EFFECTIVE: JULY 1, 2025

MEDICAL BENEFITS – SCHEDULE OF BENEFITS

Deductibles, per Plan Year

Per Plan Participant.. $1,000

Per Family Unit.. $2,000

Maximum Out-of-Pocket Amount, per Plan Year

Per Plan Participant.. $3,000

Per Family Unit.. $6,000

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

(1) Amounts over the Allowable Charge;

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

Hospital Room and Board --

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

Intensive Care Unit --

Daily limit.. Hospital's ICU Charge

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

Skilled Nursing Facility --

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

Maximum number of days payable.. 120 days maximum per Plan Year

Outpatient Hospital Services / Outpatient Surgical Center --

Reimbursement rate.. 70% after deductible

Outpatient Surgical Services --

Reimbursement rate.. 100% after deductible

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

Second Surgical Opinion --

Reimbursement rate.. 80% after deductible

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

Reimbursement rate .... 70% after deductible

Physician Services --

Inpatient visits:

Reimbursement rate .... 70% after deductible

Primary Care Physician (PCP) Office visits:

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

"Primary Care Physician (PCP)" shall mean a general practitioner, family practitioner, general internist, obstetrician/gynecologist, pediatrician, Nurse Practitioner (N.P.), Physician Assistant (P.A.), licensed professional counselor, licensed certified professional counselor, certified chemical dependency counselor, or licensed clinical social worker.

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

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

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

Specialist Office visits:

Reimbursement rate .... 70% after deductible

Allergy Testing, Injections and Serum:

Reimbursement rate .... 70% after deductible

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

Reimbursement rate .... 70% after deductible

Ambulance Service --

Reimbursement rate .... 70% after deductible

Chemotherapy and Radiation Treatment --

Reimbursement rate .... 70% after deductible

Diagnostic Testing (X-ray & Lab) --

Reimbursement rate .... 70% after deductible

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

Reimbursement rate... 100%, no deductible applies

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

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

Reimbursement rate... 70% after deductible

Durable Medical Equipment, Orthotics and Prosthetics --

Reimbursement rate... 70% after deductible

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

Reimbursement rate... 70% after deductible

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

Home Health Care --

Reimbursement rate... 70% after deductible

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

Home Infusion Therapy --

Reimbursement rate... 70% after deductible

Hospice Care --

Inpatient services:

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

Outpatient services:

Reimbursement rate.. 70% after deductible

Mental Disorders Treatment --

Inpatient Services:

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

Outpatient Services:

Reimbursement rate.. 70% after deductible

Office Visits:

Reimbursement rate.. Refer to the Physician Office Visit benefit

Organ Transplant Coverage --

Reimbursement rate	Payable per normal Plan provisions

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

Pregnancy Benefits --

Reimbursement rate	70% after deductible and $300 copayment per admission
Routine prenatal office visits	40% of Covered Charges of the global maternity fee will be payable at 100%, no deductible applies; thereafter, subject to 70% after deductible; **OR**, If billed separately,100% of the routine prenatal office visits will be payable at 100%, no deductible applies

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

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

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

Reimbursement rate	70% after deductible

Preventive Care Services --

Routine Well Care (birth through adult) --

Reimbursement rate	100%, no deductible applies

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

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

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

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

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

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

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

Diabetic Education --

Reimbursement rate.. 100%, no deductible applies

Benefit Maximum... 3 visits maximum per Plan Year

Nutritional Education Counseling --

Reimbursement rate.. 100%, no deductible applies

Benefit Maximum... 3 visits maximum per Plan Year

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

Reimbursement rate.. 100%, no deductible applies

Benefit Maximum... 26 visits maximum per Plan Year

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

Tobacco / Nicotine Cessation Counseling --

Reimbursement rate.. 100%, no deductible applies

Benefit Maximum... 3 visits maximum per Plan Year

Rehabilitation Services --

Inpatient Services:

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

Outpatient Services (Occupational, Physical and Speech Therapy):

Reimbursement rate.. 70% after deductible

Applied Behavioral Analysis:

Reimbursement rate.. 70% after deductible

Down Syndrome Therapies:

Reimbursement rate.. 70% after deductible

Renal Dialysis Services --

Reimbursement rate.. 70% after deductible

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

Spinal Manipulation/Chiropractic Services --

Reimbursement rate.. 70% after deductible

Benefit Maximum per visit.. $25

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

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

Substance Abuse Treatment --

Inpatient and Outpatient Services:

Reimbursement rate.. 70%, no deductible applies

Office Visits:

Reimbursement rate.. Refer to the Physician Office Visit benefit

All Other Covered Charges --

Reimbursement rate.. 70% after deductible

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

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

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

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

- Inpatient admissions to a Hospital, Skilled Nursing Facility, Rehabilitation Facility, or Mental Disorder/Substance Abuse Facility
- Cancer treatment Plan of Care, administered on an inpatient or outpatient basis
- Hysterectomy
- Spinal surgery
- Bariatric surgery
- Dialysis
- Genetic testing
- Injectables (administered under the Medical Benefits Plan, not those received through the Prescription Drug Benefits of this Plan)
- Home Health Care
- Hospice care
- Durable Medical Equipment (DME) over $2,000

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

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

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

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

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

Contact the Care Management administrator at: CareLink (406) 245-3575 or (866) 894-1505.

PLAN EXCLUSIONS

The following are not covered under this Plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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