.

### **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 Convalescent 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.

### **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 infirmatory-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 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.

**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 Convalescent Nursing Facility in which at least two (2) patient beds are available per room.

**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.

**USUAL AND REASONABLE CHARGE**

The term Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same geographical area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.



## 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.

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 included automatically from birth for Dependent Coverage, provided the newborn child is properly enrolled as a Dependent of the Participant within sixty (60) days of the child's date of birth.

- 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 on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

- (ii) 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).
- (iii) 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.
- (iv) 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).
- (v) 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) Dependent beneficiaries. 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.

#### **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 two (2) years 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**

When coverage under this Plan terminates, a Plan Member will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

#### **PARTICIPANT TERMINATION**

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

- A.** The last day of the month of the date of termination of the Participant's employment, except Certified Long-Term Assignment Participant coverage will end on the last contracted day of work;
- B.** The last day of the month of the date 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 month of the date 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.** The earliest date the Participant has a claim that is denied in whole or in part because the Participant has met or exceeded a lifetime limit on all benefits.

**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 month of the date the Dependent ceases to be a Dependent as defined in the Plan.
- B.** The last day of the month of the date of termination of the Participant's coverage under the Plan.
- C.** The last day of the month of the date 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 month of the date 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.** The earliest date the Dependent has a claim that is denied in whole or in part because the Dependent has met or exceeded a lifetime limit on all benefits.

**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.

## **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 an 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 may become available to the Participant when the Participant otherwise would lose group health coverage. It also can become available to other members of the Participant’s family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the covered Participant (or former Participant), Qualified Beneficiary, or any representative acting on behalf thereof. Coverage will end in certain instances, including, but not limited to, if the Plan Member fails to make timely payment of premiums. Plan Members should check with the District to see if COBRA applies to them.

### **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.” Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the employer’s plan) are not considered for continuation under COBRA.

### **What is a Qualifying Event?**

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” Plan Members could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. A domestic partner is not a Qualified Beneficiary.

A Participant will become a Qualified Beneficiary if the Participant loses coverage under the Plan due to one of the following Qualifying Events:

- The Participant’s hours of employment are reduced;
- The Participant’s employment ends for any reason other than gross misconduct; or
- The Participant loses coverage due to Medicare entitlement.

**Note:** Medicare entitlement means that a person is eligible for and enrolled in Medicare.

The Spouse of a Participant will become a Qualified Beneficiary if coverage under the Plan is lost due to one of the following Qualifying Events:

- The Participant dies;
- The Participant’s hours of employment are reduced;
- The Participant’s employment ends for any reason other than gross misconduct;
- The Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The Spouse of a Participant becomes divorced or legally separated from the Participant; or
- In certain circumstances, the Spouse of a Participant is no longer eligible for coverage under the Plan.

Children of a Participant will become Qualified Beneficiaries if coverage under the Plan is lost due to one of the following Qualifying Events:

- The Participant dies;
- The Participant's hours of employment are reduced;
- The Participant's employment ends for any reason other than gross misconduct;
- The 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."

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 **Billings Public Schools**, 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 coverage under the Plan.

#### **The employer must give notice of some Qualifying Events**

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 Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

#### **Plan Members must give notice of some Qualifying Events**

Each Plan Member is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Participant (or former Participant) from the Participant's spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Billings Public Schools  
Insurance Office  
415 N. 30th  
Billings, MT 59101

**Deadline for providing the notice**

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished 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 Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished 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 SPD or the general notice, 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.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the Qualified Beneficiary is electing COBRA Continuation Coverage, coverage under the Plan will terminate on the last date for which the Qualified Beneficiary is eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

### **Who can provide the notice?**

Any individual who is the covered Participant (or former Participant), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Participant (or former Participant) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

### **Required contents of the notice**

It is recommended that the notice include the following information:

- Name and address of the Participant or former Participant;
- If the Qualified Beneficiary is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
- A description of the Qualifying Event (for example, divorce, legal separation, cessation of Dependent status, entitlement to Medicare by the Participant or former Participant, death of the Participant or former Participant, disability of a Qualified Beneficiary or loss of disability status);
- In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan, date of divorce or legal separation. (The Plan Administrator reserves the right to require the Qualified Beneficiary to provide a copy of the decree of divorce or legal separation);
- In the case of a Qualifying Event that is Medicare entitlement of the Participant or former Participant (or in certain circumstances, the spouse), date of entitlement, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
- In the case of a Qualifying Event that is a Dependent child's cessation of Dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);
- In the case of a Qualifying Event that is the death of the Participant or former Participant, the date of death, and name(s) and address(es) of Dependents covered under the Plan;
- In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's Notice of Award letter;
- In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
- A certification that the information is true and correct, a signature and date.

If the notice does not contain all of the required information, or the Plan Administrator determines that additional information is needed, the Plan Administrator may request additional information. If the Plan Member fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough

information for the Plan Administrator to identify the plan, the Participant (or former Participant), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

### **Electing COBRA Continuation Coverage**

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. Qualified Beneficiaries then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. 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 Plan Member is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the Plan Member 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 will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. However, if, pursuant to the Plan, the first Qualifying Event is the Participant's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the Participant ends on the later of (i) 36 months after the date the Participant 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 all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

If, pursuant to the Plan, the Qualifying Event is the death of the Participant (or former Participant), the Participant's (or former Participant's) becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

If the Qualifying Event is the end of employment or reduction of the Participant's hours of employment, and the Participant became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Participant lasts until 36 months after the date of Medicare entitlement. For example, if a Participant becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Participant's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

### **Disability extension of 18-month period of COBRA Continuation Coverage**

If a Plan Member is determined by the SSA to be disabled and the Plan Administrator is notified as set forth above, the Plan Member, including all Dependents, 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 60<sup>th</sup> 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.

### **Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage**

If the Plan Members experience another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependents receiving COBRA Continuation Coverage if the 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, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

### **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 the employer ceases to provide a group health plan to any Participant;
- 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 a Participant or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules. However, a Qualified Beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less; or
- 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.

### **Payment for COBRA Continuation Coverage**

Once COBRA Continuation Coverage is elected, Qualified Beneficiaries must pay for the cost of the initial period of coverage within 45 days. Payments then are 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 45 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated. Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election

period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. Consult the Plan Administrator if the Trade Act apply.

**Additional Information**

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator and COBRA Administrator:

**Plan Administrator**

Billings Public Schools  
Insurance Office  
415 N. 30<sup>th</sup>  
Billings, MT 59101

**COBRA Administrator**

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

**Current Addresses**

Plan Members should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.



## 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.

#### PLAN BENEFIT MAXIMUM

The total Major Medical Expense Benefits payable for a Plan Member shall not exceed the 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 paid at 90% of the private room rate) 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 **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.

**C.** 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.

- D.** 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.
- E.** Fees of **Registered Nurses or Licensed Practical Nurses** for private duty nursing.
- F.** 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.

- G. 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.
- H. 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.
- I.** Charges for Medically Necessary transportation by local professional **ambulance** service, and expenses incurred for necessary transportation by licensed air ambulance.
- J.** 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.
- K.** Charges for **oxygen** and other gases and their administration.
- L.** Charges for the cost and administration of an **anesthetic**.
- M.** Charges for **x-rays, microscopic tests, laboratory tests** and other diagnostic tests and procedures.
- N.** Charges for **radiation therapy** and treatment.
- O.** Charges for **dressings, casts, splints, trusses, braces**, or other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes.
- P.** 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.
- Q.** 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.

- R. Charges covered by the **Convalescent Care Benefit** that are for Medically Necessary services, medicines and supplies.
- S. Charges for **voluntary sterilization** of a Participant or a Dependent spouse.
- T. Services and supplies in connection with **transplant procedures**, subject to the following conditions:
  1. 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.
  2. If the donor is a Plan Member under this Plan, his Covered Expenses are covered under this benefit.
  3. If the recipient is a Plan Member under this Plan, his Covered Expenses are covered under this benefit.
  4. 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.
  5. 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.
- U. Physician's charges for **obstetrical service** are paid on the same basis as for an Illness, including the mother's prenatal care. No benefits are provided for a Pregnancy of a Dependent child.

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.

- V. 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.
- W. Charges for **drugs**, including injectable drugs, that 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.
- X. Charges for **Mental/Nervous and Alcohol & Drug Treatment** 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.
- Y. Charges for **insulin, needles and clinitest** required for the treatment of diagnosed diabetes. 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.
- Z. Charges for **contraceptive devices and supplies** requiring a Physician's written prescription. This benefit will include any associated Physician's charges.
- A1. Charges for treatment of **obesity** ONLY IF it is morbid obesity as described by the AMA Standards. Dietary supplements of any kind are excluded, regardless of the prescribed treatment.
- B1. Charges for **out of country expenses** subject to the Usual and Reasonable Charges limitations of the country or area in which expense occurred.
- C1. **Poly Vi Flor vitamins**; estrogen pellets (including cost and insertion).
- D1. 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.
- E1. **Spinal manipulation/chiropractic services** by a licensed M.D., D.O. or D.C., subject to the maximums listed in the Schedule of Benefits.
- F1. **Diabetes 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.

**G1. Routine Preventive Care.** The Usual and Reasonable 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 Hepatitis B series.** Charges for the Hepatitis B immunizations and will be payable as stated in the Schedule of Benefits section of this Plan. *This benefit is available to covered Participants only.*
- **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.

**H1.** Pre-notification of services, by the Plan Member, for cancer treatment services is strongly recommended. The pre-notification request to the Claims Administrator 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 the Claims Administrator at the following numbers:

Toll Free in the United States: (800) 777-3575  
Local Call in Billings, Montana: (406) 245-3575

*A pre-notification of services by the claims administrator is not a determination by the plan that claims will be paid. All claims are subject to the provisions of the plan, including but not limited to medical necessity, exclusions and limitations in effect when charges are incurred. A pre-notification is not required as a condition to paying benefits, and cannot be appealed.*

## **ELIGIBLE DENTAL EXPENSES**

The Usual and Reasonable 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

#### CONVALESCENT CARE BENEFIT

This benefit covers charges made by a Convalescent Nursing Facility for the following services and supplies furnished by the facility during the first one hundred-twenty (120) days of convalescent confinement in any one Convalescent Period. Only charges incurred in connection with convalescence from the Illness or Injury for which the Plan Member is confined will be eligible for benefits. These charges include:

- A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charges allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area;
- B. Medical services customarily provided by the Convalescent Nursing Facility, with the exception of the charges of medical providers which are separately billed, including private duty or special nursing services and Physician's services; and
- C. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.

#### 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 paid under the applicable Plan provision for the type of expense incurred.

### **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 by a female Participant or the covered dependent spouse of a male Participant, benefits will be provided for those charges on the same basis as any other Illness.

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, unless 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.

Benefits are not provided for maternity expenses incurred by a dependent other than a Participant's spouse.

**NEWBORN CARE**

Routine Hospital expenses for 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. Circumcision is a Covered Expense.

If the baby is ill, suffers an Injury or requires other than routine 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 covered Person 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 specified.
- 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 Usual and Reasonable 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.** Charges incurred as a result of or in connection with the Pregnancy of a Dependent child.
- U.** 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/nonexperimental 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).

- V.** 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.
- W.** Charges for missed appointments or the completion of claim forms.
- X.** Charges for transportation costs other than ambulance service as specified.
- Y.** Charges for hypnotism, marriage counseling, family counseling, any goal oriented behavior modification type therapy, such as to quit smoking.
- Z.** Charges for family services, except contraceptives as specified, and genetic counseling where there has been a family history of disorder.
- A1.** Charges for elective abortions, except as specified.
- B1.** Charges for hot tubs, health club memberships, exercise bicycles or UVL tanning beds, air cleaners, air filters, humidifiers or environmental devices.



## **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 mouthguards, toothbrush, toothpaste, etc.

## **ARTICLE IX**

### **DUPLICATION OF BENEFITS**

#### **COORDINATION OF BENEFITS**

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the Participant or any Dependent who is covered by this Plan is also covered by any other Plan or Plans. When more than one coverage exists, one Plan normally pays its benefits in full and the other Plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount, if any, that when added to the benefits payable by the other Plan or Plans will not exceed 100% of allowable expenses. Only the amount paid by this Plan will be charged against the Plan Benefit Maximums. This Plan will always maintain its deductible provision.

The Coordination of Benefits provision applies whether or not a claim is filed under the other Plan or Plans. If another Plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

The Plan Administrator and Benefit Administrator may release to and obtain from any other insurer, Plan or party, any information that it deems necessary for purposes of this provision. A Plan Member shall cooperate in obtaining such information and shall furnish all information necessary to implement this provision.

#### **DEFINITIONS**

The term "Plan" as used in this provision to refer to a Plan other than this Plan means any Plan, policy or coverage providing benefits or services for or by reason of health, medical or dental care or treatment. Such Plans may include, without limitation:

- A. Group insurance or any other arrangement for coverage for Plan Members in a group whether on an insured or uninsured basis
- B. Hospital or medical service organizations on a group basis, group practice and other group pre-payment Plans;
- C. A licensed Health Maintenance Organization (HMO);
- D. Any coverage under a Federal Government plan or program. This includes, but is not limited to, Medicare and Tricare.
- E. Any coverage required or provided by law. This does not include Medicaid or any program like that, by its terms, does not allow coordination;
- F. Group automobile insurance;
- G. Individual automobile insurance coverage on an automobile leased or owned by the District;
- H. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage; or

- I. Labor/management trustee, union welfare, employer organization or employee benefit organization Plans.

**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.

**Automobile limitations.** When any payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the member's election under PIP (personal injury protection) coverage with the auto carrier.

**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 Participant /employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

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, 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. 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:

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

- (3) The benefits of a benefit plan which covers a person as a Participant/employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired Participant/employee. The benefits of a benefit plan which covers a person as a Dependent of a Participant/employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or retired Participant/employee. 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) 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) The Plan will pay primary to Tricare to the extent required by federal law.

The District has the right:

- A. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the claimant's consent;
- B. To require that the claimant provide the District with information on such other Plans so that this provision may be implemented; and

- C. To pay over the amount due under this Plan to an insurer or other organization if necessary in the District's opinion, to satisfy the terms of this provision. That repayment will count as a valid payment under this Plan.

**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 Member under the 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 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.

## 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. 30<sup>th</sup>  
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.

#### **SELECTCARE NETWORK PROVISION**

All the provisions set forth in the Plan shall remain in full force and effect, except to the extent that such provisions are modified by or in conflict with this EBMS SelectCare Network provision, in which case this EBMS SelectCare Network provision shall prevail.

This Plan participates in the EBMS SelectCare Network. Under the EBMS SelectCare Network, when services are provided by a health care provider participating in the EBMS SelectCare Network (SelectCare Provider), payment for charges eligible for payment under the provisions of this Plan shall be made directly to the SelectCare Provider. SelectCare Providers will accept as payment in full, their normal fee or the maximum allowable fee for the services as provided in the Plan, whichever is less, less a negotiated discount, and shall not seek additional payment from covered persons except for amounts specified as copayments, coinsurances, deductibles, or for services not covered by the Plan.

#### **DRG (Diagnostic Related Group)**

In rare instances, an inpatient Hospital stay (reimbursed on a DRG or per diem PPO rate) can be repriced to exceed the billed amount. The Plan will be responsible for this overage.

**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 Usual and Reasonable 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.

#### **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:

**District Superintendent  
District Self-Insurance Fund Administrative Liaison  
Benefits Technician II**

- 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.



**Plan Name: Billings Public Schools Primary Care Plan**

**Effective: July 1, 1994**

**Restated: July 1, 2008**

I, \_\_\_\_\_, certify that I am the \_\_\_\_\_

Name

Title

of the Plan Sponsor/Administrator for the above named Health Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the above referenced Plan Document and am hereby authorizing its implementation as of the effective date stated above.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_