PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

SHEPHERD PUBLIC SCHOOLS EMPLOYEE HEALTHCARE PLAN

HDHP I

Effective: July 1, 2014

Restated: July 1, 2021

JOINT POWERS TRUST

TABLE OF CONTENTS

INTRODUCTION

This document is a description of **Shepherd Public Schools Employee Healthcare Plan** (the Plan). ***This Plan is intended to be a qualifying High Deductible Health Plan (HDHP).***

The Plan participates in the **Joint Powers Trust also known as Montana Joint Powers Trust.** The benefits and principal provisions of the group contract that apply to individuals covered under the Plan are described herein.

This documentation replaces and supersedes any Plan Document or Summary Plan Description issued to Covered Persons of the Employer by the Joint Powers Trust also known as Montana Joint Powers Trust to provide the coverages set forth herein. If the Joint Powers Trust also known as Montana Joint Powers Trust does not grant such approval the coverages will not go into effect. If the Joint Powers Trust also known as Montana Joint Powers Trust does grant approval, identification cards will be distributed.

No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

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

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

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

Before filing a lawsuit, the Claimant must exhaust both levels of review as described in the Internal And External Claims Review Procedures section. A legal action to obtain benefits must be commenced within one (1) year of the date of the notice of the Plan Administrator's determination on the second level of review.

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

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

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

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

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

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

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

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

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

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

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

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

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

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

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are usual and reasonable as defined as an Allowable Charge; that services, supplies and care are not Experimental and/or Investigational.

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

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. These Network Providers have agreed to charge reduced fees to persons covered under the Plan It is the Covered Person's choice as to which Provider to use.

To access a list of Preferred Providers, please refer to the Preferred Provider website and/or toll free number listed on the **EBMS/Shepherd Public Schools Employee Healthcare Plan** identification card. Prior to receiving medical care services, the Covered Person should confirm with the provider and the Preferred Provider Organization (PPO) that the provider is a participant in this organization.

HIGH DEDUCTIBLE HEALTH PLAN

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides coverage for high cost medical events, and in a tax-advantaged way, to help build savings for future medical expenses. The Plan gives a covered Employee greater control over how health care benefits are used. An HDHP satisfies certain statutory requirements with respect to minimum deductibles and maximum out-of-pocket expenses for Single and Family Coverage. These minimum deductibles and limits for out-of-pocket expenses are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

Only those Employees covered under a qualified High Deductible Health Plan (HDHP) are eligible to contribute to a Health Savings Account (HSA).

If a Covered Person has coverage under this Plan and another plan, the other plan would also need to be a qualified HDHP in order for the Covered Person to contribute to an HSA.

DEDUCTIBLES PAYABLE BY PLAN PARTICIPANTS

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

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

Embedded Deductible: This Plan has an "embedded" deductible, which means a covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to the Plan paying benefits for that individual.

However, the deductible amount for all members of that Family Unit will only be satisfied when the family deductible has been met for that Calendar Year.

Each **January 1st**, a new deductible amount is required.

WellVia Consultation fees and HDHP Expanded Preventive Drug copayments **will apply** to the deductible.

The deductible amount **will apply** to the maximum out-of-pocket amount.

NOTE: ALL BENEFIT MAXIMUMS, DEDUCTIBLES AND MAXIMUM OUT-OF-POCKET AMOUNTS ACCUMULATE ON A **CALENDAR YEAR** BASIS.
THE BENEFIT YEAR IS **JANUARY 1** TO **DECEMBER 31**.

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

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

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

DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	$2,800
Per Family Unit	$5,600

Embedded Deductible: This Plan has an "embedded" deductible which means a covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to the Plan paying benefits for that individual.

However, the deductible amount for all members of that Family Unit will only be satisfied when the family deductible has been met for that Calendar Year.

MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Per Covered Person	$2,800
Per Family Unit	$5,600

The Plan will pay the designated percentage of Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%.

- Amounts over the Allowable Charge

COVERED CHARGES	
HOSPITAL SERVICES	
Room and Board	100% after deductible the average semiprivate room rate
Intensive Care Unit	100% after deductible Hospital's ICU Charge

When **inpatient Hospital** services are provided in **Billings, MT** it is **required that Billings Clinic be utilized** in order for benefits to be payable under the Plan. **Inpatient Hospital services provided at any other full-service intensive care Hospital will be considered ineligible for payment.**

If these services cannot be provided at the above referenced full-service intensive care Hospital, charges incurred at another full-service intensive care Hospital will be eligible for payment.

In all other regions of the State of Montana any Hospital may be utilized for inpatient Hospital services and charges will be eligible for payment under the Plan, including inpatient Hospital charges incurred outside of the State of Montana.

Emergency care can be provided at any facility. When in Billings, MT if an inpatient Hospital stay is required for a Medical Emergency, the patient will need to be moved to one of the above referenced facility after the patient has been stabilized and the move is deemed medically appropriate by the attending Physician.

Outpatient Hospital	100% after deductible
Ambulatory Surgical Center	100% after deductible
Emergency Room Services	100% after deductible

PHYSICIAN SERVICES	
Office visits	100% after deductible
Inpatient visits	100% after deductible
Surgery	100% after deductible
Outpatient Diagnostic Testing (X-ray & Lab)	100% after deductible
Imaging Procedures (i.e. MRI, CT, & PET)	100% after deductible
OTHER COVERED CHARGES	
Allergy testing, serum and other therapeutic injections	100% after deductible
Ambulance Service	100% after deductible
Applied Behavior Analysis (ABA) *(birth through age 18)*	100% after deductible 152 visits maximum per Calendar Year
Chemotherapy or Radiation Treatment	100% after deductible
Wig *After Chemotherapy or radiation treatment*	100% after deductible 1 maximum per Lifetime
Diagnostic Colonoscopy/Sigmoidoscopy	100% after deductible
Durable Medical Equipment, Orthotics, and Prosthetics	100% after deductible
Home Health Care	100% after deductible 180 visits maximum per Calendar Year
Hospice Care • Home Hospice Care • Inpatient Hospice Care	 100% after deductible 100% after deductible
Infusion Therapy • Home Infusion • Outpatient Infusion	 100% after deductible 100% after deductible
Mental Disorders and Substance Abuse • Inpatient • Office Visit • Outpatient facility	 100% after deductible 100% after deductible 100% after deductible
Organ Transplant • Transportation, meals, and lodging o Meals and lodging	100% after deductible $10,000 maximum per organ transplant $200 maximum per day
Note: Refer to the Covered Charges section for more information on organ transplant.	
Pregnancy	100% after deductible
* Routine prenatal office visits	100%, no deductible applies **OR** *If global maternity fee:* 40% of Covered Charges will be payable at 100%, no deductible applies; thereafter, 100 % after deductible
* Refer to the Coverage of Pregnancy benefit listed in the Covered Charges section for more information regarding routine prenatal office visits.	

Preventive Care	
Routine Well Care (birth through adult)	100%, no deductible applies

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

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

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

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

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

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/; and
http://www.hrsa.gov/womens-guidelines

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

Note: *Charges in connection with 3-D mammography will be a Covered Charge.*

Diabetic Education	100%, no deductible applies
Nutritional Education Counseling	100%, no deductible applies
Obesity Interventions for Covered Persons age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher	100%, no deductible applies 26 visits maximum per Calendar Year
Tobacco/Nicotine Cessation Counseling	100%, no deductible applies
Rehabilitation Therapy – Includes Occupational, Physical, and Speech Therapy	
• Inpatient	100% after deductible 30 days maximum per Lifetime
• Outpatient	100% after deductible 30 combined visits maximum per Calendar Year
• **Down Syndrome Treatment** (*birth through age 18 years only)* Occupational therapy Physical therapy Speech therapy	100% after deductible 52 visits maximum per Calendar Year 52 visits maximum per Calendar Year 104 visits maximum per Calendar Year
Renal Dialysis Services	100% after deductible
Routine Newborn Care *(while hospital confined at birth)*	100% after deductible

Skilled Nursing Facility	100% after deductible the facility's average semiprivate room rate
	60 days maximum per Calendar Year
Spinal Manipulation/Chiropractic Services	100% after deductible
	40 visits maximum per Calendar year
Note: Diagnostic Testing (X-ray & Lab) and Imaging Services (MRI, CT/PET Scans, etc.) are not applied to the visit maximum.	
Urgent Care Visit	100% after deductible
WellVia Telehealth Consultation	$35 consultation fee per consult, (the consultation fee applies to the deductible)
Note: *Please see the WellVia Telehealth benefit in the Covered Charges section for more information.*	
All Other Covered Charges	100% after deductible

PRESCRIPTION DRUG BENEFITS

Participants are required to pay 100% at the pharmacy until the Calendar Year Deductible is paid.

Coverage for certain medications is only applicable if patient advocacy program fails to provide solution. Advocacy solutions come from a variety of sources, including manufacturer assistance programs, copay cards, grants, and mail order pharmacies. The Plan may also allow for a 60-day grace period for urgent medications to allow time to complete the advocacy process. Prior authorization is required on all specialty medications.

Additionally, as part of the advocacy program, the Plan maximizes specialty copay assistance. As part of this process certain specialty Pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's maximum out-of-pocket amount. For a list of medications included in the specialty assistance program please contact SmithRx member services. Although the cost of the program drugs will not be applied towards satisfying a Plan Participant's maximum out-of-pocket amount, the cost of the program drugs will be reimbursed by the manufacturer at no cost to the Plan Participant; and copayments for certain specialty medications may be set to the max of the current Plan design or any available manufacturer-funded copay assistance.

Retail and Mail Order, *available up to a 90-day supply per prescription***, and**
Mandatory Specialty Pharmacy Program Drugs, *available up to a 30-day supply per prescription*

Generic drugs Reimbursement rate	100% after deductible
Formulary Brand Name drugs Reimbursement rate	100% after deductible
Non-Formulary Brand Name drugs Reimbursement rate	100% after deductible

Note: Coverage for **specialty drugs** requires purchase through the specialty Pharmacy program. Only first fill will be eligible through the retail Pharmacy.

HDHP Expanded Preventive Drugs

1 to 30-day supply:

Generic drugs Reimbursement rate	100%, no deductible applies
Formulary Brand Name drugs copayment	$40, no deductible applies
Non-Formulary Brand Name drugs copayment	60%, no deductible applies
Maximum copayment	$200

31 to 90- day supply:

Generic drugs Reimbursement rate	100%, no deductible applies
Formulary Brand Name drugs copayment	$80, no deductible applies
Non-Formulary Brand Name drugs copayment	60%, no deductible applies
Maximum copayment	$400

If a Covered Person requests a brand name drug instead of a generic drug, when a generic equivalent is available, then the Covered Person will be responsible for the difference in cost between a generic drug and applicable brand name drug in addition to the applicable copayment amount as stated above. The difference in cost will not apply to the maximum out-of-pocket amount shown in the Schedule of Benefits.

See the Prescription Drugs Benefit section for additional details.

ELIGIBILITY, EFFECTIVE DATE, FUNDING, AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees.

All Active and Retired Employees of the Employer.

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

(1) Is an Active Employee of the Employer who normally works at least 30 hours per week and is on the regular payroll of the Employer for that work; and

(2) Completes the applicable employment Waiting Period if any as an Active Employee imposed by the Employer. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan not to exceed 90 days.

(3) Is in a class eligible for coverage.

If the Employee is not designated as a Full-Time Employee by the Employer, the Employer has elected to use the 12-month look-back measurement period for all Employees to determine full time status. The Employee must average or be expected to average the required hours of service established by the Employer each week during the Employee's initial 12-month measurement period to become eligible for coverage.

An Employee's initial measurement period begins the first day of the month following the date of hire, with an initial stability period commencing the first day of the second full calendar month following the initial measurement period. If there is a gap between the end of the Employee's first stability period and the start of the Employer's standard stability period, the Employee will remain eligible until the first day of the standard stability period as long as the Employee is actively working for the Employer.

The Employer uses a standard 12-month measurement period**.** Coverage is effective the first day of the stability period following the applicable measurement period. To remain eligible for coverage, the Employee must average the required minimum hours of service during each subsequent standard measurement period.

For more information on benefit measurement periods, contact the Employer's Human Resources Department.

Eligibility Requirements for Retired Employee Coverage

(1) A person is eligible for Retired Employee coverage as long as he or she was a Covered Person under the Plan on the day immediately before the date of retirement, is vested in a retirement system administered by the Montana Public Employee Retirement Administration and the Public Employees' Retirement Board, is at least 50 years of age with at least 5 years of membership service, and eligible pursuant to the terms of Montana Code Annotated section 2-18-704, as amended. A person is also eligible for Retired Employee coverage if eligible for retirement under the terms and conditions of the employment policies and practices of the Employer.

In all cases, upon retirement, an Employee or Trustee/Board Member, if applicable, can choose between COBRA Continuation Coverage or continuing under the terms of the Plan as a Retired Employee if the Retired Employee satisfies the criteria as set forth above.

EFFECTIVE DATE OF EMPLOYEE COVERAGE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month or the 91st day following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

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

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

(1) A covered Employee's or Retired Employee's Spouse or Domestic Partner and children from birth to the limiting age of 26 years.

If an otherwise eligible Dependent is not the covered Employee'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 Employee may be required to pay the cost of the benefits on an after-tax basis and the employee may be subject to additional tax consequences.

The term "**Spouse**" shall mean a person of the opposite or same sex recognized as the covered Employee's husband or wife by the laws of the state in which the marriage was formalized. Spouse will not include a common-law Spouse. The Plan Administrator may require documentation proving a legal marital relationship.

The term "**Domestic Partner**" shall mean a person of either opposite sex or of the same sex meeting the following criteria: Share an intimate, exclusive committed personal relationship of mutual caring; are not related by blood closer than permitted under marriage laws of the state; are not married; are not acting under fraud or duress, and who are both at least 18 years old and competent to enter into a contract; have no other Domestic Partner nor had a different Domestic Partner in the last 12 consecutive months; shared the same principle residence for the last 12 consecutive months; are jointly responsible for each other's basic living expenses and agree that anyone who is owed for these expenses can collect from either person; and each declares in writing, under penalty of perjury, that she or he is the other's Domestic Partner. *All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated.*

The term **"children"** shall include natural children or step-children of the covered Employee, Retiree or Domestic Partner, adopted children, children placed with the covered Employee, Retiree or Domestic Partner in anticipation of adoption or Foster Children. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

If a covered Employee or Retiree is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents. The Plan Administrator may require documentation proving a legal guardianship.

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

Please be advised, the definition of "Dependent" may not be the same definition as established by the

Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax-free benefits (i.e. domestic partner or non-IRC Section 152 Dependent).

There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

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

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

(2) A covered Dependent child who reaches the limiting age and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily Dependent upon the covered Employee, Retiree or Domestic Partner for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

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

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

If both mother and father or Domestic Partner are Employees or Retirees, their children *may* be covered as Dependents of the mother, father or Domestic Partner.

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

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

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

FUNDING

Cost of the Plan. The Employer shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Employer.
The level of any Employee or Retired Employee contributions is set by the Employer. The Employer reserves the right to change the level of Employee contributions.

ENROLLMENT

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

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee is ***not*** automatically enrolled in this Plan.

There is a 60-day enrollment period beginning on the date of birth. If enrolled within the first 60 days, coverage will be retroactive to the date of birth. If the newborn child is not enrolled in this Plan during the initial 60-day enrollment period, the enrollment will be considered a Late Enrollment, there will be no payment from the Plan and the covered parent will be responsible for all costs. (Refer to the Late Enrollment and Open Enrollment sections below.) Any applicable premium will be charged starting with the month the baby is born if added to the policy.

Mid-Year Enrollment Change. An eligible Employee may prospectively enroll or dis-enroll the Employee and/or eligible Dependent(s) in certain situations if the requested change in coverage under the Plan is on account of and consistent with a change made under another employer sponsored plan (including a plan of the Employer or the employer of the Spouse or a Dependent), and is permitted by law.

TIMELY, LATE, OR OPEN ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days (or 60 days for a newborn Dependent child of the Employee or Spouse) after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees or Retired Employees (husband and wife or Domestic Partners) are covered under the Plan and the Employee or Retired Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee or Retired Employee with no Waiting Period as long as coverage has been continuous.

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

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

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

(i) **Open Enrollment** - Each year there is an annual open enrollment period designated by the Employer; during the annual open enrollment period covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Each year there is an annual open enrollment period designated by the Employer during which Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan. Benefit choices made during the open enrollment period will become effective **the first of the month designated by the Employer** and remain in effect until the next open enrollment, unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent

previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

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

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

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

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her Dependents (including his or her Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days of the birth adoption or placement for adoption, or 31 days of marriage, or registration of the Domestic Partnership relationship.

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

SPECIAL ENROLLMENT PERIODS

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

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

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

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

(c) The coverage of the Employee 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. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

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

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

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

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

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

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

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

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

(b) The Retired Employee is a participant under this Plan; and

(c) A person becomes a Dependent of the Employee or Retired Employee through marriage, registration of Domestic Partnership, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage.

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

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

The Dependent Special Enrollment Period for:

(a) Marriage or Domestic Partner relationship is a period of 31 days and begins on the date of the marriage, or date of registration of Domestic Partnership;

(b) Dependent's birth, a Dependent's adoption, placement for adoption, or Foster Child placement is a period of 60 days and begins the date of birth, adoption or placement for adoption, or Foster Child placement.

To be eligible for this Special Enrollment, the Dependent and/or Employee or Retired Employee must request enrollment during this period.

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

(a) In the case of marriage, the day of marriage, or

(b) In the case of Domestic Partner relationship, on the date of registration of the domestic partner relationship; or

(c) In the case of a Dependent's birth, as of the date of birth; or

(d) In the case of a Dependent's adoption, placement for adoption, or Foster Child placement, the date of the adoption, placement for adoption, or Foster Child placement.

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

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

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

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

If eligible, the Dependent and if not otherwise enrolled, the Employee, Spouse, and otherwise eligible Dependent children may be enrolled under this Plan.

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

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

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

TERMINATION OF COVERAGE

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

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

(1) The date the Plan is terminated;

(2) The date the covered Employee's Eligible Class is eliminated;

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

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;

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

(6) As otherwise specified in the Eligibility section of this Plan.

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

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

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

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

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

Rehiring a Terminated Employee. A terminated Employee who is rehired prior to the end of a 26 consecutive week period after the date of termination will have coverage reinstated the first day of the first calendar month following the date of rehire. Employees rehired after a break in service of 26 consecutive weeks or more will be treated as a new hire.

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

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

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

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

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

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

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

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

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

(a) The next regularly scheduled day of employment following travel time plus 8 hours, if State active duty is 30 days or less; or

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

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

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

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined

by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State active duty.

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

(1) The date the Plan is terminated;

(2) The date the covered Retired Employee's Eligible Class is eliminated;

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

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

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due**;** or

(6) As otherwise specified in the Eligibility section of this Plan.

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

(1) The date the Plan or Dependent coverage under the Plan is terminated;

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.);

(3) The last day of the month a covered Spouse or Domestic Partner loses coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.) *In the even the Domestic Partnership is terminated either partner is required to inform the Plan Administrator of the termination of the Domestic Partnership;*

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

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;

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

(7) As otherwise specified in the Eligibility section of this Plan.

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".

SURVIVING DEPENDENT OF RETIRED EMPLOYEE COVERAGE.

The surviving Spouse of a deceased covered Retired Employee may remain a Covered Person of the Plan as long as the Spouse is eligible for retirement benefits accrued by the deceased covered Retired Employee unless a participant in another group plan with substantially equivalent benefits and rates, or employed and therefore eligible to participate in another group plan with substantially equivalent benefits and rates.

The surviving children of deceased covered Retired Employee may remain Covered Persons of the Plan as long as they are eligible for retirement benefits accrued by the deceased covered Retired Employee unless they have equivalent coverage in another group plan with substantially equivalent benefits and rates, or unless employed and therefore eligible to participate in another group plan with substantially equivalent benefits and rates or are eligible for health coverage under a surviving parent's or legal guardian's employment plan.

Persons meeting these requirements who wish to remain a Covered Person of the Plan must furnish satisfactory evidence of their qualifications to the Claims Administrator within 20 days after such eligibility commences and make arrangements for payment.

SPOUSE OF RETIRED EMPLOYEE COVERAGE

The Spouse of a Retired Employee may remain a Covered Person of the Plan as long as the Spouse was a Covered Person under the Plan on the day immediately before the date of the Retired Employee's retirement or the date the covered Retiree becomes Medicare eligible as a result of age (whether or not the Retiree enrolls in Medicare) or has or is eligible for coverage in another group plan with substantially equivalent benefits and rates.

Spouse of Retired Employee Coverage does not include children of the covered Spouse, covered Employee, or covered Retired Employee.

A covered Spouse meeting these requirements who wishes to remain a Covered Person of the Plan must furnish satisfactory evidence of their qualifications to the Claims Administrator within 20 days after such eligibility commences and make arrangements for payment.

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

(1) The date the Plan is terminated;

(2) The date the covered Spouse of Retired Employee becomes a participant in another group plan with substantially equivalent benefits and rates, or becomes employed and therefore eligible to participate in another group plan with substantially equivalent benefits and rates;

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due**;**

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

(5) As otherwise specified in the Eligibility section of this Plan.

MEDICAL BENEFITS

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

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

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

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

Before filing a lawsuit, the Claimant must exhaust both levels of review as described in the Internal And External Claims Review Procedures section. A legal action to obtain benefits must be commenced within one (1) year of the date of the notice of the Plan Administrator's determination on the second level of review.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by Covered Persons of a Family Unit toward their Calendar Year deductibles, the deductibles of all Covered Persons of that Family Unit will be considered satisfied for that Calendar Year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any applicable copayment(s).

Benefit payment made by the Plan will be at the rate shown in the Schedule of Benefits. No benefits will be paid in excess of the maximum benefit amount listed in the Plan.

MAXIMUM OUT-OF-POCKET AMOUNT

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

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

COVERED CHARGES

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

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

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

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

(2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

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

The following services will continue to be payable per normal Plan provisions:

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

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

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

(a) The patient is confined as a bed patient in the facility; and

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

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

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

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

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

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

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

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Allowable Charge.

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

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

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

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

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

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

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

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

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

(a) **Allergy testing and injections.** Covered Charges will include testing, injections, serum and syringes.

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

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

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

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

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

(e) Breast pump, breast pump supplies, lactation support and counseling.

Breast pump, breast pump supplies.
A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be rented or purchased, with the cost not to exceed the purchase price.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered a Covered Charge under this Plan.

- For female Covered Persons using a breast pump from a prior Pregnancy, a new set of breast pump supplies may be covered with each subsequent Pregnancy.

- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered up to once every (3) three Calendar Years if associated with a subsequent Pregnancy.

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

Note: *Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable only for the purposes of this benefit.*

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

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

Note: *Payment will be made for Covered Charges for lactation support and counseling under the Preventive Care benefits in the Schedule of Benefits section*.

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

(g) Chemotherapy or radiation treatment with radioactive substances. The materials and services of technicians are included.

Pre-notification of services, by the Plan Participant, for cancer treatment services is strongly recommended. The pre-notification request to CareLink should include the Covered Person's plan of care and treatment protocol. Pre-notification of services should occur at least seven (7) days prior to the initiation of treatment.

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

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

A pre-notification of services by CareLink is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan, including but not limited to medical necessity, exclusions and limitations in effect when services are provided. A pre-notification is not

required as a condition precedent to paying benefits, and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.

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

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

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

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

(i) **Colonoscopy.** Covered Charges for a colonoscopy with a medical diagnosis will be payable as stated in the Schedule of Benefits. *Coverage includes reimbursement for the following: CT Colonography (virtual colonoscopy and flexible sigmoidoscopy).*

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

Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Covered Persons.

(k) Initial **contact lenses** or glasses required following cataract surgery.

(l) **Diabetic Education.** Inpatient and outpatient self-management training and education for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes.

(m) **Down Syndrome Treatment** including but not limited to professional, counseling, guidance services, and treatment programs deemed Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered Dependent child(ren).

Note: *Benefits are limited to treatment that is prescribed by a Physician and documented by a written Plan of Care and provided by the treating Physician. The Plan may require an updated treatment plan and documentation of continued medical necessity updated every 6 (six) months.*

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

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

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

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

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

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

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Covered Person if the Covered Person were to purchase the item directly. The acquisition cost of the item may be prorated over a 6 month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every 4 Calendar Years.

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Covered Person's medical condition occurs sooner than the 4 Calendar Year period.

- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Covered Person's medical condition occurs sooner than the 4 Calendar Year period.

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

Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the 4 Calendar Year limit.

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

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

(p) **Inborn Errors of Metabolism.** Treatment under the supervision of a Physician for inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standards methods of diagnosis, treatment, and monitoring exist.

Benefits include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, Prescription Drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and nutritional supplements in any form that are used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

(q) **Infertility.** Care, services and supplies for the diagnosis and treatment of Infertility. Limited to only one attempt at in vitro fertilization, per Covered Person per Lifetime. The Plan will not pay for in vitro fertilization services if the Covered Person has had an elective sterilization procedure. Prescription drugs for Infertility are not covered under this Plan.

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

(s) Treatment of **Mental Disorders and Substance Abuse**. Covered Charges will be payable for care, supplies and treatment of Mental Disorders and Substance Abuse. Partial Hospitalization is covered under the inpatient treatment benefit.

Employee Assistance Program (EAP)

The JPT has contracted with ***Sapphire Resource Connection (SRC)*** to provide Covered Persons with an Employee Assistance Program. Each Covered Person will be eligible for up to four (4) confidential therapeutic sessions per contract year *(the contract year will run from July 1 through June 30)*. The Plan will pay the cost of each covered therapeutic session with licensed clinical professional counselors (LMSW, LCPC, Ph.D.), and certified chemical dependency counselors (SAP or LAC). SRC can help Covered Persons better deal with personal, family or work-related concerns including but not limited to; marital/relationship problems, stress, depression/grief, anxiety or panic disorders, and many other common issues such as parenting, addiction, Illness, financial and legal problems.

To access your EAP benefits, please contact ***Sapphire Resource Connection*** for more information:

- Call (406) 523-7707 or the *24-hour Help Line* at (866) 767-9511
- Login at http://www.sr-connection.com (**user name**: jpt ; **password**: jpt)

(t) **Morbid Obesity.** Medically Necessary surgical and non-surgical charges for Morbid Obesity will be covered. *Treatment of complications and/or secondary surgeries related to the initial surgery will be covered only when deemed Medically Necessary. Surgical treatment of Morbid Obesity will be limited to once per Lifetime.*

The term "Morbid Obesity" means a serious disease associated with a high incidence of medical complications and a significantly shortened life span.

For **non-surgical treatment,** Morbid Obesity is defined as a body mass index (BMI) of 30 or above.

Treatment and services by licensed health care providers, includes but is not limited to dieticians; nutritional counseling; office visits, associated lab work ordered by the provider and Prescription Drugs that are U.S. Food and Drug Administration (FDA)-approved for the management of weight loss due to Morbid Obesity.

For **surgical treatment**, the definition of "Morbid Obesity" means a condition of persistent and uncontrollable weight gain and is defined as a body mass index (BMI) of 35 to 39 with any comorbid conditions that are expected to improve, reverse, or be limited by this surgical treatment ***or*** a BMI of 40 with or without accompanying comorbid conditions. Treatment must be documented in a record or letter of medical necessity that demonstrates the diagnosis of Morbid Obesity.

Note: The BMI is a factor produced by dividing a person's weight (in kilograms) by his/her height squared (in meters).

A pre-notification of services, by the Plan Participant is strongly recommended for either inpatient or outpatient surgical procedures and will require the following documentation including, but not limited to, a written treatment plan by the attending Physician and documentation that all required medical criteria in advance of any surgical treatment has been met. Please contact the Claims Administrator for further information regarding pre-notification procedures and requirements for this benefit.

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

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

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth. Such expenses must be incurred within 12 months of the date of the accident.
- Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.

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

Dental Accident services. Dental services provided by Physicians, Dentists, oral surgeons and/or any other provider are not a Covered Charge under this Plan except Medically necessary services for the initial repair or replacement of sound natural teeth which are damaged as a result of an accident. This benefit does not include orthodontics, dentofacial orthopedics, or related appliances even if related to the accident.

Services and supplies provided by a Hospital in conjunction with dental treatment will be covered only when nondental physical Illness or Injury exists which makes Hospital care Medically Necessary to safeguard the Covered Person's health. Dental treatment provided in a Hospital unrelated to a nondental physical Illness or Injury are not Covered Charges under the Plan regardless of the complexity of dental treatment and length of anesthesia.

The Plan will not pay for services for the repair of teeth which are damaged as the result of biting and chewing.

(v) **Naturopath.** Care, services and treatment by a licensed naturopath that are described as a Covered Charge under this Plan.

(w) **Nutritional Education Counseling.** Care, treatment, and services when provided by Physician, a registered dietician, or licensed nutritionist.

This benefit will not include weight loss medications or nutritional supplements whether or not prescribed by a Physician.

(x) **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act preventive services requirement. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Covered Persons age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher will be payable up to the limit as stated in the Schedule of Benefits.

Intensive, multicomponent behavioral interventions for weight management will include:

- Group and individual sessions of high intensity encompassing the following:
  - Behavioral management activities such as setting weight loss goals
  - Improving diet or nutrition and increasing physical activity
  - Addressing barriers to change
  - Self-monitoring
  - Strategizing how to maintain lifestyle changes

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

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

(y) **Occupational therapy** by a 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.

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

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

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

- **Organ procurement limits**. Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. Charges incurred by the organ donor for a covered transplant will be eligible under this Plan if the charges are not covered by any other medical expense coverage.

  The donor benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

  (i) Evaluating the organ or tissue;

  (ii) Removing the organ or tissue from the donor; and

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

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

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

There is no obligation to the Covered Person to use either a Network Provider or a Center of Excellence facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Network Provider or a Non-Network Provider and whether or not a Center of Excellence facility is utilized.

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

Travel and Lodging Expenses

If a transplant is performed at a transplant facility and the Covered Person resides **100 miles or more** from the transplant facility, the Plan will pay for the following services incurred during the transplant benefit period (subject to the maximum benefit as specifically stated in the Schedule of Benefits):

A. Transportation expenses to and from the transplant facility for the Covered Person

Transportation expenses include commercial transportation (coach class only).

B. Reasonable lodging and meal expenses incurred for the Covered Person, only while the Covered Person is receiving transplant-related services at a transplant facility.

Lodging, for purposes of this Plan, will not include private residences.

Special Transplant Benefits

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

Transplant Exclusions

Coverage for the following procedures, when Medically Necessary, will be provided under the regular medical benefits provision under this Plan, subject to any Plan provisions and applicable benefits limitations as stated under this Plan.

(1) Cornea transplantation
(2) Skin grafts
(3) Artery
(4) Vein
(5) Valve
(6) Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

Note: Pre-notification is recommended; see the Care Management Services section for additional details.

(a1) **Orthotic appliances.** The initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

Orthopedic devices, a rigid or semi rigid supportive device which restricts or eliminates motion of a weak or diseased body part, will be limited to braces, corsets and trusses.

Foot orthotics, including impression casting for orthotic appliances, padding, strapping and fabrication *will not* be a Covered Charge *unless determined Medically Necessary in the treatment of diabetes.*

(b1) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(c1) **Prescription** Drugs (as defined). *Outpatient Prescription Drugs will be payable under the separate Prescription Drug Benefit section under this Plan.*

(d1) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Preventive Care shall be provided as required by applicable law and includes services with an "A" or "B" rating from the United States Preventive Services Task Force.

Charges for Routine Well Care. Routine well care is care by a Physician that is not for an Injury or Sickness.

(e1) **Prosthetic devices.** The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts if deemed Medically Necessary. Covered Charges for deluxe prosthetics and computerized limbs will be based on Allowable Charges for a standard prosthesis.

Computer-assisted communication devices and replacement of lost or stolen prosthesis *will not* be a Covered Charge.

(f1) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

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

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

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

in a manner determined in consultation with the attending Physician and the patient.

(g1) Charges for **Rehabilitative Therapy,** will be payable up to the limits stated in the Schedule of Benefits. Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

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

Outpatient Care. Coverage will be provided for outpatient occupational, physical and speech therapy, and cardiac rehabilitation therapy and will be payable as outlined under the separate benefit provisions listed under this Plan.

(h1) **Renal Dialysis Services.** Renal dialysis visits shall include dialysis, facility services, supplies and medications provided during treatment. Laboratory testing and Physician visits will be payable per normal Plan provisions.

(i1) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either:

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

(ii) An Injury; or

(iii) A Sickness.

(j1) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C., will be payable up to the limits as stated in the Schedule of Benefits.

(k1) **Sterilization** procedures. Sterilization procedures for female Covered Persons will be payable as shown under the Preventive Care benefit as shown in the Schedule of Benefits section.

The following charges will be payable per normal Plan provisions:

- *Hysterectomies; and*
- *Sterilization procedures for male Covered Persons.*

(l1) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations and other Medically Necessary medical supplies.

(m1) **Tobacco/Nicotine Cessation Counseling.** Care and treatment for tobacco/nicotine cessation counseling. Refer to the Prescription Drug Benefit section regarding coverage of tobacco/nicotine cessation medications and products.

(n1) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge. *Circumcisions within three (3) months of birth will be covered on an inpatient or outpatient basis.*

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

The benefit is limited to Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

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

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth. *Circumcisions within three (3) months of birth will be covered on an inpatient or outpatient basis.*

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(o1) ***WellVia*** **Telehealth Consultation**

The *WellVia* Telehealth benefit offers Covered Persons telephone access to experienced board-certified licensed Physicians as a convenient alternative to receive immediate health care for common medical issues. *WellVia* Telehealth Physicians are available 24 hours a day, including weekends and holidays and are able to provide diagnoses, medical advice, and treatment recommendations, including prescription medications.

Covered Charges will be payable as stated in the Schedule of Benefits.

To contact a *WellVia* Physician, call the *WellVia* Patient Care Center toll-free at 1 (855) 935-5842, or, access their webpage at www.WellViaSolutions.com for additional information.

(p1) **Wig.** Charges associated with the initial purchase of a wig after chemotherapy or radiation treatment and will be payable up to the limits as described in the Schedule of Benefits.

(q1) **X-rays**. Covered Charges for diagnostic x-rays and imaging services.

MEDICAL EXPENSE AUDIT BONUS

The Plan offers an incentive to all Covered Persons to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the Covered Person. The Covered Person should review all medical charges and verify that each itemized service has been received and that the bill does not represent either an overcharge or a charge for services never received. Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Covered Person to avoid unnecessary payment of health care costs.

In the event a self-audit results in elimination or reduction of charges fifty percent (50%) of the amount eliminated or reduced will be paid directly to the Employee as a bonus, 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.) The bonus shall only apply to charges which have been submitted to and paid by the Plan, and for which an erroneous charge was paid by the Plan. Erroneous charges corrected by the Plan during the claims adjudication process are not eligible for this bonus. Rewards are subject to the following:

- A minimum reward of $25 (on an overcharge of $50)
- A maximum reward of $1,000 (on a charge of $2,000 or more)

This self-audit is a bonus in addition to the benefits of this Plan. The Covered Person must indicate on the corrected billing statement "This is a claim for the Medical Expense Audit Bonus" and submit to the Claims Administrator at the following address a copy of the incorrect bill and a copy of the corrected billing in order to receive the bonus:

The Joint Powers Trust a.k.a. The Montana Joint Powers Trust
c/o Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

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

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

Examples of when the Physician and Covered Person should contact CareLink prior to treatment include:

- Inpatient admissions to a Hospital;
- Inpatient admissions to free-standing chemical dependency, mental health, and rehabilitation facilities;
- Cancer treatment plan of care, administered on an inpatient or outpatient basis;
- Inpatient or outpatient surgeries relating to, but not limited to, hysterectomies, back surgery, or bariatric surgery (if applicable under this Plan); and
- Outpatient services as follows:
    - Dialysis
    - Genetic testing
    - Injectables
    - Home Health Care
    - Hospice
    - Durable Medical Equipment (DME) over $2,000

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

The Physician or Covered Person should notify CareLink at least seven (7) days before services are scheduled to be rendered with the following information:

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

If there is an emergency admission to the Hospital, the Covered Person, Covered Person's family member, Hospital or attending Physician should notify CareLink within two (2) business days after the admission.

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

Contact the Care Management administrator at:

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

PRE-ADMISSION AND POST DISCHARGE CARE CALLS

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

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

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

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

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

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

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

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

CASE MANAGEMENT

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

This plan of care may include some or all of the following:

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

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

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

The Joint Powers Trust also known as Montana Joint Powers Trust has contracted with *It Starts With Me Health Solutions* to provide a means of knowledge and management of personal health, It Starts With Me makes available the tools individuals need to take control of their health.

By meeting various requirements or completing appropriate alternative standards under the Program, participants may qualify for incentives such as but not limited to gift cards, wellness coaching, and fitness programs. Program participants may also be given opportunities to access health improvement resources and benefits designed to improve their overall health status.

The program may require an annual health screening or other completed activities to qualify for incentives.

Covered Persons should refer to the ***It Starts with Me Wellness Plan Document*** *for additional details regarding the program.*

DEFINED TERMS

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

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

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

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

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

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

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

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

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

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

Brand Name means a trade name medication.

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

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

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as

Complications of Pregnancy.

Cosmetic Dentistry means dentally unnecessary procedures.

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

Covered Person is an Employee, Retired Employee or Dependent who is covered under this Plan.

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

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

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

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is **Shepherd Public Schools**.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

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

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

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

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

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

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

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.

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

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

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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

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

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

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

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

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

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

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

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

nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

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

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

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

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

Infertility means incapable of producing offspring.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

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

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

- "In-training practitioner", which is an individual who has completed all academic requirements for licensure as a psychologist, clinical social worker or licensed professional counselor and is in the process of completing the supervised experience requirement for licensure. The in-training practitioner's services must be supervised by a Physician licensed in the same field as the In-training practitioner.

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

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

Plan Participant is any Employee, Retired Employee or Dependent who is covered under this Plan.

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

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

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

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is a person's Illness, disease or Pregnancy (including complications).

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

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

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

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

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

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

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

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

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

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

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

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

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

(3) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

(4) **Counseling.** Care and treatment for marital or pre-marital counseling, religious counseling, self-help programs, and stress management.

*Note: Counseling and other confidential assistance maybe available through the **Employee Assistance Program** offered by **Sapphire Resource Connection**, as stated in Medical Benefits section of this Plan.*

(5) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as specifically stated as a benefit under this Plan.

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

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

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

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

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

(11) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease or as otherwise deemed Medically Necessary).

Note: Orthotic appliances for the foot are not covered (unless deemed Medically Necessary in treatment of diabetes).

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

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

(14) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for Covered Charges for a wig after chemotherapy or radiation treatment.

(15) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.

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

(17) **Illegal Acts.** Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of the Covered Person engaging in, or attempting to engage in a "serious criminal act ", a riot or public disturbance; and for which the Covered Person 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. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Covered Person, or by the Covered Person in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. 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.

(18) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for sexual dysfunctions, including impotence.

(**19**) **Incarcerated**. Care, treatment, services, and supplies incurred and/or provided to a Covered Person by a government entity while housed in a governmental institution

(20) **Infertility.** Care, supplies, services and treatment for Infertility, artificial insemination, or in vitro fertilization, except as specifically stated as a benefit under this Plan.

(21) **Mailing or Sales Tax.** Charges for mailing, shipping, handling, conveyance and/or sales tax.

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

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

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

(25) **Non-traditional medical services**. Acupuncture, acupressure, massage, homeopathy, hypnotherapy, herbal and vitamin supplements, holistic medical procedures or rolfing treatments and supplies which are not specified as covered under this Plan.

(26) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

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

(28) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except as specifically stated as a benefit under this Plan.

Medically Necessary charges for Morbid Obesity will be covered. Medically Necessary surgical and non-surgical charges for Morbid Obesity will be covered as specifically stated as a benefit under this Plan.

(29) **Occupational Injury.** Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit and for which the Plan participant is eligible to receive benefits under any Workers' Compensation or occupational disease law. This exclusion will apply if the Plan participant was eligible to receive such benefits and failed to properly file a claim for such benefits or to comply with any other provision of the law to obtain such benefits.

(30) **Orthodontics.**

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

(32) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

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

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

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

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

(37) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(38) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(39) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

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

(41) **War.** Any loss that is due to a declared or undeclared act of war.

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

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

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

Before filing a lawsuit, the Claimant must exhaust both levels of review as described in the Internal And External Claims Review Procedures section. A legal action to obtain benefits must be commenced within one (1) year of the date of the notice of the Plan Administrator's determination on the second level of review.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Prescription drug coverage for Plan Participants is administered by SmithRx, which is a Pharmacy benefits manager. SmithRx provides a nationwide network of network Pharmacies and a drug formulary. The presence of a drug on this formulary does not guarantee coverage and the drugs listed on the formulary are subject to change. To find out if a medication is covered under the Plan, visit the member portal at www.mysmithrx.com or call (844) 454-5201 for the most current formulary information.

Copayments

The copayment is applied to each covered Pharmacy drug charge and is shown in the Schedule of Benefits. The copayment amount is a Covered Charge under the medical Plan.

Any one retail Pharmacy prescription is available up to a 90-day supply.

This plan requires the pharmacist to fill the prescription with a generic product whenever it is available, unless the prescription is written as Dispense as Written. If the prescription is not specified as Dispense as Written and the prescription is filled with a name brand prescription at the Plan participant's request, then the copay plus the difference between the ingredient cost of the generic drug and the brand name drug will be charged.

If a drug is purchased from a non-network Pharmacy, or a network Pharmacy when the Plan Participant's ID card is not used, the Plan Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to SmithRx for reimbursement. Reimbursement is up to the network Pharmacy Allowable Charge minus any applicable copayment as shown in the Schedule of Benefits. The contracted rate will not be applied to compound drugs, urgent/emergency claims, or foreign claims, the applicable copayment as shown in the Schedule of Benefits will apply.

If a drug is purchased and this Plan is secondary, the Plan Participant will be required to submit the prescription receipt to SmithRx for reimbursement. Reimbursement is up to the network Pharmacy Allowable Charge minus any applicable copayment as shown in the Schedule of Benefits.

At select Network Pharmacies, the Plan Participant will be able to obtain a 90-day supply, per prescription, at the same copayment level as the mail order benefit (as shown in the Schedule of Benefits). For additional information or a current list of these select Network Pharmacies, please contact SmithRx toll-free at (844) 454-5201.

m*i*Rx Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order Pharmacy is able to offer Plan Participants significant savings on their prescriptions. The mail order Pharmacy is subject to change.

The copayment is applied to each covered mail order drug charge and is shown in the Schedule of Benefits. The copayment amount is not a Covered Charge under the medical Plan.

Any one mail order prescription is available up to a 90-day supply.

Mandatory Specialty Pharmacy Program

Specialty medications are high-cost injectables, infused, oral, or inhaled medications prescribed in the treatment of chronic disease conditions (e.g., Chronic Kidney Disease, Crohn's Disease, Multiple Sclerosis, or Osteoarthritis). This Plan offers a program for specialty medications that can provide Plan Participants with greater convenience, including express delivery, follow-up care calls, expert counseling, and superior service.

Any one specialty prescription is limited to a 30-day supply. All prescriptions are subject to the terms, limitations, and exclusions as set forth this Plan.

Step Therapy Program

Step Therapy is a process that requires the use of one or more first line agents before a medication which is part of a step therapy protocol can be utilized.

The goal of step therapy is to ensure that safe and cost effective medications are used, based on recognized treatment guidelines and well documented clinical studies. This means that in some instances the Plan Participant will need to try one or more medications which are considered first line before he/she is able to receive a "second step" medication through his/her Pharmacy benefit plan.

For a complete list of medications that are subject to Step Therapy protocols, contact SmithRx Customer Care toll-free at (844) 454-5201.

What happens when a medication is Medically Necessary but it is a part of a Step Therapy protocol? If it is Medically Necessary for the Plan Participant to receive a "second step" medication before any "first step" medications have been tried, the Plan Participant's Physician may request coverage of the medication as a medical exception.

Covered Prescription Drugs

Note: Some quantity limitations and/or prior authorization may be required.

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies, including blood glucose monitors, when prescribed by a Physician.

(4) Physician prescribed blood glucose monitor.

(5) Injectable drugs or any prescription directing administration by injection.

(6) Topical and oral acne medications, through age 35; thereafter prior authorization is required.

(8) Physician-prescribed over-the-counter products designated by SmithRx such as expectorant drugs, antihistamine, certain vitamins, gastroesophageal reflux disease (GERD), and acid reflux disease.

The following will be covered at 100 %, no deductible or copayment required for formulary drugs.

Benefits may be subject to prescription formulary and/or quantity limitations. Non-formulary prescriptions may be payable subject to the applicable prescription copayment as shown in the Schedule of Benefits. Contact SmithRx Customer Care toll-free at (844) 454-5201 to request coverage of the medication as a non-formulary medical exception.

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

  Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.

- Physician-prescribed tobacco/nicotine cessation products. Physician-prescribed tobacco/nicotine replacement products (such as nicotine patch, gum, lozenges, sprays) and Physician-prescribed medications (such as Zyban, Chantix). Tobacco/nicotine cessation products are not subject to supply limitations.

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

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

  Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact SmithRx for more information regarding which medications are available.

  Note: Age and/or quantity limitations may apply:

  http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

- Certain vaccinations/immunizations as recommended by applicable federal law will be covered only when rendered through a network Pharmacy. Please note: Not all network Pharmacies may be providing vaccinations/immunizations or may vary in what they offer. It is important to check with the network Pharmacy to determine availability, age restrictions, any prescription requirements or hours of service. *Please contact* **SmithRx** toll-free at (844) 454-5201 *for more information regarding this benefit.*

HDHP Expanded List of Preventive Drugs

This Plan includes coverage of an expanded list of preventive drugs at reduced cost-share amounts as shown in the Prescription Drug Benefit Schedule.

The SmithRx expanded list of Standard Preventive medications is prescribed to:

- *Prevent the occurrence* of a disease or condition for individuals with risk factors; or
- *Prevent the recurrence* of a disease or condition for individuals who have recovered.

Preventive medications do not include drugs used to treat an existing Illness, Injury or condition.

Preventive Drug retail Pharmacy or mail order Pharmacy prescriptions are available in a 90-day supply per prescription.

For more information on Preventive drugs, contact **SmithRx** toll-free at (844) 454-5201, or access their website through www.mysmithrx.com.

Limits To This Benefit

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants,** dietary supplements or vitamin supplements, except for legend oral vitamins or prenatal vitamins requiring a prescription. *Benefits may be available under the Medical Benefits of this Plan for treatment of Morbid Obesity.*

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, insulin pumps and supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, except when deemed Medically Necessary.

(9) **Immunization.** Immunization agents or biological sera *except as specifically stated as a benefit under this Plan*.

(10) **Impotence.** A charge for sexual dysfunction medication, including impotence medications.

(11) **Infertility.** A charge for infertility medication *except as specifically stated as a Covered Charge under the Prescription Drug Benefits section.*

(12) **Inpatient medication.** A drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin, insulin, diabetic supplies, or to over-the-counter (OTC) drugs, prescribed by a Physician and as specifically stated as a Covered Charge under the Prescription Drug Benefits section of this Plan.

(17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT PHARMACY CLAIMS

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

SmithRx - toll-free (844) 454-5201
or access www.mysmithrx.com

Please submit prescription claim forms to:

SmithRx
PO Box 994
Lehi, UT 84043

HOW TO SUBMIT CLAIMS

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

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

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

- A copy of the itemized bill
- Group name and number
  (**Shepherd Public Schools Employee Healthcare Plan**, Group **0002611**)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

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

WHERE TO SUBMIT CLAIMS

Employee Benefit Management Services, LLC is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

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

WHEN CLAIMS SHOULD BE FILED

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

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

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

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

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

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

There are two types of claims:

Concurrent Care Determination

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

Post-Service Claim

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

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

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

Initial Benefit Determination

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits**. If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45 day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Adverse Benefit Determination

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

(1) Information to identify the claim involved.

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

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

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

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

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

If applicable:

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

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

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

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

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

Claims Review Procedure - General

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

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

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a

subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Internal Appeal Procedure

First Level of Internal Review

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

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

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

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

Second Level of Internal Review

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

Plan Administrator
c/o Employee Benefit Management Services, LLC (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 or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

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

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The claimant must exhaust both levels of the Internal Review Procedure

before requesting an External Review, unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the first level of review. In certain circumstances, the Claimant may also request an expedited External Review.

External Review Procedure

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

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the final internal adverse benefit determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

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

- Determination that a treatment or services is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.
- Application of treatment limits to a Claim for a Mental Disorder.

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

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

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

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. **Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies**. **A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable**.

COORDINATION OF BENEFITS

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

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

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

(1) Group or nongroup insurance contracts and subscriber contracts;

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

(3) Group and nongroup coverage through closed panel plans;

(4) Group-type contracts;

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

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

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

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

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

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

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

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

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

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

(B) Plans with a coordination provision will pay their benefits up to the Allowable Charge.

The first rule that describes which plan is primary is the rule that applies:

(1) The benefits of the plan which covers the person directly (that is, as an Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

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

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

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

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

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

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

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

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

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

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

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (5) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

(3) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or as a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Employee. This rule does not apply if Rule (1) can be used to determine the order of benefits If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(4) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.

(5) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(C) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(D) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY

Defined Terms

"Covered Person" means anyone covered under the Plan, including but not limited to minor Dependents and deceased Covered Persons. Covered Person shall include the parents, trustee, guardian, heir, personal representative or other representative of a Covered Person, regardless of applicable law and whether or not such representative has access or control of the Recovery.

"Recover," "Recovered," "Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise to compensate for any loss related to any Injury, Sickness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages and/or any other recovery of any form of damages or compensation whatsoever.

"Subrogation" means the Plan's right to exercise the Covered Person's rights to Recover or pursue Recovery from a Third Party who is liable to the Covered Person for expenses for which the Plan has paid or may agree to pay benefits.

"Third Party" means any third party including but not limited to another person, any business entity, insurance policy or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), umbrella policy.

Right to Reimbursement

To the extent that the Plan has paid benefits to or on behalf of a Covered Person, the Plan has a right of reimbursement of such benefits and is entitled to subrogation as provided herein, against a judgment or recovery received by the Covered Person from a Third Party found liable for a wrongful act or omission that caused the Injury or Sickness necessitating benefit payments.

If a Covered Person intends to institute an action for damages against a Third Party, the Covered Person shall give the Plan reasonable notice of the Covered Person's intention to institute the action. Reasonable notice shall include information reasonably calculated to inform the Plan of the facts giving rise to the Third Party action and of any potential Recovery.

The Covered Person may request that the Plan pay a proportionate share of the reasonable costs of the Third Party action, including attorney fees.

The Plan may elect not to participate in the costs of the action. If such an election is made, the Plan waives 50% of any subrogation rights granted to the Plan through this provision.

The Covered Person shall take no action through settlement or otherwise which prejudices the rights and interests of the Plan, and shall cooperate fully with the Plan and its agents, regarding the Plan's rights under this section.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

Domestic Partners and children of a covered Employee's Domestic Partner, who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision and are covered under this Plan, will also be offered the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-covered Employee dies;
- The parent-covered Employee's hours of employment are reduced;
- The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs.

You must provide this notice in writing to:

Plan Administrator
Joint Powers Trust aka Montana Joint Powers Trust
P.O. Box 81647
Billings, MT 59108
(406) 698-9588

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Members may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

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

Medicare extension of COBRA Continuation Coverage

If you (as the Covered Employee) become entitled to Medicare benefits, your Spouse and dependents may be entitled to an extension of the 18-month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18-month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Joint Powers Trust aka Montana Joint Powers Trust
P.O. Box 81647
Billings, MT 59108
(406) 698-9588

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

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or

gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Joint Powers Trust aka Montana Joint Powers Trust
P.O. Box 81647
Billings, MT 59108
(406) 698-9588

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Information

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

Plan Administrator
Joint Powers Trust aka Montana Joint Powers Trust
P.O. Box 81647
Billings, MT 59108
(406) 698-9588

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

For more information about your rights under the Public Health Services Act, COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA CONTINUATION COVERAGE
FOR RETIREE'S DEPENDENTS

COBRA Continuation Coverage will not be available to those Retired Employees that elected, at the time of retirement, to continue coverage under the terms of the Plan as a Retiree. However, the following COBRA Continuation Coverage may apply to a Retired Employee's Qualified Beneficiaries.

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to certain covered persons when group health coverage would otherwise end.

The Retired Employee's family members may have other options available when they lose group health coverage. For example, they may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, an individual may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which the individual is eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." Certain covered family members could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

Domestic Partners and children of a covered Retiree's Domestic Partner, who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision and are covered under this Plan, will also be offered the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated

If you are the Spouse of a covered Retired Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies; or
- You become divorced or legally separated from your Spouse.

Dependent children of the covered Retired Employee will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-covered Retired Employee dies;
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

Filing a proceeding in bankruptcy with respect to the Employer under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is death of the covered Retiree,

commencement of proceeding in bankruptcy with respect to the Employer, or the covered Retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other Qualifying Events (divorce or legal separation of the Retired Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator
Joint Powers Trust aka Montana Joint Powers Trust
P. O. Box 81647
Billings, Montana 59108
(406) 698-9588

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Retirees may elect COBRA Continuation Coverage on behalf of their Spouse and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally lasts for 18 months. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

If the Qualifying Event is the death of the covered Retiree (or former Retiree), divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

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

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Retiree dies, gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Joint Powers Trust aka Montana Joint Powers Trust
P. O. Box 81647
Billings, Montana 59108
(406) 698-9588

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your former Employer ceases to provide a group health plan to any Retired Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Information

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

Plan Administrator
Joint Powers Trust aka Montana Joint Powers Trust
P. O. Box 81647
Billings, Montana 59108
(406) 698-9588

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 775-3575

For more information about your rights under the Public Health Services Act, COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa/). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Joint Powers Trust also known as Montana Joint Powers Trust is the Plan Administrator.

The Plan Administrator has the authority to, and does so allocate limited fiduciary duties to American Health Holdings, Inc. Those duties are limited to a review of and determination on a Plan Participant's request (or a request by the Plan Participant's treating provider) for a pre-determination of benefits prior to the occurrence of treatment or services. As part of those limited duties, American Health Holdings shall have the discretionary authority and ultimate decision-making authority to review the request and any submitted documentation, make a decision, respond to an appeal if the decision is to deny the request, and to maintain records related to its activities related to this decision. See the Care Management Services section for additional information.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to suspend or terminate the Plan in whole or in part. The Plan Administrator reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part, in compliance with the following provisions:

(1) Amendments shall be by a resolution of the Trustees or other similar governing body of the Joint Powers Trust also known as Montana Joint Powers Trust or by the written approval of an authorized officer of the Joint Powers Trust also known as Montana Joint Powers Trust.

(2) Termination shall be by a resolution of the Trustees or other similar governing body of the Joint Powers Trust also known as Montana Joint Powers Trust or by the written approval of an authorized officer of the Joint Powers Trust also known as Montana Joint Powers Trust.

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 Administrator and Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Administrator and/or the Plan Sponsor, if the Plan Administrator or 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 Administrator 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 Administrator may receive and use PHI for Plan Administration purposes, the Plan Administrator agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

(2) Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Administrator, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Administrator becomes aware;

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

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Administrator, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following employees, or classes of employees, or other persons under control of the Plan Administrator, shall be given access to the PHI to be disclosed:

Joint Powers Trust also known as Montana Joint Powers Trust Trustees

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

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Administrator only upon receipt of a certification by the Plan Administrator that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Administrator agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Administrator and 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 Administrator and/or 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 Administrator.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Administrator 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.

GENERAL PLAN INFORMATION

PLAN NAME: Shepherd Public Schools Employee Healthcare Plan

PLAN EFFECTIVE DATE: July 1, 2014

PLAN YEAR ENDS: June 30

EMPLOYER/PLAN SPONSOR INFORMATION

Shepherd Public Schools
7842 Shepherd Rd PO Box 8
Shepherd, MT 59079
(406) 373-5461

PLAN ADMINISTRATOR

Joint Powers Trust also known as Montana Joint Powers Trust
P.O. Box 81647
Billings, Montana 59108
(406) 698-9588

CLAIMS ADMINISTRATOR

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

Plan Name: Shepherd Public Schools Employee Healthcare Plan

Plan Option: HDHP I

Effective Date: July 1, 2014

Restatement Date: July 1, 2021

I, Shane Heigis (Name), certify that I am the Plan Administrator (Title) 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 terms described herein and am hereby authorizing the implementation of the restated Health Plan as of the restatement date stated above.

Signature: 

Print Name: Shane Heigis

Date: July 1, 2021