Bozeman School District #7

YOUR GROUP HEALTH, VISION AND DENTAL PLAN

CMM $2,000

Plan Document

Effective September 1, 2025

Contents	Page(s)
Health Benefit Plan	1-92
Prescription Drugs	30-35
Vision Plan	94-95
Dental Plan	96-98
How to Submit Claims	
Medical	45
Prescription Drug (Present I.D. Card at Participating Pharmacy)	46
Vision	94
Dental	96

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- Wellness
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PBM Website www.myprime.com
Claim Forms www.myprime.com
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Specialty Care Pharmacy (BCBSMT Specialty Pharmacy Network) 1-833-721-1619
- www.bcbsmt.com or www.myprime.com
- Prescriber Fax 1-888-302-1028

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  St. Louis, MO 63166-6577
- **Ridgeway Mail-Order Pharmacy** 1-800-630-3214
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  Victor, MT 59875

Blue Cross and Blue Shield of Montana
PO Box 660255
Dallas, TX 75266-0255

FOR CLAIMS
Blue Cross and Blue Shield of Montana
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TABLE OF CONTENTS

TABLE OF CONTENTS ..... **i**
PLAN OPERATION ..... **iv**
INTRODUCTION ..... **vii**
SCHEDULE OF BENEFITS **1**
ELIGIBILITY AND COVERAGE **7**
Eligibility for Participation 7
Both Husband and Wife as Employees 7
Declining Coverage 7
Enrollment 7
PROVIDERS OF CARE FOR PARTICIPANTS **9**
In-Network and Out-of-Network Professional Providers and Facility Providers 10
PPO Providers 10
Out of PPO Network Referrals 10
How Providers are Paid by the Claim Administrator and Participant Responsibility 11
How Providers are Paid by the Claim Administrator and Participant Responsibility Outside of Montana 11
Claim Payment Assignment 12
Claim Dispute 12
OUT-OF-AREA SERVICES – THE BLUECARD PROGRAM **12**
Out-of-Area Services 12
UTILIZATION MANAGEMENT **14**
Prior Authorization 14
Prior Authorization Responsibility 15
Length of Stay/Service Review 18
Recommended Clinical Review 18
Contacting Behavioral Health 19
Post-Service Medical Necessity Review 19
Care Management 19
BENEFITS **20**
Accident 20
Advanced Practice Registered Nurses and Physician Assistants - Certified 20
Ambulance 20
Anesthesia Services 20
Approved Clinical Trials 21
Autism Spectrum Disorders 21
Birthing Centers 21
Blood Transfusions 21
Breast Examinations (Preventive and Medical) 21
Chemotherapy 21
Colonoscopies (Medical) 22
Contraceptives 22
Convalescent Home Services 22
Dental Services 22
Diabetes Treatment (Office Visit) 23
Diabetic Education 23
Diagnostic Services 23
Dialysis Treatment – Outpatient 23
Durable Medical Equipment 23
Emergency Room Care 24
Foot Orthotics 24
Hearing Coverage for Dependent Children Under Age 19 24
Home Health Care 24
Home Infusion Therapy Services 25
Hospice Care 25
Hospital Services - Facility and Professional 25
Inborn Errors of Metabolism 27
Infusion Therapy Services – Outpatient 27
Maternity Services - Professional and Facility Covered Providers 27

TABLE OF CONTENTS

Medical Supplies ... 27
Mental Health ... 28
Naturopathy ... 29
Newborn Initial Care ... 29
Office Visit ... 29
Orthopedic Devices/Orthotic Devices ... 29
Physician Medical Services ... 29
Postmastectomy Care and Reconstructive Breast Surgery ... 29
Prescription Drugs ... 30
Preventive Health Care ... 35
Prostheses ... 36
Radiation Therapy ... 37
Rehabilitation – Facility and Professional ... 37
Sigmoidoscopies (Medical) ... 38
Substance Use Disorder ... 38
Surgical Services ... 39
Telehealth ... 40
Temporomandibular Joint Dysfunction – Surgical Treatment ... 40
Therapies - Outpatient ... 40
Transplants ... 40
Travel, Meals and Lodging ... 41
Virtual Visits ... 41
Well-Child Care ... 41
EXCLUSIONS AND LIMITATIONS ... 41
CLAIMS ... 45
How to Obtain Payment for Covered Expenses for Benefits ... 45
Out-of-State Services – Claims for Family Members Who Live Out of State and All Other Claims for Out-of-State Services ... 46
Prescription Drug Claims - Filling Prescriptions at a Retail Pharmacy ... 46
Mail-Service Pharmacy ... 47
COORDINATION OF BENEFITS WITH OTHER COVERAGE ... 47
Definitions ... 47
Order of Benefit Determination Rules ... 48
Effect on the Benefits of This Plan ... 50
Right to Receive and Release Needed Information ... 50
Facility of Payment ... 50
Right of Recovery ... 50
Coordination with Medicare ... 51
Other Insurance ... 52
TERMINATION OF COVERAGE ... 52
Termination of Benefits on Termination of Coverage ... 52
Certificate of Creditable Coverage ... 52
CONTINUATION OF COVERAGE ... 52
COBRA ... 52
COMPLAINTS AND GRIEVANCES ... 57
Complaints and Grievances ... 57
APPEALS ... 58
Claims Procedures ... 58
QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) ... 67
FAMILY AND MEDICAL LEAVE ACT (FMLA) ... 67
PRIVACY OF PROTECTED HEALTH INFORMATION ... 67
Definitions ... 68
Purpose of Disclosure to Plan Sponsor ... 68
Restrictions on Plan Sponsor's Use and Disclosure of PHI ... 68
Adequate Separation Between the Plan Sponsor and the Plan ... 69
GENERAL PROVISIONS ... 70
Plan Administrator Powers and Duties ... 70

TABLE OF CONTENTS

Entire Plan; Changes 70
Modification of Plan 70
Notice of Change 70
Clerical Errors 71
Notices Under Plan 71
Rescission of Plan Document 71
Payment of Claims and Assignment of Benefits 71
Validity of Plan 71
Participants Rights 71
Alternate Care 72
Benefit Maximums 72
Pilot Programs 72
Research Fees 72
Cooperation of Participant 72
Statements are Representations 72
Overpayments 73
Participant/Provider Relationship 73
Recovery, Reimbursement, and Subrogation 74
DEFINITIONS 76
NOTICES 93
VISION REIMBURSEMENT PLAN 94
Plan Year 94
Eligibility 94
Benefits 94
Covered Vision Expenses 94
Direct Reimbursement Procedure 94
Type of Plan 94
Coordination of Benefits Between the Plan and Other Plans 95
Plan Termination 95
Individual Termination of Coverage 95
Plan is Not a Contract 95
Plan Design Approved by Plan Participants 95
Rewritten September 1, 2003 95
Revised September 1, 2005 95
DENTAL REIMBURSEMENT PLAN 96
Plan Year 96
Eligibility 96
Enrollment 96
Benefits 96
Covered Dental Expenses 96
Direct Reimbursement Procedure 96
Type of Plan 97
Coordination of Benefits Between the Plan and Other Plans 97
Plan Termination 97
Individual Termination of Coverage 97
Plan is Not a Contract 97
Approved by the Joint Insurance Committee 98
Amended by Plan Participants 98
Rewritten September 1, 2003 98
Revised September 1, 2005 98
NO SURPRISES ACT AMENDMENT 99

HEALTH BENEFIT PLAN FOR EMPLOYEES OF BOZEMAN SCHOOL DISTRICT #7
PLAN OPERATION

Plan Name

Bozeman School District #7 Employee Health Benefit Plan

Type of Plan

Bozeman School District #7 maintains the Employee Health, Dental and Vision Benefit Plan, a separate legal entity from Bozeman School District #7, for the exclusive benefit of and to provide health benefits to its eligible Employees, retired Employees, their legal Spouses, and eligible Dependents. The Plan provides Hospital, medical, surgical, dental and vision coverage for eligible Participants.

Type of Participants Covered by the Plan

Employees, retirees, their legal Spouses, and their eligible Dependent children may participate based upon the eligibility requirements set forth in the Plan.

Plan Sponsor

Bozeman School District #7
404 West Main St
PO Box 520
Bozeman, MT 59771

Plan Sponsor's Identification Number

81-6000413

Plan Number

501

Plan Effective Date

September 1, 2025

Plan Benefit Year

September 1 through August 31

Plan Year

September 1 through August 31

Plan Administrator

Lacy Clark
Director of Business Services/District Clerk
404 West Main St
PO Box 520
Bozeman, MT 59771
Phone: 406-522-6042
Fax: 406-522-6050
Email: lacy.clark@bsd7.org

Named Fiduciary(ies)

Mike Waterman
Director of Business Services
404 West Main St
PO Box 520
Bozeman, MT 59771
Phone: 406-522-6045
Fax: 406-522-6050
Email: mike.waterman@bsd7.org

Type of Administration

The Plan is a self-funded Health Plan established to reimburse Participants for covered medical, dental and vision expenses. The Plan Sponsor contracts with a Claim Administrator to process claims, provide claims payment and provide other claims management functions, under the direction of the Plan Administrator. The Plan reimburses the Claim Administrator after claims are paid.

Claim Administrator

Blue Cross and Blue Shield of Montana
PO Box 660255
Dallas, TX 75266-0255
1-855-258-3489

Claim Administrator's Disclosures

With the exception of any individual or aggregate stop-loss arrangements provided for in the Administrative Services Agreement ("Agreement") with the Plan Sponsor, Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

The Plan Sponsor, on behalf of itself and its employees, hereby expressly acknowledges its understanding that the "Agreement" constitutes an agreement solely between the Plan Sponsor and Blue Cross and Blue Shield of Montana, that Blue Cross and Blue Shield of Montana is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, which is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting Health Care Service Corporation to use the Blue Cross and Blue Shield Service Marks in the state of Montana, and that Blue Cross and Blue Shield of Montana is not contracting as the agent of the Association. The Plan Sponsor further acknowledges and agrees that it has not entered into the "Agreement" based upon representations by any person other than Blue Cross and Blue Shield of Montana and that no person, entity, or organization other than Blue Cross and Blue Shield of Montana shall be held accountable or liable to the Plan Sponsor for any of the Blue Cross and Blue Shield of Montana obligations to the Plan Sponsor created under the "Agreement." This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Montana other than those obligations created under the provisions of the "Agreement" with the Plan Sponsor.

Certain Responsibilities of the Employer and the Claim Administrator

Employer responsibility

The Employer retains full and final authority and responsibility for the Plan and its operation. The Claim Administrator is empowered to act on behalf of the Employer in connection with the Plan only as expressly stated in this Plan Document or as mutually agreed to in writing by the parties hereto.

Claim Administrator responsibility

The Claim Administrator shall have no responsibility for or liability with respect to the compliance or non - compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and the Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including but not limited to local, state or federal taxes, penalties, surcharges or other fees or amounts regardless of whether payable directly by the Employer or by or through the Claim Administrator; provided, however, the Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to the Claim Administrator in connection with the performance of its obligations under this Agreement.

Relationship of Parties

The Claim Administrator is an independent contractor with respect to the Employer. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venture nor employee of the other. Further, nothing in this Plan Document shall create or be construed to create the relationship of employer and employee between the Claim Administrator and the Employer; nor shall the Employer's agents, officers or employees be considered or construed to be considered employees of the Claim Administrator for any purpose whatsoever.

Re-Insurance Company

Aggregate and Specific Excess Loss Insurance for the Plan is underwritten by Blue Cross and Blue Shield of Montana

Funding Mechanism

Benefits under this Plan are funded from Employee, retired Employees and Employer contributions up to the Benefit limits defined in the Plan Document. Payments are made from this fund to pay Benefits.

Source of Contribution

Contributions for Employees and covered Family Members are paid in part by the Plan Sponsor out of its general assets and in part by Employees.

Agent for Service of Legal Process

The Plan Administrator has authority to control and manage the Plan and Mike Waterman is the agent for service of legal process.

Amendment, Termination, or Modification of the Plan

The Plan Administrator reserves the right to amend, modify or terminate the Plan in whole or in part at any time.

Expenses incurred prior to the effective date of any amendment are based on the provisions in effect at the time the expenses were incurred.

Plan Coverage Status

This Plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act (The Affordable Care Act).

Member Rewards Medical

Member Rewards is a free, voluntary program in which eligible Participants can earn a percentage of the claim savings in the form of a cash reward by selecting quality, low-cost In-Network facilities for qualified elective, non- emergency medical services. Participants can use the Provider Finder tool on BCBSMT's website at www.bcbsmt.com/find-care/providers-in-your-network/find-a-doctor-or-hospital to find a list of all eligible services/procedures and facility options. Shopping can also be conducted by calling Customer Service, who will shop for services/procedures and facilities on the Participant's behalf.

When the Participant chooses a rewards-eligible service/procedure, the Participant will earn a portion of the savings in the form of a check mailed to the Participant, usually within 60 days, after the claim is processed by the Claim Administrator. This reward is separate from and does not affect the Participant's claim for a covered Benefit. To earn a reward, the Participant must:

1. Have active coverage on the date the Participant shops for a rewards-eligible service/procedure;
2. Have active coverage on the date the medical service/procedure is rendered; and
3. Complete the rewards-eligible service/procedure within thirteen calendar months of the date of shopping.

Incentive amounts and eligible services/procedures are subject to change; however, the maximum reward amount the Participant may earn on any single procedure is $500. Any reward amounts received may be taxable.

The Participant's provider may refer the Participant to a facility or location to complete the Participant's medical service/ procedure that is not eligible for a reward. However, the Participant must use a facility that is eligible for the program to receive a reward. If the Participant's provider refers the Participant to a facility that is not eligible for a reward under the program, Customer Service may be able to coordinate with the Participant's provider to find an eligible facility, if one is available. Remember, all decisions on where to receive care are between the Participant and the Participant's provider.

Member Rewards is not a discount program and will not impact Benefits or claims processing. The Plan may discontinue this program upon 180 days' notice. To maintain eligibility for a reward, the Participant must complete shopping for a rewards-eligible service/procedure prior to the program termination following such notice. All rewards earned under this program will be funded by the Claim Administrator, and are subject to the provided provisions of this program and all other applicable articles of coverage under the Plan including payment of Benefits, termination of coverage, and review of claim determinations. A referral or Prior Authorization may be required for the Participant's service/procedure.

If the Participant has questions about this program, call Customer Service or visit BCBSMT's website at www.bcbsmt.com.

INTRODUCTION

This document is a description of Bozeman School District #7 Group Health Benefit Plan. No oral interpretations can change this Plan. The Plan is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

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.

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, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Participants are limited to covered charges incurred before termination.

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

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

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

Prior Authorization. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

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

Exclusions and Limitations. Shows what charges are not covered.

Claim Provisions. 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.

Recovery, Reimbursement and Subrogation. Explains the Plan's rights to recover payment.

Definitions. Defines those Plan terms that have a specific meaning.

Certain terms in this Plan Document are defined in the Definitions section. Defined terms are capitalized.

SCHEDULE OF BENEFITS

Employee Health Benefit Plan PPO

Group Name:	**Bozeman School District #7**	
Group Number:	**X66680**	
Effective Date:	**September 1, 2025**	
Benefit Period:	**September 1 to August 31**	

The Benefits are subject to the Benefit Period unless otherwise specified.

Deductible:	**Individual:**	**$2,000**
	Family:	**$4,000**

The Transplant Benefit may have a separate Deductible. Refer to the specific Benefit.

Deductible does not apply to the following Benefits:

- Colonoscopy (Medical) – age 45 or older (1 every 10 years)
- Generic Prescription Drugs
- Preventive Health Care
- Sigmoidoscopy (Medical) – age 45 or older (1 every 5 years)
- Transplant Travel
- Travel
- Well-Child Care

The Coinsurance is the percentage the Participant pays to providers. Providers may require that the Participant's Coinsurance be paid at the time of service.

Coinsurance:	**In-Network:**	**30%**
	Out-of-Network:	**30%**

Coinsurance does not apply to the following Benefits:

- Colonoscopy (Medical) – age 45 or older (1 every 10 years)
- Generic Prescription Drugs
- Preventive Health Care
- Sigmoidoscopy (Medical) – age 45 or older (1 every 5 years)
- Transplant Travel
- Travel
- Well-Child Care

Copayment:	**Varies**	

Out of Pocket Amount:	**Individual:**	**$4,000**
	Family:	**$8,000**

The Deductible, Coinsurance and Copayment apply to the Out of Pocket Amount. Some Benefits have specific Benefit Period maximums. Even if the Out of Pocket Amount is met, Benefits will not be paid for services after the maximum Benefit is paid. These specific Benefit maximums are listed in this Schedule of Benefits.

The following amounts do not accumulate to meet the Out of Pocket Amount:

- Charges in excess of the Allowable Fee
- Transplants not provided at a Center of Excellence
- Travel, meals, and lodging

This means that Deductible, Coinsurance and Copayment paid for these Benefits **do not** accumulate to help meet the Out of Pocket Amount. Also, if the Out of Pocket Amount is met, any Deductible, Coinsurance and Copayment that may apply to these Benefits will still apply and these Benefits will never be paid at 100% of the Allowable Fee.

Some Benefits may have payment limitations. Refer to the specific Benefit in this Schedule of Benefits for additional information. In addition:

- Nonemergency services for Mental Illness or Substance Use Disorder provided in an emergency setting will be paid the same as Emergency Services.
- Out-of-Network providers may bill the Participant the difference between the Allowable Fee and the provider's charge, in addition to any applicable Deductible, Copayment and/or Coinsurance, even if Prior Authorization is obtained for the service, or if treatment is provided for Emergency Services.

Term of Plan Document:	**Monthly**

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Accident		
Professional Provider Services	30%	30%
Facility Services	30%	30%
Ambulance	30%	30%
Autism Spectrum Disorders	30%	30%
Services, except medications/prescription drugs and Applied Behavior Analysis (ABA) services that are described in the Benefit section entitled Autism Spectrum Disorders are covered under medical Benefits.		
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Medications/prescription drugs are covered under Prescription Drugs.		
Benefits for Autism Spectrum Disorders are not subject to any applicable Physical, Occupational or Speech Therapy visit maximum.		
Birthing Centers	30%	30%
Blue Distinction Centers (BDC)		
Transplants*		
Professional Provider Services	30%	30%
Facility Services	30%	30%
Travel Expenses	Deductible and/or Coinsurance Do Not Apply	
Maximum per Transplant – $2,000		
Lodging and Meals	Deductible and/or Coinsurance Do Not Apply	
Maximum per Day – $100		
Benefits for travel, lodging and meals if the Participant lives more than 50 miles from the approved facility and the expenses are incurred within 4 days of the procedure to discharge to home date.		
Benefits at any Facility other than a Center of Excellence – $5,000 Deductible*	30%	30%
Travel, lodging and meal expenses are not covered.		
***This Deductible is separate from the medical Deductible and does not apply to the Out of Pocket Amount. The Out of Pocket Amount provisions do not apply to services not provided at a Center of Excellence.**		
Breast Examinations		
Preventive	Deductible, Copayment and/or Coinsurance Do Not Apply	
Medical	Deductible, Copayment and/or Coinsurance Do Not Apply	
Colonoscopies* (Medical)		
Professional Provider Services	30%	30%
Facility Services	30%	30%
(Deductible and Coinsurance will not apply to one colonoscopy every 10 years for age 45 or older.)		
*Colonoscopies with a preventive diagnosis are paid under the Preventive Health Care Benefit for Participants, regardless of age.		
Convalescent Home Services	30%	30%
Maximum Per Benefit Period – 90 Days		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Diabetic Education Benefit		
First $250	Deductible, Copayment and/or Coinsurance Do Not Apply	
After the first $250 in payment	30%	30%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Diagnostic Services		
Professional Provider Services	30%	30%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Facility Services	30%	30%
Dialysis Services – Outpatient		
See the separately issued Outpatient Dialysis Program Document.		
Durable Medical Equipment		
Rental (up to Purchase Price), Purchase and Repair and Replacement of Durable Medical Equipment	30%	30%
Emergency Room Care	30%*	30%*
***Nonemergency Mental Illness and Substance Use Disorder services provided by an In-Network provider or an Out-of-Network provider pay as Emergency Room Care.		
Emergency Room Care not related to an Emergency Medical Condition, accidental Injury, Mental Illness or Substance Use Disorder.	30%	30%
Foot Orthotics	30%	30%
Hearing Coverage for Dependent Children Under Age 19	30%	30%
Maximum one Amplification Device per ear every three years or as required by an audiologist.		
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Home Health Care	30%	30%
Maximum Per Benefit Period – 100 Visits		
Hospice Care		
Professional Provider Services	30%	30%
Facility Services	30%	30%
Hospital		
Professional Provider Services		
Outpatient	30%	30%
Inpatient	30%	30%
Facility Services		
Outpatient	30%	30%
Inpatient	30%	30%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Maternity Services		
Professional Provider Services		
Outpatient	30%	30%
Refer to the section of the Schedule of Benefits entitled Office Visit. However, the Office Visit Copayment only applies to the initial visit. Subsequent visits are included in the charges for labor and delivery.		
Inpatient	30%	30%
Facility Services		
Outpatient	30%	30%
Inpatient	30%	30%
Medical Supplies	30%	30%
Mental Health		
Professional Provider Services		
Outpatient	30%	30%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Inpatient	30%	30%
Facility Services		
Outpatient	30%	30%
Inpatient	30%	30%
Newborn Initial Care		
Professional Provider Services	30%	30%
Facility Services	30%	30%
Office Visit		
Primary Care Provider (PCP)	$50*, No Deductible	30%
*The Copayment applies to the office visit and covered services provided during the office visit.		
Specialist	$100*, No Deductible	30%
*The Copayment applies to the office visit and covered services provided during the office visit.		
*Deductible, Copayment and/or Coinsurance do not apply to the In-Network Preventive Health Care services. Refer to the section entitled Preventive Health Care.		
Orthopedic Devices/Orthotic Devices	30%	30%
Other Facility Services – Inpatient and Outpatient	30%	30%
Physician Medical Services	30%	30%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Prescription Drugs		
(The Prescription Drugs Benefit utilizes a Drug List.) Any Deductible and Coinsurance do not apply to certain contraceptive products. Refer to the Preventive Health Care Benefit. Any Deductible and Coinsurance also do not apply to prescription smoking cessation products and over-the-counter smoking cessation aids/medications, for two 90-day treatment regimens.		
Retail Pharmacy and Specialty Pharmaceuticals – 34-day supply		
Mail Service Maintenance Prescriptions – 90-day supply		
Extended Supply Network – Up to a 90-day supply		
Specialty Pharmaceuticals – 30-day supply		
Brand-Name Drug	30%	30%
Generic Drug	Deductible, Copayment and/or Coinsurance Do Not Apply	
Please refer to Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefits section of this Plan Document.		
Preventive Health Care		
Preventive Services	Deductible, Copayment and/or Coinsurance Do Not Apply	
Prostheses Benefit		
Rental (up to Purchase Price), Purchase and Repair and Replacement of Prosthetics	30%	30%
Rehabilitation Therapy		
Professional Provider Services		
Outpatient	30%	30%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Inpatient	30%	30%
Facility Services		
Outpatient	30%	30%
Inpatient	30%	30%
Sigmoidoscopies* (Medical)		
Professional Provider Services	30%	30%
Facility Services	30%	30%
(Deductible and/or Coinsurance will not apply to one sigmoidoscopy every 5 years for age 45 or older.)		
*Sigmoidoscopies with a preventive diagnosis are paid under the Preventive Health Care Benefit for Participants, regardless of age.		
Substance Use Disorder		
Professional Provider Services		
Outpatient	30%	30%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Inpatient	30%	30%
Facility Services		
Outpatient	30%	30%
Inpatient	30%	30%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Surgery Center Services – Outpatient		
Professional Provider Services	30%	30%
Facility Services	30%	30%
Telehealth		
Primary Care Provider (PCP), including Mental Health and Substance Use Disorder providers	30%	30%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Specialists	30%	30%
Temporomandibular Joint Dysfunction (Surgical)	30%	30%
Therapies – Outpatient		
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy		
Professional Provider Services	30%	30%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Facility Services	30%	30%
Maximum Benefit per Benefit Period for Physical Therapy on the spinal column – 10 Visits		
Refer to the Autism Spectrum Disorders section for information on autism spectrum disorder therapies.		
Travel, Meals and Lodging Benefit	Deductible, Copayment and/or Coinsurance do not apply	
Maximum Benefit Per Day - $40		
Maximum Number of Days Per Benefit Period – 60		
The Out of Pocket Amount provisions do not apply to this Benefit.		
Urgent Care	$75*, No Deductible	30%
*Urgent care visit and any covered services provided during the urgent care visit.		
*Deductible, Copayment and/or Coinsurance do not apply to the In-Network Preventive Health Care services. Refer to the section entitled Preventive Health Care.		
Virtual Visits – MDLIVE Providers Only	30%	Not a Benefit
Well-Child Care Services	Deductible, Copayment and/or Coinsurance Do Not Apply	

ELIGIBILITY AND COVERAGE

Eligibility for Participation

The following Participants are eligible for participation in the Plan:

1. Active Employees who are eligible for coverage per the terms of:
   a. A collective bargaining agreement; or
   b. The District Policies manual.
2. Non-Medicare eligible retirees and non-Medicare eligible spouses and Dependents who are eligible per the terms of:
   a. A collective bargaining agreement; or
   b. The District Policies manual.
3. Classified Employees regularly scheduled to work 20 or more hours per week.
4. Employees in a class eligible for coverage.

Both Husband and Wife as Employees

1. Any person covered under the Plan as an Employee cannot be covered under the Plan as a Dependent.
2. Children will be covered as a Dependent of the mother or father, but not both.

Declining Coverage

If an eligible person, as outlined above, declines coverage under this Plan, the eligible person must state the reason(s) for declining coverage in writing. Failure to provide these reasons in writing may result in the Plan refusing enrollment at a later date or may require that the only time in the future the eligible person may enroll is during an open enrollment period, if applicable.

Enrollment

1. Enrollment Requirements.

   An Employee must enroll for coverage by filling out and signing an enrollment application. If the covered Employee already has dependent child coverage, a newborn child will be automatically enrolled from birth; otherwise, separate enrollment for a newborn child is required. If the Employee does not apply, coverage will default to the specified plan. The signed application must be given to the Benefits Clerk.

2. Enrollment Requirements for Newborn Children.

   A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section “Timely Enrollments” following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

   Charges for covered Routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

   For coverage of sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child must be enrolled as a Dependent under this Plan within 31 days of the child’s birth in order for non-routine coverage to take effect from the birth.

3. Timely (Initial or Late) Enrollment.
   a. Timely Initial Enrollment. The enrollment will be “timely” if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

b. 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 on September 1.

4. Open Enrollment.

Each year there is an open enrollment period designated by the Employer during which Covered Employees and covered Retired Employees may change their Benefit elections under the Plan. In addition, eligible Employees who previously declined to enroll in the Plan may enroll themselves and any eligible Dependents in the Plan during this time. The Effective Date of these Benefit choices made during the open enrollment period will be outlined by the Employer at the time of the open enrollment.

5. Plan Identification Card.

Participants enrolled in the Plan will be issued Plan identification cards. The identification card is an important document and should be protected from mutilation or loss. The Participant may need to present the identification card to providers or pharmacies to receive Benefits under the Plan.

6. Change of Status.

Any addition or deletion of Family Members under the Plan requires completion of a Change of Status form that the Participant may obtain from the Employer or Claim Administrator. Completed Change of Status forms must be returned to the Benefits Clerk.

7. Special Enrollment When Other Coverage is Lost.

a. Eligible Individuals. A special enrollment period may be available if an eligible Employee, when initially eligible, declined enrollment for himself/herself and/or the Spouse and/or Dependents because of coverage under other health insurance. When that coverage ends, the following persons can enroll:

1. Eligible Employee;
2. Dependents of the covered Employee, including the Spouse; or
3. Eligible Employee and Dependents, including the Spouse.

b. Conditions for Special Enrollment. When the Employee declined enrollment for the Employee and/or eligible Family Members, and the Employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment, the Employee and/or eligible Family Members will be eligible to enroll if any of the following occurs:

1. The Employee or Family Member had COBRA continuation coverage and the COBRA continuation coverage has expired; or
2. The Employee or Family Member had other coverage that was not under a COBRA continuation provision and the other coverage has been terminated because any of the following occurs:

    a. A loss of eligibility for the coverage. Loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. However, loss of eligibility does not include a loss of coverage due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause;
    b. Employer contributions toward the other coverage have been terminated;
    c. A situation in which the Employee or Family Member incurs a claim that would meet or exceed a lifetime limit on all Benefits; or
    d. A situation in which the Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

3. The Employee or Family Member loses eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the Employee or Family Member becomes eligible for financial assistance for group health coverage, under either the Children's Health Insurance Program or the Medicaid Program.

c. Enrollment Procedures. The Employee must request enrollment for the Employee and/or Family Members not later than 31 days after the exhaustion of COBRA continuation coverage or termination of the other coverage because of loss of eligibility or termination of Employer contributions. Enrollment during a special enrollment period is subject to all other applicable enrollment requirements of the Plan and the provisions of this Plan Document.

The Employee must request enrollment for the Employee and or Family Member not later than 60 days after the date of termination of coverage under either the Children's Health Insurance Program or the Medicaid Program.

The Employee must request enrollment for the Employee or Family Member not later than 60 days after the date the Employee or Family Member is determined to be eligible for financial assistance under the Children's Health Insurance Program or the Medicaid Program.

d. Effective Date of Enrollment. Enrollment due to loss of coverage will be effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Plan.

8. Special Enrollment for Marriage, Newborn, Adoption, or Placement for Adoption.

a. Eligible Individuals. When a marriage, birth, adoption, or placement for adoption occurs, the following individuals are eligible to enroll:

1. The Employee who previously declined to enroll;
2. The new Spouse or Spouse who previously declined to enroll; or
3. Dependents who previously declined to enroll and new Dependents as a result of one of these events.

b. Enrollment Period. The special enrollment period for eligible persons under this provision is for a period of 31 days from the date of the event. Enrollment during a special enrollment period is subject to all other applicable enrollment requirements of the Plan.

c. Effective Date of Coverage. Enrollment will be effective as follows:

1. In the case of marriage, the date of marriage if the completed request for enrollment (application) is received by the Plan within 31 days after the date of marriage. If the application is received after 31 days of the date of marriage, the enrollee will be considered a Late Enrollee.
2. In the case of the Dependent's birth, from and after the moment of birth. Within 31 days from the date of birth, the Plan must be notified and any premiums/fees must be paid or the child will not have coverage.

   In addition, coverage for the newborn child will be provided only if the Beneficiary Member remains covered on the health plan. Coverage for a Dependent's newborn child will be provided only if the Beneficiary Member adopts the newborn child, or is the legal guardian of the newborn child.
3. In the case of the Dependent's adoption or placement for adoption, the date of such an event. In the event the placement for adoption is disrupted prior to the legal adoption and the child is removed from placement, coverage shall cease upon the date the placement is disrupted.

Individuals enrolling during a special enrollment period are not Late Enrollees.

9. When Benefits Begin. Benefits of this Plan begin on the Participant's Effective Date.

PROVIDERS OF CARE FOR PARTICIPANTS

The participation or nonparticipation of providers from whom a Participant receives services, supplies, and medication impacts the amount the Plan will pay and the Participant's responsibility for payment. Professional

providers and facility providers are either In-Network or Out-of-Network providers. In-Network providers include Participating Providers and PPO providers. Out-of-Network providers are nonparticipating and non-PPO providers.

Bozeman School District #7 has established a separate program for the administration and payment of benefits for outpatient dialysis. The outpatient dialysis program is described in the separately issued Outpatient Dialysis Program Document. Please review that document for information about coverage for and administration of claims for outpatient dialysis.

In-Network and Out-of-Network Professional Providers and Facility Providers

Professional providers include, but are not limited to, Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, audiologists, Advanced Practice Registered Nurses, physician assistants, naturopathic physicians, and physical therapists.

Primary Care Providers (PCPs) include general practitioners, family practitioners, internists, pediatricians, obstetricians, gynecologists, physicians' assistants and registered nurse practitioners.

A specialist is a Physician, not included in the list of PCPs, who provides medical services in any generally accepted medical specialty or sub-specialty.

Facility providers include, but are not limited to, Hospitals, Rehabilitation Facilities, Home Health Agencies, Convalescent Homes, skilled nursing facilities, freestanding facilities for the treatment of Substance Use Disorder or Mental Illness, and free standing surgical facilities (surgery center).

The Participant may obtain a list of Participating Providers from the Claim Administrator free of charge by contacting the Plan at the number listed on the inside cover of this Plan Document.

PPO Providers

The Claim Administrator has a PPO Network of Hospitals and surgery centers in Montana that is utilized under this Benefit Plan. Outside of the state of Montana, there are also Blue Cross and/or Blue Shield PPO Hospitals and surgery centers nationwide. The Participant receives the In-Network Benefit when utilizing the PPO Network or the nationwide Blue Cross and/or Blue Shield PPO Hospitals and surgery centers. If the Participant obtains services or supplies from a non-PPO Network provider, the Out-of-Network Deductible and Coinsurance and Out of Pocket Amount will apply as indicated on the Schedule of Benefits.

The exceptions to the Benefit reduction are:

1. Emergency Services provided when a Participant cannot reasonably reach a PPO Network provider;
2. Nonemergency services for treatment of Mental Illness and/or Substance Use Disorder provided in an emergency setting; and/or
3. Services that are unavailable within the PPO Network.

If a Participant receives services from an out-of-state provider, then services must be provided by:

1. Blue Cross and/or Blue Shield PPO facility providers; and/or
2. Blue Cross and/or Blue Shield participating professional providers* or PPO professional providers.

*Some Blue Cross and/or Blue Shield Plans require services to be provided by a PPO professional provider for the Participant to receive the In-Network Benefits. Contact the Plan for additional information on out-of-state services. Emergency Services and services that are unavailable within the PPO Network will be covered as In-Network.

However, any nonparticipating provider or non-PPO provider can bill the Participant for the difference between payment by the Blue Cross and Blue Shield of Montana and provider charges plus any Deductible, Copayment and/or Coinsurance even if Prior Authorization was obtained for such services. The Participant will be responsible for the balance of the nonparticipating provider's or non-PPO provider's charges after payment by the Blue Cross and Blue Shield of Montana and payment by the Participant of any Deductible, Copayment and/or Coinsurance.

Out of PPO Network Referrals

There may be circumstances under which the most appropriate treatment for the Participant's condition is not available through the PPO Network. When this occurs, it is recommended the Participant's attending Physician

contact the Claim Administrator for an out of PPO Network referral. If the referral is not approved, and the Participant chooses to obtain services from a non-PPO Network provider, the Participant will be responsible for the Out-of-Network Deductible and Coinsurance, in addition to any difference between the Blue Cross and Blue Shield of Montana Allowable Fee and the provider's billed charges.

If the Claim Administrator approves the referral, those services will process with the In-Network Deductible, Copayment and/or Coinsurance. However, any nonparticipating provider or non-PPO provider can bill the Participant for the difference between payment by the Claim Administrator and provider charges plus Deductible, Copayment and/or Coinsurance even if the Claim Administrator approves the referral.

How Providers are Paid by the Claim Administrator and Participant Responsibility

Payment by the Claim Administrator for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield of Montana provider network.

An **In-Network Provider** agrees to accept the payment of the Allowable Fee from the Claim Administrator for Covered Medical Expenses, together with any Deductible, Copayment and/or Coinsurance from the Participant, as payment in full. Generally, the Claim Administrator will pay the Allowable Fee for a Covered Medical Expense directly to Participating Provider or PPO Provider. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

Out-of-Network providers do not have to accept the Claim Administrator's payment as payment in full. Payment to a nonparticipating provider or a non-PPO provider for Covered Medical Expenses is based on the Allowable Fee. The nonparticipating provider or a non-PPO provider can bill the Participant for the difference between payment by the Claim Administrator and provider charges plus any Deductible, Copayment and/or Coinsurance. The Participant will be responsible for the balance of the nonparticipating provider's or a non-PPO provider's charges after payment by the Claim Administrator and payment of any Deductible, Copayment and/or Coinsurance.

Generally, the Claim Administrator will pay the Allowable Fee for Covered Medical Expenses directly to the Participant. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

How Providers are Paid by the Claim Administrator and Participant Responsibility Outside of Montana

Payment by the Claim Administrator for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield provider network in the state where services are provided.

An **In-Network Provider** agrees to accept payment of the Allowable Fee from the Claim Administrator for Covered Medical Expenses, together with any Deductible, Copayment and/or Coinsurance from the Participant, as payment in full. Generally, the Claim Administrator will pay the Allowable Fee for a Covered Medical Expense directly to Participating Provider or PPO Provider. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

Out-of-Network providers do not have to accept the Claim Administrator's payment as payment in full. Payment to a nonparticipating provider or a non-PPO provider for Covered Medical Expenses is based on the Allowable Fee. The nonparticipating provider or a non-PPO provider can bill the Participant for the difference between payment by the Claim Administrator and provider charges plus Deductible, Copayment and/or Coinsurance. The Participant will be responsible for the balance of the nonparticipating provider's or a non-PPO provider's charges after payment by the Claim Administrator and payment of any Deductible, Copayment and/or Coinsurance.

For Prescription Drug Products, the Participant will be responsible for paying the specific Copayment/Coinsurance and Deductible as described in the Prescription Drugs section.

The Claim Administrator will not pay for any services, supplies or medications which are not a Covered Medical Expense, or for which a Benefit maximum has been met, regardless of whether provided by a Participating Provider or a nonparticipating provider. The Participant will be responsible for all charges for such services, supplies, or medications.

Claim Payment Assignment

All benefits payable to the Participant which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Participant.

Claim Dispute

Once Covered Medical Expenses are rendered by a provider, the Participant has no right to request the Claim Administrator not to pay the claim submitted by such provider and no such request by a Participant or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Participant or any other person because of its rejection of such request.

OUT-OF-AREA SERVICES – THE BLUECARD PROGRAM

Out-of-Area Services

Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever a Plan Participant obtains healthcare services outside of the Blue Cross and Blue Shield of Montana service area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program. The Inter-Plan Arrangements available to Participants under this Plan Document are described generally below.

Typically, when accessing care outside the Blue Cross and Blue Shield of Montana service area, the Plan Participant will obtain care from healthcare providers that have a contractual agreement (i.e., are “Participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, the Plan Participant may obtain care from nonparticipating healthcare providers. Blue Cross and Blue Shield of Montana payment practices in both instances are described below.

1. **BlueCard® Program**

   Under the BlueCard® Program, when a Plan Participant incurs Covered Medical Expenses within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Montana will remain responsible for fulfilling Blue Cross and Blue Shield of Montana’s contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   For inpatient facility services received in a Hospital, the Host Blue’s Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue’s contractual agreement with the provider, and the Participant will be held harmless for the provider sanction.

   Whenever the Plan Participant incurs Covered Medical Expenses outside the Blue Cross and Blue Shield of Montana service area and the claim is processed through the BlueCard Program, the amount the Plan Participant pays for Covered Medical Expenses is calculated based on the lower of:

   a. The billed covered charges for the Plan Participant’s covered services; or

   b. The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Montana.

   Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Plan Participant’s healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Plan Participant’s healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield of Montana uses for the Plan Participant’s claim because they will not be applied retroactively to claims already paid.

Federal laws or the laws in a small number of states may require the Host Blue to add a surcharge to the Plan Participant's calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Blue Cross and Blue Shield of Montana would then calculate the Plan Participant's liability for any Covered Medical Expenses according to applicable law.

2. Value-Based Programs

a. BlueCard® Program

If a Plan Participant receives Covered Medical Expenses under a Value-Based Program inside a Host Blue's service area, the Plan Participant will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Cross and Blue Shield of Montana through average pricing or fee schedule adjustments.

b. Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Blue Cross and Blue Shield of Montana has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan Participant's employer on their behalf, Blue Cross and Blue Shield of Montana will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

3. Nonparticipating Healthcare Providers Outside of the Blue Cross and Blue Shield of Montana Service Area

a. Plan Participant Liability Calculation

When the Plan Participant incurs Covered Medical Expenses outside of the Blue Cross and Blue Shield of Montana service area for services provided by nonparticipating healthcare providers, the amount the Plan Participant pays for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Plan Participant may be liable for the difference between the amount that the nonparticipating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

b. Exceptions

In certain situations, Blue Cross and Blue Shield of Montana may use other payment bases, such as (i) The provider's billed charges for Covered Medical Expenses, (ii) the payment Blue Cross and Blue Shield of Montana would make if the Covered Medical Expenses had been received within the Blue Cross and Blue Shield of Montana service area, (iii) a special negotiated payment, or (iv) the lesser of any of the foregoing payment methods or the Allowable Fee determined for nonparticipating providers outside of Montana to pay for services provided by nonparticipating providers. In these situations, the Plan Participant may be liable for the difference between the amount that the nonparticipating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

4. Blue Cross Blue Shield Global® Core

If the Participant is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), the Participant may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists the Participant with accessing a network of inpatient, Outpatient and professional providers, the network is not served by a Host Blue. As such, when the Participant receives care from providers outside the BlueCard service area, the Participant will typically have to pay the providers and submit the claims himself/herself to obtain reimbursement for these services.

If the Participant needs medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, the Participant should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if the Participant contacts the service center for assistance, Hospitals will not require the Participant to pay for covered inpatient services, except for the cost-share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Participant's claims to the service center to begin claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to receive reimbursement for Covered Medical Expenses.

The Participant must contact Blue Cross and Blue Shield of Montana to obtain Prior Authorization to verify that inpatient services are for the treatment of an Emergency Medical Condition.

b. Outpatient Services

Outpatient Services are available for the treatment of an Emergency Medical Condition. Physicians, urgent care centers and other Outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require the participant to pay in full at the time of service. The Participant must submit a claim to obtain reimbursement for Covered Medical Expenses.

c. Submitting a Blue Cross Blue Shield Global Core Claim

When the Participant pays for Covered Medical Expenses outside the BlueCard service area, the Participant must submit a claim to obtain reimbursement. For institutional and professional claims, the Participant should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the Participant claim. The claim form is available from the Plan, service center or online at www.bcbsglobalcore.com. If the Participant needs assistance with the Participant claim submission, the Participant should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

UTILIZATION MANAGEMENT

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, inpatient admission and length of stay is based on the Claim Administrator's Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services being rendered, during the course of care, or after care has been completed as a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity Review. If requested, services normally subject to a Post-Service Medical Necessity Review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Refer to the definition of Medically Necessary in the Definitions section of this Plan Document for additional information regarding any limitations and/or special conditions pertaining to the Participant's Benefits.

Prior Authorization

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services described below for which the Participant has obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

If Prior Authorization is required, the review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions of this Plan Document. The Plan recommends the Participant confirm with the provider if Prior Authorization has been obtained.

To determine if a specific service or category requires Prior Authorization, visit the Claim Administrator's website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. The Participant can also call the Claim Administrator's Customer Service at the number on the back of the Participant's identification card.

Prior Authorization Responsibility

Participating Provider (In-Network) Prior Authorization

The Participant's Participating Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held financially responsible and will not be able to bill the Participant for the services.

For additional information about Prior Authorization for services outside of the Blue Cross and Blue Shield of Montana service area, see the section entitled, Out-of-Area Services – The BlueCard Program.

NOTE: Providers that contract with other Blue Cross and Blue Shield Plans may not be familiar with the Prior Authorization requirements of the Plan. Unless a provider contracts directly with the Plan as a Participating Provider, the provider is not responsible for being aware of the Plan's Prior Authorization requirements, except as described in the section entitled Out-of-Area Services – The BlueCard® Program.

Nonparticipating Provider (Out-of-Network) Prior Authorization

If any provider outside of Montana (except for those contracting as Participating Providers directly with the Plan) or any nonparticipating provider recommends an admission or a service that requires Prior Authorization, the provider is not obligated to obtain the Prior Authorization for the Participant. In such cases, it is the Participant's responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, the Participant may be entirely responsible for the charges if the service is determined to not be Medically Necessary. If the services were determined to be Medically Necessary, Out-of-Network Benefits will apply. The provider may call on the Participant's behalf, but it is the Participant's responsibility to ensure that the Plan is called.

Inpatient Admissions

The Participant's provider will need to obtain Prior Authorization from the Plan for an inpatient admission, if inpatient admissions are identified as needing a Prior Authorization. In the case of an elective inpatient admission, if services require an authorization it is recommended that the call for Prior Authorization should be made at least two working days before the Participant is admitted. If the admission is due to an Emergency Medical Condition and obtaining Prior Authorization would delay Emergency Services, it is recommended that Prior Authorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

If Prior Authorization is not obtained for inpatient services and the services are denied as not Medically Necessary, the Participating Provider will be held financially responsible and will not be able to bill the Participant for the services.

If the provider is not a network provider then the Participant, the Participant's provider, or the Participant's authorized representative should obtain Prior Authorization by the Plan by calling the toll-free number shown on the back of the Participant's identification card. The call should be made between 8:00 a.m. and 5:00 p.m., Mountain Time, on business days. After business hours or on weekends, please call the toll-free number listed on the back of the Participant's identification card. The Participant's call will be recorded and returned the next business day. A benefits management nurse will follow up with the Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if the Participant uses an In-Network provider or In-Network specialty care provider. If the Participant elects to use Out-of-Network providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not reasonably available from In-Network providers as defined by applicable law, and the Plan authorizes the Participant's visit to an Out-of-Network provider to be covered at the In- Network Benefit level prior to the visit, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When Prior Authorization of an inpatient admission is obtained, a length of stay is assigned. The Participant's provider may seek an extension for the additional days if the Participant requires a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the Length of Stay/Service Review subsection of this Plan Document.

If the Plan determines that the Participant's treatment does not require inpatient level of care, the Participant and the Participant's provider will be notified of that decision. If the Participant proceeds with an inpatient stay without the Plan's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant, the Participant's provider, or other appropriate party, as identified above, does not request Prior Authorization, the Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

For Behavioral Health Inpatient Hospital Admissions please see Contacting Behavioral Health section below.

Prior Authorization not Required for Maternity Care Unless Extension of Minimum Length of Stay Requested

The Plan is required to provide a minimum length of stay in a Hospital facility for the following:

Maternity Care

1. 48 hours following an uncomplicated vaginal delivery; or
2. 96 hours following an uncomplicated delivery by caesarean section.

The Participant or the Participant's provider will not be required to obtain Prior Authorization from the Plan for a length of stay less than 48 hours (or 96 hours) for Maternity Care. If the Participant requires a longer stay, the Participant, the Participant's authorized representative, or the Participant's provider must seek an extension for the additional days by obtaining Prior Authorization from the Plan.

Outpatient Service Prior Authorization Review

There may be general categories of covered Outpatient services that require Prior Authorization.

To determine if a specific service or category requires Prior Authorization, visit the Claim Administrator's website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. The Participant can also call Customer Service at the number on the back of the Participant's identification card.

For Behavioral Health Outpatient Service review please see Contacting Behavioral Health section below.

Prior Authorization Duration

A Prior Authorization is valid for at least three Months from the date the Participant's provider receives approval from the Plan. Actual availability of Benefits is subject to eligibility and other terms, conditions and limitations and Exclusions of this Plan Document.

It is NOT necessary to obtain Prior Authorization for standard x-ray and lab services or Routine office visits.

If the Plan does not approve the Outpatient Service, the Participant and the Participant's provider will be notified of that decision. If the Participant proceeds with the services without the Plan's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant, the Participant's provider, or other appropriate party, as identified above, does not request Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

Response to Prior Authorization Requests Involving Non-Urgent Care

Except in the case of a Prior Authorization request involving Urgent Care (see below), the Plan will provide a written response to the Participant's Prior Authorization request no later than seven business days following the date the Plan receives the Participant's request. This period may be extended one time for up to seven additional business days, if the Plan determines that additional time is necessary due to matters beyond our control.

If the Plan determines that additional time is necessary, the Plan will notify the Participant in writing, prior to the expiration of the original seven business day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Plan expects to make the determination. If an extension of time is necessary due to the need for additional information, the Plan will notify the Participant of the specific information needed, and the Participant will have 45 days from receipt of the notice to provide the additional information.

The Plan will provide a written response to the Participant's request for Prior Authorization within seven business days following either the receipt of the additional information or, if the additional information is not received, the deadline

for the receipt of the additional information. The procedure for appealing an adverse Prior Authorization determination is set forth in the section entitled Complaints and Grievances.

Response to Prior Authorization Requests Involving Urgent Care

A Prior Authorization request involving Urgent Care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Prior Authorization request.

In case of a Prior Authorization request involving Urgent Care, the Plan will respond to the Participant no later than 48 hours after receipt of the request, unless the Participant fails to provide sufficient information, in which case, the Participant will be notified of the missing information within 24 hours of the Plan's receipt of the Urgent Care request and will have no less than 48 hours to provide the information. A response will be given as soon as possible (taking into account medical exigencies) but no later than 48 hours after the initial request, or, in the case where further information is requested, within 24 hours after the missing information is received or of the end of the period for the Participant to provide the missing information.

NOTE: The Plan's response to the Participant's Prior Authorization request involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Prior Authorization Required for Certain Prescription Drug Products and Other Medications

Prescription Drug Products, which are self-administered, process under the Prescription Drugs section of this Plan Document. There are other medications that are administered by a Covered Provider which process under the medical Benefits.

1. **Prescription Drugs – Covered Under the Prescription Drugs Benefit**

   Certain prescription drugs, which are self-administered, require Prior Authorization. Please refer to the Prescription Drugs section for complete information about the Prescription Drug Products that are subject to Prior Authorization, step therapy, and quantity limits, the process for requesting Prior Authorization, and related information.

2. **Other Medications – Covered Under Medical Benefits**

   Medications that are administered by a Covered Provider will process under the medical Benefits of this Plan Document. Certain medications administered by a Covered Provider require Prior Authorization. The medications that require Prior Authorization are subject to change by the Plan.

   In making determinations of coverage, the Plan may rely upon Pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in Montana, Medical Necessity, and Medical Policies. The Pharmacy policies and Medical Policies are located on the Plan website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.

   To determine which medications are subject to Prior Authorization, the Participant or provider should refer to the list of medications which applies to the Participant's Plan on the Plan website at www.bcbsmt.com or call the Customer Service toll-free number identified on the Participant's identification card or the Plan website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.

General Provisions Applicable to All Required Prior Authorizations

1. **No Guarantee of Payment**

   Prior Authorization does not guarantee payment of Benefits by the Plan. Even if the service has been approved through Prior Authorization, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible for coverage as of the date of service or the Participant's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Prior Authorization process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Prior Authorization, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of

the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

3. **Failure to Obtain Prior Authorization**

   If the Participant, the Participant's provider, or other appropriate party, as identified above, does not obtain Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

Length of Stay/Service Review

Length of stay/concurrent service review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions under this Plan Document.

Upon completion of the inpatient or emergency admission review, the Claim Administrator will send a letter to the Participant, the Participant's provider, behavioral health practitioner and/or Hospital or facility with a determination on the approved length of service or length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient Care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the Appeal Procedure section of this Plan Document.

A length of stay/service review, also known as a concurrent Medical Necessity review, occurs when the Participant, the Participant's provider, or other authorized representative submits a request to the Plan for continued services. If the Participant, the Participant's provider or the Participant's authorized representative requests to extend care beyond the approved time limit and it is a request involving Urgent Care or an ongoing course of treatment, The Plan will make a determination on the request as soon as possible but no later than 48 hours after it receives an urgent request, within 48 hours after it receives requested information (if the initial request is incomplete) or within seven business days after receipt of a non-urgent Concurrent Care request.

Recommended Clinical Review

A Recommended Clinical Review is a Medical Necessity review for a covered service that occurs before services are completed and helps limit the situations where the Participant may have to pay for a non-approved service. The Plan will review a Clinical Review request to determine if it meets the approved Claim Administrator's Medical Policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, the services will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit the Claim Administrator's website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed, or call Customer Service at the number on the back of the Participant's identification card. The Participant or provider may request a Recommended Clinical Review.

Please coordinate with the provider to submit a written request for Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is not a guarantee of Benefits or payment of Benefits by the Plan. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Plan Document. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible for coverage as of the date of service or the Participant's Benefits may have changed as of the date of service.

2. Request for Additional Information

The Recommended Clinical Review process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

Contacting Behavioral Health

The Participant, the Participant's provider, or authorized representative may contact the Plan for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of the Participant's identification card and follow the prompts to the behavioral health unit. During regular business hours (7:00 a.m. and 5:00 p.m., Mountain Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 5:00 p.m., on weekends, and on holidays, the same behavioral health line is answered by clinicians available for inpatient acute Recommended Clinical Reviews only. Requests for residential or Partial Hospitalization are reviewed during regular business hours.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Participant eligibility, availability of Benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a post-service review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Plan Document. Post-Service Medical Necessity Review does not guarantee payment of Benefits by the Plan, for instance a Participant may become ineligible for coverage as of the date of service or the Participant's Benefits may have changed as of the date of service.

2. Request for Additional Information

The Post-Service Medical Necessity Review process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

Care Management

The goal of Care Management is to help the Participant receive the most appropriate care that is also cost effective. If the Participant has an ongoing medical condition or a catastrophic Illness, the Participant should contact the Plan. If appropriate, a care manager will be assigned to work with the Participant and the Participant's providers to facilitate a treatment plan. Care Management includes Participant education, referral coordination, utilization review and individual care planning. Involvement in Care Management does not guarantee payment by the Plan.

BENEFITS

The Plan will pay for the following Benefits provided by a Covered Provider based on the Allowable Fee and is subject to any Deductible, Copayment and/or Coinsurance and other provisions, as applicable.

Please note that services must be determined to be Medically Necessary by the Plan in order to be covered. Coverage of Benefits is subject to Blue Cross and Blue Shield of Montana policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, Utilization Management, and clinical payment and coding policies, which may be updated throughout the plan year. The policies and guidelines are resources utilized by Blue Cross and Blue Shield of Montana when making coverage determinations and lay out the procedure and/or criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Medical Expense or is not eligible for coverage as not Medically Necessary, Experimental/Investigational/Unproven, cosmetic, a convenience item, or a Plan Document Exclusion.

The clinical payment and coding policies are intended to ensure the creation and submission of accurate documentation of the services performed and require all providers to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (“HIPAA”) approved code sets. Under the clinical payment and coding policies, claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to: Uniform Billing (“UB”) Editor, American Medical Association (“AMA”), Current Procedural Terminology (“CPT®”), CPT® Assistant, Healthcare Common Procedure Coding System (“HCPCS”), ICD-10 CM and PCS, National Drug Codes (“NDC”), Diagnosis Related Group (“DRG”) guidelines, Centers for Medicare and Medicaid Services (“CMS”) National Correct Coding Initiative (“NCCI”) Policy Manual, CCI table edits and other CMS guidelines.

Provider claims are subject to the code edit protocols for services/procedures billed as well as to other applicable claim review which may include, but is not limited to, review of any terms of Benefit coverage, provider contract language, medical and medical management policies, utilization or clinical review or Utilization Management policies, medical records, clinical payment and coding policies as well as coding software logic, including but not limited to, lab management or other coding logic or edits.

Any line on the claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included as a Covered Medical Expense and will not be eligible for payment by the Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the provider rendering the item or service or submitting the claim is In-Network or Out-of-Network. The most up-to-date medical policies and clinical procedure and coding policies are available at www.bcbsmt.com or by contacting Customer Service at the number shown on the Participant’s identification card.

Accident

Services which are provided for bodily injuries resulting from an Accident.

Advanced Practice Registered Nurses and Physician Assistants - Certified

Services provided by an Advanced Practice Registered Nurse or a Physician Assistant-Certified who is licensed to practice medicine in the state where the services are provided and when payment would otherwise be made if the same services were provided by a Physician.

Ambulance

Licensed ground and air ambulance transport required for a Medically Necessary condition to the nearest appropriate site.

Anesthesia Services

Anesthesia services provided by a Physician (other than the attending Physician) or nurse anesthetist including the administration of spinal anesthesia and the injection or inhalation of a drug or other anesthetic agent.

The Plan will not pay for:

1. Hypnosis;
2. Local anesthesia or intravenous (IV) sedation that is considered to be an Inclusive Service/Procedure;

3. Anesthesia consultations before surgery that are considered to be Inclusive Services/Procedures because the Allowable Fee for the anesthesia performed during the surgery includes this anesthesia consultation; or
4. Anesthesia for dental services or extraction of teeth, except anesthesia provided at a Hospital in conjunction with dental treatment will be covered only when a nondental physical Illness or Injury exists which makes Hospital care Medically Necessary to safeguard the Participant's health. Dental services and treatment are not a Benefit of this Plan Document, except:

    a. As specifically included in the Dental Accident Benefit; or
    b. Anesthesia Services associated with any Medically Necessary dental procedure when provided to a Participant who is severely disabled; or who has a medical or emotional condition which requires **h**ospitalization or general anesthesia for dental care; or who, in the judgment of the treating provider, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

Approved Clinical Trials

Routine Patient Costs provided in connection with an Approved Clinical Trial.

Autism Spectrum Disorders

Diagnosis and treatment of autistic disorder, Asperger's Disorder or Pervasive Developmental Disorder.

Covered services include:

1. Habilitative Care or Rehabilitative Care, including, but not limited to, professional, counseling and guidance services and treatment programs; Applied Behavior Analysis (ABA), also known as Lovaas Therapy; discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention;
2. Medications;
3. Psychiatric or psychological care; and
4. Therapeutic care provided by a speech-language pathologist, audiologist, occupational therapist or physical therapist.

Birthing Centers

Services for the delivery of a newborn provided at a birthing center.

Blood Transfusions

Blood transfusions, including the cost of blood, blood plasma, blood plasma expanders and packed cells. Storage charges for blood are paid when a Participant has blood drawn and stored for the Participant's own use for a planned surgery.

Breast Examinations (Preventive and Medical)

Mammography examinations.

The minimum mammography examination recommendations are:

1. One baseline mammogram for women ages 35 through 39.
2. One mammogram every two years for women ages 40 through 49, or more frequently as recommended by a Physician.
3. One mammogram every year for women age 50 or older.

NOTE: Benefits will be provided for Medically Necessary Diagnostic and Supplemental Breast Examinations at no cost-share.

Chemotherapy

The use of drugs approved for use in humans by the U.S. Food and Drug Administration (FDA) and ordered by the Physician for the treatment of disease.

Colonoscopies (Medical)

One colonoscopy, every ten years for a Participant who is:

1. Age 45 or older; or
2. A Physician has ordered the colonoscopy due to the Participant's family medical history.

This Benefit covers the first medical colonoscopy during the timeframes shown above. Any additional colonoscopies with a medical diagnosis will be covered under regular medical Benefits.

Under age 45, if the reason for the colonoscopy is family history, the claim may initially deny. Medical records will be reviewed to determine family history.

The Schedule of Benefits describes payment limitations for these services.

Contraceptives

Services and supplies related to contraception, including but not limited to, oral contraceptives, contraceptive devices and injections, subject to the terms and limitations of the Plan Document.

Deductible and Coinsurance do not apply to contraceptives covered under the Preventive Health Care Benefit, whether provided during an office visit or through the Prescription Drugs Benefit.

Convalescent Home Services

Services of a Convalescent Home as an alternative to Hospital Inpatient Care when and if:

1. The patient is confined as a bed patient in the facility;
2. The confinement starts within 14 days of a Hospital confinement of at least 3 days;
3. The Attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
4. The Attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Convalescent Home.

The Plan considers extended care confinements separated by less than 7 days as one period of confinement.

The Plan will not pay for Custodial Care.

NOTE: The Plan will not pay for the services of a Convalescent Home if the Participant remains inpatient at the Convalescent Home when a skilled level of care is not Medically Necessary.

The Schedule of Benefits describes payment limitations for these services.

Dental Services

Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges only if that care is for the following oral surgical procedures:

1. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth.
2. Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
3. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
4. Excision of benign bony growths of the jaw and hard palate.
5. External incision and drainage of cellulitis.
6. Incision of sensory sinuses, salivary glands or ducts.
7. Removal of impacted wisdom teeth.

The Plan will provide Benefits for orthodontia care of the teeth when necessitated by an Injury to the mouth, if such care is determined to be Medically Necessary. The orthodontia care must not have been necessary had it not been for the Injury of the sound natural teeth.

No charge will be covered for dental and oral surgical procedures involving periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diabetes Treatment (Office Visit)

Services and supplies for the treatment of diabetes provided during an office visit. For additional Benefits related to the treatment of diabetes, e.g., surgical services and medical supplies, refer to that specific Benefit.

Diabetic Education

Outpatient self-management training and education services for the treatment of diabetes provided by a Covered Provider with expertise in diabetes.

NOTE: Benefits for outpatient diabetic self-management training and education are not subject to any visit limitations.

Diagnostic Services

Diagnostic x-ray examinations, laboratory and tissue diagnostic examinations and medical diagnostic procedures (machine tests such as EKG, EEG) are covered. Covered services include, but are not limited to, the following:

1. X-rays and Other Radiology. Some examples of other radiology include:
   a. Computerized tomography scan (CT Scan)
   b. MRIs
   c. Nuclear medicine
   d. Ultrasound
2. Laboratory Tests. Some examples of laboratory tests include:
   a. Urinalysis
   b. Blood tests
   c. Throat cultures
3. Diagnostic Testing. Tests to diagnose an Illness or Injury. Some examples of diagnostic testing include:
   a. Electroencephalograms (EEG)
   b. Electrocardiograms (EKG or ECG)

This Benefit does not include diagnostic services such as biopsies which are covered under the surgery Benefit.

Dialysis Treatment – Outpatient

For Outpatient dialysis, see separate dialysis booklet.

Durable Medical Equipment

The appropriate type of equipment used for therapeutic purposes **where the Participant resides**. Durable medical equipment, which requires a written prescription, must also be:

1. Able to withstand repeated use (consumables are not covered);
2. Primarily used to serve a medical purpose rather than for comfort or convenience; and
3. Generally, not useful to a person who is not ill or injured.

Replacement Equipment.

1. Replacement of durable medical equipment will not be subject to any reduced replacement Coinsurance that may be applicable if the replacement is five (5) years or longer after the original purchase.
2. Durable medical equipment will not be considered a replacement if the current equipment no longer meets the medical needs of the Participant due to physical changes or a deteriorating medical condition.

The Plan will not pay for the following items:

1. Exercise equipment;
2. Car lifts or stair lifts;
3. Biofeedback equipment;
4. Self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition;

5. Air conditioners and air purifiers;
6. Whirlpool baths, hot tubs, or saunas;
7. Waterbeds;
8. Other equipment which is not always used for healing or curing;
9. Deluxe equipment. The Plan has the right to decide when deluxe equipment is required. However, upon such decision, payment for deluxe equipment will be based on the Allowable Fee for standard equipment;
10. Computer-assisted communication devices;
11. Durable medical equipment required primarily for use in athletic activities;
12. Replacement of lost or stolen durable medical equipment;
13. Repair to rental equipment; and/or
14. Duplicate equipment purchased primarily for Participant convenience when the need for duplicate equipment is not medical in nature.

Emergency Room Care

1. Emergency room care for an accidental Injury.
2. Emergency room care for Emergency Services.
3. Emergency room care for the treatment of Mental Illness and/or Substance Use Disorder.

If the Participant disagrees with the Plan's determination in processing Benefits as nonemergency services instead of Emergency Services, the Participant may call the Plan at the number on the back of the Participant's identification card. Please see the section entitled How to File an Internal Appeal of an Adverse Benefit Determination in this document for specific information on the Participant's right to seek and obtain a full and fair review of the claim.

Foot Orthotics

Foot orthotics provided by a Covered Provider.

Hearing Coverage for Dependent Children Under Age 19

Coverage is available for the Medically Necessary diagnosis and treatment of hearing loss for a covered Dependent under age 19, when prescribed, provided, or ordered by a licensed health care provider. One Amplification Device, with required accessories, are available for each ear, every three years, or as required by a licensed audiologist.

The Schedule of Benefits describes payment limitations for these services.

Home Health Care

The following services, when prescribed and supervised by the Participant's attending Physician provided in the Participant's home by a licensed Home Health Agency and which are part of the Participant's treatment plan:

1. Nursing services;
2. Home Health Aide services;
3. Hospice services;
4. Physical Therapy;
5. Occupational Therapy;
6. Speech Therapy;
7. Medical social worker;
8. Medical supplies and equipment suitable for use in the home; and/or
9. Medically Necessary personal hygiene, grooming and dietary assistance.

The Plan will not pay for:

1. Maintenance or Custodial Care visits.
2. Domestic or housekeeping services.
3. "Meals-on-Wheels" or similar food arrangements.

4. Visits, services, medical equipment, or supplies not approved or included as part of the Participant's treatment plan.
5. Services provided for the treatment of Mental Illness.
6. Services provided in a nursing home or skilled nursing facility.

Prior Authorization is required for home health care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

The Schedule of Benefits describes payment limitations for these services.

Home Infusion Therapy Services

The preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Participant by a Home Infusion Therapy Agency, including the following:

1. Education for the Participant, the Participant's caregiver, or a Family Member;
2. Pharmacy;
3. Supplies;
4. Equipment; and
5. Skilled nursing services when billed by a Home Infusion Therapy Agency.

NOTE: Skilled nursing services billed by a Licensed Home Health Agency will be covered under the home health services Benefit.

Home infusion therapy services must be ordered by a Physician and provided by a licensed Home Infusion Therapy Agency. A licensed Hospital, which provides home infusion therapy services, must have a Home Infusion Therapy Agency license or an endorsement to its Hospital facility license for home infusion therapy services.

Prior Authorization is required for home infusion therapy services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Hospice Care

A coordinated program of home care and Inpatient Care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill Participant and the Participant's Immediate Family. Benefits include:

1. Inpatient and Outpatient care;
2. Home care;
3. Nursing services – skilled and non-skilled;
4. Counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally ill Participant; and
5. Instructions for care of the Participant, counseling and other support services for the Participant's Immediate Family.

The Plan will not pay for services that do not require skilled nursing care, including Custodial Care or care for the convenience of the patient or Family Member.

Prior Authorization is required for hospice care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Hospital Services - Facility and Professional

Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations
    a. Room and board, which includes special diets and nursing services.
    b. Intensive care and cardiac care units which include special equipment and concentrated nursing services provided by nurses who are Hospital employees.

2. Miscellaneous Hospital Services

   a. Laboratory procedures.
   b. Operating room, delivery room and recovery room.
   c. Anesthetic supplies.
   d. Surgical supplies.
   e. Oxygen and use of equipment for its administration.
   f. X-ray.
   g. Intravenous injections and setups for intravenous solutions.
   h. Special diets when Medically Necessary.
   i. Respiratory therapy, chemotherapy, radiation therapy and dialysis therapy.
   j. Physical Therapy, Speech Therapy and Occupational Therapy.
   k. Drugs and medicines which:

      1. Are approved for use in humans by the FDA; and
      2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
      3. Require a Physician's written prescription.

      Drugs and medicines which are used in off-label situations may be reviewed for Medical Necessity.

Inpatient Care services are subject to the following conditions:

1. Days of care

   a. The number of days of Inpatient Care provided by the Plan is 365 days.
   b. In computing the number of Inpatient Care days available, days will be counted according to the standard midnight census procedure used in most Hospitals. The day a Participant is admitted to a Hospital is counted, but the day a Participant is discharged is not. If a Participant is discharged on the day of admission, one day is counted.
   c. The day a Participant enters a Hospital is the day of admission. The day a Participant leaves a Hospital is the day of discharge.

2. The Participant will be responsible to the Hospital for payment of its charges if the Participant remains as an Inpatient Participant when Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed reserved for a Participant. No Benefits will be paid for Inpatient Care provided primarily for diagnostic or therapy services.

Prior Authorization is required for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Inpatient Care Medical Services Provided and Billed by a Professional Provider

Nonsurgical services by a Covered Provider, Concurrent Care and Consultation Services. Refer to the Surgical Services section for coverage of surgical services.

Medical services do not include surgical or maternity services. Inpatient Care medical services are covered only if the Participant is eligible for Benefits under the Hospital Services, Inpatient Care Services section for the Hospital admission.

Medical care visits are limited to one visit per day per Covered Provider unless a Participant's condition requires a Physician's constant attendance and treatment for a prolonged period of time.

Observation Beds/Rooms

Benefits will be made available for observation beds when Medically Necessary.

Outpatient Hospital Services

Use of the Hospital's facilities and equipment for surgery, respiratory therapy, chemotherapy, radiation therapy and dialysis therapy.

Inborn Errors of Metabolism

Treatment under the supervision of a Physician of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard 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 Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

Infusion Therapy Services – Outpatient

Some Outpatient infusion services for Routine maintenance drugs have been identified as capable of being administered outside of an Outpatient Hospital setting. The Out of Pocket Amount expenses may be lower when services are provided by a professional provider in an Infusion Suite, a home or an office, instead of a Hospital. Non-maintenance Outpatient infusion therapy services will be covered the same as any other Illness.

Maternity Services - Professional and Facility Covered Providers

1. Prenatal and postpartum care.
2. Delivery of one or more newborns.
3. Hospital Inpatient Care for conditions related directly to pregnancy are covered. Inpatient Care following delivery will be covered for whatever length of time is Medically Necessary and will be at least 48 hours following a vaginal delivery and at least 96 hours following a delivery by cesarean section. The decision to shorten the length of stay of Inpatient Care to less than that stated in the preceding sentence must be made by the attending health care provider and the mother.

   Under federal law, Benefits may not be restricted 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, under federal law, Covered Providers may not be required to obtain Prior Authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.
4. Payment for any maternity services by the professional provider is limited to the Allowable Fee for total maternity care, which includes delivery, prenatal, and postpartum care.

Please refer also to the Newborn Initial Care section.

Medical Supplies

The following supplies for use outside of a Hospital:

1. Supplies for insulin pumps, syringes and related supplies for conditions such as diabetes;
2. Injection aids, visual reading and urine test strips, glucagon emergency kits for treatment of diabetes. One insulin pump for each warranty period is covered under the Durable Medical Equipment Benefit;
3. Sterile dressings for conditions such as cancer or burns;
4. Catheters;
5. Splints;
6. Colostomy bags and related supplies; and/or
7. Supplies for renal dialysis equipment or machines.

Medical supplies are covered only when:

1. Medically Necessary to treat a condition for which Benefits are payable; and
2. Prescribed by a Covered Provider.

Mental Health

Benefits provided for mental health are for the treatment of Mental Illness as defined in the section entitled Definitions.

Benefits include but are not limited to, Inpatient Care services, Outpatient services, rehabilitation services and medication for the treatment of Mental Illness.

Payment for mental health Benefits will be made as for any other Illness.

Outpatient Services

Care and treatment of Mental Illness if the Participant is not an Inpatient Participant and is provided by:

1. A Hospital;
2. A Physician or prescribed by a Physician;
3. A Mental Health Treatment Center;
4. A Substance Use Disorder Treatment Center;
5. A licensed psychologist;
6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. A licensed psychiatrist;
10. A licensed Advanced Practice Registered Nurse with a specialty in mental health;
11. A licensed Advanced Practice Registered Nurse with prescriptive authority and specializing in mental health; or
12. Other Qualified Health Care Provider.

Outpatient Benefits are subject to the following conditions:

1. The services must be provided to diagnose and treat recognized Mental Illness; and
2. The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by Mental Illness.

The Plan will not pay for hypnotherapy or for services given by a staff member of a school or halfway house.

Inpatient Services

Care and treatment of Mental Illness, while the Participant is an Inpatient Participant, and which are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity residential services provided at a Residential Treatment Center are Benefits of this Plan Document.

Prior Authorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Partial Hospitalization

Care and treatment of Mental Illness, while the Partial Hospitalization services are provided in or by any of the following:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Prior Authorization is required for Partial Hospitalization. Please refer to the section entitled Utilization Management.

Naturopathy

Services provided by a licensed naturopathic provider are covered if such services are a Benefit of this Plan Document.

Newborn Initial Care

1. The initial care of a newborn at birth provided by a Physician.
2. Nursery Care - Hospital nursery care of newborn infants.

Office Visit

Covered services provided in a Covered Provider's office during a Professional Call and covered services provided in the home by a Covered Provider. Visits are limited to one visit per day per provider.

Orthopedic Devices/Orthotic Devices

A supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, when Medically Necessary, Benefits will be provided for adjustments, repairs or replacement of the device because of a change in the Participant's physical condition.

Physician Medical Services

Medical services by a Covered Provider for:

1. Inpatient Hospital Physician visits.
2. Convalescent Home facility Physician visits.
3. Surgical facility Physician services.

The Plan will not pay for pre- or postsurgical visits that are considered to be Inclusive Services/Procedures that are included in the payment for the surgery.

This Benefit does not include services provided in the home or the Covered Provider's office.

Postmastectomy Care and Reconstructive Breast Surgery

Postmastectomy Care

Medically Necessary Inpatient Care for the period of time determined by the attending Physician and the Participant, following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

Prior Authorization is required for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Reconstructive Breast Surgery

1. All stages of Reconstructive Breast Surgery after a mastectomy including, but not limited to:
    a. All stages of reconstruction of the breast on which a mastectomy has been performed.
    b. Surgery and reconstruction of the other breast to establish a symmetrical appearance.
    c. Chemotherapy.
    d. Prostheses and physical complications of all stages of a mastectomy and breast reconstruction, including lymphedemas.

    Coverage described in 1(a) through 1(d) will be provided in a manner determined in consultation with the attending Physician and the patient.
2. Breast prostheses as the result of a mastectomy.

For specific Benefits related to postmastectomy care, refer to that specific Benefit, e.g., surgical services and Hospital services.

Prescription Drugs

Refer to the Prescription Drugs section in the Schedule of Benefits for specific information on the application of any Deductible, Copayment and/or Coinsurance.

The Prescription Drugs Benefit is for Prescription Drug Products which are self-administered. This Benefit does not include medications which are administered by a Covered Provider. If a medication is administered by a Covered Provider, the claim will process under the Participant's medical Benefits. **Please refer to the Utilization Management section for complete information about the medications that are subject to the Participant's medical Benefits, the process for requesting Prior Authorization for medications subject to the Participant's medical Benefits, and related information.**

Subject to the terms, conditions, and limitations of this Plan Document, the Claim Administrator will pay for Prescription Drug Products, which:

1. Are approved for use in humans by the FDA; and
2. Require a Physician's written prescription; and
3. Are dispensed under federal or state law pursuant to a prescription order or refill.

Prescription Drug Products which are used in off-label situations may be reviewed for Medical Necessity.

Drug Lists

Drugs listed on the Drug List are selected by the Claim Administrator based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Claim Administrator. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the Drug List. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost, and how it compares with drugs currently on the Drug List.

Positive changes (e.g., adding drugs to the Drug List, drugs moving to a lower payment tier) occur quarterly after review by the Committee. Changes to the Drug List that could have an adverse financial impact to the Participant (e.g., drug Exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or Prior Authorization) occur annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the Drug List may occur more frequently.

The Drug List and any modifications will be made available to the Participant. By accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists or calling the Customer Service toll-free number on the Participant's identification card, the Participant will be able to determine the Drug List that applies to the Participant's Plan and whether a particular drug is on the Drug List.

The Participant, or the Participant's prescribing health care provider, can ask for a Drug List exception if the Participant's drug is not on the Drug List. To request this exception, the Participant or the Participant's prescriber, can call the number on the back of the Participant's identification card to ask for a review. The Claim Administrator will notify the Participant or the Participant's prescriber of its decision with respect to the request within 72 hours after the request is received.

If the Participant has a health condition that may jeopardize their life, health or keep the Participant from regaining function, or the Participant's current drug therapy uses a non-covered drug, the Participant's prescriber, may be able to ask for an expedited review process by marking the review as an urgent request. The Claim Administrator will notify the Participant or the Participant's prescriber, of the coverage decision within 24 hours after they receive the request for an expedited review.

If the coverage request is denied, the Claim Administrator will let the Participant and the Participant's prescriber, know why it was denied and offer the Participant a covered alternative drug (if applicable). If the Participant's exception is denied, the Participant may appeal the decision according to the appeals process the Participant will receive with the denial determination. The Participant should call the number on the back of the Participant's identification card if the Participant has any questions.

Covered Prescription Drug Products

The following Prescription Drugs Products, obtained from a Participating Pharmacy, either retail or mail order, or a retail nonparticipating Pharmacy, are covered:

1. Legend drugs - drugs requiring written prescriptions and dispensed by a licensed pharmacist for treatment of an Illness or Injury.
2. One prescription oral agent for controlling blood sugar levels for each class of drug approved by the FDA.
3. Insulin with a prescription.
4. Disposable insulin needles/syringes.
5. Test strips.
6. Lancets.
7. Contraceptives as specified on the Drug List.
8. Smoking cessation products and over-the-counter smoking cessation aids/medications with a written prescription, as required by the Affordable Care Act. Tobacco counseling is available under the Preventive Health Care Benefit.
9. Compounded Drugs.
10. Non-sedating antihistamines.
11. Folic acid, iron supplements, vitamins and injectable vitamins are covered as a prescription.
12. Prescription prenatal vitamins.

The Schedule of Benefits lists any Deductible, Copayment and/or Coinsurance that the Participant is responsible for and payment limitations for these Prescription Drug Products.

Non-Covered Prescription Drug Products

The Plan will not pay for:

1. Drugs/products which are not included on the Drug List, unless specifically covered elsewhere in this Plan Document and/or such coverage is required in accordance with applicable law or regulatory guidance.
2. Drugs, that the use or intended use of which would be illegal, abusive, not Medically Necessary, or otherwise improper such as anabolic steroids.
3. Any drug used for the purpose of weight loss.
4. Fluoride supplements, except as required by the Affordable Care Act for children under age 6.
5. Devices, technologies, and/or Durable Medical Equipment of any type (even though such devices may require a prescription order), such as, but not limited to, therapeutic devices, artificial appliance, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections);.
6. Over-the-counter drugs that do not require a prescription, except over-the-counter smoking cessation aids with a written prescription.
7. Prescription Drug Products for which there is an exact over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined.
8. Prescription Drug Products for cosmetic purposes, including the treatment of alopecia (hair loss) (e.g., Minoxidil, Rogaine).
9. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those otherwise covered under this section.
10. Prescription Drug Products used for erectile dysfunction.
11. Insulin pumps and glucose meters. Insulin pumps and glucose meters are covered under the Durable Medical Equipment Benefit. Insulin pump supplies are covered under the Medical Supplies Benefit.
12. Drugs or items labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Participant is charged for the item.
13. Biological sera, blood, or blood plasma.
14. Prescription Drug Products which are to be taken by or administered to the Participant, in whole or in part, while the Participant is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility’s charge.

15. Any Prescription Drug Product refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
16. Replacement prescription drugs or Prescription Drug Products due to loss, theft or spoilage.
17. Prescription Drug Products obtained from a Pharmacy located outside the United States for consumption within the United States.
18. Prescription Drug Products provided by a mail-order Pharmacy that is not approved by the Plan.
19. Repackagers, Institutional Packs, Clinic Packs or other custom packaging.
20. Prescription Drug Products determined by the Claim Administrator to have inferior efficacy or significant safety issues.
21. Administration or injection of any drugs.
22. Non-FDA approved drugs.
23. Drugs which do not by law require a Prescription from a provider or health care practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies); and drugs or covered devices for which no valid Prescription is obtained.
24. Vitamins (except those vitamins which by law require a Prescription and for which there is no non–prescription alternative).
25. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select vaccinations administered through certain Participating Pharmacies are an exception to this Exclusion.
26. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as otherwise specifically mentioned for in this Plan Document.

    NOTE: This exception does not apply to dietary formula necessary for the treatment of Inborn Errors of Metabolism.
27. Drugs used or intended to be used in the treatment of a condition, sickness, disease, Injury, or bodily malfunction which is not covered under the Plan Document, or for which Benefits have been exhausted.
28. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Participant's identification card.
29. Benefits will not be provided for any self-administered drugs dispensed by a Physician.
30. Experimental/Investigational/Unproven status of a drug or device is determined by the Claim Administrator taking into consideration a variety of factors, including demonstration of efficacy in peer reviewed literature. With respect to FDA approval, if FDA approval is not obtained, the drug will be considered Experimental/Investigational/Unproven, but if FDA approval is obtained, while this will be considered by the Claim Administrator in making its determination of Experimental/Investigational/Unproven status, such approval will not be determinative.
31. Pharmaceutical aids, such as excipients found in the UPS-NF (United States Pharmacopeia National Formulary) including, but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.
32. Certain drug classes where there are over-the-counter alternatives available.
33. Bulk Powders.
34. Surgical supplies (e.g. Amvisc, Cellugel, Duovisc, Hyalgan, Provisc, Supartz, Synvisc, Viscoat).
35. Prescription Drug Products used for the Treatment of Infertility.
36. Diagnostic agents (except for diabetic testing supplies or test strips).
37. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
38. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, the Claim Administrator may limit Benefits to only certain therapeutic equivalents/therapeutic alternatives. If the Participant does not choose the therapeutic equivalents/therapeutic alternatives that are covered under the Prescription Drug Program, the drug purchased will not be covered under any Benefit level.
39. Prescription Drug Products without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives.
40. New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

Vaccinations Obtained Through Select Participating Pharmacies

Select vaccinations are available through select Participating Pharmacies that have contracted with the Claim Administrator. To obtain a current list of Participating Pharmacies and a list of covered vaccines, the Participant can call the Customer Service toll-free number identified on the Participant's identification card or access www.bcbsmt.com and click on "Member Services". Then click on the "Prescription Drug Plan Information" and select "Pharmacy Program." The Participant should present the Participant's identification card to the pharmacist at the time services are received. The pharmacist will inform the Participant of any applicable Copayment and/or Coinsurance.

Each select Participating Pharmacy that has contracted with the Claim Administrator to provide this service may have age, scheduling, or other requirements that will apply, so the Participant should contact the Participating Pharmacy in advance. Childhood immunizations subject to state regulations are not available under this Pharmacy Benefit but are covered under the medical Benefits of the health plan.

Controlled Substances Limitation

If it is determined that a Participant may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any Benefit for additional drugs may be subject to review to assess whether Medically Necessary or appropriate and restrictions may include but not be limited to a certain provider and/or Pharmacy and/or quantities and/or days' supply for the prescribing and dispensing of the controlled substance medication. Additional Copayments and/or Coinsurance may apply.

Multi-Category Split-Fill Program

If it is the Participant's first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if the Participant has not filled a select medication within the previous 120 days, the Participant may only be eligible for a partial fill (14 - 15-day supply) of the medication for up to the first 3 Months of therapy. The partial fill is designed to determine how the medication is working therapeutically for the Participant. Any applicable Copayment and/or Coinsurance may be adjusted to align with the quantity of pills dispensed. If the medication is working and the Participant's provider would like to continue on this medication, the Participant may be eligible to receive up to a 30-day supply after completing up to 3 Months of the partial supply. Call the number on the back of the Participant's identification card for any questions or for a list of drugs that are included in this program, or visit the Claim Administrator's website at www.bcbsmt.com/rx-drugs/pharmacy/pharmacy-programs.

GLP-1 New to Therapy

If this is the Participant's first time using select GLP-1 medications or the Participant has not filled a select GLP-1 medication within the previous 120 days, the Participant may only be eligible to receive a 30-day supply of the medication for the first fill. After the first 30-day fill of select GLP-1 medications, the Participant may be eligible to fill up to a 90-day supply, per the Plan Benefits.

The 30-day supply limit may continue to apply after the first fill if the Participant changes GLP-1 medications and/or dosing strength.

Purchase and Payment of Prescription Drug Products

Prescription Drug Products may be obtained using an Outpatient retail Pharmacy, an extended supply Pharmacy or a mail-order Pharmacy approved by the Claim Administrator. To use a mail-order Pharmacy, the Participant must send an order form with the prescription to the address listed on the mail-order service form and pay any required Deductible, Copayment and/or Coinsurance. The address of each mail order Pharmacy approved by the Plan is listed on the inside cover of this Plan Document.

Available Prescription Drug Products include Brand-Name Drugs and Generic Drugs. If a Generic Drug equivalent becomes available during the period of coverage for the Plan, it will be added to the Drug List maintained by and available to the Participant on the Claim Administrator's website and the Pharmacy Benefit Manager's website. Refer to the inside cover of this Plan Document for information on the Claim Administrator's Pharmacy Benefit Manager. The availability of a Generic Drug may allow the Participant to obtain a drug at a potentially lower out of pocket cost. The factors that determine the costs to a Participant include the terms of the coverage and the Drug List in effect as of the date of the prescription and the Pharmacy service date, as well as the use of a Participating Pharmacy or nonparticipating Pharmacy.

If drugs or Prescription Drug Products are purchased at a Participating Pharmacy, an extended supply Pharmacy or a mail order Pharmacy approved by the Claim Administrator, and the Participant presents the Participant's identification card at the time of purchase, the Participant must pay for the Prescription Drug Product and the

Participating Pharmacy will submit a claim for the Prescription Drug Product to the Plan's Pharmacy Benefit Manager. The cost of the covered drug or Prescription Drug Product will then accumulate to the Participant's Deductible and Out of Pocket Amount. Once the Deductible is met, the Participant will only be required to pay the appropriate Coinsurance if the amount can be determined by the Pharmacy at the time of purchase.

If the Participant uses a Participating Pharmacy to fill a prescription, but elects to submit the claim directly to the Claim Administrator's Pharmacy Benefit Manager, instead of having the Participating Pharmacy submit the claim, the Participant will be reimbursed for the prescription drug based on the amount that would have been paid to the Participating Pharmacy, less the Participant's Deductible, Copayment and/or Coinsurance.

If drugs or Prescription Drug Products are purchased at a nonparticipating Outpatient Pharmacy, the Participant must pay for the prescription at the time of dispensing and then file a prescription drug claim form with the Claim Administrator's Pharmacy Benefit Manager for reimbursement. The Participant will be reimbursed for the prescription drugs at the amount that would have been paid to a Participating Pharmacy, less the Participant's Deductible and Coinsurance.

Please refer to Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefits section of this Plan Document for additional information.

The Participant's Employer has chosen to participate in FlexAccess™ (FlexAccess) which lowers your out of pocket costs for select drugs by obtaining drug manufacturer assistance when available. Under this program, out of pocket costs for select drugs may be set to the maximum amount of the current design or be based on any available manufacturer-funded assistance. Drug manufacturers may provide financial support for some, or all, of your out of pocket costs for select drugs. The Participant may be required to pay an amount typically $0 - $35.00 for select drugs. Any amount paid through a drug manufacturer assistance program (e.g., manufacturer cost-share assistance, manufacturer discount plans, and/or manufacturer coupons) will not apply to the Participant's Deductible (if part of the Plan) or yearly Out of Pocket Amounts. The list of drugs covered under FlexAccess is subject to change. Please call the toll-free telephone number on the back of your Identification Card, or FlexAccess at 1-888-302-3618 to determine whether the Participant's drug is covered under this FlexAccess program. If the Participant is taking a qualifying drug, a FlexAccess representative will contact the Participant to participate in the FlexAccess program. The Participant is not required to participate in this FlexAccess program; however, if the Participant chooses to opt-out of the FlexAccess program, or if the Participant does not affirmatively enroll in any manufacturer's assistance, the Particpant will be responsible for up to 100% of the cost of the drug. Please note there is a difference between opting out of the FlexAccess program and being ineligible for the Flex Access program. Ineligibility may be due to a drug's exclusion from a drug manufacturer's assistance program, or if the Participant switches to a drug that has no assistance program available, or the Participant is taking a drug that is not on the FlexAccess Drug list. In the event the Participant is ineligible for the FlexAccess program, the Participant's cost for a select drug will be equal to the amount specified under this health care Plan.

Prescription Drug Products Subject to Prior Authorization, Step Therapy or Dispensing Limits

1. Prescription Drug Products subject to Prior Authorization require prior approval from the Plan's Pharmacy Benefit Manager before they can qualify for coverage under the Plan. If the Participant does not obtain Prior Authorization before a Prescription Drug Product is dispensed, the Participant may pay for the prescription and then pursue authorization of the drug from the Plan's Pharmacy Benefit Manager. If the authorization is approved by the Plan's Pharmacy Benefit Manager, the Participant should then submit a claim for the prescription drug on a prescription claim form to the Plan's Pharmacy Benefit Manager for reimbursement.
2. Prior Authorization does not guarantee payment of the Prescription Drug Product by the Plan. Even if the prescription drug has been approved through Prior Authorization, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date the drug is dispensed, or the Participant's Benefits may have changed as of the date the drug is dispensed.
3. The step therapy program requires that the Participant has a prescription history for a prerequisite medication before the Plan will cover a targeted drug. If the Participant and the Participant's provider decide that a prerequisite drug is not right for the Participant or is not as good in treating Participant's condition, the provider should submit a Prior Authorization request for coverage of the second-line drug.
4. A dispensing limit is a limitation on the number or amount of a Prescription Drug Product covered within a certain time period and quantity of covered medication per prescription. Dispensing limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, appropriate utilization, and to avoid misuse/abuse of the medication. A prescription written for a quantity in excess of the established limit will require a clinical review before Benefits are available.

Certain Prescription Drug Products, such as those used to treat rheumatoid arthritis, growth hormone deficiency, or hepatitis C, may be subject to Prior Authorization, step therapy, or dispensing limits. The Prescription Drug Products included in these programs are subject to change, and medications for other conditions may be added to the program.

If the Participant's provider is prescribing a Prescription Drug Product subject to Prior Authorization, step therapy, or dispensing limits, the provider should fax the request for Prior Authorization to the Claim Administrator's Pharmacy Benefit Manager at the fax number listed on the inside cover of this Plan Document. The Participant and provider will be notified of the Claim Administrator's Pharmacy Benefit Manager's determination. If the request is denied, the decisions may be appealed according to the appeals process provided with the denial determination.

In making determinations of coverage, the Claim Administrator's Pharmacy Benefit Manager may rely upon Pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in Montana, Pharmacy Benefit Manager evaluations, Medical Necessity, and Medical Policies. The Pharmacy policies and Medical Policies are located on the Claim Administrator website at www.bcbsmt.com.

To find out more about Prior Authorization/step therapy/dispensing limits or to determine which Prescription Drug Products are subject to Prior Authorization, step therapy or dispensing limits, the Participant or provider should refer to the Drug List which applies to the Participant's Plan at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists or www.myprime.com or call the Customer Service toll-free number identified on the Participant's identification card.

Specialty Medications

1. Specialty Medications are generally prescribed for individuals with complex medical conditions such as multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These medications also have one or more of the following characteristics:
   a. Injected or infused, but some may be taken by mouth.
   b. Unique storage or shipment requirements.
   c. Additional education and support required from a health care professional.
   d. Usually not stocked at retail Pharmacies.
2. For the highest level of Benefits, Specialty Medications must be acquired through the Plan's contracted Specialty Pharmacies listed on the inside cover of this Plan Document. A list of covered Specialty Medications may be found on the Plan website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. Registration and other applicable forms are also located on the website.
3. Coverage for Specialty Medications is limited to a 30-day supply. However, some Specialty Medications have FDA approved dosing regimens exceeding the 30-day supply limit and may be dispensed for more than a 30-day supply, if allowed by The Plan. Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

Preventive Health Care

Covered preventive services include, but are not limited to:

1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's (USPSTF) current recommendations (additional information is provided by accessing http://www.uspreventiveservicestaskforce.org); and
2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention (CDC); and
3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;

In addition to the screening services recommended under the HRSA Guidelines, the following services are included:

a. Lactation Services

Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. In addition, Benefits are provided for the purchase of manual or electric breast pumps or the rental of Hospital-grade pumps. The purchase of an electric breast pump is limited to one electric breast pump per Benefit Period.

b. Contraceptives

FDA approved contraceptive methods, including certain contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity; and

4. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to or after November 2009.
5. Current recommendations of the United States Preventive Service Task Force regarding obesity screening and counseling.

The preventive services listed above may change as USPSTF, CDC and HRSA guidelines are modified and any such changes will be implemented by the Claim Administrator in the quantities and at the times required by applicable law.

Examples of Preventive Health Care services as defined under federal law include, but are not limited to, colonoscopies, immunizations and vaccinations. Examples of other Preventive Health Care services include, but are not limited to, physical examinations. Any services (other than Diagnostic Breast Examinations) that are billed as a diagnostic service, will be covered under regular medical Benefits.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a nonparticipating Pharmacy, may be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximums.

A Copayment waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

For more detailed information on all covered services, contact Customer Service or access www.bcbsmt.com.

Prostheses

The appropriate devices used to replace a body part missing because of an Accident, Injury, or Illness.

When placement of a prosthesis is part of a surgical procedure, it will be paid under Surgical Services.

Payment for deluxe prosthetics will be based on the Allowable Fee for a standard prosthesis.

Replacement Prosthesis.

1. Replacement of a prosthesis will not be subject to any reduced replacement Coinsurance that may be applicable if the replacement is five (5) years of longer after the original purchase.
2. A prosthesis will not be considered a replacement if the original prosthesis no longer meets the medical needs of the Participant due to physical changes or a deteriorating medical condition.

The Plan will not pay for the following items:

1. Prostheses required primarily for use in athletic activities;
2. Replacement of lost or stolen prostheses;
3. Duplicate prosthetic devices purchased primarily for Participant convenience when the need is not medical in nature; or
4. Computer-assisted communication devices.

Radiation Therapy

The use of x-ray, radium, or radioactive isotopes ordered by the attending Physician and performed by a Covered Provider for the treatment of disease.

Rehabilitation – Facility and Professional

Rehabilitation Therapy and other covered services, as outlined in this Rehabilitation section, billed by a Rehabilitation Facility provider or a professional provider for services provided to a Participant.

The Plan will not pay when the primary reason for Rehabilitation is any one of the following:

1. Custodial Care;
2. Diagnostic admissions;
3. Maintenance, nonmedical self-help, or vocational educational therapy;
4. Social or cultural rehabilitation;
5. Learning and developmental disabilities; and
6. Visual, speech, or auditory disorders because of learning and developmental disabilities or psychoneurotic and psychotic conditions.

Benefits will not be provided under this Rehabilitation section for treatment of Substance Use Disorder or Mental Illness as defined in the Substance Use Disorder and Mental Health sections.

Benefits will be provided for services, supplies and other items that are within the scope of the rehabilitation Benefit described in this Rehabilitation section only as provided in and subject to the terms, conditions and limitations applicable to this Rehabilitation section and other applicable terms, conditions and limitations of this Plan Document. Other Benefit sections of this Plan Document, such as but not limited to Hospital Services, do not include Benefits for any services, supplies or items that are within the scope of the rehabilitation Benefit as outlined in this section.

Rehabilitation Facility Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations: Room and Board, which includes but is not limited to dietary and general, medical and rehabilitation nursing services.
2. Miscellaneous Rehabilitation Facility Services (whether or not such services are Rehabilitation Therapy or are general, medical or other services provided by the Rehabilitation Facility during the Participant's admission), including but not limited to:
    a. Rehabilitation Therapy services and supplies, including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy.
    b. Laboratory procedures.
    c. Diagnostic testing.
    d. Pulmonary services and supplies, including but not limited to oxygen and use of equipment for its administration.
    e. X-rays and other radiology.
    f. Intravenous injections and setups for intravenous solutions.
    g. Special diets when Medically Necessary.
    h. Operating room, recovery room.
    i. Anesthetic and surgical supplies.
    j. Drugs and medicines which:
        1. Are approved for use in humans by the FDA; and
        2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
        3. Require a Physician's written prescription.

        Drugs and medicines which are used in off-label situations may be reviewed for Medical Necessity.

3. Rehabilitation Facility Inpatient Care Services do not include services, supplies or items for any period during which the Participant is absent from the Rehabilitation Facility for purposes not related to rehabilitation, including but not limited to intervening inpatient admissions to an acute care Hospital.

Prior Authorization is required for Rehabilitation Facility Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Rehabilitation Facility Inpatient Care is subject to the following conditions:

1. The Participant will be responsible to the Rehabilitation Facility for payment of the Facility's charges if the Participant remains as an Inpatient Participant when Rehabilitation Facility Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed reserved for a Participant.
2. The term Rehabilitation Facility does not include:
    a. A Hospital when a Participant is admitted to a general medical, surgical or specialty floor or unit (other than a rehabilitation unit) for acute Hospital care, even though rehabilitation services are or may be provided as a part of acute care;
    b. A nursing home;
    c. A rest home;
    d. Hospice;
    e. A skilled nursing facility;
    f. A Convalescent Home;
    g. A place for care and treatment of Substance Use Disorder;
    h. A place for treatment of Mental Illness; and/or
    i. A long-term, chronic-care institution or facility providing the type of care listed above.

Rehabilitation Facility Inpatient Care Services Billed by a Professional Provider

All professional services provided by a Covered Provider who is a physiatrist or other Physician directing the Participant's Rehabilitation Therapy. Such professional services include care planning and review, patient visits and examinations, consultation with other Physicians, nurses or staff, and all other professional services provided with respect to the Participant. Professional services provided by other Covered Providers (i.e., who are not the Physician directing the Participant's Rehabilitation Therapy) are not included in the rehabilitation Benefit, but are included to the extent provided in and subject to the terms, conditions and limitations of other contract Benefits (e.g., Physician Medical Services).

Outpatient Rehabilitation

Rehabilitation Therapy provided on an Outpatient basis by a facility or professional provider.

Sigmoidoscopies (Medical)

One medical sigmoidoscopy, every five years for a Participant who is:

1. Age 45 or older; or
2. A Physician has ordered the sigmoidoscopy due to the Participant's family medical history.

This Benefit covers the first medical sigmoidoscopy during the timeframes shown above. Any additional sigmoidoscopies with a medical diagnosis will be covered under regular medical Benefits;

Under age 45, if the reason for the sigmoidoscopy is family history, the claim may initially deny. Medical records will be reviewed to determine family history.

The Schedule of Benefits describes payment limitations for these services.

Substance Use Disorder

Benefits for Substance Use Disorder will be paid as any other Illness.

Outpatient Services

Care and treatment for Substance Use Disorder when the Participant is not an Inpatient Participant and provided in or by:

1. A Hospital;
2. A Mental Health Treatment Center;
3. A Substance Use Disorder Treatment Center;
4. A Physician or prescribed by a Physician;
5. A licensed psychologist;
6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. A licensed psychiatrist; or
10. Other Qualified Health Care Provider.

Outpatient services are subject to the following conditions:

1. The services must be provided to diagnose and treat recognized Substance Use Disorder; and
2. The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Substance Use Disorder.

The Claim Administrator will not pay for hypnotherapy or for services given by a staff member of a school or halfway house.

Inpatient Care Services

Care and treatment of Substance Use Disorder, while the Participant is an Inpatient Participant, and which are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity services provided at a Residential Treatment Center are Benefits of the Plan.

Prior Authorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Partial Hospitalization

Care and treatment of Substance Use Disorder, while the Partial Hospitalization services are provided by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Prior Authorization is required for Partial Hospitalization services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Surgical Services

Surgical Services Billed by a Professional Provider

Services by a professional provider for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery. The charge for a surgical suite outside of the Hospital is included in the Allowable Fee for the surgery.

Surgical Services Billed by an Outpatient Surgical Facility or Freestanding Surgery Centers

Services of a surgical facility or a freestanding surgery center licensed, or certified for Medicare, by the state in which it is located and have an effective peer review program to ensure quality and appropriate patient care. The surgical

procedure performed in a surgical facility or a freestanding surgery center is recognized as a procedure which can be safely and effectively performed in an Outpatient setting.

The Plan will allow Benefits for a Recovery Care Bed when Medically Necessary and provided for less than 24 hours. Payment will not exceed the semiprivate room rate that would be billed for an inpatient stay.

Surgical Services Billed by a Hospital (Inpatient and Outpatient)

Services of a Hospital for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery.

Telehealth

Medically Necessary Telehealth services are covered when provided by a Covered Provider.

Temporomandibular Joint Dysfunction – Surgical Treatment

Services and supplies for surgical treatment of temporomandibular joint dysfunction.

Therapies - Outpatient

Services provided for Physical Therapy, Speech Therapy, cardiac therapy and Occupational Therapy, not including Rehabilitation Therapy.

Transplants

A heart, heart/lung, single lung, double lung, liver, pancreas, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplants to a Participant.

The Claim Administrator contracts with Blue Distinction Centers or Blue Distinction Centers+ for certain transplant services and highly recommends use of these centers because they have a proven record of delivering specialty care and results. Two levels of recognition allow the Participant and the Participant's Physician to pick the option that best meets their needs. Blue Distinction Centers offer quality care, treatment expertise and better overall patient results. Participants being considered for a transplant procedure are encouraged to contact the Claim Administrator's Customer Service to discuss the possible benefits of utilizing the Blue Distinction Centers or Blue Distinction Centers+.

Transplant services include:

1. Organ procurement including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ and transportation of the donor or donor organ to the location of the transplant operation.
2. Donor services including the pre-operative services, transplant related diagnostic lab and x-ray services, and the transplant surgery hospitalization. Transplant related services are covered for up to six Months after the transplant.
3. Hospital Inpatient Care services.
4. Surgical services.
5. Anesthesia.
6. Professional provider and diagnostic Outpatient services.
7. Licensed ambulance travel or commercial air travel for the Participant receiving the treatment to the nearest Hospital with appropriate facilities.

Payment by the Plan is subject to the following conditions:

1. When both the transplant recipient and donor are Participants, both will receive Benefits.
2. When the transplant recipient is a Participant and the donor is not, both will receive Benefits to the extent that benefits for the donor are not provided under other hospitalization coverage.
3. When the transplant recipient is not a Participant and the donor is, the donor will receive Benefits to the extent that benefits are not provided to the donor by hospitalization coverage of the recipient.

The Plan will not pay for:

1. Experimental/Investigational/Unproven procedures.
2. Transplants of a nonhuman organ or artificial organ implant.
3. Donor searches.

Transplant Travel includes:

Travel, meals and lodging expenses if associated with a covered transplant at a Center of Excellence located more than 50 miles from the Participant's residence. Eligible expenses must be incurred within 4 days of the procedures to discharge to home date.

The Schedule of Benefits describes payment limitations for these services.

Travel, Meals and Lodging

Travel, meals and lodging expenses if associated with a Medically Necessary referral by a Physician for services not available in Montana. Expenses in connection with an organ transplant are not eligible. The date of out-of-state treatment must be verified in writing by the Physician ordering the services.

The Schedule of Benefits describes payment limitations for these services.

Virtual Visits

Benefits for services provided by consultation with a licensed provider participating in the MDLIVE program through interactive video via an online portal or mobile application. Virtual Visits provide access to providers who can provide diagnosis and treatment of nonemergency medical and mental health conditions and Mental Illness in situations that may be handled without a traditional office visit, urgent care visit or emergency room care.

For an MDLIVE provider, call the telephone number listed on the inside cover of this Plan Document.

Well-Child Care

Well-child care provided by a Physician or a health care professional supervised by a Physician.

Benefits shall include coverage for:

1. Histories;
2. Physical examinations;
3. Developmental assessments;
4. Anticipatory guidance;
5. Laboratory tests;
6. Preventive immunizations.

EXCLUSIONS AND LIMITATIONS

All Benefits provided under this Plan are subject to the Exclusions and limitations in this section and as stated under the Benefit section. **The Plan will not pay for:**

1. All services, supplies, drugs and devices which are provided to treat any Illness or Injury arising out of employment when the Participant's Employer has elected or is required by law to obtain coverage for Illness or Injury under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This Exclusion applies to all services and supplies provided to treat such Illness or Injury even though:
    a. Coverage under the government legislation provides benefits for only a portion of the services incurred.
    b. The Employer has failed to obtain such coverage required by law.
    c. The Participant waives his or her rights to such coverage or benefits.
    d. The Participant fails to file a claim within the filing period allowed by law for such benefits.
    e. The Participant fails to comply with any other provision of the law to obtain such coverage or benefits.

f. The Participant was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

This Exclusion will not apply if the Participant is permitted by statute not to be covered and the Participant elects not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws.

This Exclusion will not apply if the Participant's employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws or employer's liability acts of any state, country, or the United States.

2. Services, supplies, drugs and devices which the Participant is entitled to receive or does receive TRICARE, the Veteran's Administration (VA), but not Medicaid. This Exclusion is not intended to exclude Covered Medical Expenses from coverage if a Participant is a resident of a Montana state institution when services are provided.

NOTE: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Participant. When such a circumstance occurs, the Participant will receive an Explanation of Benefits.

3. Services, supplies, and medications provided to treat any Injury to the extent the Participant receives or would be entitled to receive where liability is reasonably clear, benefits under an automobile insurance policy. Such benefits received by the Participant shall be used first to satisfy any remaining Coinsurance, Copayment and Deductible related to the Injury for which claims are submitted to the Plan. The Injury related claims must be submitted to the Plan to apply any applicable credit to Coinsurance, Copayment and/or Deductible.

4. Services, supplies, and medications provided to treat any Injury to the extent the Participant receives or would be entitled to receive where liability is reasonably clear, benefits from a premises liability policy. Examples of such policies are a homeowners or business liability policy. Such benefits received by the Participant shall be used first to satisfy any remaining Coinsurance, Copayment and Deductible related to the Injury for which claims are submitted to the Plan. The Injury related claims must be submitted to the Plan to apply any applicable credit to Coinsurance, Copayment and/or Deductible.

5. Services, supplies, drugs and devices to treat any Injury or Illness resulting from war, declared or undeclared, insurrection, rebellion, or armed invasion.

6. Any loss for which a contributing cause was the commission of a felony or serious illegal act, or an attempt to commit a felony or an attempt to commit a serious illegal act, for which the Participant has been found guilty in a court of competent jurisdiction or to which the Participant has plead guilty or no contest. This Exclusion does not apply to the extent the Participant suffers a loss as a victim of domestic violence.

7. Services for which a Participant is not legally required to pay or charges that are made only because Benefits are available on this Plan.

8. Services, supplies, drugs and devices provided to the Participant before the Participant's Effective Date or after the Participant's coverage terminates.

9. Nonsurgical treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction, anterior or internal dislocations, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances.

10. Orthodontics.

11. All dental services, including but not limited to ridge augmentation and vestibuloplasty, whether performed by Physicians, dentists, oral surgeons and/or any other provider, except for (i) services provided as the result of a Dental Accident; (ii) services provided as a result of or to treat either a congenital defect or a cancer; or (iii) services in connection with a transplant.

12. Vision services, including but not limited to prescription, fitting or provision of eyeglasses or contact lenses and Lasik Surgery, except that vision services may be covered for specific conditions in Medical Policy.

13. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging, or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

14. Hearing aids, except as otherwise provided under this Plan Document, and Medically Necessary cochlear implants may also be covered per Medical Policy.

15. Cosmetic services or complications resulting therefrom except when covered services are provided to correct a condition resulting from an Accident, a condition resulting from an Injury or to treat a congenital anomaly, as applicable in Medical Policy.

16. For travel by a Participant, except as specifically included in this Plan Document or travel by a provider.

17. Any related services to a non-covered service except for Routine Patient Costs for Participants in an Approved Clinical Trial. Related services are:

    a. Services in preparation for the non-covered service;
    b. Services in connection with providing the non-covered service;
    c. Hospitalization required to perform the non-covered service; or
    d. Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

18. Any service or procedure which is determined by the Claim Administrator to be an Inclusive Service/Procedure.

19. Any services, supplies, drugs and devices which are:

    a. Experimental/Investigational/Unproven services, except any services, supplies, drugs and devices considered to be Experimental/Investigational/Unproven and which are provided during a Phase I or II clinical trial, or the experimental or research arm of a Phase III clinical trial, except for services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial. This includes services, supplies, drugs and devices under study to determine the maximum tolerated dosage(s), toxicity, safety or efficacy as compared with standard treatment, or for the diagnosis of the condition in question. The Plan has the ultimate authority and right to determine what services are Experimental/Investigational/Unproven and are excluded from coverage.
    b. Not accepted standard medical practice. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice.
    c. Not a Covered Medical Expense.
    d. Not Medically Necessary.
    e. Not covered under applicable Medical Policy.

20. Private duty nursing.

21. Transplants of a nonhuman organ or artificial organ implant.

22. Reversal of an elective sterilization.

23. Services, supplies, drugs and devices related to infertility.

24. Services, supplies, drugs and devices related to in vitro fertilization.

25. Chiropractic services and supplies.

26. Routine foot care for Participants without co-morbidities, except Routine foot care is covered if a Participant has co-morbidities such as diabetes.

27. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot, except as specifically included in this Plan Document.

28. Services, supplies, drugs and devices related to treatment for psychological or psychogenic sexual dysfunctions.

29. Services, supplies, drugs and devices relating to any of the following treatments or related procedures:

    a. Acupuncture;
    b. Acupressure;
    c. Homeopathy;
    d. Hypnotherapy;
    e. Rolfing;
    f. Holistic medicine;

g. Religious counseling;
h. Self-help programs.

30. Services provided by a massage therapist.

31. Sanitarium care, Custodial Care, rest cures, or convalescent care to help the Participant with daily living tasks. No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, or extended care facility for the types of care outlined in this Exclusion. Examples include but are not limited to, help in:

a. Walking.
b. Getting in and out of bed.
c. Bathing.
d. Dressing.
e. Feeding.
f. Using the toilet.
g. Preparing special diets.
h. Supervision of medication which is usually self-administered and does not require the continuous attention of medical personnel.

No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, or extended care facility for the types of care outlined in this Exclusion.

32. Over-the-counter food supplements, formulas, and/or Medical Foods, regardless of how administered except when used for Inborn Errors of Metabolism, except to the extent as required by the Affordable Care Act.

33. Services, supplies, drugs and devices for the surgical treatment of any degree of obesity, whether provided for weight control or any medical condition.

34. Services, supplies, drugs and devices for weight reduction or weight control. This Exclusion does not include intensive behavioral dietary counseling when services are provided by a Physician, physician assistant or nurse practitioner.

35. Services, supplies, drugs and devices for obesity, weight reduction or control whether rendered for weight control or any other condition.

36. Charges associated with health clubs, weight loss clubs or clinics.

37. Services, supplies, drugs and devices for the treatment of Illness, Injury and/or complications resulting from services that are not Covered Medical Expenses, except for any services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial.

38. Tutoring services.

39. Any services, supplies, drugs and devices not provided in or by a Covered Provider.

40. Services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature.

41. Deluxe medical equipment including, but not limited to, durable medical equipment, prosthetics and communication devices except as included in the Durable Medical Equipment Benefit and the Prosthetic Benefit in the section entitled Benefits.

42. Services or supplies for:

a. Intersegmental traction;
b. All types of home traction devices and equipment;
c. Vertebral axial decompression sessions;
d. Surface Electromyography (EMG); the measurement of muscle electrical activity with electrodes placed on the skin over the muscle;
e. Spinal manipulation under anesthesia;
f. Muscle testing through computerized kinesiology machines;

g. Balance testing through computerized dynamic posturography sensory organization test.

43. Testing of:

a. Blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood;
b. Urine for measurement of collagen cross links;
c. Cervicovaginal fluid for amniotic fluid protein;

d. Allergen specific IgG measurement

44. Care, treatment or supplies provided outside of the United States if travel is for the sole purpose of obtaining medical services.

45. Applied Behavior Analysis (ABA) services, except as specifically included in this Plan Document under Autism Spectrum Disorders.

46. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

47. The Plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

48. Services, supplies, drugs and devices which are not listed as a Benefit as described in this Plan Document.

CLAIMS

How to Obtain Payment for Covered Expenses for Benefits

1. If a Participant obtains services from a Participating Provider, the Participating Provider will submit claims to the Claim Administrator for the Participant. If a Participant obtains services from a nonparticipating provider, the Participant may be required to submit all claims to the Plan. All claims for services must be submitted no later than 12 Months from the date of service. All claims must provide enough information about the services for the Claim Administrator to determine whether or not they are a Covered Medical Expense. Submission of such information is required before payment will be made.

Itemized bill must contain the following information:

- Employee's name;
- Employee Plan Identification Number from the ID card;
- Name of patient;
- Patient's date of birth;
- Employee's address;
- Provider name, address, telephone number;
- Provider number;
- Type of service;
- Procedure code for each service;
- Date of each service;
- Diagnosis;
- Charge for each service.

In certain instances, the Claim Administrator may require that additional documents or information including, but not limited to, Accident reports, medical records, and information about other insurance coverage, claims, payments and settlements, be submitted within the timeframe requested for the additional documentation before payment will be made.

2. If a Participant purchases drugs or Prescription Drug Products at a Participating Pharmacy, an Extended Supply Pharmacy or a mail order Pharmacy approved by the Plan, and the Participant's identification card is presented at the time of purchase, the Participant must pay for the Prescription Drug Product and the Participating Pharmacy will submit a claim for the cost of the covered prescription drug or Prescription Drug Product to the Plan's Pharmacy Benefit Manager. The Participant's responsibility for the cost of the covered drug or Prescription Drug Product will then accumulate to the Participant's In-Network Deductible and In-Network Out of Pocket Amount. Once the Deductible, if applicable, is met, the Participant will only be required to pay the appropriate Copayment and/or Coinsurance if the amount can be determined by the pharmacy at the time of purchase.

   If a Participant purchases drugs or Prescription Drug Products at a nonparticipating pharmacy, the Participant must pay for the prescription at the time of dispensing and then within one year of the date of purchase submit a claim for the prescription drug on a form to the Claim Administrator's Pharmacy Benefit Manager for reimbursement. The Participant's Deductible, Copayment and/or Coinsurance for the covered drug or Prescription Drug Product will then accumulate to the Out-of-Network Deductible and the Out-of-Network Out of Pocket Amounts.

   Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

3. Claims must be submitted to the address listed on the inside cover of this Plan Document, on the claim form. Contact the Customer Service number on the back of the Participant's identification card for information on how to submit a claim.

Out-of-State Services – Claims for Family Members Who Live Out of State and All Other Claims for Out-of-State Services

Family Members who live out-of-state or Participants who have health care services out-of-state should use Participating Blue Cross and Blue Shield Providers in that state. In most cases, providers will file claims directly with the Claim Administrator. Please refer to the BlueCard Program section. If the provider does not file the claim, the Participant should use the same procedures outlined in the section entitled Claims Information.

Prescription Drug Claims - Filling Prescriptions at a Retail Pharmacy

Outpatient prescription drugs are available through the Prime Therapeutics Prescription Drugs Benefit. Prime Therapeutics is the Pharmacy Benefit Manager.

1. Go to a Prime Therapeutics Participating Pharmacy or a Participating Pharmacy that accepts Participant identification cards. To find out if a Pharmacy takes part in the program, ask the pharmacist. To find a Prime Therapeutics Participating Pharmacy or a Participating Pharmacy nearest the Participant, check the list on the website www.bcbsmt.com or call the Pharmacy locator at the telephone number on the inside cover of this document.
2. Present the prescription and the Participant's identification card to the pharmacist.
3. Make sure that the pharmacist has complete and correct information about the Participant for whom the prescription is written, including sex and date of birth.
4. When the Participant receives a prescription, he or she should sign the Pharmacy log and pay his or her share of the cost.
5. If a Participant purchases prescription drugs from a Participating outpatient Pharmacy, an extended supply Pharmacy or mail-service Pharmacy approved by the Plan, the Participant must pay for the Prescription Drug Product and the Pharmacy will submit the prescription drug claims to the Pharmacy Benefit Manager.
6. For prescriptions filled at a Pharmacy that is not part of the network, the Participant will need to pay the pharmacist the entire cost of the prescription at the time the prescription is filled and dispensed and submit a paper claim to Prime Therapeutics for reimbursement. If a Participant does not present his or her identification card at a Participating Pharmacy, a paper claim must be submitted by the Participant to Pharmacy Benefit Manager for reimbursement. The Participant will be reimbursed at the contracted rate minus Coinsurance and Deductible, if applicable, in both situations. The Participant will not receive the preferred pricing.

Prime Therapeutics claim forms are available by calling the Claim Administrator at the telephone number on the inside cover of this document.

Mail-Service Pharmacy

The Participant may obtain maintenance prescriptions through the mail. Maintenance prescriptions are those that the Participant expects to continue using for an extended period of time and for which a prescription can be written for up to a 90-day supply. Coverage for costly prescriptions should be verified prior to ordering. Specific Benefits are outlined in the Prescription Drugs section in this document.

To obtain a mail service claim form, call the Claim Administrator at the telephone number on the inside cover of this document.

To order a prescription:

1. Complete all sections and sign the Mail-Service order form.
2. Enclose the following:
   a. The original prescription written for up to a 90-day supply;
   b. The Participant's current Pharmacy telephone number and prescription numbers to be transferred; and
   c. The Participant's telephone number.
3. Mail the form to the mail service Pharmacy at the address listed on the form.

COORDINATION OF BENEFITS WITH OTHER COVERAGE

The following Coordination of Benefits (COB) provisions apply when a Participant has health care coverage under more than one plan. "Plan" is defined below.

The order in which each plan will make payment for Covered Medical Expenses is governed by the order of benefit determination rules. The plan that pays first is called the primary plan. The primary plan must pay Covered Medical Expenses in accordance with its plan document terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce payment for Covered Medical Expenses so that payment by all plans does not exceed 100% of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

Plan

Any of the following that provide benefits, or services, for medical or dental care or treatment include:

1. Group and nongroup health insurance contracts;
2. Health Maintenance Organization (HMO) contracts;
3. Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured);
4. Medical care components of long-term care contracts, such as skilled nursing care; and
5. Medicare or any other federal governmental plan, as permitted by law.

The term plan does not include:

1. Hospital indemnity coverage or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified Accident coverage;
4. Limited benefit health coverage or excepted benefits;
5. School Accident type coverage;
6. Benefits for non-medical components of long-term care policies;
7. Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

Each contract of coverage or group health plan is a separate coverage plan.

This Plan

"This Plan" means the Plan represented by this Plan Document.

Order of Benefit Determination Rules

The rules that determine whether a plan is a primary plan or a secondary plan, when a covered person has health care coverage under more than one plan.

1. When a plan is primary, it determines payment for covered medical expenses first before those of any other plan without considering any other plan's benefits.
2. When a plan is secondary, it determines its benefits after those of another plan. A secondary plan may reduce payment for covered medical expenses so that payment by all plans does not exceed 100% of the total allowable expense.

Allowable Expense

A Covered Medical Expenses, including Deductibles, Copayment and/or Coinsurances, that is covered at least in part by any plan covering a covered person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering a covered person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an allowable expense, unless one of the plans provides coverage for private Hospital room expenses.
2. If a covered person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
3. If a covered person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
4. If a covered person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan

A plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent

The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a Participant is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan; and

2. Except as provided below, a plan that does not contain a COB provision that is consistent with applicable regulations is always primary unless the provisions of both plans state that the complying plan is primary.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits, and provides that this supplementary coverage, shall be excess to any other parts of the plan provided by the group. Examples of such situations include major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.

3. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

4. Each plan determines its order of benefits using the first of the following rules that apply:

   Non-Dependent or Dependent

   The plan that covers a person as an employee or retiree is the primary plan and the plan that covers the employee or retiree as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee or retiree is the secondary plan and the other plan is the primary plan.

   Dependent Child Covered Under More Than One Plan

   Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan, the order of benefits is determined as follows:

   1. **Dependent Child - Parents are married or are living together**

      a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      b. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

   2. **Dependent Child - Parents are divorced or separated or not living together**

      a. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
      b. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above shall determine the order of benefits;
      c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above shall determine the order of benefits; or
      d. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         1. The plan covering the custodial parent;
         2. The plan covering the Spouse of the custodial parent;
         3. The plan covering the non-custodial parent and then;
         4. The plan covering the Spouse of the non-custodial parent.

   3. **Dependent Child Covered Under More than One Plan of Individuals Who Are Not the Parents of the Child**

      The provisions of 1. or 2. above shall determine the order of benefits as if those individuals were the parents of the child.

   4. **Active Employee or Retired or Laid-off Employee**

      The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, (or a Dependent of such employee) is the primary plan. The plan covering that same person as a retired or

laid-off employee (or a Dependent of such employee) is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the section entitled Non-Dependent or Dependent can determine the order of benefits.

5. **COBRA or State Continuation Coverage**

   If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee or retiree or covering the person as a Dependent of an employee or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the section entitled Non-Dependent or Dependent can determine the order of benefits.

6. **Longer or Shorter Length of Coverage**

   The plan that covered the person as an employee or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of ‘plan’. In addition, This Plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Plan and other plans. The Claim Administrator may obtain the facts and information it needs from or provide such facts and information to other organizations or persons for the purpose of applying these COB rules and determining Benefits payable under this Plan and other plans covering the Participant claiming Benefits. The Claim Administrator need not inform, or get the consent of, any person to obtain such information. Each Participant claiming Benefits under this Plan must provide the Claim Administrator any facts it needs to apply those rules and determine Benefits payable.

Facility of Payment

A payment made by another plan may include an amount that should have been paid under This Plan. In such a case, the Claim Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means the reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, the Claim Administrator may recover the excess from one or more of the Participants it has paid or for whom it has paid; or any other person or organization that may be responsible for the Benefits or services provided for the Participant. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

Coordination with Medicare

This Plan will coordinate Benefits with Medicare according to the federal Medicare secondary payor laws and regulations ("MSP rules"). This means that This Plan and/or Medicare may adjust payment so that the combined payments by This Plan and Medicare will be no more than the charge for the Benefits received by the Participant. This Plan will never pay more than it would pay if the Participant was not covered by Medicare. The general rules for coordination with Medicare are as follows:

1. For Working Aged

   Medicare pays secondary to a plan sponsored by employers with 20 or more employees, for covered persons who qualify for age-based Medicare as a result of attaining age 65 and older and who are covered by virtue of the covered person's current employment status.

   Medicare will be the primary for a covered person that refuses coverage under the plan.

   Medicare will pay primary to the plan for the working aged individuals covered by employers with fewer than 20 employees, including a multi-employer association if the covered person is covered by an employer within the multi-employer association with fewer than 20 employees.

2. For Disabled Participants under Age 65

   Medicare pays secondary to a plan covering individuals under age 65, covered by employers with 100 or more employees, who qualify for disability-based Medicare and are covered by virtue of a covered person's current employment status.

   Medicare pays primary to a plan for disabled individuals under age 65 covered by employers with fewer than 100 employees.

3. For End-Stage Renal Disease

   Medicare pays secondary to a plan covering individuals who qualify for Medicare as a result of end-stage renal disease ("ESRD"), regardless of employer size, for the first 30 months that a particular covered person qualifies for Medicare as a result of ESRD. After the 30-month period, Medicare will pay primary to the plan.

   Special Coordination of Benefits rules apply if a covered person is entitled to Medicare based on ESRD and Medicare based on either age or disability:

   a. If a plan is required to pay before Medicare under 1 or 2 above for an individual before the individual qualifies for Medicare based on ESRD, the plan will continue to pay primary to Medicare after the individual becomes covered under Medicare based on ESRD but only for the 30-month period above, after which Medicare will pay primary to the plan.
   b. If a plan is required to pay primary to Medicare based on ESRD and an individual that qualifies for Medicare based on ESRD above later becomes entitled to age-based or disability-based Medicare during the 30-month period, Medicare will pay secondary to the plan for the duration of the 30-month period, after which Medicare will pay primary to the plan. If the individual qualifies for age-based or disability-based Medicare after the 30-month period, Medicare will pay primary to the plan.
   c. Medicare continues to be primary to a plan after an aged or disabled individual becomes eligible for Medicare based on ESRD if:

      1. The individual is already entitled to Medicare on the basis of age or disability when the individual becomes eligible for Medicare based on ESRD; and
      2. The employer has fewer than 20 employees in the case of age-based Medicare or fewer than 100 employees in the case of disability-based Medicare.

4. For Retired Persons

   Medicare is primary to a plan if an individual is a Medicare-qualified individual age 65 and over and retired.

   Medicare is primary to a plan for an individual's spouse who is also a plan participant and who is a Medicare-qualified individual if both the covered person and the covered person's spouse are age 65 and over and retired.

5. Current Employment Status

   Under the MSP rules, a covered person has current employment status if the covered person is:

   a. Actively working as an employee; or
   b. Not actively working but is receiving disability benefits from an employer but only for a period of up to 6 months; or
   c. Not actively working but retains employment rights in the industry (including but not limited to a covered person who is temporarily laid off or on sick leave, who is a teacher or other seasonal worker), has not been terminated by an employer, is not receiving disability benefits from an employer for more than 6 months, is not receiving Social Security disability benefits and has group health coverage under a plan that is not COBRA coverage.

Other Insurance

If a property or casualty insurer pays for services provided to the Participant and coordination of benefits is not applicable, This Plan will credit the Participant's Deductible, Copayment or Coinsurance, as applicable, if the Participant notifies This Plan of the payment, within 12 months of the date of service.

TERMINATION OF COVERAGE

Coverage under the Plan will terminate under the following circumstances:

1. Termination When the Participant is No Longer Eligible for Coverage

   The Participant's and enrolled Family Members' participation in the Plan will terminate the last day of the Month in which the Participant becomes ineligible for coverage, including termination of employment.

2. Termination for Nonpayment of Premium

   If the Participant's premiums are not paid when due, coverage will terminate automatically for the eligible Participant and enrolled Family Members on the last day of the Month in which premiums were paid.

3. Termination of Coverage of Children and Spouse.

   Coverage will terminate automatically at midnight, Mountain Time, on the last day of the Month in which a child reaches age 26. Coverage for a spouse will terminate at midnight, Mountain Time, on the last day of the Month in which the spouse's marriage to the Employee is terminated.

Termination of Benefits on Termination of Coverage

When the participation of an eligible Employee and/or Family Members is terminated for any reason listed in this section or any other section of this Plan, the Benefits of this Plan will no longer be provided, and the Plan will not make payment for services provided to the Employee and/or Family Members after the date on which cancellation becomes effective.

Certificate of Creditable Coverage

Even though this health plan does not have a preexisting condition exclusion period, the Claim Administrator will issue a Certificate of Creditable Coverage to the Participant, upon request, following termination of coverage.

CONTINUATION OF COVERAGE

COBRA

Certain employers maintaining group health coverage plans (whether insured or self-insured) must provide COBRA continuation coverage for qualified beneficiaries when group health coverage is lost. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985

(COBRA). To lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before a qualifying event. A loss of coverage need not occur immediately after a qualifying event so long as the loss of coverage occurs before the end of the maximum COBRA coverage period. A qualified beneficiary is entitled to the coverage made available to similarly situated employees.

COBRA requires qualified beneficiaries or a representative acting on behalf of a qualified beneficiary to provide certain notices to the Plan Administrator (generally the employer) and requires the Plan Administrator to provide certain notices to qualified beneficiaries. The Plan Administrator is also the COBRA Administrator unless the Plan Administrator has designated another individual or entity to administer COBRA.

1. Small Employer Exception

Small employer plans are generally exempt from the COBRA regulations. A small employer plan, for the purposes of COBRA, is defined as an employer plan that normally employed fewer than 20 employees, including part-time employees, during the preceding calendar year. A group health plan that is a multi-employer plan (as defined in Internal Revenue Code (IRC)) is a small-employer plan if each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. Whether the plan is a multi-employer plan or not, the term employer includes all members of a controlled group.

A small employer employs fewer than 20 employees during a calendar year if it had fewer than 20 employees on at least 50 percent of its typical business days during that year. Only common-law employees are counted for purposes of the small employer exception; self-employed individuals, independent contractors (and their employees and independent contractors), and corporate directors are not counted.

2. Qualified Beneficiaries

Continuation of coverage is available to qualified beneficiaries. A qualified beneficiary is:

a. Any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the Spouse of a covered employee, or the Dependent child of a covered employee; or
b. Any child born to or placed for adoption with a covered employee during a period of COBRA continuation.

Individuals added to a qualified beneficiary's COBRA coverage (e.g., a new Spouse or person added as the result of a Special Enrollment event, etc.) do not become qualified beneficiaries in their own right, with the exception of 2(b) above.

Nonresidents - An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of IRC section 911(d)(2)) that constituted income from sources within the United States (within the meaning of IRC section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

3. Qualifying Events

A qualifying event is any of a set of specified events that occur while a group health plan is subject to COBRA and which causes a qualified beneficiary to lose coverage under the plan.

a. Employee

An employee will become a qualified beneficiary if the employee loses coverage under the plan because either one of the following qualifying events happen:

1. Employee’s hours of employment are reduced; or
2. Employment ends for any reason other than gross misconduct.

b. Spouse

The Spouse of an employee will become a qualified beneficiary if the Spouse loses coverage under the plan because any of the following qualifying events happen:

1. The employee dies;
2. The employee’s hours of employment are reduced;
3. The employee’s employment ends for any reason other than gross misconduct;
4. The employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or

5. Divorce or legal separation from the employee.

c. Dependent Children

Dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happen:

1. The employee dies;
2. The employee's hours of employment are reduced;
3. The employee's employment ends for any reason other than gross misconduct;
4. The employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The employee becomes divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "Dependent child."

d. Retirees

If the plan provides retiree health coverage, a proceeding in bankruptcy under Title 11 of the United States Code can sometimes 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 for any retired employee covered under the plan, the covered retiree will become a qualified beneficiary with respect to the bankruptcy. The covered retiree's covered Spouse or surviving Spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

4. Period of Coverage

a. A qualified beneficiary may continue coverage for up to 18 months when the employee loses coverage under the plan due to one of the following qualifying events:

1. A reduction in work hours; or
2. Voluntary or involuntary termination of employment for reasons other than gross misconduct.

b. A qualified beneficiary may continue coverage for up to 36 months when the qualified beneficiary loses coverage under the plan due to one of the following qualifying events:

1. The employee's death;
2. Divorce or legal separation from the employee;
3. The covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or
4. A covered Dependent child ceases to be a Dependent child of the covered employee under the terms of the group health plan.

c. Bankruptcy

If the employer files Chapter 11 bankruptcy which results in loss of coverage (or substantial elimination of coverage within one year before or after bankruptcy is filed), a qualified beneficiary may continue coverage up to the following applicable periods:

1. Covered retiree: The maximum duration of the COBRA coverage is the lifetime of the retired covered employee.
2. Covered Spouse, surviving Spouse, or Dependent child of covered retiree: The maximum duration of the COBRA coverage ends the earlier of:

a. The date of death (of the Spouse, surviving Spouse or Dependent child); or
b. 36 months after the death of the covered retiree.

5. Providing Notice of Qualifying Events

a. Responsibilities of Qualified Beneficiaries

1. General Notice Requirements

The qualified beneficiary or a representative of the qualified beneficiary must notify the administrator of the qualifying events listed below within 60 days after the latest of (1) the qualifying event; (2) the loss of coverage, or (3) the date that the qualified beneficiary receives information concerning COBRA coverage in a General Notice.

a. Divorce or legal separation;
b. Covered Dependent child ceases to be a Dependent child of a covered employee under terms of the plan; or
c. A second qualifying event. (See 5(a)(2)).

Notification of a qualifying event must be timely mailed to the Plan Administrator (generally the Participant's employer), or to the entity identified as the COBRA Administrator in the General COBRA Notice provided to the Participant upon enrollment or when the Participant's coverage is terminated. **Important Information: If notices are not received within the timeframes specified below, the qualified beneficiary will not be provided COBRA coverage.**

A single notice sent by or on behalf of the covered employee or any one of the qualified beneficiaries affected by the qualifying event satisfies the notice requirement for all qualified beneficiaries.

The following information should be included:

a. Name of covered employee;
b. Subscriber identification number;
c. Employee and qualified beneficiary names, address and telephone number (also note any different addresses for other qualified beneficiaries);
d. Employer/former employer;
e. Whether the event is a qualifying event, disability, or second qualifying event; and
f. Date of qualifying event.

Certain COBRA qualifying events have additional notice requirements which are explained in more detail below.

2. Second Qualifying Event

The qualified beneficiary or a representative of the qualified beneficiary must notify the administrator within 60 days of a second qualifying event. **Important Information: If notice is not received within the timeframes specified below, an extension of COBRA coverage will not be provided to the qualified beneficiary.**

The initial 18-month COBRA coverage period may be extended for an additional 18 months (for a total of 36 months) for Spouses and Dependents who initially elected COBRA coverage if:

a. The first qualifying event is the employee's termination of employment or reduction in hours;
b. The second qualifying event occurs during the initial 18-month COBRA coverage period;
c. The second qualifying event has a 36-month maximum coverage period (see Period of Coverage (4)(b)); and
d. The second qualifying event is one that would have caused loss of coverage in the absence of the first qualifying event.

If COBRA coverage was previously extended from 18 months to 29 months due to a Medicare disability determination, the maximum COBRA coverage period under a second qualifying event will be 36 months.

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the Spouse and Dependent children will end 36 months from the date the employee became entitled to

Medicare as a result of turning 65 (but the covered employee's maximum coverage period will be 18 months).

3. Disability Extension

A qualified beneficiary may be entitled to a disability extension of up to 11 additional months. If a qualified beneficiary is entitled to the extension, which shall not extend the total period of continuation coverage beyond 29 months, the extension applies to each qualified beneficiary who is not disabled, as well as to the disabled beneficiary, and it applies independently with respect to each of the qualified beneficiaries.

To qualify for a disability extension, the following requirements must be met:

a. The qualifying event must be a termination or reduction of hours of a covered employee's employment; and
b. The qualified beneficiary must have been determined under Title II or XVI of the Social Security Act (SSA) to be disabled at any time during the first 60 days of the COBRA continuation coverage.

Individuals who have been determined by SSA to be disabled prior to the occurrence of a qualifying event and the disability continues to exist at the time of the qualifying event, qualified beneficiaries are considered to meet the statutory requirements of being disabled within the first 60 days of COBRA coverage.

In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption.

The qualified beneficiary must provide a disability notice before the end of the first 18 months of coverage.

The qualified beneficiary or a representative of the qualified beneficiary must also provide notice to the administrator within 30 days after the date of any final determination under the SSA that the qualified beneficiary is no longer disabled. Coverage will be terminated the later of (1) the first day of the month that is more than 30 days after a final determination by SSA that the individual is no longer disabled; or (2) the end of the COBRA period that applies without regard to the disability extension.

b. Responsibilities of Plan Administrator

The Plan Administrator must notify the party responsible for administering COBRA within 30 days of the following events.

1. The employee's death;
2. The employee's termination (other than for gross misconduct);
3. Reduction in work hours of employment;
4. A proceeding in bankruptcy with respect to an employer from whose employment a covered employee retires; and
5. The covered employee becomes entitled to Medicare.

c. Responsibilities of the COBRA Administrator

The COBRA administrator must notify qualified beneficiaries of their right to COBRA coverage within 14 days after receiving notice of a qualifying event by providing qualified beneficiaries with a COBRA Election form.

If the Plan Administrator is the COBRA administrator, the Plan Administrator must notify qualified beneficiaries of their right to COBRA coverage within 44 days after receiving notice of a qualifying event.

6. Election of COBRA Coverage - Notice Requirements

After a qualified beneficiary or COBRA administrator has provided notice of a qualifying event, the qualified beneficiary will receive a COBRA Election form.

Each qualified beneficiary has an independent right to elect COBRA coverage. The qualified beneficiary or a representative of the qualified beneficiary must return the COBRA Election form to the administrator within 60 days from the date on the COBRA Election form. **Important Information: If the COBRA Election form is not**

returned within the 60-day timeframe, COBRA coverage will not be provided to any qualified beneficiaries.

7. Trade Adjustment Assistance Eligible Employees

Employees who lost coverage as the result of a termination or a reduction of hours and who qualify for "Trade Adjustment Assistance" ("TAA") under the Trade Act of 1974, as amended, are entitled to a second opportunity to elect COBRA coverage, if such coverage was not elected within the first 60 days after coverage is lost.

The second COBRA election period provisions are effective for individuals with respect to whom petitions for certification for trade adjustment assistance are filed on or after November 4, 2002. The second election period begins on the first day the employee began receiving TAA (or would have become eligible to begin receiving TAA but for exhaustion of unemployment compensation), but only if made within 6 months after group health coverage is lost. Notice must be provided in accordance with "Responsibility of Qualified Beneficiary" above.

This coverage may continue for 18 months from the date COBRA coverage begins. When the employee elects coverage, the election can include coverage for previously covered Dependents. Dependents are not qualified beneficiaries in their own right under this provision and therefore do not have an independent election.

8. Payment of Premium

The first premium payment must be made within 45 days of the date of the election of COBRA continuation coverage and must include payments retroactive to the date coverage would normally have terminated under this plan.

Subsequent payments must be made within 30 days after the first day of each coverage period. Payment is considered to be made on the date payment is sent to the employer or COBRA administrator. If the premium is not paid by the first day of the coverage period, a grace period of 30 days will be allowed for payment. The Participant may instead request to be billed for continuation coverage for the following coverage periods: quarterly, semi-annually or annually.

9. Termination of Continued Coverage

- **a.** Coverage terminates the last day of the maximum required period under COBRA;
- **b.** Any of the following events will result in termination of coverage prior to expiration of the 18-Month, 29-Month, or 36-Month period:
  1. The first day on which timely payment is not made with respect to the qualified beneficiary;
  2. The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;
  3. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes covered under any other group health plan; or
  4. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

10. Questions Concerning COBRA Coverage

For any questions concerning COBRA coverage, contact the Claim Administrator at 1-855-258-3489.

11. Provide Notice of Address Changes

In order to protect all COBRA rights, Participants must notify the administrator of the COBRA coverage and the Claim Administrator of any changes to the Participant's or Family Member's addresses. A Participant should also keep a copy of any notices for personal records.

COMPLAINTS AND GRIEVANCES

Complaints and Grievances

The Plan has established a Complaint and Grievance process. A complaint involves a communication from the Participant expressing dissatisfaction about the Plan's services or lack of action or disagreement with the Plan's

response. A grievance will typically involve a complaint about a provider or a provider's office and may include complaints about a provider's lack of availability or quality of care or services received from a provider's staff.

Most problems can be handled by calling Customer Service at the number appearing on the inside cover of this Plan Document. The Participant may also file a written complaint or grievance with the Claim Administrator. The fax number, email address, and mailing address of the Claim Administrator appears on the inside cover of this Plan Document. Written complaints or grievances will be acknowledged within 10 days of receipt. The Participant will be notified of the Claim Administrator's response within 60 days from receipt of the Participant's written complaint or grievance.

APPEALS

Claims Procedures

Types of Claims

Claims are classified by type of claim and the timeline in which a decision must be decided and a notice provided depends on the type of claim involved. The initial Benefit claim determination notice will be included in the Participant's Explanation of Benefits (EOB) or in a letter from the Claim Administrator, whether adverse or not. There are five types of claims:

1. **Pre-Service Claims**

   A pre-service claim is any claim for a Benefit that, under the terms of this Plan Document, requires authorization or approval from the Claim Administrator or the Claim Administrator's subcontracted administrator prior to receiving the Benefit.

2. **Urgent Care Claims**

   An Urgent Care claim is any pre-service claim where a delay in the review and adjudication of the claim could seriously jeopardize the Participant's life or health or ability to regain maximum function or subject the Participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

3. **Post-Service Claims**

   A post-service claim is any claim for payment filed after a Benefit has been received and any other claim that is not a pre-service claim.

4. **Rescission Claims**

   A rescission of coverage is considered a special type of claim. A rescission is defined as any cancellation or discontinuation of coverage that has a retroactive effect and is based upon the Participant's fraud or an intentional misrepresentation of a material fact. A cancellation or discontinuance of coverage that has a retroactive effect is not a rescission if and to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage or to routine changes, such as eligibility updates. A cancellation or discontinuance with a prospective effect only is not a rescission.

5. **Concurrent Care Claim**

   A Concurrent Care decision represents a decision of the Claim Administrator approving an ongoing course of medical treatment for the Participant to be provided over a period of time or for a specific number of treatments. A Concurrent Care claim is any claim that relates to the ongoing course of medical or emergency treatment (and the basis of the approved Concurrent Care decision), such as a request by the Participant for an extension of the number of treatments or the termination by the Claim Administrator of the previously approved time period for medical treatment.

Initial Claim Determination by Type of Claim

1. Pre-Service Claim Determination and Notice

a. Notice of Determination

Upon receipt of a pre-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial determination, but no later than 15 days after receiving the claim.

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

The Claim Administrator may extend the 15-day time period for an additional 15 days for reasons beyond the Claim Administrator's control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which the Claim Administrator expects to render a decision.

2. For receipt of information from the Participant to decide the claim

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the Participant will be given 45 days from receipt of the notice within which to provide the specified information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

c. Notice of Improperly Submitted Claim

If a pre-service claim request was not properly submitted, the Claim Administrator will notify the Participant of the improper submission as soon as practicable, but no later than 5 days after the Claim Administrator's receipt of the claim and will advise the Participant of the proper procedures to be followed for filing a pre-service claim.

2. Urgent Care Claim Determination and Notice

a. Designation of Claim

Upon receipt of a pre-service claim, the Claim Administrator will make a determination if the claim involves Urgent Care. If a Physician with knowledge of the Participant's medical condition determines the claim involves Urgent Care, the Claim Administrator will treat the claim as an Urgent Care claim.

b. Notice of Determination

If the claim is treated as an Urgent Care claim, the Claim Administrator will provide the Participant with notice of the determination, either verbally or in writing, as soon as possible consistent with the Participant's medical exigencies but no later than 72 hours from the Claim Administrator's receipt of the claim. If verbal notice is provided, the Claim Administrator will provide a written notice within 3 days after the date the Claim Administrator notified the Participant.

c. Notice of Incomplete or Improperly Submitted Claim

If an Urgent Care claim is incomplete or was not properly submitted, the Claim Administrator will notify the Participant about the incomplete or improper submission no later than 24 hours from the Claim Administrator's receipt of the claim. The Participant will have at least 48 hours to provide the necessary information. The Claim Administrator will notify the Participant of the initial claim determination no later than 48 hours after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

3. Post-Service Claim Determination and Notice

a. Notice of Determination

In response to a post-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial **determination, but no later than 30 days after receiving the claim.**

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

The Claim Administrator may extend the 30-day timeframe for an additional 15-day period for reasons beyond the Claim Administrator's control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which the Claim Administrator expects to render a decision in such case.

2. For receipt of information from the Participant to decide the claim

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed. The Participant will be given 45 days from receipt of the notice to provide the information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator receives the specific information requested, or the due date for the information.

4. Concurrent Care Determination and Time Frame for Decision and Notice

a. Request for Extension of Previously Approved Time Period or Number of Treatments

1. In response to the Participant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Participant's claim involves Urgent Care, the Claim Administrator will review the claim and notify the Participant of its determination no later than 24 hours from the date the Claim Administrator received the Participant's claim, provided the Participant's claim was filed at least 24 hours prior to the end of the approved time period or number of treatments.

2. If the Participant's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Participant's claim will be treated as and decided within the timeframes for an Urgent Care claim as described in the section entitled, "Initial Claim Determination by Type of Claim."

3. If the Participant's claim did not involve Urgent Care, the time periods for deciding pre-service claims or post-service claims, as applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

Other than through a Plan amendment or termination, the Claim Administrator may not subsequently reduce or terminate an ongoing course of treatment for which the Participant has received prior approval unless the Claim Administrator provides the Participant with written notice of the reduction or termination and the scheduled date of its occurrence sufficiently in advance to allow the Participant to appeal the determination and obtain a decision before the reduction or termination occurs.

5. Rescission of Coverage Determination and Notice of Intent to Rescind

If the Claim Administrator makes a decision to rescind the Participant's coverage due to a fraud or an intentional misrepresentation of a material fact, the Claim Administrator will provide the Participant with a Notice of Intent to Rescind at least thirty (30) days prior to rescinding coverage. The Notice of Intent to Rescind will include the following information:

a. The specific reason(s) for the rescission that show the fraud or intentional misrepresentation of a material fact;

b. The date when the notice period ends and the date to which coverage is to be retroactively rescinded;

c. A statement that the Participant will have the right to appeal any final decision of the Claim Administrator to rescind coverage prior to or after the thirty (30) day period, and a description of the Claim Administrator's appeal procedures;

d. A reference to the Plan provision(s) on which the rescission is based; and/or

e. A statement that the Participant is entitled to receive upon request and free of charge reasonable access to, and copies of all documents and records and other information relevant to the rescission.

Notice of an Adverse Benefit Determination

An "adverse benefit determination" is defined as a rescission or a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Benefit. If the Claim Administrator's determination constitutes an adverse benefit determination, the notice to the Participant will include:

1. Information sufficient to identify the Benefit or claim involved, including, if applicable, the date of service, the health care provider, and the claim amount;
2. The reason(s) for the adverse benefit determination. If the adverse benefit determination is a rescission, the notice will include the basis for the fraud and/or intentional misrepresentation of a material fact;
3. A reference to the applicable Plan Document provision(s), including identification of any standard relied upon in the Plan to deny the claim (such as a Medical Necessity standard), on which the adverse benefit determination is based;
4. A description of the Claim Administrator's internal appeal and external review procedures (and for Urgent Care claims only, a description of the expedited review process applicable to such claims), a description of and contact information for any consumer appeal assistance program and, if applicable, a statement of the Participant's right to file a civil action under Section 502(a) of ERISA;
5. If applicable, a description of any additional information necessary to complete the claim and why the information is necessary;
6. If applicable, a statement that any internal Medical Policy or guideline or other medical information relied upon in making the adverse benefit determination, and an explanation for the same, will be provided, upon request and free of charge;
7. If applicable, a statement that an explanation for any adverse benefit determination that is based on an experimental treatment or similar Exclusion or limitation or a Medical Necessity standard will be provided, upon request and free of charge;
8. If applicable, a statement that diagnosis and treatment codes will be provided, and their corresponding meanings, upon request and free of charge; and
9. A statement that reasonable access to and copies of all documents and records and other information relevant to the adverse benefit determination will be provided, upon request and free of charge.

How to File an Internal Appeal of an Adverse Benefit Determination

1. Time for Filing an Internal Appeal of an Adverse Benefit Determination

If the Participant disagrees with an adverse benefit determination (including a rescission), the Participant may appeal the determination within 180 days from receipt of the adverse benefit determination. With the exception of Urgent Care claims, the Participant's appeal may be made verbally or in writing, should list the reasons why the Participant does not agree with the adverse benefit determination, and must be sent to the address or fax number listed for appeals on the inside cover of this Plan Document. If the Participant is appealing an Urgent Care claim, the Participant may appeal the claim verbally by calling the telephone number listed for Urgent Care appeals on the inside cover of this Plan Document.

2. Authorized Representative

The Participant may name another individual to act on the Participant's behalf for purposes of an appeal or review of an adverse benefit determination, by filing a written designation with the Claim Administrator. Contact the Claim Administrator at the number listed on the inside cover of this Plan Document for information on how to designate an authorized representative.

3. Access to Plan Documents

The Participant may, at any time during the filing period, receive reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination upon request and free of charge. Documents may be viewed at the Claim Administrator's office, at 3645 Alice Street, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m. Mountain Time, Monday through Friday, excluding holidays. The Participant may also request that the Claim Administrator mail copies of all documentation to the Participant free of charge.

4. Submission of Information and Documents

The Participant may present written evidence and written testimony, including any new or additional records, documents or other information that are relevant to the claim for consideration by the Claim Administrator until a final determination of the Participant's appeal has been made.

5. Consideration of Comments

The review of the claim on appeal will take into account all evidence, written testimony, new and additional records, documents, or other information the Participant submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial adverse benefit determination.

If the Claim Administrator considers, relies on or generates new or additional evidence in connection with its review of the Participant's claim, the Claim Administrator will provide the Participant with the new or additional evidence free of charge as soon as possible and with sufficient time to respond before a final determination is required to be provided by the Claim Administrator. If the Claim Administrator relies on a new or additional rationale in denying the Participant's claim on review, the Claim Administrator will provide the Participant with the new or additional rationale as soon as possible and with sufficient time to respond before a final determination is required to be provided by the Claim Administrator.

6. Scope of Review

The person who reviews and decides the Participant's appeal will be a different individual than the person who decided the initial adverse benefit determination. The review on appeal will not give deference to the initial adverse benefit determination and will be made anew. The Claim Administrator will not make any decision regarding hiring, compensation, termination, promotion or other similar matters with respect to the individual selected to conduct the review on appeal based upon how the individual will decide the appeal.

7. Consultation with Medical Professionals

If the claim is, in whole or in part, based on medical judgment, the Claim Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not have been involved in the initial adverse benefit determination. The Participant may request information regarding the identity of any health care professional whose advice was obtained during the review of the Participant's claim.

Time Period for Notifying Participant of Final Internal Adverse Benefit Determination

The time period for deciding an appeal of an adverse benefit determination and notifying the Participant of the final internal adverse benefit determination depends upon the type of claim. The chart below provides the time period in which the Claim Administrator will notify the Participant of its final internal adverse benefit determination for each type of claim.

Type of Claim on Appeal	**Time Period for Notification of Final Internal Adverse Benefit Determination**
Urgent Care Claim	No later than 72 hours from the date the Claim Administrator received the Participant's appeal, taking into account the medical exigency.
Pre-Service Claim	No later than 30 days from the date the Claim Administrator received the Participant's appeal.
Post-Service Claim	No later than 60 days from the date the Claim Administrator received the Participant's appeal.
Concurrent Care Claim	• If the Participant's claim involved Urgent Care, no later than 72 hours from the date the Claim Administrator received the Participant's appeal, taking into account the medical exigency. • If the Participant's claim did not involve Urgent Care, the time period for deciding a pre-service (non-Urgent Care) claim or a post-service claim, as applicable, will govern.
Rescission Claim	No later than 60 days from the date the Claim Administrator received the Participant's appeal.

Content of Notice of Final Internal Adverse Benefit Determination

If the decision on appeal upholds, in whole or in part, the initial adverse benefit determination, the final internal adverse benefit determination notice will include the following information:

1. Information sufficient to identify the claim involved in the appeal, including, as applicable, the date of service, the health care provider, and the claim amount;
2. The title and qualifying credentials of each health care professional participating in the appeal;
3. A statement from each health care professional participating in the appeal of their understanding of the basis for the Participant's appeal;
4. The specific reason(s) for the final internal adverse benefit determination, including a discussion of the decision. If the final internal adverse benefit determination upholds a rescission, the notice will include the basis for the fraud or intentional misrepresentation of a material fact;
5. A reference to the applicable Plan Document provision(s), including identification of any standard relied upon in the Plan Document to deny the claim (such as a Medical Necessity standard), on which the final internal adverse benefit determination is based;
6. If applicable, a statement describing the Participant's right to request an external review and the time limits for requesting an external review;
7. If applicable, a statement that any internal Medical Policy or guideline or medical information relied on in making the final internal adverse benefit determination will be provided, upon request and free of charge;
8. If applicable, an explanation of the scientific or clinical judgment for any final internal adverse benefit determination that is based on a Medical Necessity or an experimental treatment or similar Exclusion or limitation as applied to the Participant's medical circumstances;
9. If applicable, a statement that diagnosis and treatment codes will be provided, with their corresponding meanings, upon request and free of charge;
10. A description of and contact information for any consumer appeal assistance program and a statement of the Participant's right to file a civil action under Section 502(a) of ERISA;and
11. A statement that reasonable access to and copies of all documents and records and other information relevant to the final internal adverse benefit determination will be provided, upon request and free of charge.

Deemed Exhaustion of Internal Appeal Process

1. The Participant will be deemed to have exhausted the internal appeal process and may request external review or pursue any available remedies under state law or a civil action under 502(a) of ERISA, if the Claim Administrator fails to comply with its claims and appeals procedures, except that claims and appeals procedures will not be deemed exhausted based on violations that are:
    a. De minimis;
    b. Non-prejudicial to the Participant;
    c. Attributable to good cause or matters beyond the Claim Administrator's control;
    d. In the context of an ongoing, good faith exchange of information between the Participant and the Claim Administrator; and
    e. Not reflective of a pattern or practice of violations by the Claim Administrator.
2. Upon request of the Participant, the Claim Administrator will provide an explanation of a violation within 10 days. The explanation will include a description of the basis for the Claim Administrator's assertion that the violation does not result in the deemed exhaustion of the Claim Administrator's internal claims and appeals procedures.
3. If the Participant seeks external or judicial review based on deemed exhaustion of the Claim Administrator's internal claims and appeals procedures, and the external reviewer or court rejects the Participant's request, the Claim Administrator will notify the Participant within a reasonable period of time, not to exceed 10 days, of the Participant's right to resubmit the Participant's internal appeal. The timeframe for appealing the adverse benefit determination begins to run when the Participant receives the notice of the right to resubmit the Participant's internal appeal.

External Review Procedures – In General

In most cases, and except as provided in the next two sections, the Participant must follow and exhaust the internal appeals process outlined above before the Participant may submit a request for external review. In addition, external review is limited to only those adverse benefit determinations that involve:

1. Rescissions of coverage; and
2. Medical judgment, including those adverse benefit determinations that are based on requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or adverse benefit determinations that certain treatments are experimental or investigational.

External review is not available for:

1. Adverse benefit determinations that are based on contractual or legal interpretations without any use of medical judgment; and
2. Adverse benefit determinations that are based on a failure to meet requirements for eligibility under a group health plan.

Standard External Review Procedures

There are two types of external review: a standard external review and an expedited external review. An expedited external review is generally based upon the seriousness of the Participant's medical circumstances and entitles the Participant to an expedited notice and decision-making process. The procedures for requesting standard (non-expedited) external reviews are discussed in this section. The procedures for requesting expedited external reviews are discussed in the next section.

1. **Request for a Standard External Review**

   The Participant or the Participant's authorized representative (hereafter, the Participant) must submit a written request to the Claim Administrator for a standard external review within 4 Months from the date the Participant receives an adverse benefit determination or a final internal adverse benefit determination.

2. **Preliminary Review**

   The Claim Administrator must complete a preliminary review within 5 business days from receipt of the Participant's request for a standard external review to determine whether:

   a. The Participant is or was covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Participant was covered under the Plan when the health care item or service was provided;
   b. The adverse benefit determination or final internal adverse benefit determination relates to the Participant's failure to meet the Plan's eligibility requirements;
   c. The Participant has exhausted (or is not required to exhaust) the Claim Administrator's internal appeals process; and/or
   d. The Participant has provided all the information and forms required to process the external review.

   Within 1 day after completing its review, the Claim Administrator will notify the Participant in writing if the request is eligible for external review. If further information or materials are necessary to complete the review, the written notice will describe the information or materials and the Participant will be given the remainder of the 4-Month period or 48 hours after receipt of the written notice, whichever is later, to provide the necessary information or materials. If the request is not eligible for external review, the Claim Administrator will outline the reasons for ineligibility in the notice and will provide contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272).

3. **Assignment of an IRO**

   If the Participant's request is eligible for external review, the Claim Administrator will within 1 business day assign the request for external review to an accredited Independent Review Organization (IRO) on a random basis or using another method of assignment that ensures the independence and impartiality of the assignment process, to conduct the external review. In making the assignment, the Claim Administrator will consider whether an IRO is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination. The Claim Administrator will also take into account other circumstances, including conflict of interest concerns.

4. **Initiation of External Review and Opportunity to Submit Additional Documents**

   Within 1 business day of assigning the IRO, the Claim Administrator will notify the Participant or the Participant's authorized representative in writing that the Claim Administrator has initiated an external review and that the Participant or the Participant's authorized representative may submit additional information to the IRO within 10

business days following the date of receipt of the notice for the IRO's consideration in its external review. The IRO may accept and consider additional information submitted after the 10 business days.

5. Claim Administrator Submission of Documents to the IRO

Within 5 business days after the date the IRO is assigned, the Claim Administrator must submit the documents and any information considered in making the benefits denial to the IRO. The Claim Administrator's failure to timely provide such documents and information will not constitute cause for delaying the external review. If the Claim Administrator fails to timely provide the documents and information, the IRO may terminate the external review and reverse the adverse benefit determination or final internal adverse benefit determination. If the IRO does so, it must notify the Participant and the Claim Administrator within 1 business day after making the decision.

6. Reconsideration by Claim Administrator

On receiving any information submitted by the Participant, the IRO must forward the information to the Claim Administrator within 1 business day. The Claim Administrator may then reconsider its adverse benefit determination or final internal adverse benefit determination. If the Claim Administrator decides to reverse its adverse benefit determination or final internal adverse benefit determination, the Claim Administrator must provide written notice to the Participant and IRO within 1 business day after making the decision. On receiving the Claim Administrator's notice, the IRO must terminate its external review.

7. Standard of Review

In reaching its decision, the IRO will review the claim and will not be bound by any decisions or conclusions reached under the Claim Administrator's internal claims and appeals process. In addition to the documents and information timely received, and to the extent the information or documents are available, the IRO will consider the following in reaching a decision:

- **a.** The Participant's medical records;
- **b.** The Participant's treating provider(s)'s recommendations;
- **c.** Reports from appropriate health care professionals and other documents, opinions, and recommendations submitted by the Claim Administrator and the Participant;
- **d.** The terms and conditions of the Plan, including specific coverage provisions, to ensure that the IRO's decision is not contrary to the terms and conditions of the Plan, unless the terms and conditions do not comply with applicable law;
- **e.** Appropriate practice guidelines, which must include applicable Evidence-Based Standards;
- **f.** Any applicable clinical review criteria developed and used by the Claim Administrator unless the criteria are inconsistent with the terms and conditions of the Plan or do not comply with applicable law;
- **g.** The applicable Medical Policies of the Claim Administrator; and/or
- **h.** The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider them appropriate.

8. Written Notice of the IRO's Final External Review Decision

The IRO will send written notification of its decision to the Participant and to the Claim Administrator within 45 days after the IRO's receipt of the request for external review. The notice will include:

- **a.** A general description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;
- **b.** The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
- **c.** References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and Evidence-Based Standards;
- **d.** A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any Evidence-Based Standards relied on in making the decision;
- **e.** A statement that the IRO's determination is binding, unless other remedies are available to the Claim Administrator or the Participant under state or federal law; and
- **f.** A statement that judicial review may be available, to the Participant and the Plan.

9. Compliance with IRO Decision

If the IRO reverses the Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator will immediately provide coverage or issue payment according to the written terms and Benefits of the Plan Document.

Expedited External Review Procedures

In general, the same rules that apply to standard external review apply to expedited external review, except that the timeframe for decisions and notifications is shorter.

1. Request for Expedited External Review

Under the following circumstances, the Participant may request an expedited external review:

- **a.** If the Participant received an adverse benefit determination that denied the Participant's claim and: (1) the Participant filed a request for an internal Urgent Care appeal; and (2) the delay in completing the internal appeal process would seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function; or
- **b.** Upon receipt of a final internal adverse benefit determination which involves: (1) a medical condition of the Participant for which a delay in completing the standard external review would seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function; or (2) an admission, availability of care, a continued stay, or a health care item or service for which the Participant received Emergency Services, but has not been discharged from a facility.

2. Preliminary Review

Upon receiving the Participant's request for expedited external review, the Claim Administrator will immediately determine whether the request is eligible for external review, considering the same preliminary review requirements set forth in the Preliminary Review paragraph, Standard External Review Procedures section. After the preliminary review is complete, the Claim Administrator will immediately notify the Participant or the Participant's authorized representative in writing of its eligibility determination. If the request is not eligible for external review, the Claim Administrator will outline the reasons for ineligibility in the notice and will provide contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

3. Assignment of an IRO

If a request is eligible for expedited external review, the Claim Administrator will assign an IRO pursuant to and in compliance with the independence and other selection requirements set forth in the Assignment of an IRO paragraph, Standard External Review Procedures section. The Claim Administrator will transmit all documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO in as expeditious of a manner as possible (including by phone, facsimile, or electronically).

4. Standard of Review

In reaching its decision, the IRO will review the claim and will not be bound by any decisions or conclusions reached under the Claim Administrator's internal claims and appeals process. In addition to the documents and information timely received, and to the extent the information or documents are available, the IRO will consider the same documents and information set forth in the Standard of Review paragraph, Standard External Review Procedures section.

5. Notice of Final External Review Decision

The IRO will provide the Participant and the Claim Administrator with notice of its final external review decision as expeditiously as the Participant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO must provide written confirmation of its decision to the Participant and to the Claim Administrator within 48 hours after the date the IRO verbally conveyed the decision. The written notice will include:

- **a.** A description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;
- **b.** The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

c. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and Evidence-Based Standards;
d. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any Evidence-Based Standards relied on in making the decision;
e. A statement that the IRO's determination is binding, unless other remedies are available to the Claim Administrator or the Participant under state or federal law; and
f. A statement that judicial review may be available to the Participant or the Claim Administrator.

6. **Compliance with IRO Decision**

   If the IRO reverses the Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator will immediately approve coverage that was the subject of the adverse benefit determination or final internal adverse benefit determination according to the written terms and Benefits of the Plan Document.

7. **Inapplicability of Expedited External Review**

   An expedited external review may not be provided for retrospective adverse benefit determinations or retrospective final internal adverse benefit determinations.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Participant can obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Claim Administrator.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

1. The Family and Medical Leave Act of 1993 (FMLA) requires employers, who employ at least 50 workers within a 75-mile radius of the workplace, to provide eligible employees with up to 12 weeks of leave during any 12-Month period for any of the following reasons:
   a. To care for a newborn child;
   b. Because a child has been placed with the employee for adoption or foster care;
   c. To care for a Spouse, child, or parent of the employee;
   d. The employee's own serious health condition makes the employee unable to perform his or her job.
2. Eligible employees are those who have been employed by the employer for at least 12 Months and who have worked at least 1,250 hours for that employer during the previous 12-Month period.
3. The health benefits of an employee and Dependents, if any, will be maintained during FMLA leave on the same terms and conditions as if the employee had not taken leave.
4. The health Benefits of an employee and Dependents, if any, may lapse at the employer's discretion during FMLA leave because the employee does not pay his or her share of the premiums in a timely manner or the employee does not elect health Benefits during the FMLA leave. Upon return from leave, the employee and Dependents, if any, will be reenrolled in the health Benefit Plan as if the coverage had not lapsed.
5. The employee's reenrollment in the health Plan will be effective upon the date on which the employee returns to work.
6. An employee who takes FMLA leave and fails to pay any required premium contribution or fails to return from leave will be entitled to COBRA coverage for the maximum COBRA coverage period beginning when the FMLA coverage terminated.

PRIVACY OF PROTECTED HEALTH INFORMATION

Protected Health Information about a Plan Participant will not be disclosed to the Plan Sponsor by the Health

Plan or any Business Associate servicing the Health Plan, unless the Plan Sponsor certifies that the Plan Documents have been amended to include this section and the Plan Sponsor agrees to abide by this section. Any disclosure to and use by the Plan Sponsor will comply with all provisions of this section.

Definitions

For the purpose of this section, the following definitions apply:

1. Business Associate.

   A person or entity who performs or assists in performing or provides a function or activity that involves the use or disclosure of Protected Health Information on behalf of the Health Plan. Such functions or activities include, but are not limited to, claims processing, claims administration, data analysis, data processing, data administration, utilization review, quality assurance, billing, benefit management, legal services, marketing services, accounting services, and administration services.

2. Federal Regulations.

   Those regulations entitled Standards for Privacy of Individually Identifiable Health Information, 45 CFR §160 and §164.

3. Group Health Plan.

   A self-insured employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act (ERISA) that provides coverage for medical care.

4. Health Plan or Plan.

   The Group Health Plan, provided to the Plan Participants by or through the Plan Sponsor. The Group Health Plan may be administered by a third-party health insurance carrier or other third-party administrator. The health insurance issuer or third-party administrator is the Business Associate of the Group Health Plan.

5. Plan Participant.

   A person covered under the Group Health Plan.

6. Plan Sponsor.

   The Employer or other entity that sponsors the Group Health Plan, as defined in Section 3(16)(B) of ERISA.

7. Protected Health Information (PHI).

   Individually identifiable health information transmitted, including electronic transmission, or maintained in any form or medium.

Purpose of Disclosure to Plan Sponsor

A Plan Participant's PHI will only be disclosed to the Plan Sponsor by the Health Plan, or a Business Associate servicing the Health Plan, subject to the following:

1. To permit the Plan Sponsor to carry out Plan administration functions that are in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. Disclosures to the Plan Sponsor of a Plan Participant's PHI will be explained in the Notice of Privacy Practices issued to Plan Participants by the Health Plan.
3. No Plan Participant's PHI will be disclosed to the Plan Sponsor for the purpose of employment – related actions or decisions or in connection with any other Benefit or employee benefit plan of the Plan Sponsor.

Restrictions on Plan Sponsor's Use and Disclosure of PHI

The Plan Sponsor will:

1. Not use or further disclose PHI except as permitted or required by the Plan Documents, as amended by this section, or required by law.
2. Ensure that any agent, including subcontractors, to whom it provides PHI agrees to the restrictions and provisions of the Plan Documents, including this section.

3. Not use or disclose PHI for the purpose of employment-related actions or decisions or in connection with any other Benefit or Employee Benefit plan of the Plan Sponsor.
4. Promptly report to the Health Plan any use or disclosure of PHI that does not comply with the provisions of this section upon learning of such noncompliance.
5. Make PHI, located in a Plan Participant's designated record set, available to the Plan Participant who is the subject of the information, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for their information.
6. Make PHI, located in a Plan Participant's designated record set, available for amendment, and amend PHI, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for amendment.
7. Provide an accounting of disclosure to Plan Participants in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for an accounting of disclosures.
8. Make its internal practices, books, and records, relating to its use and disclosure of PHI, available to the Health Plan and the United States Department of Health and Human Services to determine compliance with Federal Regulations.
9. If feasible, and subject to 9b below:

    a. Return or destroy all PHI, and retain no copies, when the PHI is no longer needed for the Plan administration functions for which the disclosure was made. This includes:

        1. PHI, in whatever form or medium (including any electronic medium under the Plan Sponsor's custody or control), received from the Health Plan or a Business Associate; and

        2. Any data or compilations derived from and allowing identification of any Plan Participant who is the subject of the PHI.

    b. If it is not feasible to return or destroy all PHI, the Plan Sponsor will limit the use or disclosure of any PHI that it cannot return or destroy to those purposes that make it unfeasible to return or destroy the PHI.

Adequate Separation Between the Plan Sponsor and the Plan

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to PHI received from the Health Plan or the Business Associate servicing the Plan. This includes those Employees who may receive PHI relating to payment under, health care operations of, or other matters pertaining to the Health Plan in the ordinary course of business:

Lacy Clark, Director of Business Services/District Clerk
Mary Sandvold, Payroll Supervisor
Alyssa Pack, Benefits & Wellness Coordinator
Mike Waterman, Director of Business Services
PayneWest Insurance/Marsh & McLennan Agency LLC
Infinite Visions (Tyler Tech) Online Enrollment – Eligibility Only
Health Cost and Risk Management – Claims and Eligibility
Prism Health Strategists, LLC/ScriptPoint, LLC - Pharmacy claims only
WEX – COBRA Eligibility only
Renalogic – Dialysis Claims and Eligibility only
AmeriHealth Associates – Dialysis Claims and Eligibility only

Access to PHI will be given to the Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, only to perform the Plan administration functions that the Plan Sponsor provides for the Health Plan.

The Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, will be subject to disciplinary action and sanctions, up to and including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of PHI in breach or violation of, or noncompliance with the provisions of this section.

The Plan Sponsor will promptly report any breach or violation of, or noncompliance as required in the section entitled "Restrictions on Plan Sponsor's use of Disclosure of PHI," Item 4 of this section. The Plan Sponsor will cooperate with the Health Plan to:

1. Correct the breach or violation of or noncompliance.
2. Impose appropriate disciplinary action or sanctions on the person(s) responsible for causing the breach or violation of or noncompliance.
3. Mitigate any detrimental effect of the breach or violation of or noncompliance on any Plan Participant who may have had the privacy of PHI compromised by the breach or violation of or noncompliance.

GENERAL PROVISIONS

Plan Administrator Powers and Duties

The Plan Administrator shall have total and exclusive responsibility to control, operate, manage, and administer the Plan in accordance with its terms. The Plan Administrator shall have all the authority that may be necessary or helpful to enable it to discharge its responsibilities with respect to the Plan. Without limiting the generality of the preceding sentence, the Plan Administrator shall have the exclusive right: to interpret the Plan; to determine eligibility for coverage under the Plan; to determine eligibility for Benefits under the Plan; to construe any ambiguous provisions of the Plan; to correct any default; to supply any omission; to reconcile any inconsistency; and to decide any and all questions arising in administration, interpretation, and application of the Plan.

The Plan Administrator shall have full discretionary authority in all matters related to the discharge of its responsibilities and the exercise of authority under the Plan, including, without limitation, the construction of the terms of the Plan, and the determination of eligibility for coverage and Benefits. The decisions of the Plan Administrator, as Plan Administrator, shall be conclusive, binding and final upon all persons having or claiming to have any right or interest in or under the Plan and no such decision shall be modified under judicial review unless such decision is proven to be arbitrary or capricious.

The Plan Administrator may delegate some or all of its authority under the Plan or revoke such delegation to any person or persons provided that any such delegation or revocation of delegation is in writing. The Plan Administrator may delegate its authority to determine eligibility for Benefits to the Claim Administrator.

Entire Plan; Changes

This Plan supersedes any previous plan. This Plan, including the amendments and attached papers, if any, constitutes the entire Plan. No change in this Plan is valid until made pursuant to the section entitled Modification of Plan.

Modification of Plan

The Plan Sponsor and Plan Administrator reserve the right to amend the Plan in whole or in part at any time, including the right to make any amendments to a contract with an insurance company, and the right to amend any rules adopted for the administration of the Plan. Expenses incurred prior to the Effective Date of any amendment are based on the provisions in effect at the time the expenses were incurred. The Employer reserves the right to change or cancel any Benefits under the Plan, at any time. Any such change in Benefits will be based solely on the decisions of the Employer and may apply to active Employees, future retirees and current retirees as either separate groups or as one group. If the Employer cancels any Benefits under the Plan, participation in the canceled Benefits terminates on the date of the cancellation, unless otherwise specified.

The Employer may terminate the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate, unless the Plan is continued by a successor to the Employer. Any such termination in Benefits will be based solely on the decision of the Employer and may apply to current Employees and their Dependents, future retirees and current retirees as either separate groups or as one group.

Notice of Change

All changes or amendments to this Plan that directly or indirectly relate to any Benefit or coverage under the Plan including any increase in contribution for coverage required from a Participant, will be reported to all eligible Participants in accordance with federal law after the date such change or amendment is adopted.

Clerical Errors

No clerical error on the part of the Claim Administrator shall operate to defeat any of the rights, privileges, or Benefits of any Participant covered under this Plan. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits will be made. Clerical errors shall not prevent administration of this Plan in strict accordance with its terms.

Notices Under Plan

Any notice required by this Plan may be given by United States mail, postage paid. Notice to the Participant will be mailed to the address appearing on the records of the Plan. Notice to the Plan should be sent to the Plan Sponsor. Any time periods included in a notice shall be measured from the date the notice was mailed.

Rescission of Plan Document

This Plan Document is subject to rescission if the Participant commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, concerning a Participant's health, claims history, or current receipt of health care services. The Claim Administrator will provide at least 30 days advance written notice to the Participant before coverage may be rescinded.

Payment of Claims and Assignment of Benefits

Claim Payment Assignment

All payments by the Claim Administrator for the benefit of any Participant may be made directly to any Provider furnishing Covered Medical Expenses for which such payment is due, and the Claim Administrator is authorized by such Participant to make such payments directly to such providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Participant or provider furnishing Covered Medical Expenses. All benefits payable to the Participant which remain unpaid at the time of the death of the Participant will be paid to the estate of the Participant.

Claim Dispute

Once Covered Medical Expenses are rendered by a provider, the Participant has no right to request the Claim Administrator not to pay the Claim submitted by such provider and no such request by a Participant or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Participant or any other person because of its rejection of such request.

Plan Coverage Assignment

Neither the Plan nor a Participant's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non-assignable or non-transferable and will be forfeited if a Participant attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the Claim Administrator makes payment because of a person's wrongful use of the identification card of a Participant, such payment will be considered a proper payment and the Claim Administrator will have no obligation to pursue recovery of such payment.

Validity of Plan

If any part, term, or provision of this Plan is held by the courts to be illegal or in conflict with any law of the state of Montana, the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the Plan did not contain the particular part, term, or provision held to be invalid.

Participants Rights

A Participant has no rights or privileges except as specifically provided in this Plan. Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any Participant, or as the right of any Participant to continue in the employment of the Employer or as a limitation of the right of the Employer to discharge any of its Employees with or without cause.

Alternate Care

This Plan may make payment for services that are not listed as a Benefit of this Plan. Such payment will be made only upon mutual agreement by the Participant, the Plan Administrator, and/or the Claim Administrator. Such payment does not act as a waiver of the terms of this Plan.

Benefit Maximums

If a Participant receives services payable under any section of this Plan and exhausts all Benefits available under that section, no Benefits are available under any other section for that same condition.

Pilot Programs

The Plan reserves the right to develop and enter into pilot programs to test the success of providing Benefits for care not normally covered under this Plan. The existence of a pilot program does not guarantee that all Participants are eligible for the pilot program Benefits or that such Benefits will be permanent. A pilot program is an initial small-scale implementation that is used to prove the variability of a project idea. This could involve either the exploration of a novel new approach or idea or the application of a standard approach new to the organization. It enables an organization to manage the risk of a new idea and identify any deficiencies before substantial resources are committed.

Research Fees

The Plan reserves the right to charge a reasonable fee when extensive research is necessary to reconstruct information or documents which were previously provided in writing to the Participant by the Plan. Fees may be charged for the costs of copying labor, supplies and postage. Fees will not be charged for searching for and retrieving the requested information.

Cooperation of Participant

The Participant must cooperate fully with the Plan, and any person or entity administering this Plan Document on behalf of the Plan, in providing documents and information requested to determine whether the Participant is or remains eligible for membership; to determine whether services are Covered Medical Expenses; to determine whether any term or exclusion of this Plan Document applies; and to make any other determination necessary to administer this Plan Document. Required cooperation by a Participant includes executing such consents, releases, disclosure authorizations and other documents as may be requested by the Plan in order to obtain documents or information from a third party necessary to make such determinations.

Required cooperation of a Participant includes but is not limited to providing or authorizing the provision of the following to the Plan:

1. All medical, hospital, dental, vision and other health care records relating to the diagnosis or treatment of or services or items provided to the Participant;
2. All information and documents regarding coverage, policy limits, claim payments, demands, litigation, settlement (including disputed and undisputed liability settlements) under any applicable or potentially applicable insurance, health plan, government benefit program or other health or medical payor plan or program, including but not limited to:
    a. Workers' compensation, FELA or other similar plan or program providing benefits for Injury or Illness arising out of employment;
    b. Personal, commercial or other automobile insurance, including but not limited to no-fault medical payment, liability or other coverages; and
    c. Personal, homeowners, commercial, or other premises insurance, including but not limited to no-fault medical payment, liability or other coverages.

Statements are Representations

Any representations or statements made to a Participant by the Plan Administrator, their representatives or agent, about being covered for Benefits under the Plan, which conflict with the provisions of the Plan shall:

1. Not be considered as representations or statements made by, or on behalf of, the Plan Administrator;
2. Not bind the Plan Administrator for Benefits under the Plan.

In the absence of fraud, all statements by applicants or the Participant shall be deemed to be representations and not warranties. Any Participant who, with intent to defraud or knowing that he or she is facilitating a fraud against the Employer or the Plan, submits an application or files a claim containing a false, incomplete, or misleading statement may be found guilty of fraud. The Employer reserves the right to take appropriate action in any instance where fraud is at issue.

Overpayments

Effective on or after January 1, 2020, if the Plan or the Claim Administrator pays Benefits for Covered Medical Expenses incurred by the Participant and it is found that the payment was more than it should have been, or it was made in error ("overpayment"), the Plan or the Claim Administrator has the right to obtain a refund of the overpayment amount from: (i) the person to, or for whom, such Covered Medical Expenses were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Out-of-Network providers.

If no refund is received, the Plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any overpayment due up to an amount equal to the overpayment, from:

1. Any future Benefit payment made to any person or entity under this Plan Document, whether for the same or a different Participant; or
2. Any future Benefit payment made to any person or entity under another Blue Cross and Blue Shield of Montana administered ASO Benefit program and/or Blue Cross and Blue Shield of Montana administered insured Benefit program or policy, if the future Benefit payment owed is to a Participating Provider; or
3. Any future Benefit payment made to any person or entity under another Blue Cross and Blue Shield of Montana insured group Benefit plan or individual policy, if the future Benefit payment owed is to a Participating Provider; or
4. Any future Benefit payment, or other payment, made to any person or entity; or
5. Any future payment owed to one or more Participating Providers.

Further, the Claim Administrator has the right to reduce the Plan's payment to a Participating Provider by the amount necessary to recover another Blue Cross and Blue Shield of Montana's Plan or policy overpayment to the same provider and to remit the recovered amount to the other Blue Cross and Blue Shield of Montana Plan or policy.

Participant/Provider Relationship

Choosing a Provider

The choice of a Provider is solely the choice of the Participant and the Claim Administrator will not interfere with the Participant's relationship with any provider.

Claim Administrator's Role

It is expressly understood that the Claim Administrator does not itself undertake to furnish Hospital, medical or dental services, but solely to make payment to a provider for the Covered Medical Expenses received by Participants. The Claim Administrator is not in any event liable for any act or omission of any provider or the agent or employee of such provider, including, but not limited to, the failure or refusal to render services to a Participant. Professional services which can only be legally performed by a provider are not provided by the Claim Administrator. Any contractual relationship between a provider and the Claim Administrator shall not be construed to mean that the Claim Administrator is providing professional services.

Intent of Terminology

The use of an adjective such as approved, administrator, participating, in-network or network in modifying a provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such provider. In addition, the omission, non-use or non-designation of approved, administrator, participating, in-network, network or any similar modifier or the use of a term such as non-approved, non-administrator, nonparticipating, out-of-network or non-network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such provider.

Provider's Role

Each provider provides Covered Medical Expenses only to covered Participants and does not deal with or provide any services to the Employer (other than as an individual Participant) of the Plan.

Recovery, Reimbursement, and Subrogation

By enrollment in this Plan, Participants agree to the provisions of this section as a condition precedent to receiving Benefits under this Plan. Failure of a Participant to comply with the requirements of this section may result in the pending of the payment of Benefits.

1. Right to Recover Benefits Paid in Error

If the Plan makes a payment in error on behalf of a Participant or an assignee of a Participant to which the Participant is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefited from the payment. The Plan can deduct the amount paid from the Participant's future Benefits or from the Benefits of any covered Family Member even if the erroneous payment was not made on that Family Member's behalf.

Payment of Benefits by the Plan for Participants' spouses, ex-spouses, or children, who are not eligible for coverage under this Plan, but for whom Benefits were paid based upon inaccurate, erroneous, false information or omissions of information provided or omitted by the Employee, will be reimbursed to the Plan by the Employee. The Employee's failure to reimburse the Plan after demand is made may result in an interruption in or loss of Benefits to the Employee and could be reported to the appropriate governmental authorities for investigation of criminal fraud and abuse.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine. By receipt of Benefits under this Plan, each Participant authorizes the deduction of any excess payment of such Benefits or other present or future compensation payments.

The provisions of this subsection apply to any licensed health care provider who receives an assignment of Benefits or payment of Benefits under this Plan. If a licensed health care provider refuses to refund improperly paid claims, the Plan may refuse to recognize future assignments of Benefits to that provider.

2. Reimbursement

The Plan's right to reimbursement is separate from and in addition to the Plan's right of subrogation. Reimbursement means to repay a party who has paid something on another's behalf. If the Plan pays Benefits for medical expenses on a Participant's behalf, and another party was actually responsible or liable to pay those medical expenses, the Plan has the right to be reimbursed for the amounts the Plan paid.

Accordingly, if a Participant, or anyone on his or her behalf, settles, is reimbursed, or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any Accident, Injury, condition, or Illness for which Benefits were provided by the Plan, the Participant or whoever received the money, agrees to hold the money received in trust for the Benefit of the Plan. The Plan shall be reimbursed, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Participant or on his or her behalf or that will be paid as a result of said Accident, Injury, condition, or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Participant is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability, or other expenses or damages.

3. Subrogation

The Plan's right to subrogation is separate from and in addition to the Plan's right to reimbursement. Subrogation is the right of the Plan to exercise the Participant's rights and remedies in order to recover from third parties who are legally responsible to the Participant for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Participant, with or without his or her consent, to recover the money paid under the Plan. In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to the Participant's Accident, Injury, condition, or Illness, which the Plan has paid, then the Plan is entitled to recover, by legal action or otherwise, the money paid; in effect the Plan has the right to "stand in the shoes" of the Participant for whom Benefits were paid, and to take any action the Participant could have undertaken to recover the money paid.

The Participant agrees to subrogate to the Plan any and all claims, causes of action, or rights that he or she has or that may arise against any entity who has or may have caused, contributed to, or aggravated the Accident, Injury, condition, or Illness for which the Plan has paid Benefits, and to subrogate any claims, causes of action, or rights the Participant may have against any other coverage, including but not limited to liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event that a Participant decides not to pursue a claim against any third party or insurer, the Participant will notify the Plan, and specifically authorize the Plan in its sole discretion, to sue for, compromise, or settle any such claims in the Participant's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

4. The Following Paragraphs Apply to Both Reimbursement and Subrogation:

a. Under the terms of this Plan, the Plan Administrator is not required to pay any claims where there is evidence of liability of a third party. However, the Plan, in its discretion, may instruct the Claim Administrator not to withhold payment of Benefits while the liability of a party other than the Participant is being legally determined.

b. If the Plan makes a payment which the Participant, or any other party of the Participant's behalf, is or may be entitled to recover against any third party responsible for an Accident, Injury, condition or Illness, the Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. The Participant receiving payment from this Plan will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the Plan's right of recovery.

c. The Participant will cooperate fully with the Plan Administrator, its agents, attorneys, and assigns, regarding the recovery of any monies paid by the Plan for any party other than the Participant who is liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Plan Administrator, upon request and in a timely manner, of all material facts regarding the Accident, Injury, condition, or Illness; all efforts by any person to recover any such monies; provide the Plan Administrator with any and all documents, papers, reports, and the like regarding demands, litigation or settlements involving recovery of monies paid by the Plan; and notifying the Plan Administrator of the amount and source of any monies received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.

d. Participants will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers, including but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Participant will notify the Plan immediately of the name and address of any attorney whom the Participant engages to pursue any personal Injury claim on his or her behalf.

e. The Participant will not act, fail to act, or engage in any conduct directly, indirectly, personally, or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Participant will not conceal or attempt to conceal the fact that recovery occurred or will occur.

f. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Participant pursuing a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund," or similar statute, regulation, prior court decision, or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

5. Right of Offset

The Plan has a right of offset to satisfy reimbursement claims against Participants for money received by the Participant from a third party, including any insurer. If the Participant fails or refuses to reimburse the Plan for funds paid for claims, the Plan may deny payment of future claims of the Participant, up to the full amount paid by the Plan and subject to reimbursement for such claims. The right of offset applies to all reimbursement claims owing to the Plan whether or not formal demand is made by the Plan, and not withstanding any anti-subrogation, "common fund," "made whole," or similar statutes, regulations, prior court decisions, or common law theories.

DEFINITIONS

This section defines certain words used throughout this Plan Document. These words are capitalized whenever they are used as defined.

ACCIDENT

An unexpected traumatic incident or unusual strain which is:

1. Identified by time and place of occurrence;
2. Identifiable by part of the body affected; and
3. Caused by a specific event on a single day.

Some examples include:

1. Fracture or dislocation.
2. Sprain or strain.
3. Abrasion, laceration.
4. Contusion.
5. Embedded foreign body.
6. Burns.
7. Concussion.

ADVANCED PRACTICE REGISTERED NURSE

Nurses who have additional professional education beyond the basic nursing degree required of a registered nurse and are considered Advanced Practice Registered Nurses by applicable state law. Advanced Practice Registered Nurses include nurse practitioners, nurse-midwives, nurse-anesthetists and clinical nurse specialists.

ALLOWABLE FEE

The Allowable Fee is based on, but not limited to, the following:

1. Medicare RBRVS based is a system established by Medicare to pay Physicians for a “work unit.” The RBRVS value is determined by multiplying a “relative value” of the service by a “converter” to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers’ billed charge; or
2. Diagnosis-related group (DRG) methodology is a system used to classify Hospital cases into one of approximately 500 to 900 groups that are expected to have similar Hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of Hospital resources for the given DRG regardless of the actual Hospital resources used. Therefore, the amount paid by the Claim Administrator to a nonparticipating provider under the DRG system can be considerably less than the nonparticipating providers’ billed charge; or
3. Billed charge is the amount billed by the provider; or
4. Case rate methodology is an all-inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the case rate system can be considerably less than the nonparticipating providers’ billed charge; or
5. Per diem methodology is an all-inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the per diem system can be considerably less than the nonparticipating providers’ billed charge; or
6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to a nonparticipating provider under the flat fee per category of service system can be considerably less than the nonparticipating providers’ billed charge; or

7. Flat fee per unit of service fixed payment amount for a unit of service. For instance, a unit of service could be the amount of "work units" customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the flat fee per unit system can be considerably less than the nonparticipating providers' billed charge; or
8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or
9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or
10. The amount negotiated with the Pharmacy Benefit Manager or manufacturer or the actual price for prescription or drugs; or
11. The American Society of Anesthesiologists' Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a "work unit." The payment value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the system can be considerably less than the nonparticipating providers' billed charge.
12. For nonparticipating providers in Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for nonparticipating providers will represent an average contract rate for Participating Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by nonparticipating providers which may also alter the Allowable Fee for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

    Any change to the Medicare reimbursement amount will be implemented by the Plan within 90 days after the Effective Date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

13. For nonparticipating providers outside Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee (i) for professional providers is based on publicly available data and historic reimbursement to providers for the same or similar professional services, adjusted for geographic differences where applicable, or (ii) for Hospital or other facility providers is based on publicly available data reflecting the approximate cost that Hospitals or other facilities have incurred historically to provide the same or similar service, adjusted for geographic differences where applicable, plus a margin factor for the Hospital or facility.

In the event the nonparticipating Allowable Fee does not equate to the nonparticipating provider's billed charges, the Participant will be responsible for the difference, along with any applicable Deductible, Copayment and/or Coinsurance amount. This difference may be considerable. To find out an estimate of the Plan's nonparticipating Allowable Fee for a particular service, Participants may call the Customer Service number shown on the back of the Participant's identification card.

AMPLIFICATION DEVICE

A hearing device, hearing aid, or a wearable, non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold, batteries and cords.

APPLIED BEHAVIOR ANALYSIS (ABA) - (ALSO KNOWN AS LOVAAS THERAPY)

Medically Necessary interactive therapies or treatment derived from evidence-based research. The goal of ABA is to improve socially significant behaviors to a meaningful degree, including:

1. Increase desired behaviors or social interaction skills;

2. Teach new functional life, communication, or social, skills;
3. Maintain desired behaviors, such as teaching self-control and self-monitoring procedures;
4. Appropriate transfer of behavior from one situation or response to another;
5. Restrict or narrow conditions under which interfering behaviors occur;
6. Reduce interfering behaviors such as self-injury.

ABA therapy and treatment includes Pivotal Response Training, Intensive Intervention Programs, and Early Intensive Behavioral Intervention, and the terms are often used interchangeably. The ABA Benefit also includes Discrete Trial Training, a single cycle of behaviorally based instruction routine that is a companion treatment with ABA.

Services must be provided by an appropriately certified provider.

APPROVED CLINICAL TRIAL

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV, clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition. The trial must be:

1. Conducted under an investigational new drug application reviewed by the FDA;
2. Exempt from an investigational new drug application; or
3. Approved or funded by:

    a. The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
    b. A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
    c. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
    d. The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and provide unbiased scientific review by individuals who have no interest in the outcome of the review.

BENEFIT

Services, supplies and medications that are provided to a Participant and covered under this Plan Document as a Covered Medical Expense.

BENEFIT PERIOD

For the Plan - is the period of time shown in the Schedule of Benefits.

For the Participant - Is the same as for the Plan except that if the Participant's Effective Date is after the Effective Date of the Plan, the Participant's Benefit Period begins on the Participant's Effective Date and ends on the same date the Plan Benefit Period ends. Thus, the Participant's Benefit Period may be less than 12 Months.

BEST EVIDENCE

Means evidence based on:

1. Randomized Clinical Trials;
2. A Cohort Study or Case-Control Study, if Randomized Clinical Trials are not available;
3. A Case Series, if Randomized Clinical Trials, Cohort Studies or Case-Control Studies are unavailable;
4. An Expert Opinion, if Randomized Clinical Trials, Cohort Studies, Case-Control Studies or Case Series are unavailable.

BLUE CROSS AND BLUE SHIELD OF MONTANA

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, is the Claim Administrator for this Plan.

BLUE CROSS AND BLUE SHIELD OF MONTANA SPECIALTY NETWORK

Specialty Pharmacy providers who have entered into an agreement with the Plan or third party on behalf of the Claim Administrator to provide Specialty Medications to Participants and which have agreed to accept specified reimbursement rates.

BRAND-NAME DRUG

A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand-Name Drug. There may also be situations where a drug's classification changes from Generic Drug to Brand-Name Drug due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to payment obligations from Generic Drug to Brand-Name Drug.

CARE COORDINATION

Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Plan Participant's healthcare needs across the continuum of care.

CARE COORDINATOR

An individual within a provider organization who facilitates Care Coordination for patients.

CARE COORDINATOR FEE

A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

CARE-MANAGEMENT

A process that assesses and evaluates options and services required to meet the Participant's health care needs. Care Management may involve a team of health care professionals, including Covered Providers, the Plan and other resources to work with the Participant to promote quality, cost-effective care.

CASE-CONTROL STUDY

A retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

CASE SERIES

An evaluation of a series of patients with a particular outcome, without the use of a control group.

CLAIM ADMINISTRATOR

Claim Administrator means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Claim Administrator is Blue Cross and Blue Shield of Montana. The Claim Administrator provides ministerial duties only, exercises no discretion over Plan assets, and will not be considered a fiduciary as defined by ERISA (Employee Retirement Income Security Act) or any other state or federal law or regulation.

CLINICAL PEER

A Physician or other health care provider who:

1. Holds a nonrestricted license in a state of the United States; and
2. Is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

CODE

The Internal Revenue Code of 1986, as amended.

COHORT STUDY

A prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

COINSURANCE

The percentage of the Allowable Fee payable by the Participant for Covered Medical Expenses. The applicable Coinsurance is stated in the Schedule of Benefits.

COMPOUNDED DRUGS

Drugs or inert ingredients that have been measured and mixed by a pharmacist to produce a unique formulation because commercial products either do not exist or do not exist in the prescribed dosage, size, or form.

CONCURRENT CARE

Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or

Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Participant's condition requires the skills of separate Physicians.

CONSULTATION SERVICES

Services of a consulting Physician requested by the attending Physician. These services include discussion with the attending Physician and a written report by the consultant based on an examination of the Participant.

CONVALESCENT HOME

An institution, or distinct part thereof, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is a/an:

1. A skilled nursing facility;
2. An extended care facility;
3. An extended care unit; or
4. A transitional care unit.

A Convalescent Home is primarily engaged in providing continuous nursing care by or under the direction and supervision of a registered nurse for sick or injured persons during the convalescent stage of their Illness or Injuries and is not, other than incidentally, a rest home or home for Custodial Care, or for the aged.

NOTE: A Convalescent Home shall not include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and treatment of Mental Illness or Substance Use Disorder.

COPAYMENT

The specific dollar amount payable by the Participant for Covered Medical Expenses. The applicable Copayments are stated in the Schedule of Benefits.

COSMETIC

Services that are provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical function.

COVERED MEDICAL EXPENSE

Expenses incurred for Medically Necessary services, supplies and medications that are based on the Allowable Fee and:

1. Covered under the Plan;
2. In accordance with Medical Policy; and
3. Provided to the Participant by and/or ordered by a Covered Provider for the diagnosis or treatment of an active Illness or Injury or in providing maternity care.

In order to be considered a Covered Medical Expense, the Participant must be charged for such services, supplies and medications.

COVERED PROVIDER

A participating or nonparticipating provider which has been recognized by the Claim Administrator as a provider of services for Benefits described in this Plan Document. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine if a provider is covered, the Claim Administrator looks to the nature of the services rendered, the extent of licensure and is recognized by the Claim Administrator as a provider of services for Benefits described in the Plan Document.

Covered Providers include professional providers and facility providers including Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, audiologists, nurse specialists, naturopathic physicians, Advanced Practice Registered Nurses, physician assistants, Hospitals and Freestanding Surgical Facilities.

CREDITABLE COVERAGE

Coverage that the Participant had for medical Benefits under any of the following plans, programs and coverages:

1. A group health plan;

2. Health insurance coverage;
3. Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1935c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4 (Medicare);
4. Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s (Medicaid);
5. Title 10, chapter 55, United States Code (TRICARE);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A health plan offered under Title 5, chapter 89, of the United States Code (Federal Employee Health Benefits Program);
8. A public health plan;
9. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e); or
10. A high-risk pool in any state.

Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits.

CUSTODIAL CARE

Any service, primarily for personal comfort or convenience, that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the Participant's condition. Custodial Care services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable nonprofessional personnel, are to assist with Routine medical needs (e.g. simple care and dressings, administration of Routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

DEDUCTIBLE

The dollar amount each Participant must pay for Covered Medical Expenses incurred during the Benefit Period before the Plan will make payment for any Covered Medical Expense to which the Deductible applies.

Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. Thus, Copayments and/or Coinsurance, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Participant's responsibility.

If two or more Participants covered under the same family satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Participant of the family.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, only one Deductible will be applied to that Hospital stay (facility charges only). If the Participant satisfied the Participant's Deductible prior to that Hospital stay, no Deductible will be applied to that stay.

DEPENDENT

A Participant who has been enrolled by an enrolled Employee and who is one of the following:

1. The Employee's legal Spouse;
2. The Employee's unmarried or married biological child, adopted child, or child placed for adoption and who is under the age of 26 years;
3. Children for who the Employee becomes legally responsible by reason of placement for adoption, as defined in Montana law;
4. An unmarried or married child of the Employee and/or Spouse who is 26 years of age or older may qualify as a Family Member if the child:
    a. Has been covered under the Plan before age 26; and
    b. Cannot support himself/herself because of intellectual disability or physical handicap; and
    c. Is legally dependent on the enrolled Employee for support.

Proof of those qualifications must be supplied to the Plan within 31 days of the child's 26th birthday. Although there is no limiting age for handicapped children, the Plan reserves the right to require periodic certification from the enrolled Employee of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child's 26th birthday.

Notwithstanding any other restrictions or criteria in this definition of Dependent of the section entitled Eligibility and Coverage, as provided in ERISA 609(a), the Plan shall provide coverage to any "alternate recipient" with respect to a "qualified medical child support order."

DIAGNOSTIC BREAST EXAMINATION

A Medically Necessary and clinically appropriate examination of the breast, including diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

DRUG LIST

A list of all drugs that may be covered under the Prescription Drugs section of this Plan Document. A current list is available on the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. Contact a Customer Service representative at the telephone number shown on the back of the Participant's identification card for more information.

EFFECTIVE DATE

For a Participant, the Effective Date is the date the Participant has met the requirements of the Plan and is shown on the records of the Plan to be eligible for Benefits. For the Plan, the Effective Date is the date shown on the Schedule of Benefits. However, certain provisions shall be effective as of the dates specified within those provisions. The Effective Date of any amendment to the Plan is the Effective Date set forth on such amendment.

EMERGENCY SERVICES

Health care items or services furnished or required to evaluate and treat an Emergency Medical Condition.

EMPLOYEE

Any person (other than a nonresident alien who receives no U.S. income from the Employer) who is employed by the Employer. Notwithstanding the foregoing, the term "Employee" shall also include any officer, or former officer of the Employer for whom the Employer is contractually bound by written agreement to provide health Benefits. Employee shall not include any person who is classified by the Employer as an independent contractor or as a leased Employee.

EMPLOYER

Bozeman School District #7

EVIDENCE-BASED STANDARD

The conscientious, explicit, and judicious use of the current Best Evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

EXCLUSION

A provision which states that the Plan has no obligation under this Plan Document to make payment.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device, biological product or medical treatment or procedure is Experimental, Investigational and/or Unproven if **the Plan determines** that:

1. The drug, device, biological product or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product or medical treatment or procedure is furnished; or
2. The drug, device, biological product or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials, or 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
3. The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product or 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.

Approval by a governmental or regulatory agency will be taken into consideration in assessing the Experimental/Investigational/Unproven status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

EXPERT OPINION

A belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

EXPLANATION OF BENEFITS (EOB)

A notification issued to the Participant when a health care claim is processed. The EOB shows how the claim was processed.

FAMILY MEMBER

A Dependent who has been enrolled by an enrolled Employee into the Plan and has been accepted as a Participant of the Plan.

FREESTANDING INPATIENT FACILITY

For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorder in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment.

Services include medical evaluation and health supervision; Substance Use Disorder education; organized individual, group and family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up program after discharge.

For treatment of Mental Illness, it means a facility licensed by the state and specializing in the treatment of Mental Illness.

GENERIC DRUG

A drug that has the same active ingredient as a Brand-Name Drug and is allowed to be produced after the Brand-Name Drug's patent has expired. In determining the brand or generic classification for covered drugs, the Claim Administrator uses the generic/brand status assigned by a nationally recognized provider of drug product database information. Not all drugs identified as a "generic" by the drug product database, manufacturer, pharmacy or Physician may process as a Generic Drug. Generic Drugs are listed on the Drug List which is available on the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. The Participant may also contact Customer Service for more information.

HABILITATIVE CARE

Coverage will be provided for Habilitative Care services when the Participant requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Other services for people with disabilities.

These services may be provided in a variety of inpatient and/or Outpatient settings as prescribed by a Physician.

HOME HEALTH AGENCY

An agency licensed by the state which provides home health care to the Participant in the Participant's home.

HOME HEALTH AIDE

A nonprofessional worker who has been trained for home care of the sick and is employed by a Home Health Agency.

HOME HEALTH SERVICE

The services provided by a Home Health Agency that must be:

1. Prescribed and supervised by the Participant's attending Physician;
2. Provided through a licensed Home Health Agency; and
3. Provided to the Participant in the Participant's home.

HOME INFUSION THERAPY AGENCY

A health care provider that provides home infusion therapy services.

HOSPITAL

A facility providing, by or under the supervision of licensed Physicians, services for medical diagnoses, treatment, rehabilitation, and care of injured, disabled, or sick individuals. A Hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week and provides 24-hour nursing care by licensed registered nurses. Hospital does not include the following, even if such facilities are associated with a Hospital:

1. A nursing home;

2. A rest home;
3. A Convalescent Home; and/or
4. A long-term, chronic-care institution or facility providing the type of care listed above.

ILLNESS

An alteration in the body or any of its organs or parts which interrupts or disturbs the performance of a vital function, thereby causing or threatening pain or weakness.

IN-NETWORK

Providers who are:

1. Participating Blue Cross and Blue Shield of Montana Professional Providers;
2. Participating Blue Cross and Blue Shield of Montana Facility Providers, except for Hospitals and surgery centers;
3. PPO Hospitals and surgery centers;
4. Blue Cross and/or Blue Shield PPO providers outside of Montana; or
5. Participating Pharmacies.

INCLUSIVE SERVICES/PROCEDURES

A portion of a service or procedure which is necessary for completion of the service or procedure or a service or procedure which is already described or considered to be part of another service or procedure.

INDEPENDENT REVIEW ORGANIZATION (IRO)

An organization that offers an independent review and determination of an adverse benefit determination once a Participant has exhausted all internal appeal options available through the health care plan.

INFUSION SUITE

An alternative to Hospital and clinic-based infusion settings where Specialty Medications can be infused.

INJURY

Physical damage to an individual's body, caused directly and independent of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

INPATIENT CARE

Care provided to a Participant who has been admitted to a facility as a registered bed patient and who is receiving services, supplies and medications under the direction of a Covered Provider with staff privileges at that facility. Examples of facilities to which a Participant might be admitted include:

1. Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent Homes; or
5. Freestanding Inpatient Facilities.

INPATIENT PARTICIPANT

A Participant who has been admitted to a facility as a registered bed patient for Inpatient Care.

LATE ENROLLEE

An eligible Employee or Dependent, other than a special enrollee under the special enrollment provisions who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 31 days. However, an eligible Employee or Dependent is not considered a Late Enrollee if a court has ordered that coverage be provided for a Spouse, minor, or Dependent child under a covered Employee's health Benefit Plan and request for enrollment is made within 31 days after issuance of the court order. If an individual is employed by an employer that offers multiple health benefit plans, and the individual elects a different plan during an open enrollment period, that individual is not a Late Enrollee.

LIFE-THREATENING CONDITION

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MEDICAL FOODS

Nutritional substances in any form that are:

1. Formulated to be consumed or administered enterally under supervision of a Physician;
2. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;
3. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
4. Essential to optimize growth, health, and metabolic homeostasis.

MEDICAL OR SCIENTIFIC EVIDENCE

Evidence found in the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's library of medicine for indexing in Index Medicus and Excerpta Medica, published by the Reed Elsevier group;
3. Medical journals recognized by the Secretary of Health and Human Services under 42 U.S.C. 1395x(t)(2)(B) of the federal Social Security Act;
4. The following standard reference compendia:
   a. The American Hospital Formulary Service Drug Information;
   b. Drug Facts and Comparisons;
   c. The American Dental Association Guide to Dental Therapeutics; and
   d. The United States Pharmacopeia;
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
   a. The federal Agency for Healthcare Research and Quality;
   b. The National Institutes of Health;
   c. The National Cancer Institute;
   d. The National Academy of Sciences;
   e. The Centers for Medicare and Medicaid Services;
   f. The Food and Drug Administration; and
   g. Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6. Any other Medical or Scientific Evidence that is comparable to the sources listed in subsection 4 or 5.

MEDICAL POLICY

The Claim Administrator’s policy which is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

Medical Policy is reviewed and modified periodically as is necessary.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s Illness, Injury or disease; and

3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a Covered Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Participant receives the services, supplies, or medications and a claim is submitted to the Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MEDICALLY NECESSARY (FOR AUTISM, ASPERGER'S DISORDER AND PERVASIVE DEVELOPMENTAL DISORDER)

Any care, treatment, intervention, service, or item that is prescribed, provided or ordered by a Physician or psychologist and that will or is reasonably expected to:

1. Prevent the onset of an Illness, condition, Injury, or disability;
2. Reduce or improve the physical, mental, or developmental effects of an Illness, condition, or Injury, or disability; or
3. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

MENTAL HEALTH TREATMENT CENTER

A treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by an interdisciplinary team, including a Qualified Health Care Provider, psychiatric social worker and psychologist. The facility must be:

1. Licensed as a Mental Health Treatment Center by the state;
2. Funded or eligible for funding under federal or state law; or
3. Affiliated with a Hospital under a contractual agreement with an established system for patient referral.

MENTAL ILLNESS

A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

1. Present distress or a painful symptom;
2. A disability or impairment in one or more areas of functioning; or
3. A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

Mental Illness does not include:

1. Developmental disorders;
2. Speech disorders;
3. Psychoactive Substance Use Disorders;
4. Eating disorders (except for bulimia and anorexia nervosa); or
5. Impulse control disorders (except for intermittent explosive disorder and trichotillomania).

MONTH

For the purposes of this Plan Document, a Month has 30 days
even if the actual calendar Month is longer or shorter.

MULTIDISCIPLINARY TEAM

A group of health service providers who are either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. For the purposes of Rehabilitation Therapy, members of the Multidisciplinary Team may include, but are not limited to, a licensed psychologist, licensed speech therapist, registered physical therapist, or licensed occupational therapist.

NEGOTIATED ARRANGEMENT

An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

OCCUPATIONAL THERAPY

Therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of speech tasks or goal-directed activities designed to improve the functional performance of an individual.

OUT-OF-NETWORK

Providers who are:

1. Nonparticipating professional providers;
2. Nonparticipating facility providers;
3. Non-PPO Network Hospitals and surgery centers; or
4. Blue Cross and Blue Shield of Montana Participating Hospitals and surgery centers that are not in the PPO Network.

OUT OF POCKET AMOUNT

For the Participant:

The total amount of applicable Deductible, Copayment and Coinsurance a Participant must pay for Covered Medical Expenses incurred during the Benefit Period. Once the Participant has satisfied the applicable Out of Pocket Amount, the Participant will not be required to pay the Participant's applicable Deductible, Copayment and Coinsurance for Covered Medical Expenses for the remainder of that Benefit Period. The Out of Pocket Amount for the Participant is listed in the Schedule of Benefits.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, the applicable Deductible and applicable Coinsurance for the entire Hospital stay (facility charges only) will only apply to the applicable Out of Pocket Amount of the Benefit Period in which the inpatient stay began. If the Participant satisfied the Out of Pocket Amount prior to that Hospital stay, no applicable Deductible or applicable Coinsurance will be applied to that stay.

Non-covered services, transplants not provided at a Center of Excellence and amounts over the allowed amount billed by a nonparticipating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

For the Family:

The total amounts of applicable Deductible, Copayment and Coinsurance for Covered Medical Expenses a family must pay for services incurred during that Benefit Period. Once the applicable Deductible, Copayment and applicable Coinsurance paid by the Participant during the Benefit Period for two or more Family Members covered under the same family total the applicable Out of Pocket Amount for the family, the Participants covered under the same family will not be required to pay the applicable Deductible and applicable Copayment and/or Coinsurance for Covered Medical Expenses the remainder of that Benefit Period. The Out of Pocket Amount for the family is listed on the Schedule of Benefits.

Non-covered services, transplants not provided at a Center of Excellence and amounts over the allowed amount billed by a nonparticipating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

OUTPATIENT

Services or supplies provided to the Participant by a Covered Provider while the Participant is not an Inpatient Participant.

PARTIAL HOSPITALIZATION

A time-limited ambulatory (Outpatient) program offering active treatment which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day,

evening and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

A Partial Hospitalization program should offer four to eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PARTICIPANT

An eligible Employee or Eligible Family Member who has applied for participation in accordance with the section entitled Eligibility and Coverage, has been accepted as a participant of the Plan, and maintains participation in the Plan.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA FACILITY PROVIDER

A facility which has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana and may include, but is not limited to, Hospitals, Home Health Agencies, Convalescent Homes, skilled nursing facilities, Freestanding Inpatient Facilities and freestanding surgical facilities. Please read the section entitled Providers of Care for Participants.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA PROFESSIONAL PROVIDER

A provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana and may include, but is not limited to, Physicians, physician assistants, nurse specialists, dentists, podiatrists, speech therapists, physical therapists and occupational therapists. Please read the section entitled Providers of Care for Participants.

PARTICIPATING PHARMACY

A Pharmacy which has entered into an agreement with the Claim Administrator or a third party on behalf of the Claim Administrator to provide Prescription Drug Products to Participants and has agreed to accept specified reimbursement rates

PARTICIPATING PROVIDER

A provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana.

PHARMACY

A state and federally licensed entity that is physically separate and apart from any provider’s office, and where legend drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he or she practices.

PHARMACY BENEFIT MANAGER

The company with whom the Claim Administrator has entered into an agreement for the processing of prescription drug claims.

PHYSICAL THERAPY

Treatment of a disease or Injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and pain relief..

PHYSICIAN

A person licensed to practice medicine in the state where the service is provided.

PLAN

The health benefit plan for Employees of the company, the Plan Document, or any other relevant documents pertinent to the operation and maintenance of the Plan.

PLAN ADMINISTRATOR

The company and/or its designee who is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purpose of the Employee Retirement Income Security Act of 1974, as amended, and any applicable state legislation of a similar nature, the company will be deemed to be the Plan Administrator of the Plan unless by action of the board of directors, the company designates an individual or committee to act as Plan Administrator of the Plan.

PLAN BENEFIT YEAR

The period specified as the Benefit Period in the Schedule of Benefits.

PLAN DOCUMENT

This document which sets forth and governs the rights and duties of the Plan Sponsor, Plan Administrator, Claim Administrator, and Participants under the Plan and modified by any policies, interpretations, rules, practices, and procedures made by the Sponsor.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

PPO-A PREFERRED PROVIDER ORGANIZATION

A provider or group of providers which have contracted with Blue Cross and Blue Shield of Montana to provide services to Participants covered under PPO Benefit contracts.

PPO NETWORK

A provider or group of providers which have a PPO contract with Blue Cross and Blue Shield of Montana. The Participant may obtain a list of PPO providers from Blue Cross and Blue Shield of Montana upon request. Payment to a non-PPO Network provider is subject to the non-PPO Network provider reduction shown in the Schedule of Benefits and the Special Provisions section of this document.

PRESCRIPTION DRUG PRODUCT

A medication, product or device approved by the FDA.

PRIOR AUTHORIZATION

The process that determines in advance the Medical Necessity or Experimental/Investigational/Unproven nature of certain care and services under the Plan Document. Prior Authorization is used to inform the Participant whether or not a proposed service, medication, supply, or on-going treatment is Medically Necessary and is a Covered Medical Expense of the Plan Document.

Prior Authorization does not guarantee that the care and services a Participant receives are eligible for Benefits under the Plan Document. At the time the Participant’s claims are submitted, they will be reviewed in accordance with the terms of the Plan Document.

PROFESSIONAL CALL

An interview between the Participant and the professional provider in attendance. The professional provider must examine the Participant and when appropriate provide or prescribe medical treatment. Professional Call does not include telephone calls or any other communication where the Participant is not examined by the professional provider, except as included in the Benefits section entitled Telehealth and Virtual Visits.

PROOF OF LOSS

The documentation accepted by the Claim Administrator upon which payment of Benefits is made.

PROVIDER INCENTIVE

An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

QUALIFIED HEALTH CARE PROVIDER

A person licensed as a Physician, audiologist, psychologist, social worker, clinical professional counselor, marriage and family therapist, or addiction counselor or another appropriate licensed health care practitioner.

QUALIFIED INDIVIDUAL (FOR AN APPROVED CLINICAL TRIAL)

An individual with group health coverage or group or individual health insurance coverage who is eligible to participate in an Approved Clinical Trial according to the trial protocol for the treatment of cancer or other Life-Threatening Condition because:

1. The referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate; or
2. The individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

RANDOMIZED CLINICAL TRIAL

A controlled, prospective study of patients who have been assigned at random to an experimental group or a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention. The term includes a study of the groups for variables and anticipated outcomes over time.

RECOMMENDED CLINICAL REVIEW

An optional voluntary review of a provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to determine whether the procedure, treatment or test meets approved Claim Administrator Medical Policy guidelines and Medical Necessity requirements.

RECONSTRUCTIVE BREAST SURGERY

Surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

RECOVERY CARE BED

A bed occupied in an Outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATION FACILITY

A facility, or a designated unit of a facility, licensed, certified or accredited to provide Rehabilitation Therapy including:

1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or a facility associated or co-located with a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital; and/or
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Participant, regardless of the category of facility licensure.

REHABILITATION THERAPY

A specialized, intense and comprehensive program of therapies and treatment services (including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy) provided by a Multidisciplinary Team for treatment of an Injury or physical deficit. A Rehabilitation Therapy program is:

1. Provided by a Rehabilitation Facility in an Inpatient Care or Outpatient setting;
2. Provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;
3. Designed to restore the patient's maximum function and independence; and
4. Medically Necessary to improve or restore bodily function and the Participant must continue to show measurable progress.

REHABILITATIVE CARE

Coverage will be provided for Rehabilitative Care services when the Participant requires help to keep, recover or improve skills and functioning for daily living that have been lost or impaired because the Participant was sick, hurt or disabled. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Psychiatric rehabilitation.

These services may be provided in a variety of inpatient and/or Outpatient settings as prescribed by a Physician.

RESIDENTIAL TREATMENT CENTER

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure Medically Necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a residential treatment facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to

be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long-term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

ROUTINE

Examinations or services provided when there is no objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any Injury or Illness.

ROUTINE PATIENT COSTS

All items and services covered by a group health plan or a plan of individual or group health insurance coverage when the items or services are typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. The term does not include:

1. An investigational item, device, or service that is part of the trial;
2. An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis.

SPECIALTY MEDICATIONS

Specialty Medications are used to treat complex medical conditions and are typically given by injection, but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements and may not be stocked by retail Pharmacies. Some conditions such as hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with Specialty Medications.

SPECIALTY PHARMACY

A Pharmacy which has entered into an agreement with the Claim Administrator or a third party on behalf of the Claim Administrator to provide Specialty Medications to Participants and which has agreed to accept specified reimbursement rates.

SPEECH THERAPY

Speech Therapy is the treatment of communication impairment and swallowing disorders.

SPOUSE

The opposite sex or the same sex person to whom the Employee is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

SUBSTANCE USE DISORDER

The uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a licensed addiction counselor or other appropriate medical practitioner.

SUBSTANCE USE DISORDER TREATMENT CENTER

A treatment facility that provides a program for the treatment of an individual’s Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider. The treatment facility must be licensed or approved as a Substance Use Disorder Treatment Center by the Department of Health and Human Services or must be licensed or approved by the state where the facility is located.

SUPPLEMENTAL BREAST EXAMINATION

A Medically Necessary and appropriate examination of the breast, including breast magnetic resonance imaging or breast ultrasound, that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person’s risk of breast cancer.

TELEHEALTH

The use of audio, video, or another telecommunications technology or media, including audio-only communication that is:

1. Used by a health care provider or health care facility to deliver health care services; and
2. Delivered over a secure connection that complies with state and federal laws.

Telehealth does not include delivery of health care services by means of facsimile machine or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

URGENT CARE

Urgent Care services are considered treatment in any setting that, if delayed, could seriously jeopardize the Participant's life and health or ability to regain maximum function or would subject the Participant, in the opinion of a health care provider with knowledge of the Participant's medical condition, to severe pain that cannot be adequately managed without the service or treatment.

VALUE-BASED PROGRAM (VBP)

An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

VIRTUAL VISIT

Consultation with a licensed provider through interactive video, or other communication technology allowed by applicable law, via online portal or mobile application.

IN WITNESS WHEREOF, the Employer has caused this Plan to be duly executed, effective as of the Plan's Effective Date.

Bozeman School District #7

By: _____

Title: _____

Date: _____

Notice That Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under this group health plan coverage no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to reenroll in the plan. Individuals have 30 days beginning with the start of the plan year to request enrollment.

Enrollment will be effective retroactively to the first day of the plan year beginning on or after September 23, 2010.

Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage for children ended before attainment of age 26 are eligible to enroll in this group health coverage, regardless of student status, financial dependency or marital status. Individuals may request enrollment for such children for 30 days beginning with the start of the plan year.

Enrollment will be effective retroactively to the first day of the plan year beginning on or after September 23, 2010.

For additional information regarding these notices, contact:

Blue Cross and Blue Shield of Montana
3645 Alice Street
P.O. Box 660255
Dallas, TX 75266-0255
1-800-447-7828

BOZEMAN SCHOOL DISTRICT #7

VISION REIMBURSEMENT PLAN

Plan Year

The plan year is September 1st through August 31st.

Eligibility

If you, and/or Dependents, are enrolled in the medical care benefit program you are automatically enrolled in the vision plan. Your coverage under this plan will include eligible Employees, retirees, Spouses and Dependent children. Definition of these groups will be the same as in the medical care benefit program.

Once you are in the plan, it is necessary that you notify the School District Benefits Clerk promptly when you have a change in your Dependents. Notification should be made to the Benefits Clerk by completing a new enrollment form when your marital status changes, when you have a new Dependent or when your Dependents are no longer eligible for coverage.

Benefits

This plan will pay 75% of covered vision procedure expenses with a maximum of $250 of annual benefits per covered individual. If the vision process is covered by a medical plan it is not covered by the vision plan; examples are surgery, prescription, accidents, and hospitalization.

Covered Vision Expenses

All vision correction procedures are covered vision expenses if provided by or under the direction of an optometrist or ophthalmologist licensed to practice by the state in which he or she practices. Also covered are glasses and contacts.

Direct Reimbursement Procedure

1. Each claim needs to have an itemized bill and proof of payment (a copy of a cancelled check, a paid receipt or a charge card receipt). Include the name of the Employee and the patient on each bill and receipt.
2. If the claim has been partially paid by another insurance plan, attach a copy of the Explanation of Benefits and your proof of payment.
3. Benefits are paid as a direct reimbursement to the Employee. The claims will be processed weekly, if possible, and the reimbursement will take a minimum of two weeks. The reimbursement will be sent to the mailing address on record in the District Benefits office.
4. Submit claims to:

Vision Claims, Bozeman Schools P.O. Box 520 Bozeman, MT 59771	or	Vision Claims, Bozeman Schools Payroll Office Willson Building

5. Vision expenses are to be submitted within one year of service.

Type of Plan

The Vision Plan is a self-insured reimbursement plan. Premium contributions go directly into a Bozeman School District fund which is used to pay the cost of the benefits and administration for Plan members.

The Vision Plan is a “direct reimbursement” plan, which means that no outside insurance company is involved. The employer will reimburse vision charges as outlined below directly to the eligible Employee. Note this is a reimbursement plan only, liability for vision work remains with the Employee.

Coordination of Benefits Between the Plan and Other Plans

The Plan has been designed to help meet the cost of vision treatment. Since it is not intended that greater benefits be paid to you than your actual vision expenses, the amount of benefits payable under the Plan will take into account any coverage a family member has under other "plans." This Plan may pay deductibles and co-insurance not paid by other plans or programs, if they are within plan benefit amounts.

If a person is covered under this Plan and one or more other plans, as defined below, the benefits payable with respect to him/her under this Plan will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, will not exceed 100% of the allowable expenses.

"Plan" means any plan under which medical or vision benefits or services are provided by group insurance, self-insurance, school, other educational institution, governmental programs or coverage required or provided by any stature, or any similar plan or program.

If your Spouse or Dependents are covered by another vision plan, vision expenses must first be submitted to their plan. Any expenses which are not covered by their plan, and you have paid, may be submitted for reimbursement according to the plan reimbursement schedule.

Plan Termination

The District may terminate the plan upon 30 days notice. Upon termination the right of participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the plan will be communicated to the participants.

Individual Termination of Coverage

If an eligible Employee is terminated or resigns, any vision expense (s) incurred before his/her termination or resignation will be reimbursed as outlined in this Plan.

Unless he/she contributes premium for continued participation as required by COBRA, the coverage of any Employee covered under the Plan shall terminate on the earliest of the following dates:

1. The date of termination of the plan; or;
2. The date his/her membership ceases in an eligible class; or the date all or certain benefits are terminated;
3. The date he/she becomes a full-time member of the Armed Forces of any country; or
4. The date he/she fails to make a required contribution, if any.

Plan is Not a Contract

The Plan shall not be deemed to constitute a contract between the Employer and any Employees or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time, provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Employer with the Bargaining representatives of any Employees.

Plan Design Approved by Plan Participants

April 1998

Rewritten September 1, 2003

Revised September 1, 2005

BOZEMAN SCHOOL DISTRICT #7

DENTAL REIMBURSEMENT PLAN

Plan Year

The plan year is September 1st through August 31st.

Eligibility

Same as defined under the medical care benefit program. Eligibility under this plan will include eligible Employees, retirees, Spouses and Dependent children. Definitions of these groups will be the same as in the medical care benefit program.

Once you are in the plan, it is necessary that you notify the School District Benefits Clerk promptly when you have a change in your Dependents. Notifications should be made to the Benefits Clerk by completing a new enrollment form when your marital status changes, when you have a new Dependent or when your Dependents are no longer eligible for coverage.

Enrollment

Each year the participant will receive an enrollment form. Complete the dental enrollment information and return during the enrollment period, July and August, to the Benefits Clerk in the Willson Building.

Benefits

This plan will pay 100% of the first $200 of covered dental and orthodontic procedure expenses and 50% of additional covered expenses to a maximum of $800 per covered family member per plan year. If the dental process is covered by a medical plan, it is not covered by the dental plan. Examples are surgery, prescription, accidents, and hospitalization.

Covered Dental Expenses

All dental procedures are covered dental expenses if provided by or under the direction of a dentist licensed to practice by the state in which he or she practices.

Direct Reimbursement Procedure

1. Each claim needs to have an itemized bill and proof of payment (a copy of a cancelled check, a paid receipt or a charge card receipt). Include the name of the Employee and the patient on each bill and receipt. It is not necessary to pay the entire bill to submit a claim – you may submit a claim for partial payments of the bill as you pay them.
2. If the claim has been partially paid by another insurance plan, attach a copy of the Explanation of Benefits and your proof of payment to the dentist.
3. Benefits are paid as a direct reimbursement to the Employee. The claims will be processed weekly, if possible, and the reimbursement will take a minimum of two weeks. The reimbursement will be sent to the mailing address on record in the District Benefits office.
4. Submit claims to:

Dental Claims, Bozeman Schools P.O. Box 520 Bozeman, MT 59771	or	Dental Claims, Bozeman Schools Payroll Office Willson Building

5. Dental expenses are to be submitted within one year of service.

Type of Plan

The Dental Plan is a self-insured reimbursement plan. Premium contributions go directly into a Bozeman School District fund which is used to pay the cost of the benefits and administration for Plan members.

The Dental Plan is a “direct reimbursement” plan, which means that no outside insurance company is involved. The Employer will reimburse dental/orthodontic charges as outlined below directly to the eligible Employee. Note this is a reimbursement plan only, liability for dental/orthodontic work remains with the Employee.

Coordination of Benefits Between the Plan and Other Plans

The Plan has been designed to help meet the cost of dental treatment. Since it is not intended that greater benefits be paid to you than your actual dental expenses, the amount of benefits payable under the Plan will take into account any coverage a family member has under other “plans.” This Plan may pay deductibles and co-insurance not paid by other plans or programs, if they are within plan benefit amounts.

If a person is covered under this Plan and one or more other plans, as defined below, the benefits payable with respect to him/her under this Plan will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, will not exceed 100% of the allowable expenses.

“Plan” means any plan under which medical or dental benefits or services are provided by group insurance, self-insurance, school, other educational institution, governmental programs or coverage required or provided by any stature, or any similar plan or program.

If your Spouse or Dependents are covered by another dental plan, dental expenses must first be submitted to their plan. Any expenses which are not covered by their plan, and you have paid, may be submitted for reimbursement according to the plan reimbursement schedule.

Plan Termination

The District may terminate the plan upon 30 days notice. Upon termination the right of participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the plan will be communicated to the participants.

Individual Termination of Coverage

If an eligible Employee is terminated or resigns, any dental or orthodontic expense(s) incurred before his/her termination or resignation will be reimbursed as outlined in this Plan.

Unless he/she contributes premium for continued participation as required by COBRA, the coverage of any Employee covered under the Plan shall terminate on the earliest of the following dates:

1. The date of termination of the plan; or;
2. The date his/her membership ceases in an eligible class; or the date all or certain benefits are terminated;
3. The date he/she becomes a full-time member of the Armed Forces of any country; or
4. The date he/she fails to make a required contribution, if any.

Plan is Not a Contract

The Plan shall not be deemed to constitute a contract between the Employer and any Employees or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time, provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Employer with the Bargaining representatives of any Employees.

Approved by the Joint Insurance Committee

December 9 ,1993

Amended by Plan Participants

April 1998

Rewritten September 1, 2003

Revised September 1, 2005

PLAN DOCUMENT
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of the Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Plan Document to which this Amendment is attached and becomes a part of the Plan Document. Unless otherwise required by Federal or Montana law, in the event of a conflict between the terms on this Amendment and the terms of the Plan Document, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to 'You' and 'Your' mean any Participant, including Subscriber and Dependents.

The Plan Document is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of an in-network Provider as defined in the Plan Document who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the in-network Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Plan Document.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section II. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Plan Document and this Amendment, those terms will apply only to their use in the Plan Document or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious

jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- covered services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSMT for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSMT for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Participant) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Participant) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. <u>Federal No Surprises Act Surprise Billing Protections</u>

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or Out of Pocket Amount, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.



Blue Cross and Blue Shield of Montana
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PO Box 660255
Dallas, TX 75266-0255