

**WRAP PLAN DOCUMENT
FOR MEDICAL, PRESCRIPTION DRUG,
DENTAL AND VISION BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF
STATE OF MONTANA**

This booklet describes the Medical, Prescription Drug,
Dental and Vision Plan Benefits
in effect as of January 1, 2019 and renews January 1, 2020

The Wrap Plan Document has been published
for the benefit of
eligible Employees, Retirees and their Dependents of:

STATE OF MONTANA

The Flex Plan Document and Summary Plan Description for the State of Montana are included as part of the Wrap Plan Document.

The terms of the Wrap Plan Document are not applicable to the Flex Plan Document and Summary Plan Description.

If any conflict arises between the Wrap Plan Document and the Flex Plan Document and Summary Plan Description, the terms of the Flex Plan Document and Summary Plan Description will control first, followed by the Wrap Plan Document.

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INTRODUCTION

Effective January 1, 2019 and renews January 1, 2020, State of Montana, hereinafter referred to as the "State" or "Employer", republished its Wrap Plan Document for the medical, prescription drug, dental and vision benefits, rights and privileges which will pertain to participating Employees, referred to as "Participants," and the eligible Dependents of such Participants, and Retirees and their eligible Dependents, as defined, and which medical, prescription drug, dental and vision benefits are provided through a fund established by the State and referred to as the "Plan" or "Wrap Plan Document". This booklet describes the Plan in effect as of January 1, 2019 and renews January 1, 2020.

Coverage provided under this Wrap Plan Document together with the Summary Plan Descriptions for Employees, Retirees and their Dependents will be in accordance with the Eligibility, Effective Date, Qualified Medical Child Support Order, Termination, Family and Medical Leave Act and other applicable provisions as stated in this Plan.

State of Montana (the Plan Sponsor) has retained the services of independent Plan Supervisors, experienced in claims processing, to handle health, prescription drug, dental and vision claims. The Plan Supervisors for the Plan are:

For Medical Benefits:

Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Dental Benefits:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA, 30023

For Pharmacy Benefits:

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999

For Vision Benefits:

Cigna Vision
P.O. Box 997561
Sacramento, CA 95899-7561

Please read this booklet carefully before incurring any medical expenses. For specific questions regarding coverage or benefits, please refer to the Wrap Plan Document or Summary Plan Descriptions which are available for review in the Personnel Office or at the office of the applicable Plan Supervisor, call or write to the applicable Plan Supervisor listed above regarding any detailed questions concerning the Plan.

These benefits are not intended to, and cannot be used as workers' compensation coverage for any Employee or any covered Dependent of an Employee. Therefore, this Plan generally excludes claims related to any activity engaged in for wage or profit including, but not limited to, farming, ranching, part-time and seasonal activities. See Plan Exclusions for specific information.

The information contained in this Wrap Plan Document is only a general statement regarding FMLA, COBRA, USERRA, and QMCSO's. It is not intended to be and should not be relied upon as complete legal information about those subjects. Covered Persons and Employers should consult their own legal counsel regarding these matters.

Pre-certification or Pre-treatment Review by the Plan is strongly recommended for certain services. If pre-certification or Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.

SEE THE APPENDICES FOR MEDICAL PLAN BENEFITS, PRESCRIPTION DRUG PLAN BENEFITS, DENTAL PLAN BENEFITS AND VISION PLAN BENEFITS IMMEDIATELY FOLLOWING THE WRAP PLAN DOCUMENT.

ELIGIBILITY PROVISIONS

EMPLOYEE ELIGIBILITY

Eligible Employees include the following:

1. Employees of a department or agency of the judicial, legislative and executive branches of the State;
2. Elected Officials;
3. Officers of the legislative branch;
4. Judges;
5. Employees of Montana State Fund; and
6. Members of the legislature.

An Employee becomes eligible under this Plan for each employment status and schedule as follows:

STATUS	SCHEDULE	INSURANCE
Seasonal < 6 months	Full-Time Part-Time Variable	No. Audit for employment > 6 months.
Short-Term Worker	Full-Time Part-Time	Yes.
Short-Term Worker	Variable	No. Audit for 90 days in a year.
Short-Term Recurring	Full-Time Part-Time Variable	No. Audit for 90 days in a year.
Regular Temporary Seasonal	Variable	No. Audit for average hours > 20 hours per week.
Regular Temporary Seasonal	Full-Time Part-Time	Yes.

An Employee is eligible while on active military duty or in a leave of absence status.

WAIVER OF COVERAGE AND RE-ENROLLMENT

If an eligible Employee waives coverage under this Plan, the State Employer contribution continues to accrue to the benefit plan for the group benefit cost (§ 2-18-703, MCA).

An eligible Employee may enroll for Employee only coverage under this Plan at anytime.

STATUS DEFINITIONS

1. "Temporary" means an Employee who is hired on a temporary basis, and will not work in that position more than twelve (12) months. If the Employee is in a Temporary position and meets the requirements of "Seasonal < 6 Months", the Employee is moved into the "Seasonal < 6 Months" status.
2. "Seasonal < 6 Months" means an Employee hired in a position that is both filled for a particular season roughly the same time every AND for a period of less than six (6) months. If the Employee is temporary, employment must be terminated at the end of the six (6) months. If the Employee is permanent, the Employee should be put on a leave of absence without pay at the end of the six (6) month period.
3. "Seasonal" means an Employee who performs duties interrupted by seasons and who may be recalled. Seasonal status is used when the Employee is expected to work six (6) months or more in a "Regular" position that is re-hired roughly the same time every year.
4. "Short-Term Worker" means an Employee who is hired to work ninety (90) days or less in a twelve (12) month period and is in a position that does not recur each year.
5. "Short-Term Recurring" means an Employee who is hired to work ninety (90) days or less in a twelve (12) month period and the position is filled on a recurring basis, roughly the same time of year and within six (6) months.
6. "Regular" means an Employee who is permanent or eligible to become permanent.

SCHEDULE DEFINITIONS

1. "Variable" means an Employee is expected to work an average of less than twenty (20) hours per week, or the number of hours vary, or the days worked are intermittent or unknown. Employee is not offered benefits until the Employee completes a Measurement Period of twelve (12) consecutive months, during which the Variable Employee averages twenty (20) hours per week of actual work and/or paid leave, FMLA leave or jury duty whether paid or not for twelve (12) consecutive months.
2. "Full-Time" means an Employee is expected to work forty (40) hours per week. Employee is offered benefits when employment begins.
3. "Part-time" means an Employee is expected to work an average of twenty (20) hours or more, but less than forty (40) hours per week. Employee is offered benefits when employment begins.

AFFORDABLE CAE ACT (ACA) COVERAGE DETERMINATION DEFINITIONS

1. "Standard Measurement Period" or "SMP" means the 12-month period adopted by the Plan for during which Employees' work hours and applicable leave are measured to determine whether such Employees are eligible for coverage. The SMP begins each year on October 3rd.
2. "Initial Measurement Period" or "IMP" means the initial 12-month period during which a newly hired Employee's work hours and applicable leave is measured to determine whether such Employee is eligible for coverage.
3. "Initial Stability Period" or "ISP" means the 12-month period a Variable Employee may be eligible for coverage under the Plan after completion of an IMP. The Variable Employee remains eligible for benefits during the entire ISP, regardless of the number of hours worked and applicable leave, as long as the Variable Employee remains in active employee status with the Employer. A Variable Employee's ISP begins the first of the month following a 30-day administrative period.

4. "Standard Stability Period" or "SSP" means the 12-month period of time the Employees may be eligible for coverage under the Plan after completion of a SMP. An Employee remains eligible for benefits during the entire SSP, regardless of the number of hours worked and applicable leave, as long as the Employee remains in active employee status with the Employer. The SSP begins each January 1st, which is the 1st of the month following a 90-day administrative period.

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien or is otherwise legally present in the United States or in any other jurisdiction that the related Participant or Retiree has been assigned by the Employer, who submits the Dependent Verification described in the next section, and who is either:

1. The Participant's or Retiree's legal spouse, according to the marriage laws of the state where the marriage was first solemnized or established

An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant or a Retiree and has a court order or decree stating such from a court of competent jurisdiction, and regardless of a court order requirement to carry or pay for a legally separated or divorced spouse's coverage.

2. The Participant's or Retiree's domestic partner provided all of the following "Required Eligibility Conditions" are met:

- A. The Participant or Retiree and domestic partner are both eighteen (18) years of age or older;

- B. The Participant or Retiree and domestic partner share a common residence;

- C. Neither the Participant or Retiree nor the domestic partner is married to any other person;

- D. The Participant or Retiree and domestic partner are not legally related to each other as a parent, brother or sister, half-brother or half-sister, niece, nephew, aunt, uncle, grandparent or grandchild;

- E. The Participant or Retiree and domestic partner have a financially-interdependent relationship as evidenced by at least one (1) of the following:

- 1) Mutually granted powers of attorney or mutually granted health care powers of attorney; or

- 2) Designation of each other as primary beneficiary in wills, life insurance policies, or retirement plans;

and

- F. The Participant or Retiree and domestic partner share a residence.

3. The Participant's or Retiree's Dependent child who meets all of the following "Required Eligibility Conditions":
 - A. Is a natural child; step-child; legally adopted child; a child who has been Placed For Adoption (must provide pre-adoption placement agreement) with the Participant or Retiree or spouse/domestic partner and for whom as part of such placement the Participant or Retiree or spouse/domestic partner has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant or Retiree or spouse/domestic partner has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining eighteen (18) years of age; and
 - B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant's or Retiree's child was mentally handicapped/challenged or physically handicapped/challenged provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant or Retiree for support and maintenance.

An eligible Dependent does not include a spouse of the Dependent child or a child of the Dependent child.

If both spouses are employed by the Employer, and both are eligible for Dependent Coverage, either spouse, but not both, may elect Dependent Coverage for their eligible Dependents. No one can be covered under this Plan as both an Employee and a Dependent. No one can be covered under this Plan as a Dependent by more than one Participant.

VERIFICATION OF DEPENDENT ELIGIBILITY REQUIREMENTS

For each applicable Dependent enrolled, the Participant shall submit the following information:

For a spouse:

1. A copy of the marriage certificate; or
2. A copy of the front page of the most recent tax-return showing the tax filing status as "married". Any financial information may be blacked out; or
3. A copy of the recorded and notarized Affidavit of Common Law Marriage (available on the Health Care & Benefits website at: www.benefits.mt.gov/forms).

For a domestic partner:

1. A Declaration of Domestic Partner Relationship form available at: www.benefits.mt.gov/forms; and
2. Proof of a shared residence; and
3. A copy of mutually-granted powers of attorney or health care powers of attorney; or
4. A copy of mutual designations of primary beneficiary in will, life insurance policies or retirement plans.

For Dependent children:

1. A copy of the Dependent child's birth certificate, adoption order or pre-adoption papers, or
2. A copy of a court-ordered parenting plan, custody agreement or guardianship order.

For stepchildren:

1. Required documentation listed above for domestic partner or spouse, if individual is not enrolled; and
2. A copy of the stepchild's birth certificate, adoption order or pre-adoption papers; or
3. A copy of a court-ordered parenting plan, custody agreement or guardianship order.

For incapacitated children, proof of incapacity must be furnished to the Plan Supervisor as follows:

1. The incapacity commenced before the date the child's Plan coverage would otherwise terminate.
2. The child is dependent upon the eligible Participant or Retiree for support and maintenance within the current meaning of the COBRA disability continuation criteria. In other words, the Social Security Administration (SSA) must have determined that the child is disabled and qualifies for disability benefits through Social Security Disability Insurance (SSDI) or Supplemental Security Insurance (SSI) (SSA documentation must be provided).
3. Notification, SSA documentation and tax documentation must be submitted to the Plan Supervisor within thirty-one (31) days of the date the child's coverage would otherwise terminate.
4. Must submit the most recent tax return which indicates the disabled child is a qualified tax dependent of the Participant or Retiree.
5. Re-certification of the disability may be required annually by the Plan.

For grandchildren:

1. A copy of the grandchild's adoption order or pre-adoption papers; or
2. A copy of a court-ordered custody agreement or legal guardianship.

SURVIVING DEPENDENT ELIGIBILITY

Pursuant to § 2-18-704, MCA, surviving spouses and Dependent children may remain covered as follows:

1. The surviving spouse of a Participant or Retiree may remain a Covered Person of the Plan as long as the spouse is eligible for retirement benefits accrued by the deceased Participant or Retiree as provided by law unless the spouse is eligible for Medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.
2. The surviving children of a Participant may remain Covered Persons of the Plan as long as they are eligible for retirement benefits accrued by the deceased Participant as provided by law unless they have equivalent coverage with substantially the same or greater benefits at an equivalent cost or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

To determine if a Participant, surviving spouse or the surviving children are eligible for retiree benefits as accrued by the deceased Participant, please refer to:

<http://mpera.mt.gov/MEMBERS/member-Handbooks>.

RETIREE ELIGIBILITY

A Retiree is considered eligible for coverage under this Plan only if the Retiree was covered under this Plan as a Participant on their last day of Active Service for the Employer prior to retirement, and coverage is subject to the terms of § 2-18-704, MCA. A Retiree's Dependents and surviving Dependents upon the death of the Retiree are also eligible if the Retiree was eligible for coverage and covered under this Plan, subject to the terms of § 2-18-704, MCA.

The Retiree must notify the Employer within sixty (60) days of the date Active Service ends to continue post-retirement coverage. The Retiree may continue coverage on the Plan on a self-pay basis, retroactive to the date Active Service ended.

A Retiree may transfer coverage and become a Dependent of an actively employed or retired spouse/domestic partner on the Plan while still retaining the right to return to coverage under their own name in the case of an event resulting in loss of eligibility for spouse coverage (divorce, death of the spouse/domestic partner, etc.).

CONTINUATION COVERAGE FOR LEGISLATORS

1. A legislator may continue coverage under this Plan if the legislator:
 - A. Terminates service in the legislature and is a vested member of a state retirement system provided by law; and
 - B. Notifies the Plan in writing within ninety (90) days of the end of the legislator's legislative term.
2. A former legislator may not remain covered under the Plan under the provisions of subsection (1) if the person:
 - A. Is a member of a plan with substantially the same or greater benefits at an equivalent cost; or
 - B. Is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.
3. A legislator who remains covered under the Plan under the provisions of subsection (1) and subsequently terminates coverage may not rejoin the Plan unless the person again serves as a legislator or is eligible under another provision of the Plan.
4. Subsequent monthly benefit payments must be received by the Plan by the first (1st) of each month.
5. A legislator who is involuntarily terminated from performing service in either house of the legislature because of term limits is entitled to remain covered by the Plan and to the continuation of the Employer contributions to the Plan for up to six (6) months from the last day of the legislator's final term of office in that house. The provisions of this section are in addition to the rights and benefits provided under § 2-18-704, MCA and do not affect the right of a legislator to remain on the Plan after six (6) months if the legislator is otherwise eligible under § 2-18-704, MCA, notwithstanding the legislator's eligibility for Medicare, to remain covered.

CONTINUATION COVERAGE FOR JUDGES

1. A member of the judges' retirement system who leaves judicial office but continues to be an inactive vested member of the judges' retirement system as provided by § 19-5-301, MCA, may continue coverage under the Plan if the judge notifies the Plan in writing within ninety (90) days of the end of the judges' judicial service of the judge's choice to continue coverage under the Plan.
2. A former judge may not remain covered under the Plan under the provisions of subsection (1) if the person:
 - A. Is a member of a plan with substantially the same or greater benefits at an equivalent cost; or
 - B. Is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.
3. A judge who remains covered under the Plan under the provisions of this subsection (1) and subsequently terminates membership may not rejoin the Plan unless the person again serves in a position that is eligible under the Plan.

DOMESTIC PARTNER TAX STATUS

For a domestic partner, the Employee must declare the tax status as required by the Internal Revenue Service to apply the proper tax treatment (pre-tax or after-tax) to benefits. The qualification of these individuals as a dependent for tax purposes does not affect their eligibility but impacts the tax treatment of that coverage and any required monthly contributions.

If the tax status is not indicated, the domestic partner will default to non-qualified tax dependent status. The Declaration of Tax Status form is available at: www.benefits.mt.gov.

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan commences at 12:01 A.M. in the time zone in which the Covered Person permanently resides on the date such coverage becomes effective.

PARTICIPANT COVERAGE (Initial Enrollment Period)

Participant coverage under the Plan is retroactively effective to the Enrollment Date and the first day of eligibility for newly-eligible Employees, provided application for enrollment is received within the thirty-one (31) day initial enrollment period. If these requirements are met, the Employee may be offered coverage or an opportunity to waive coverage even if the offer is after the date coverage becomes effective, regardless of the time that has elapsed, provided that the reason coverage was not offered was as a result of an administrative error on the part of the Employer, Plan Administrator or Plan Supervisor.

Participant coverage for a newly-eligible Variable Employee is effective the first of the month following the end of a 30-day or 90-day administrative period, provided application for the enrollment is received within the applicable administrative period. See AFFORDABLE CARE ACT (ACA) COVERAGE DETERMINATION DEFINITIONS.

Elected Officials become eligible to enroll on the first day they take the oath of office or the day the term begins, whichever is earlier.

MID-YEAR OPEN ENROLLMENT

An Employee who waives coverage during their Initial Enrollment Period may enroll other than during an Open Enrollment Period or Special Enrollment Period. An Employee who enrolls outside of the Open Enrollment Period or Special Enrollment Period is effective the first day following the receipt of the online enrollment application.

DEPENDENT COVERAGE (Initial Enrollment Period)

Each Participant who applies for Dependent Coverage on the Plan may become covered for Dependent Coverage as follows:

1. On the Participant's effective date of coverage, if online application for Dependent Coverage is made during the same Initial Enrollment Period and verification of dependent eligibility documentation is submitted. See "Dependent Verification of Eligibility Requirements" within ELIGIBILITY PROVISIONS for required documentation. This subsection applies only to Dependents who are eligible during the Participant's Initial Enrollment Period.
2. In the event Dependent Coverage is waived during the Initial Enrollment Period, refer to Open Enrollment Period or Special Enrollment Period.

OPEN ENROLLMENT PERIOD

The Open Enrollment Period is a two (2) week period in the last quarter of each year, during which an Employee may request Participant coverage changes, or request or waive Dependent coverage.

Coverage requested/waived during any Open Enrollment Period begins on the first day of the subsequent Plan Year following the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

“Special Enrollment Period” means a period of time allowed under this Plan, other than the eligible person’s Initial Enrollment Period or an Open Enrollment Period, during which an eligible person may request coverage under this Plan as a result of certain events that create special enrollment rights.

In addition to other enrollment times allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below. Dependent verification is required for all events. See “Dependent Verification of Eligibility Requirements” within ELIGIBILITY PROVISIONS for required documentation.

Automatic coverage of an infant born to a Plan Participant or a Plan Participant’s covered spouse begins at birth for a thirty-one (31) day period. Automatic coverage for a thirty-one (31) day period does not apply to the newborn grandchild of a Plan Participant or a Plan Participant’s covered spouse. Permanent coverage becomes effective as stated below for birth, adoption and Placement for Adoption if the Employee completes the online event application and verification of dependent eligibility documentation is submitted within ninety-one (91) days of the special enrollment event. See “Dependent Verification of Eligibility Requirements” within ELIGIBILITY PROVISIONS for required documentation.

Coverage becomes effective as stated below for all other special enrollment events if the Employee completes the online event application and verification of dependent eligibility documentation is submitted within sixty (60) days of the special enrollment event. See “Dependent Verification of Eligibility Requirements” within ELIGIBILITY PROVISIONS for required documentation. If coverage becomes effective due to Loss of Coverage, documentation showing proof of loss will also be required to be submitted within sixty (60) days of the loss.

1. An eligible Employee or Retiree may enroll eligible Dependents who are acquired under the following specific events, and coverage will become covered on the date of event:
 - A. Marriage to the Employee.
2. An eligible Employee or Retiree, and all eligible Dependents who are not enrolled, may enroll and become covered under the following specific events and coverage will become effective on the date of the event:
 - A. Birth of the Participant’s child or birth of the spouse or domestic partner’s child; or
 - B. Adoption of a child by the Participant, provided the child is under the age of 18; or
 - C. Placement for Adoption with the Employee (must provide pre-adoption placement agreement), provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 18; or
 - D. Establishment of domestic partnership.
3. The following individuals may enroll and become covered when Loss of Coverage is experienced, subject to the following:
 - A. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee who also lost coverage may enroll and become covered as of the date of the loss.
 - B. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee who previously waived coverage may enroll and become covered as of the date of the loss.

- C. If an eligible Dependent of a covered Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered as of the date of the loss.

Loss of Coverage means one of the following:

- A. COBRA Continuation Coverage under another plan has been terminated because the maximum period of COBRA Continuation Coverage under the other plan has been exhausted; or
- B. Group or insurance health coverage has been terminated as a result of termination of employer contributions* towards the other coverage; or
- C. Group or insurance health coverage (includes other coverage that is Medicare) has been terminated as a result of a loss of eligibility for coverage for any of the following reasons:
 - 1) Legal separation or divorce of the eligible Employee;
 - 2) Cessation of Dependent status;
 - 3) Death of the eligible Employee;
 - 4) Termination of employment of the eligible Dependent;
 - 5) Reduction in the number of hours of employment of the eligible Dependent;
 - 6) Termination of the eligible Dependent's employer's plan;
 - 7) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or
 - 8) Any loss of eligibility for individual or group coverage because the eligible Employee or Dependent no longer resides, lives or works in the service area of a HMO or other such plan.

*Employer contributions include contributions by any current or former employer that was contributing to the other non-COBRA coverage.

A Loss of Coverage does not occur if coverage was terminated due to a failure of the Employee or Dependent to pay premiums on a timely basis or coverage was terminated for cause.

- 4. Individuals may enroll and become covered as of the date of coverage loss under this Plan when coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 is terminated due to loss of eligibility, subject to the following:
 - A. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
 - B. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee who previously waived coverage may enroll and become covered.
 - C. If an eligible Dependent of a covered Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.
- 5. Individuals who are eligible for coverage under this Plan may enroll and become covered on the date they become entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement is the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (CHIP or Medicaid).

COURT ORDERED ENROLLMENT

An eligible Dependent for whom the Employee is the legal guardian, or that the Employee is required to cover as result of a valid court order or by operation of law may enroll and become covered on the date the Employee assumes the legal obligation for total or partial support of the Dependent provided the Employee completes the online life event application and submits the required verification of dependent eligibility documentation (copy of court order) within sixty (60) days of the date the Employee assumes the legal obligation.

If the Employer received a Qualified Medical Child Support Order (QMCSO) the effective date of coverage will be the date of receipt of the QMCSO.

CHANGE IN STATUS

If a Covered Dependent under this Plan becomes an eligible Employee of the Employer, the Covered Dependent may continue their coverage as a Dependent or elect to be covered as a Participant, but may not be covered as both a Dependent and a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of the State, but is eligible to be covered as a Dependent under another Participant, the former Employee may elect to continue their coverage as a Dependent of such Participant.

The online life event application and any required verification of dependent eligibility documentation must be submitted within sixty (60) days of the date the Employee becomes or ceases to be an eligible Employee. See "Dependent Verification of Eligibility Requirements" within ELIGIBILITY PROVISIONS for required documentation.

JOINT CORE COVERAGE

Under Joint Core, the family is subject to only one Out-of-Pocket Maximum.

Joint Core enrollment is available when two (2) Employees are:

- A. Married;
- B. Both spouses are covered under the Plan; and
- C. Cover at least one (1) Dependent under the Plan.

Contact the Health Care & Benefits Division (HCB) at (800) 287-8266 or benefitsquestions@mt.gov for additional information regarding Joint Core eligibility.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

Pursuant to Section 609(a) of ERISA, the Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified in accordance with ERISA's requirements, to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. Employer adopts ERISA standards to comply with child support enforcement obligation of Part D of Title IV of the Social Security Act of 1975 as amended.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.
2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:
 - A. Provides for child support for a child of a Participant under this Plan;
 - B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and
 - C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.
3. "Plan" means this self-funded Employee Health Benefit Plan, including all supplements and amendments in effect.
4. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Plan Administrator to meet the qualification requirements as outlined under "Procedures" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

To be qualified, a Medical Child Support Order must clearly:

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and
2. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

In the case of any Medical Child Support Order received by this Plan:

1. The Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the plan's procedures for determining whether Medical Child Support Orders are qualified orders; and
2. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination.

NATIONAL MEDICAL SUPPORT NOTICE

If the plan administrator of a group health plan which is maintained by the employer of a non-custodial parent of a child, or to which such an employer contributes, receives an appropriately completed National Medical Support Notice as described in Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the criteria shown above for a qualified order, the Notice will be deemed to be a Qualified Medical Child Support Order in the case of such child.

FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act (FMLA) requires Employers who are subject to FMLA to allow their “eligible” Employees to take unpaid, job-protected leave. The Employer may also require or allow the Employee to substitute appropriate paid leave including, but not limited to, vacation and sick leave, if the Employee has earned or accrued it. The maximum leave required by FMLA is twelve (12) workweeks in any twelve (12) month period for certain family and medical reasons and a maximum combined total of twenty-six (26) workweeks during any twelve (12) month period for certain family and medical reasons and for a serious Injury or Illness of a member of the Armed Forces to allow the Employee, who is the spouse, son, daughter, parent, or next of kin to the member of the Armed Forces, to care for that member of the Armed Forces. In certain cases, this leave may be taken on an intermittent basis rather than all at once, or the Employee may work a part-time schedule.

DEFINITIONS

For these Family and Medical Leave Act of 1993 provisions only, the following definitions apply:

1. “Member of the Armed Forces” includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation or therapy.
2. “Next of Kin” means the nearest blood relative to the service member.
3. “Parent” means Employee’s biological parent or someone who has acted as Employee’s parent in place of Employee’s biological parent when Employee was a son or daughter.
4. “Serious health condition” means an Illness, Injury impairment, or physical or mental condition that involves:
 - A. Inpatient care in a hospital, hospice, or residential medical facility; or
 - B. Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services).
5. “Serious Injury or Illness” means an Injury or Illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform his or her military duties.
6. “Son or daughter” means Employee’s biological child, adopted child, stepchild, legal foster child, a child placed in Employee’s legal custody, or a child for which Employee is acting as the parent in place of the child’s natural blood related parent. The child must be:
 - A. Under the age of eighteen (18); or
 - B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.
7. “Spouse” means a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides, including “common law” marriage and same-sex marriage.

EMPLOYERS SUBJECT TO FMLA

In general, FMLA applies to any employer engaged in interstate commerce or in any industry or activity affecting interstate commerce who employs 50 or more Employees for each working day during each of 20 or more calendar work weeks in the current or preceding Calendar Year. FMLA also applies to those persons described in Section 3(d) of the Fair Labor Standards Act, 29 U.S.C. 203(d). The FMLA applies to government entities, including branches of the United States government, state governments and political subdivisions thereof. FMLA does not apply to members of the Montana Legislature.

ELIGIBLE EMPLOYEES

Generally, an Employee is eligible for FMLA leave only if the Employee satisfies all of the following requirements as of the date on which any requested FMLA leave is to commence: (1) has been employed by the Employer for a total of at least twelve months (whether consecutive or not); (2) the Employee has worked (as defined under the Fair Labor Standards Act) at least 1,250 hours during the twelve-(12) month period immediately preceding the date the requested leave is to commence; (3) the Employee is employed in any state of the United States, the District of Columbia or any Territories or possession of the United States; and (4) at the time the leave is requested, the Employee is employed at a work site where 50 or more Employees are employed by the Employer within 75 surface miles of the work site.

REASONS FOR TAKING LEAVE

FMLA leave must be granted (1) to care for the Employee's newborn child; (2) to care for a child placed with the Employee for adoption or foster care; (3) to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; (4) because the Employee's own serious health condition prevents the Employee from performing his or her job; or (5) because of a qualifying exigency, as determined by the Secretary of Labor, arising out of the fact that a spouse, son, daughter or parent of the Employee is on active duty or has been called to active duty in the Armed Forces in support of a contingency operation (e.g., a war or national emergency declared by the President or Congress).

ADVANCE NOTICE AND MEDICAL CERTIFICATION

Ordinarily, an Employee must provide thirty (30) days advance notice when the requested leave is "foreseeable." If the leave is not foreseeable, the Employee must notify the Employer as soon as is practicable, generally within one to two working days. An employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee's serious health condition, the Employer may require second or third opinions, at the Employer's expense, and a certification of fitness to return to work prior to allowing the Employee to return to work.

PROTECTION OF JOB BENEFITS

For the duration of FMLA leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same conditions as coverage would have been provided if the Employee had been in Active Service during FMLA leave period. Taking FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave, unless the loss would have occurred even if the Employee had been in Active Service.

UNLAWFUL ACTS BY EMPLOYERS

Employers cannot interfere with, restrain or deny the exercise of any right provided under the FMLA or to manipulate circumstances to avoid responsibilities under the FMLA. Employers may not discharge, or discriminate against any person who opposes any practice made unlawful by the FMLA or who may be involved in a proceeding under or relating to the FMLA.

ENFORCEMENT

The U.S. Department of Labor is authorized to investigate and resolve complaints of FMLA violations. An eligible Employee may also bring a civil action against an employer for FMLA violations. The FMLA does not supersede any federal or state law prohibiting discrimination, and does not supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. For additional information, contact the nearest office of Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant coverage will automatically terminate at 12:00 P.M. upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Employee is employed;
2. On the last day of the month in which the Participant ceases to be eligible for coverage;
3. The last day of the month for which the Participant fails to make any required contribution for coverage;
4. On the last day of the month the Plan is terminated;
5. The date the State terminates the Participant's coverage;
6. The date the Participant dies; or
7. For Variable Employees on the last day of the Stability Period, unless at the expiration of the Stability Period, the Participant is otherwise eligible as the result of a subsequent Measurement Period or as a result of status change to a Full-Time or Part-Time Employee.

A Participant whose Active Service ceases because of Illness or Injury or as a result of any other approved leave of absence may remain covered as an Employee in Active Service for a period of twelve (12) weeks, or such other length of time that is consistent with and stated in the State's current Employee Personnel Policy Manual or pursuant to the Family and Medical Leave Act. Coverage under this provision is subject to all the provisions of FMLA if the leave is classified as FMLA leave.

Under the State Employee Protection Act (§§ 2-18-1201 through 2-18-1206, MCA), a Participant whose Active Service ceases due to temporary layoff is considered employed by the State for the purposes of his/her coverage under this Plan, and such coverage may continue for six (6) months from the effective date of the layoff, or until the Participant becomes employed in a job that provides comparable benefits and must only self-pay the employee benefit payments. See REDUCTION IN FORCE CONTINUATION COVERAGE for additional information.

If a Participant's coverage is to be continued during disability, approved leave of absence or temporary layoff, the amount of his or her coverage is the same as the Plan benefits in force for an active Employee, subject to the Plan's right to amend coverage and benefits.

A Participant who has been continuously covered under the Plan since August 1, 1998 whose Active Service ceases other than for death is entitled to an additional month of the Employer contribution and Participant and Dependent coverage provided any required Employee contributions are paid. This is referred to as the "grandfathered" month.

RETIREE TERMINATION

Retiree coverage will automatically terminate at 12:00 P.M. upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which final benefits payments are made;
2. The date the Plan is terminated;

3. The date the State terminates the Retiree's coverage; or
4. The day following the date the Retiree dies.

REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of termination of employment and who again becomes eligible for coverage under the Plan within a thirteen (13) week period immediately following the date of such termination of employment will become eligible for reinstatement of coverage on the date of renewed eligibility. Coverage is reinstated for the Employee and eligible Dependents on the date of renewed eligibility. Reinstatement of Coverage is subject to the following:

1. Credit may be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.
2. All prior accumulations toward annual or lifetime benefit maximums apply.

If renewed eligibility occurs under any circumstances other than as stated in this sub-section, enrollment for coverage for the Employee and their Dependents is treated as if initially hired for purposes of eligibility and coverage under this Plan.

Employees terminated and rehired within thirty-one (31) days are automatically reinstated in the same benefit options elected prior to termination. Employees terminated and rehired after thirty-one (31) days shall complete the new hire enrollment process.

The Reinstatement of Coverage provision is not applicable to a Variable Employee except for any period of time that the Variable Employee is actually enrolled and covered during the Stability Period.

DEPENDENT TERMINATION

Each Covered Person, whether Participant or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of Dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage After Termination.

Coverage for a Dependent automatically terminates at 12:00 P.M. upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan;
2. On the last day of the month in which the Participant's coverage terminates under the Plan;
3. On the last day of the month in which the Participant ceases to be eligible for Dependent Coverage;
4. The last day of the month for which the Participant fails to make any required contribution for Dependent Coverage;
5. The date the Plan is terminated;
6. The date the State terminates the Dependent's coverage;
7. The last day of the month following the date the Participant dies, or the last date of the month following the date the Retiree, or other self-pay participant, or COBRA Qualified Beneficiary dies;

8. The date the Dependent dies;
9. On the last day of the month in which the Dependent experienced an event that qualifies for a Special Enrollment Period, as long as the online life event application and event verification documentation is submitted within sixty (60) days of the event; or
10. In the event notice of Dependent ineligibility is not received within sixty (60) days, on the first day of the month following receipt of online notification of the Dependent's ineligibility. This subsection does not apply if the Dependent is still eligible for Plan coverage.

RESPONSIBILITY TO REMOVE INELIGIBLE DEPENDENTS

It is the member's responsibility (Employee, Retiree, COBRA enrollee, or surviving spouse/domestic partner) to remove any Dependents that cease to be eligible from coverage within sixty (60) days of the date eligibility is lost. The Employee, Retiree, COBRA enrollee, or surviving spouse/domestic partner is responsible for repayment of any claim dollars paid out for an ineligible Dependent. Any excess benefit contributions paid for the terminated Dependent are refunded as applicable based upon the termination date assigned under "Dependent Termination".

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant shall receive written notice at least thirty (30) days before the coverage is rescinded.

CONTINUATION COVERAGE AFTER TERMINATION

Under the Public Health Service Act, as amended, Employees, spouses or domestic partners and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more employees.

The Plan Administrator is State of Montana, 100 N. Park St. Suite 320, P.O. Box 200130, Helena, MT, 59620 (406) 444-7462, (800)287-8266, TTY: (406) 444-1421, (406) 444-0080 (Fax), benefitsquestions@mt.gov (Email). COBRA Continuation Coverage for the Plan is administered by: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222, (406) 523-3131 (Fax), COBRAinquire@askallegiance.com (Email).

COBRA Continuation Coverage is available to any Qualified Beneficiary whose coverage would otherwise terminate due to any Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day immediately following the date coverage terminates as a result of a Qualifying Event.

1. Qualifying Events for Participants, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:
 - A. The termination (other than by reason of gross misconduct) of the Participant's employment.
 - B. The reduction in hours of the Participant's employment.
2. Qualifying Events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:
 - A. Death of the Participant or Retiree.
 - B. Termination of the Participant's employment.
 - C. Reduction in hours of the Participant's employment.
 - D. The divorce or legal separation of the Participant or Retiree from his or her spouse.
 - E. A covered Dependent child ceases to be a Dependent as defined by the Plan.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Employer of the following Qualifying Events within sixty (60) days after the date the event occurs. The Employer must notify the Plan Supervisor of any of the following:

1. Death of the Participant or Retiree.
2. The divorce or legal separation of the Participant or Retiree from his or her spouse.
3. A covered Dependent child ceases to be a Dependent as defined by the Plan.

The Employer must notify the Plan Supervisor of the following Qualifying Events within thirty (30) days after the date of the event occurs:

1. Termination (other than by reason of gross misconduct) of the Participant's employment.
2. Reduction in hours of the Participant's employment.

ELECTION OF COVERAGE

When the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than fourteen (14) days after the Plan Administrator is notified of the Qualifying Event.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notification from the Plan Administrator, whichever is later, to notify the Plan Administrator that he or she elects to continue coverage under the Plan. Failure to elect continuation within that period will cause coverage to end.

MONTHLY PREMIUM PAYMENTS

A Qualified Beneficiary is responsible for the full cost of Continuation Coverage. Monthly premium for continuation of coverage must be paid in advance to the Plan Administrator. The premium required under the provisions of COBRA is as follows:

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).
2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.
3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:
 - A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce or legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.
 - B. If the second Qualifying Event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Plan Administrator of the applicable monthly premium for such coverage. The monthly premium for Continuation Coverage under this provision is due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Employer.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222, (406) 523-3131 (Fax), COBRAInquire@askallegiance.com (Email).

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and Dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and Dependent children if the former employee dies or becomes divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. **In all of these cases, the Plan Supervisor must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222, (406) 523-3131 (Fax), COBRAinquire@askallegiance.com (Email). Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

The dependents of a former employee are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of the former employee's enrollment in Part A and Part B of Medicare, whichever occurs earlier.

When the former employee enrolls in Medicare before the Qualifying Event of termination, or reduction in hours, of employment occurs, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends on the later of:

1. Eighteen (18) months after the Qualifying Event of termination of employment or reduction in hours of employment; or
2. Thirty-six (36) months after the former employee's enrollment in Medicare.

When the former employee enrolls in Medicare after the Qualifying Event of termination, or reduction in hours, of employment, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends eighteen (18) months after the Qualifying Event, unless a second Qualifying Event, as described above occurs within that eighteen (18) month period.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage and any coverage under the Plan that has been elected with respect to any Qualified Beneficiary will cease on the earliest of the following:

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance.
2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A and Part B).
3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to the Plan Administrator.
4. On the date the Employer ceases to provide any group health plan coverage to any Employee.
5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.
6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:
 - A. Eighteen (18) months for a former employee who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment;

- B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen-month period entitling that Dependent to an additional eighteen (18) months;
 - C. For the Dependent who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment of the former employee if that former employee enrolled in Medicare before termination, or reduction in hours, of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.
 - D. On the first day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.
 - E. Twenty-nine (29) months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.
 - F. Thirty-six (36) months for all other Qualified Beneficiaries.
7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222, (406) 523-3131 (Fax), COBRAinquire@askallegiance.com (Email), or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

In order to protect the Employee's family's rights, the Employee should keep the Plan Administrator informed of any changes in the addresses of family members. The Employee should also keep a copy, for his/her records, of any notices sent to the Plan Administrator.

REDUCTION IN FORCE CONTINUATION COVERAGE

During the period of unemployment as a result of privatization, reorganization of an agency, closure of or a reduction in force at an agency or other actions by the legislature, the employee is entitled to remain covered by the state's group health insurance plan and to the continuation of the employer's contribution to the employee's group health insurance for six (6) months from the effective date of layoff or until the employee becomes employed, whichever occurs first. (§ 2-18-1205, MCA)

A covered Employee may continue coverage under this Plan for a period of six (6) months following termination due to a reduction in force (RIF). A covered Employee will continue to receive the Employer contribution for the six-month period and all benefits will remain intact (with the exception of the Dependent Flexible Spending Account).

Reduction in force continuation coverage is subject to the following requirements:

1. The Employee's position must fall within the definition of RIF.
2. The Employee must remain in the current position until the RIF date.
3. The Employee must continue to pay the out-of-pocket contribution amount.

If the Employee obtains another position with the State of Montana and becomes eligible for benefits, the Employee's coverage will automatically continue as an active Employee under the new position.

In the event the Employee is eligible for retirement at the end of the six (6) month period, the following conditions apply:

Retirement before age sixty-five (65):

1. The Employee may continue coverage under the Plan as a Retiree, will not receive the Employer contribution. The Employee may continue until age sixty-five (65), and will then be moved to Medicare Retiree; or
2. The Employee may terminate coverage and move to another health insurance product (Insurance Market plan, spouse plan, etc.)

Retirement after age sixty-five (65):

1. The Employee may enroll in Medicare and continue on the State Plan as a Medicare Retiree, will not receive the Employer contribution; or
2. The Employee may terminate coverage and move to Medicare Part A, Part B, or Part D, Medicare Supplement Plan or Medicare Advantage Plan.

The following rules apply immediately following the six (6) month period of time in which the Employee is entitled to continue on the State Plan and receive the Employer contribution:

1. A 1985 federal law (P.L. 99-272, Title X), the Consolidated Omnibus Budget Reconciliation Act (COBRA), modified by the 1996 Health Insurance Portability and Accountability Act (HIPAA), gives employees and all covered dependents who are losing edibility for employer group health care benefits the right to continue certain coverage by self-paying the entire monthly group benefits payment.

2. The Employee will receive a letter from the State of Montana containing a summary of rights under federal law to continue group health care benefits upon termination of existing benefits. The Employee and Dependents losing eligibility due to a Qualifying Event also receive this letter to ensure the Employee receives the information needed to choose whether or not to continue health care benefits under COBRA.

COVERAGE FOR A MILITARY RESERVIST

To the extent required by the Uniform Services Employment and Reemployment Rights Act (USERRA), the following provisions will apply:

1. If a Participant's employment is terminated with Employer by reason of service in the uniformed services, the Participant may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:
 - A. The twenty-four (24) month period beginning on the date on which the Participant's absence begins; or
 - B. The period beginning on the date on which the Participant's absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment, as required by USERRA.
2. A Participant who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.
3. In the case of a Participant whose coverage under the Plan is terminated by reason of service in the uniformed services, an exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who notifies the Employer of his or her intent to return to employment in a timely manner as defined by USERRA, and is reemployed and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee. **This provision will not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.**
4. The requirements of this section shall not supersede any anti-discrimination in coverage requirement promulgated by TriCare or Champus/VA related to eligibility for those coverages.

COVERAGE FOR A MONTANA NATIONAL GUARD MEMBER

To the extent required by the Montana Military Service Employment Rights Act (MMSERA), the following provisions will apply:

“State Active Duty” means duty performed by a Montana National Guard member when a disaster is declared by the proper State authority and shall include the time period as certified by a licensed Physician to recover from an Illness or Injury incurred while performing the state active duty.

1. In any case in which a Covered Person has coverage under this Plan, and such Covered Person is absent from employment with Employer by reason of State Active Duty, the Covered Person may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election shall be the period beginning on the thirty-first consecutive day of State Active Duty and ending on the day immediately before the day the Covered Person returns to a position of employment with the Employer, provided the Covered Person returns to employment in a timely manner, or ending on the day immediately after the day the Covered Person fails to return to a position of employment in a timely manner.

For purposes of this subsection, a timely manner means the following:

- A. For State Active Duty of thirty (30) days but not more than one hundred eighty (180) days, the next regularly scheduled day of Active Service following fourteen (14) days after the termination of State Active Duty.
 - B. For State Active Duty of more than one hundred eighty (180) days, the next regularly scheduled day of Active Service following ninety (90) days after the termination of State Active Duty.
2. An eligible Covered Person who elects to continue Plan coverage under this Section may be required to pay:
 - A. Not more than one hundred percent (100%) of the contribution required from a similarly situated active Employee until such Covered Person becomes eligible for coverage under the State of Montana Health Benefit Plan as an employee of the Department of Military Affairs.
 - B. Not more than one hundred two percent (102%) of the contribution required from a similarly situated active Employee for any period of time that the Covered Person is also eligible for coverage under the State of Montana Health Benefit Plan as an employee of the Department of Military Affairs.
 3. In the case of a person whose coverage under the Plan is terminated by reason of State Active Duty, a Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if such an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who is reemployed in a timely manner as defined by MMSERA and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee.
 4. **In no event will this Plan cover any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State Active Duty.**
 5. The requirements of this section shall not supersede any anti-discrimination in coverage requirement promulgated by TriCare or Champus/VA related to eligibility for those coverages.

COORDINATION OF BENEFITS

The Coordination of Benefits provision prevents the payment of benefits which exceed the Allowable Expense. It applies when the Participant or Dependent who is covered by this Plan is or may also be covered by any other plan(s). This Plan pays either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan(s), may not exceed 100% of the Allowable Expense. Only the amount paid by this Plan may be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization is hereby given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Wrap Plan Document are subject to this provision.

This Plan will be primary for any charges covered under this Plan that may also be covered under another plan sponsored by the State.

DEFINITIONS

“Allowable Expense” as used herein means:

1. If the claim as applied to the primary plan is subject to a contracted or negotiated rate, Allowable Expense is equal to that contracted or negotiated amount.
2. If the claim as applied to the primary plan is not subject to a contracted or negotiated rate, but the claim as applied to the secondary plan is subject to a contracted or negotiated rate, the Allowable Expense is equal to that contracted or negotiated amount of the secondary plan.
3. If the claim as applied to the primary plan and the secondary plan is not subject to a contracted or negotiated rate, then the Allowable Expense is equal to the secondary plan’s chosen limits for non-contracted providers.

“Plan” as used in this Coordination of Benefits section means any plan providing benefits or services for or by reason of medical, prescription drug, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis including, but not limited to:
 - A. Hospital indemnity benefits; and
 - B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A licensed Health Maintenance Organization (HMO);
5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or

6. Any coverage under a governmental program and any coverage required or provided by any statute; or
7. Auto or premises “no fault” medical payment coverage in automobile or premises insurance (also known as Med Pay or PIP).

“Plan” in this Coordination of Benefits section is construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION

1. **Non-Dependent/Dependent:**

The plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. **Dependent Child Covered Under More Than One Plan:**

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

- A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - 1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - 2) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - 1) 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. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
 - 2) 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 subparagraph A of this paragraph shall determine the order of benefit;
 - 3) 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 subparagraph A of this paragraph shall determine the order of benefit;
 - 4) If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
 - a) The plan covering the custodial parent;
 - b) The plan covering the custodial parent’s spouse;
 - c) The plan covering the non-custodial parent; and then
 - d) The plan covering the non-custodial parent’s spouse.

- C. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a or b of this paragraph as if those individuals were parents of the child.
- D. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph 5 applies.
- E. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in subparagraph A to the dependent child's parent(s) and the dependent's spouse.

3. Active Employee or Retired or Laid-Off Employee

- A. The plan that covers a person as an active employee that is an employee who is neither laid-off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
- B. 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.
- C. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.

4. COBRA or State Continuation Coverage:

- A. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering the same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
- B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- C. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.

5. Longer or Shorter Length of Coverage

- A. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered person for the shorter period of time is the secondary plan.
- B. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.
- C. The start of a new plan does not include:
 - 1) A change in the amount or scope of a plan's benefits;
 - 2) A change in the entity that pays, provides or administers the plan's benefits; or
 - 3) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

- D. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
6. If none of the preceding rules determines the order of benefits, the Allowable Expense shall be shared equally between the plans.

COORDINATION WITH MEDICARE

Medicare Part A and Part B will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits.

1. For Working Aged

A covered Employee who is eligible for Medicare Part A and Part B as a result of age may be covered under this Plan and be covered under Medicare in which case this Plan will pay primary. A covered Employee, eligible for Medicare Part A and Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan terminates.

A covered Dependent, eligible for Medicare Part A and Part B as a result of age, of a covered Employee may also be covered under this Plan and be covered under Medicare in which case this Plan again will pay primary. A covered Dependent, eligible for Medicare Part A and Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan terminates.

2. For Retired Persons

Medicare is primary and this Plan is secondary for the covered Retiree if the Retiree is an individual who is enrolled in Medicare Part A as a result of age.

Medicare is primary and this Plan is secondary for the covered Retiree's Dependent who is enrolled in Medicare Part A if both the covered Retiree and the covered Dependent are enrolled in Medicare Part A as a result of age and retired.

Medicare is primary for the Retiree's Dependent when the Retiree is not enrolled for Medicare Part A as a result of age and the Retiree's Dependent is enrolled in Medicare Part A as a result of age.

3. For Covered Persons who are Disabled

This Plan is primary and Medicare is secondary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability, if the Employee is actively employed by the Employer.

This Plan is secondary and Medicare is primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

4. **For Covered Persons with End Stage Renal Disease**

Except as below stated*, for Employees or Retirees and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan is primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan is secondary with respect to Medicare coverage, unless after the thirty-month period described, the Covered Person has no dialysis for a period of twelve (12) consecutive months and:

- A. Resumes dialysis, at which time this Plan becomes primary for a period of thirty (30) months; or
- B. Undergoes a kidney transplant, at which time this Plan becomes primary for a period of thirty (30) months.

*If a Covered Person is covered by Medicare as a result of disability and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare continues to be primary and this Plan is secondary.

Federal law requires that group health plans report certain information about individuals covered under its group health plan for the purpose of coordinating benefits with Medicare under the Medicare Secondary Payer Rules. Information required to be reported includes the Social Security Numbers (SSNs) for all Participant's and all Dependents over the age of forty-four (44).

COORDINATION WITH MEDICAID

If a Covered Person is covered by Medicaid, this Plan is primary and Medicaid is secondary.

COORDINATION WITH TRICARE/CHAMPVA

If a Covered Person is covered under TRICARE/CHAMPVA, this Plan is primary and TRICARE/CHAMPVA is secondary. TRICARE coverage includes programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

If the Covered Person is eligible for Medicare and entitled to veterans benefits through the Department of Veterans Affairs (VA), this Plan is primary and the VA is secondary for non-service connected medical claims. For these claims, this Plan makes payment to the VA as though this Plan was making payment secondary to Medicare.

PROCEDURES FOR REQUESTING ELIGIBILITY REVIEW

The Plan offers a one-level review procedure for a review of an adverse eligibility determination. The request for reconsideration must be submitted in writing to the Plan Administrator within one-hundred eighty (180) days of the receipt of the eligibility denial and include an explanation of why the Employee disagrees with the eligibility denial. The Employee must include any supporting documentation or records with the written request for reconsideration. The letter should be addressed to the Plan Administrator at:

Plan Administrator
Health Care & Benefits Division
Attn: Eligibility Appeals Committee
100 North Park Ave, Suite 320
Helena, MT 59620

The Plan Administrator will review the Employee's request and all submitted documentation. If additional records are necessary to make a determination of the request, the Plan Administrator will notify the Employee. The time for making a determination on the request will be deferred from the date that additional information is requested until the date the information is received by the Plan Administrator. The Plan Administrator will provide its decision in writing to the Employee within thirty (30) days of the receipt of the Employee's written request.

A written request for reconsideration of an eligibility denial is not considered an appeal and is not eligible for review under the Plan's appeal procedures for adverse determination on medical, prescription drug, dental and vision claims. However, a denial on a submitted claim for any medical, prescription drug, dental or vision benefits due to a denial of the Employee's eligibility on the Plan must be appealed under the Procedures for Claiming Medical, Prescription Drug, Dental and Vision Benefits.

PROCEDURES FOR CLAIMING MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION BENEFITS

Medical, prescription drug, dental and vision claims must be submitted to the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan within twelve (12) months after the date services or treatments are received or completed. Non-electronic claims may be submitted on any approved medical, prescription drug, dental or vision claim form, available from the provider. The claim must be completed in full with all the requested information. A complete claim must include the following information:

- Date of service;
- Name of the Participant;
- Name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- Diagnosis [code] of the condition being treated;
- Treatment or service [code] performed;
- Amount charged by the provider for the treatment or service; and
- Sufficient documentation, in the sole determination of the Plan Administrator, to support the Medical or Dental Necessity of the treatment or service being provided and sufficient to enable the Medical, Prescription Drug, Dental or Vision Plan Supervisor to adjudicate the claim pursuant to the terms and conditions of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan.

Medical, prescription drug, dental and vision claims are processed separately. See the "CLAIMS PROCESSING" section for where to send medical, prescription drug, dental and vision claims.

A claim will not, under any circumstances, be considered for payment of benefits if initially submitted to the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan more than twelve (12) months from the date that services were incurred.

Upon termination of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan, final claims must be received within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

CLAIMS ARE NOT DEEMED SUBMITTED UNTIL RECEIVED BY THE APPROPRIATE PLAN SUPERVISOR.

The Plan Administrator has the right, in its sole discretion and at its own expense, to require a claimant to undergo a medical, prescription drug, dental or vision care examination, when and as often as may be reasonable, and to require the claimant to submit, or cause to be submitted, any and all medical, prescription drug, dental or vision care and other relevant records it deems necessary to properly adjudicate the claim.

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims are considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines and administrative practices not inconsistent with the terms of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan. The Plan Administrator may, when appropriate or when required by law, consult with relevant health care, prescription drug care, dental care or vision care professionals and access professional industry resources in making decisions about claims that involve specialized medical, prescription drug, dental or vision knowledge or judgment. Initial eligibility and claims decisions are made within the time periods below stated. For purposes of this section, "Covered Person" will include the claimant and the claimant's Authorized Representative;

“Covered Person” does not include a health care, prescription drug care, dental care or vision care provider or other assignee, and said health care provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

“Authorized Representative” means a representative authorized by the claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The claimant must authorize the representative in writing, and this written authorization must be provided to the Plan Administrator. The Plan Administrator may recognize this Authorized Representative only after the Plan Administrator receives the written authorization.

INFORMATION REGARDING URGENT CARE CLAIMS IS PROVIDED UNDER THE DISCLOSURE REQUIREMENTS OF APPLICABLE LAW; THE PLAN DOES NOT MAKE TREATMENT DECISIONS. ANY DECISION TO RECEIVE TREATMENT MUST BE MADE BETWEEN THE PATIENT AND THE PATIENT’S HEALTHCARE PROVIDER, PRESCRIPTION DRUG CARE PROVIDER, DENTAL CARE PROVIDER OR VISION CARE PROVIDER. HOWEVER, THE MEDICAL PLAN, PRESCRIPTION DRUG PLAN, DENTAL PLAN OR VISION PLAN ONLY PAYS BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN, PRESCRIPTION DRUG PLAN, DENTAL PLAN OR VISION PLAN. SOME SERVICES ARE EXCLUDED UNDER THIS PLAN REGARDLESS OF MEDICAL NECESSITY.

1. **Urgent Care Claims** - An Urgent Care Claim is any claim for medical care or treatment with respect to which:
 - A. In the judgment of a prudent layperson possessing an average knowledge of health and medicine may seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
 - B. In the opinion of a Physician with knowledge of the claimant’s medical condition, may subject the claimant to severe pain that may not be adequately managed without the care or treatment that is the subject of the claim.

There are no Pre-Service Urgent Care requirements under this Plan, and therefore, there are no rights to appeal a pre-service Urgent Care Claim denial.

2. **Pre-Service Claims** - Pre-Service Claims must be submitted to the appropriate Plan before the Covered Person receives medical treatment, prescription drug, dental or vision care services. A Pre-Service Claim is any claim for a medical, prescription drug, dental or vision care benefit which the appropriate Plan terms condition the Covered Person’s receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are procedures stated in the Summary Plan Descriptions which the Plan Administrator recommends be utilized before a Covered Person obtains medical, prescription drug, dental or vision care.
3. **Post-Service Claims** - A Post-Service Claim is any claim for a medical, prescription drug, dental or vision benefit under the applicable Plan with respect to which the terms of the Plan do not condition the Covered Person’s receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, prescription drug care, dental care or vision care, and for which medical, prescription drug, dental or vision treatment has been obtained prior to submission of the claim(s).

In most cases, initial claims decisions on Post-Service Claims are made within thirty (30) days of the appropriate Plan’s receipt of the claim. The appropriate Plan shall provide timely notice of the initial determination once sufficient information is received to make an initial determination, no later than thirty (30) days after receiving the claim.

4. **Concurrent Care Review** - For patients who face early termination or reduction of benefits for a course of treatment previously certified by the appropriate Plan, a decision by the appropriate Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the appropriate Plan's benefit maximums is not an Adverse Benefit Determination.) The appropriate Plan shall notify the Covered Person sufficiently in advance to allow an appeal for uninterrupted continuing care before the benefit is reduced or terminated. Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time must be decided within twenty-four (24) hours of the appropriate Plan's receipt of the request. The appeal for ongoing care or treatment must be made to the appropriate Plan at least twenty-four (24) hours prior to the expiration of the initially-prescribed period.

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

If a medical, prescription, dental or vision claim is denied in whole or in part, the Covered Person shall receive written notification of the Adverse Benefit Determination. A claim denial is provided by the appropriate Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, the Covered Person may contact the appropriate Plan Supervisor at the address or telephone number shown on the claim denial.

The Covered Person shall appeal the Adverse Benefit Determination before the Covered Person may exercise the Covered Person's right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person shall exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person shall submit in writing an appeal or a request for review of the Adverse Benefit Determination to the appropriate Plan Supervisor within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person shall include any additional information supporting the appeal or the information required by the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan which was not initially provided and forward it to the appropriate Plan Supervisor within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period renders the determination final. Any appeal received after the 180-day time period has expired receives no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the appropriate Plan Supervisor in writing. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail):

For Medical Benefits:

Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Dental Benefits:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA, 30023

For Pharmacy Benefits:

Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Vision Benefits:

Cigna Vision
P.O. Box 997561
Sacramento, CA 95899-7561

1. First Level of Benefit Determination Review

The first level of benefit determination review is completed by the Medical, Prescription Drug, Dental or Vision Plan Supervisor. The appropriate Plan Supervisor researches the information initially received and determines if the initial determination was appropriate based on the terms and conditions of the appropriate Plan and other relevant information. Notice of the decision on the first level of review must be sent to the Covered Person within fifteen (15) days following the date the appropriate Plan Supervisor receives the request for reconsideration.

If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person may initiate the second level of benefit review. The Covered Person shall request the second review in writing and send it to the appropriate Plan Supervisor, not later than sixty (60) days after receipt of the Plan Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period renders the determination final.

2. Second Level of Benefit Determination Review

The Plan Administrator reviews the claim in question along with the additional information submitted by the Covered Person. The Plan Administrator, who is neither the original decision maker nor the decision maker's subordinate, conducts a full and fair review of the claim. The Plan Administrator may not give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care, prescription drug care, dental care or vision care professionals in making decisions about appeals that involve specialized medical, dental or vision care judgment. Where the appeal involves issues of Medical or Dental Necessity or experimental treatment, the Plan Administrator shall consult with a health care, prescription drug care, dental care or vision care professional with appropriate training who was neither the medical nor dental care professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan Administrator shall provide a written or electronic notice of the final benefit determination containing the same information as notices for the initial determination within fifteen (15) days.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

INDEPENDENT EXTERNAL REVIEW FOR A PRE-SERVICE CLAIM

Does not apply to dental or vision claims.

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person shall request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Plan Administrator through the Medical Plan Supervisor shall forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO shall notify the Covered Person of its procedures to submit further information.

The IRO shall issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO is final and binding except that the Covered Person has the right to appeal the matter to a court with jurisdiction.

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

If a medical, prescription, dental or vision claim is denied in whole or in part, the Covered Person shall receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) is provided by the Plan Administrator through the appropriate Plan Supervisor showing:

1. The reason the claim was denied;
2. Reference(s) to the specific Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the appropriate Plan Supervisor at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the appropriate Plan Supervisor within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal or the information required by the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan which was not initially provided and forward it to the appropriate Plan Supervisor within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the appropriate Plan Supervisor in writing. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail):

For Medical Benefits:

Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Dental Benefits:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA, 30023

For Pharmacy Benefits:

Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Vision Benefits:

Cigna Vision
P.O. Box 997561
Sacramento, CA 95899-7561

1. First Level of Benefit Determination Review

The first level of benefit determination review is completed by the Medical, Prescription Drug, Dental or Vision Plan Supervisor. The appropriate Plan Supervisor researches the information initially received and determines if the initial determination was appropriate based on the terms and conditions of the appropriate Plan and other relevant information. Notice of the decision on the first level of review is sent to the Covered Person within thirty (30) days following the date the appropriate Plan Supervisor receives the request for reconsideration.

If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the appropriate Plan Supervisor, not later than sixty (60) days after receipt of the Plan Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. Second Level of Benefit Determination Review

The Plan Administrator reviews the claim in question along with the additional information submitted by the Covered Person. The Plan Administrator, who is neither the original decision maker nor the decision maker's subordinate, conducts a full and fair review of the claim. The Plan Administrator may not give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care, prescription drug care, dental care or vision care professionals in making decisions about appeals that involve specialized medical, dental or vision care judgment. Where the appeal involves issues of Medical or Dental Necessity or experimental treatment, the Plan Administrator shall consult with a health care, prescription drug care, dental care or vision care professional with appropriate training who was neither the medical nor dental care professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan Administrator shall provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan Administrator at each level of review.

All claim payments are based upon the terms contained in the Wrap Plan Document and Summary Plan Descriptions, on file with the Plan Administrator and the appropriate Plan Supervisor. The Covered Person may request, free of charge, more detailed information, names of any medical, prescription drug, dental or vision care professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan Administrator to adjudicate the claim.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

INDEPENDENT EXTERNAL REVIEW FOR A POST-SERVICE CLAIM

Does not apply to dental or vision claims.

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person shall request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Plan Administrator through the Medical Plan Supervisor shall forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO notifies the Covered Person of its procedures to submit further information.

The IRO issues a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO is final and binding except that the Covered Person has an additional right to appeal the matter to a court with jurisdiction.

CLAIMS PROCESSING

Medical, prescription drug, dental and vision claims are processed separately. Completed medical, prescription drug, dental and vision claims must be sent accordingly for processing to the following:

MEDICAL BENEFIT CLAIMS:

Name: Allegiance Benefit Plan Management, Inc.
Address: P.O. Box 3018
Missoula, MT 59806-3018
Phone: (855) 999-1057 or (406) 523-3199
Fax: (406) 721-2252
Web: www.askallegiance.com/som

Medical claims may also be submitted through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

PRESCRIPTION DRUG CLAIMS:

Name: Navitus Health Solutions
Address: P.O. Box 999
Appleton, WI 54912-0999
Phone: (866) 333-2757
Web: www.navitus.com

DENTAL BENEFIT CLAIMS:

Name: Delta Dental Insurance Company
Address: P.O. Box 1809
Alpharetta, Georgia 30023-1809
Phone: (866) 496-2370
Web: www.deltadentalins.com/stateofmontana

Claims for dental benefits must be filed on a standard claim form which may be obtained from Delta Dental Insurance Company.

VISION BENEFIT CLAIMS:

Name: Cigna Vision, Claims Department
Address: P.O. Box 385018
Birmingham, AL 35238-5018
Phone: (877) 478-7557
Web: www.mycigna.com

PAYMENT OF CLAIMS

All Plan benefits are payable to a Participant, Qualified Beneficiary or Alternate Recipient, whichever is applicable. All or a portion of any benefits payable by the Plan may, at the Covered Person's option and unless the Covered Person requests otherwise in writing not later than the time of filing the claim, be paid directly to the health care provider rendering the service, if proper written assignment is provided to the Plan and the health care provider is a Participating Provider. No payments may be made to any provider of services unless the Covered Person is liable for such expenses and such expenses are eligible for payment by the Plan.

The Plan may not recognize assignments of payment of benefits from non-Participating Providers. The Plan, at the discretion of the Plan Administrator, pays the Procedure Based Maximum Expense (PBME) amount to the Covered Person or to the Covered Person and the provider jointly who incurred the claim (or the Participant, Qualified Beneficiary or Alternate Recipient if the Covered Person is a minor), and notifies the provider that the Plan does not recognize or accept assignments for payment of claims from non-Participating Providers.

If any benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor, or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate. The Plan, in its sole option, may require that an estate, guardianship or conservatorship be established by a court of competent jurisdiction prior to payment of any benefit. Any payment made under this subsection constitutes a complete discharge of the Plan's obligation to the extent of such payment and the Plan may not be required to oversee the application of the money so paid.

FRAUD AND ABUSE

THIS PLAN IS SUBJECT TO FEDERAL LAW WHICH PERMITS CRIMINAL PENALTIES FOR FRAUDULENT ACTS COMMITTED AGAINST THE PLAN. STATE LAW MAY ALSO APPLY.

Anyone who knowingly defrauds or tries to defraud the Plan or obtains Plan funds through false statements or fraudulent schemes, may be subject to criminal prosecution and penalties. The following may be considered fraudulent:

1. Falsifying eligibility criteria for a Dependent to get or continue coverage for that Dependent when not otherwise eligible for coverage;
2. Falsifying or withholding medical history or information required to calculate benefits;
3. Falsifying or altering documents to get coverage or benefits;
4. Permitting a person not otherwise eligible for coverage to use a Plan ID card to get Plan benefits; or
5. Submitting a fraudulent claim or making untruthful statements to the Plan to get reimbursement from the Plan for services that may or may not have been provided to a Covered Person.

The Plan Administrator, in its sole discretion, may take additional action against the Participant or Covered Person including, but not limited to, terminating the Participant or Covered Person's coverage under the Plan.

MISSTATEMENT OF AGE

If the Covered Person's age was misstated on an enrollment form or claim, the Covered Person's eligibility or amount of benefits, or both, must be adjusted to reflect the Covered Person's true age. If the Covered Person was not eligible for coverage under the Plan or for the amount of benefits received, the Plan has a right to recover any benefits paid by the Plan. A misstatement of age may not continue coverage that was otherwise properly terminated or terminate coverage that is otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If a Participant misrepresents a Dependent's marital status, domestic partnership status, age, Dependent child relationship or other eligibility criteria to get coverage for that Dependent, when he or she would not otherwise be eligible, coverage for that Dependent terminates as though never effective.

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not otherwise eligible as a Covered Person to use an ID card, the Plan Sponsor may, at the Plan Sponsor's sole discretion, terminate the Covered Person's coverage.

REIMBURSEMENT TO PLAN

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan but for whom benefits were paid based upon fraud as defined in this section must be reimbursed to the Plan by the Participant. Failure to reimburse the Plan upon request may result in an interruption or a loss of benefits by the Participant and Dependents.

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant shall receive written notice at least thirty (30) days before the coverage is rescinded.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person 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 benefitted from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits, or from the benefits for 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, false information provided by, or information omitted by, the Employee is 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.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine.

The provisions of this section apply to any Physician or Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Physician or Licensed Health Care Provider fails to refund a payment of benefits, the Plan may refuse to recognize future assignments of benefits to that provider.

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was responsible or liable for payment of those medical expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid, but the Plan may seek reimbursement only if the Covered Person has been made whole.

Accordingly, if a Covered Person, 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 and the Covered Person has been made whole, in that event, the Covered Person agrees to hold the money received for the benefit of the Plan. The Covered Person agrees to reimburse the Plan, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that is paid as a result of the accident, Injury, condition or Illness.

Provided that the Covered Person has been made whole, reimbursement to the Plan is paid first, in its entirety, 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.

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 Covered Person's rights and remedies in order to recover from any third party who is liable to the Covered Person for a loss or benefits paid by the Plan, provided the Covered Person has been made whole. The Plan may proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover benefits paid under the Plan.

Provided that he/she has been made whole, the Covered Person 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 Covered Person 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.

If a Covered Person has been made whole and decides not to pursue a claim against any third party or insurer, the Covered Person will notify the Plan, and specifically authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Covered Person'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.

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

1. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any liable third party, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment, provided that the Covered Person has been made whole.
2. If the Covered Person has been made whole, he/she will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any benefits paid by the Plan from any liable third party. This cooperation includes, but is not limited to, make full and complete disclosure in a timely manner of all material facts regarding the accident, Injury, condition or Illness to the Plan Administrator; report all efforts by any person to recover any such money; provide the Plan Administrator with any and all requested documents, reports and other information in a timely manner, regarding any demand, litigation or settlement involving the recovery of benefits paid by the Plan; and notify the Plan Administrator of the amount and source of funds received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.
3. Covered Persons 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 Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.
4. The Covered Person 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 Covered Person will not conceal or attempt to conceal the fact that recovery has occurred or will occur.
5. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage including, but not limited to, attorney fees or costs of litigation. The Plan recognizes the Covered Person has a right to be made whole, as set forth in §§ 2-18-901 and 902, MCA.

PLAN ADMINISTRATION

PURPOSE

The purpose of the Wrap Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of the claim. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees, Retirees and their covered Dependents.

EFFECTIVE DATE

The effective date of the Plan is January 1, 1979; restated January 1, 2020.

PLAN YEAR

The Plan Year commences January 1 and ends on December 31 of each year.

PLAN SPONSOR

The Plan Sponsor is State of Montana.

PLAN SUPERVISOR

The Plan Supervisor for the Medical Plan is: Allegiance Benefit Plan Management, Inc.

The Plan Supervisor for the Prescription Drug Plan is: Navitus Health Solutions.

The Plan Supervisor for the Dental Plan is: Delta Dental Insurance Company.

The Plan Supervisor for the Vision Plan is: Cigna Vision.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is State of Montana, a Montana governmental entity, who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator has the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

PLAN INTERPRETATION

The Named Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Except as provided in the Health Plan Administrator and Provider Network Services Contract DOA2016-0011P between the State and Allegiance Benefit Plan Management, Inc., final authority to interpret and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator made in good faith are final and binding.

CONTRIBUTIONS TO THE PLAN

State Agencies shall contribute the amount established in § 2-18-703, MCA to the Plan fund for group benefit costs on a per eligible Employee per month basis regardless of whether the eligible Employee elects health benefit coverage. The State may from time to time evaluate the costs of the Plan and determine the amount to be contributed by the State, if any, and the amount to be contributed, if any, by each Participant.

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Wrap Plan Document contains all the terms of the Plan and may be amended at any time by the Plan Administrator. Any changes are binding on each Participant and on any other Covered Persons referred to in this Wrap Plan Document. The authority to amend the Plan is delegated by the Plan Administrator to the Director of Department of Administration or their equivalent, whichever is applicable, of the State. Any such amendment, modification, revocation or termination of the Plan is authorized and signed by the Director of Department of Administration or their equivalent, whichever is applicable, of the State, pursuant to a governmental policy, granting that individual the authority to amend, modify, revoke or terminate this Plan. A copy of the executed policy shall be supplied to the appropriate Plan Supervisor. Written notification of any amendments, modifications, revocations or terminations shall be given to Plan Participants at least sixty (60) days prior to the effective date, except for amendments effective on the first day of a new Plan Year, for which thirty (30) days advance notice is required.

TERMINATION OF PLAN

The State reserves the right at any time to terminate the Plan by a written notice. All previous contributions by the State will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or may be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

WRAP PLAN DOCUMENT

Each Participant covered under this Plan shall be issued a Wrap Plan Document (WPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits and the limitations and exclusions of the Plan.

GENERAL PROVISIONS

EXAMINATION

The Plan has the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim when and so often as it may reasonably require to adjudicate the claim. The Plan may also have the right to have an autopsy performed in case of death to the extent permitted by law.

LEGAL PROCEEDINGS

No action at law or equity may be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor may such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

CHOICE OF LAW, VENUE AND ATTORNEY FEES

This Plan is interpreted pursuant to the laws of the state of Montana except as preempted by federal law (e.g., PPACA and COBRA). As a condition precedent to receiving benefits under this Plan, all Covered Persons under this Plan agree that any litigation related to the terms, benefits, limitations or exclusions of the Plan must be brought in the First Judicial District in and for the County of Lewis and Clark, State of Montana, and each party shall pay their own costs and attorney fees.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan may be waived, and there is no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver may be deemed a continuing waiver unless specifically stated therein, and each such waiver may operate only as to the specific term or condition waived and may not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

ORAL STATEMENTS

Oral statements or representations of the Plan Administrator, its agents and Employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and Employees, or Covered Persons may be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection may not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF PHYSICIAN

The Covered Person has free choice of any licensed Physician, Licensed Health Care Provider or surgeon and the patient-provider relationship is maintained.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the applicable law. Only that provision which is contrary to applicable law is amended to conform; all other parts of the Plan remain in full force and effect.

MISCELLANEOUS

Section titles are for convenience of reference only and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan may affect the right thereafter to enforce such provision, nor may such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan may have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of this provision. Amounts so paid are deemed to be benefits paid under this Plan and to the extent of such payments, the Plan must be fully discharged from liability under this Plan.

The benefits that are payable may be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan is subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same is void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which becomes due to any Participant, the Plan Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application is a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Wrap Plan Document constitutes the primary authority for Plan administration. The establishment, administration and maintenance of this Plan may not be deemed to constitute a contract of employment, give any Participant of the State the right to be retained in the service of the State, or to interfere with the right of the State to discharge or otherwise terminate the employment of any Participant.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following general exclusions and limitations apply to all Expenses Incurred under this Plan:

1. Charges for services rendered or started or supplies furnished prior to the effective date of coverage under the Plan or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions.
2. Charges which are caused by or arising out of war or act of war, (whether declared or undeclared), civil unrest, armed invasion or aggression, or caused during service in the armed forces of any country.
3. Charges to the extent that the Covered Person may have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid.
4. Charges by the Covered Person for all services and supplies resulting from any Illness or Injury which occurs in the course of employment for wage or profit, or in the course of any volunteer work when the organization, for whom the Covered Person is volunteering, has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including Employees' compensation or liability laws of the United States (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though:
 - A. Coverage for the Covered Person under Workers' Compensation provides benefits for only a portion of the services Incurred;
 - B. The Covered Person's employer/volunteer organization has failed to obtain such coverage required by law;
 - C. The Covered Person waived his/her rights to such coverage or benefits;
 - D. The Covered Person fails to file a claim within the filing period allowed by law for such benefits;
 - E. The Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits;
 - F. The Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective; or
 - G. The Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

This exclusion will not apply to household and domestic employment, employment not in the usual course of the trade, business, profession or occupation of the Covered Person or Employee, or employment of a Dependent member of an Employee's family for whom an exemption may be claimed by the Employee under the Internal Revenue Code, or in cases in which it is legally impossible to obtain Workers' Compensation coverage for a specific Illness or Injury.
5. Charges for which the Covered Person is not, in the absence of this coverage, legally obligated to pay or for which a charge would not ordinarily be made in the absence of this coverage.

6. Charges for non-prescription vitamins or nutritional supplements, except as specifically covered under the Preventive Care Benefit.
7. Charges for services or supplies used primarily for Cosmetic, personal comfort, convenience, beautification items, television or telephone use that are not related to treatment of a medical condition.
8. Charges for non-medical expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician, except as specifically covered.
9. Expenses Incurred by persons other than the Covered Person receiving treatment.
10. Charges in excess of the Eligible Expense.
11. Charges for services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person, or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services.
12. Charges for professional services on an Outpatient basis in connection with disorders of any type or cause, that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis.
13. Charges for services, treatment or supplies not considered legal in the United States.
14. Travel Expenses Incurred by any person for any reason, except as specifically covered under the Non-Ambulance Travel Benefit.
15. Charges for services, treatments or supplies that may be useful to persons in the absence of Illness or Injury such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, dehumidifiers, exercise equipment, health club memberships, etc., whether or not they have been prescribed or recommended by a Physician.
16. Charges for preparation of reports or itemized bills in connection with claims, unless specifically requested and approved by the Plan.
17. Charges for services or supplies that are not specifically listed as a covered benefit of this Plan.
18. Charges for any services or supplies to the extent that benefits are otherwise provided under this Plan or under any other plan of group benefits that the Participant's Employer contributes to or sponsors.
19. Charges for incidental supplies or common first-aid supplies such as, but not limited to; adhesive tape, bandages, antiseptics, analgesics, etc.
20. Charges for dental braces or corrective shoes, except for orthotics for diabetes as specifically listed as a covered service.
21. Charges for the following treatments, services or supplies:
 - A. Charges related to or connected with treatments, services or supplies that are excluded under this Plan.
 - B. Charges that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan.

22. Charges for treatment, services or supplies not actually rendered to or received and used by the Covered Person.
23. Charges for care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
24. Charges arising out of or relating to any violation of a health care-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below. If the defined term is not used in this document, the term does not apply to this Plan.

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

Any words used herein in the singular or plural will include the alternative as applicable.

ABORTION (Elective or Therapeutic)

“Elective Abortion” means the interruption of a Pregnancy at the woman’s request

“Therapeutic Abortion” means the interruption of a Pregnancy to protect the life of the mother or when Pregnancy is the result of rape or incest.

ACCIDENTAL INJURY

“Accidental Injury” means an Injury sustained as a result of an external force or forces that is/are sudden, direct and unforeseen and is/are exact as to time and place. A hernia of any kind will only be considered as an Illness.

ACTIVE SERVICE

“Active Service” means that an Employee is in service with the State on a day which is one of the State's regularly scheduled work days and that the Employee is performing all of the regular duties of his/her employment with the State on a regular basis, either at one of the State's business establishments or at some location to which the State's business requires him/her to travel.

ADVERSE BENEFIT DETERMINATION

“Adverse Benefit Determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate, or a rescission of coverage if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

ALCOHOLISM

“Alcoholism” means a morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health, social or economic functioning.

ALCOHOLISM AND/OR CHEMICAL DEPENDENCY TREATMENT FACILITY

“Alcoholism and/or Chemical Dependency Treatment Facility” means a licensed institution which provides a program for diagnosis, evaluation, and effective treatment of Alcoholism and/or Chemical Dependency; provides detoxification services needed with its effective treatment program; provides infirmity-level medical services or arranges with a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (RN); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards.

AMBULANCE SERVICE

“Ambulance Service” means an entity, its personnel and equipment including, but not limited to, automobiles, airplanes, boats or helicopters, which are licensed to provide Emergency medical and Ambulance services in the state in which the services are rendered.

AMBULATORY SURGICAL CENTER

“Ambulatory Surgical Center” (also called same-day surgery center or Outpatient surgery center) means a licensed establishment with an organized staff of Physicians and permanent facilities, either freestanding or as a part of a Hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous Physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for ambulatory surgery centers in the state in which the facility is located.

“Ambulatory Surgical Center” does not include an office or clinic maintained by a Dentist or Physician for the practice of dentistry or medicine, a Hospital emergency room or trauma center.

AUTISM SPECTRUM DISORDER

“Autism Spectrum Disorder” means neurological disorders, usually appearing in the first three (3) years of life, that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

BENEFIT PERCENTAGE

“Benefit Percentage” means that portion of Eligible Expenses payable by the Plan, which is stated as a percentage in the Schedule of Benefits.

BENEFIT PERIOD

“Benefit Period” refers to a time period of one year, which is either a Calendar Year or other annual period, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or
2. The date the Plan terminates.

BIRTHING CENTER

A “Birthing Center” means a freestanding or hospital based licensed facility which provides obstetrical delivery services under the supervision of a Physician, and through an arrangement or an agreement with a Hospital.

CALENDAR YEAR

“Calendar Year” means a period of time commencing on January 1 and ending on December 31 of the same year.

CENTER OF EXCELLENCE

“Center of Excellence” is any facility that provides transplant services which the Plan Administrator has determined to be a Center of Excellence and for which the Plan Administrator is able to obtain a discount for services.

CHEMICAL DEPENDENCY

“Chemical Dependency” means the physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine, caffeine or eating disorders are not included in this definition.

CLOSE RELATIVE

“Close Relative” means the spouse, parent, brother, sister, child, or in-laws of the Covered Person.

COBRA

“COBRA” means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. § 300bb-1 through § 300bb-8], which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

“COBRA Continuation Coverage” means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of “COBRA”.

CONTRACEPTIVE MANAGEMENT

“Contraceptive Management” means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation, placement or removal of any contraceptive device.

CONVALESCENT NURSING FACILITY

See “Skilled Nursing Facility”.

COSMETIC

“Cosmetic” means services or treatment ordered or performed solely to change a Covered Person's appearance rather than for the restoration of bodily function.

COVERED PERSON

“Covered Person” means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

CUSTODIAL CARE

“Custodial Care” means the type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEDUCTIBLE

“Deductible” means a specified dollar amount that must be incurred before the Plan will pay any amount for any benefit during each Benefit Period.

DENTAL HYGIENIST

“Dental Hygienist” means a person who is licensed to practice dental hygiene and who works under the supervision and direction of a Dentist.

DENTALLY NECESSARY OR DENTAL NECESSITY

“Dentally Necessary” or “Dental Necessity” means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose a Dental condition or dental disease; and
2. Are ordered by a Dentist or Licensed Health Care Provider and consistent with the symptoms or diagnosis and treatment of the dental condition or dental disease; and
3. Are not primarily for the convenience of the Covered Person, Dentist or other Licensed Health Care Provider; and
4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person; and
5. Are not of an Experimental/Investigational or solely educational nature; and
6. Are not provided primarily for dental, medical or other research; and
7. Do not involve excessive, unnecessary or repeated tests; and
8. Are commonly and customarily recognized by the dental profession as appropriate in the treatment or diagnosis of the diagnosed condition; and
9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration, Centers for Medicare/Medicaid Services (CMS), or American Dental Association, pursuant to that entity’s program oversight authority based upon the dental treatment circumstances.

DENTIST

“Dentist” means a person holding one of the following degrees—Doctor of Dental Science, Doctor of Medical Dentistry, Master of Dental Surgery or Doctor of Medicine (oral surgeon) -- who is legally licensed as such to practice dentistry in the jurisdiction where services are rendered, and the services rendered are within the scope of his or her license.

A “Dentist” will not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

DENTURIST

“Denturist” means a dental technician, duly licensed, specializing in the making and fitting of dentures.

DEPENDENT

“Dependent” means a person who is eligible for coverage under the Dependent Eligibility subsection of this Plan.

DEPENDENT COVERAGE

“Dependent Coverage” means eligibility for coverage under the terms of the Plan for benefits payable as a consequence of Eligible Incurred Expenses for an Illness or Injury of a Dependent.

DURABLE MEDICAL EQUIPMENT

“Durable Medical Equipment” means equipment which is:

1. Able to withstand repeated use, e.g., could normally be rented, and used by successive patients; and
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

The Plan limits coverage to one (1) item of equipment, for the same or similar purpose and the accessories needed to operate the item.

ELIGIBLE EXPENSES

“Eligible Expenses” means the maximum amount of any charge for a covered service, treatment or supply that may be considered for payment by the Plan, including any portion of that charge that may be applied to the Deductible or used to satisfy the Out-of-Pocket Maximum. Eligible Expenses are equal to the Procedure Based Maximum Expense (PBME) as defined by this Plan.

EMERGENCY

Except for Emergency Air Ambulance services, “Emergency” means a medical condition manifesting itself by acute symptoms which occur suddenly and unexpectedly and for which the Covered Person receives medical care no later than 48 hours after the onset of the condition. Emergency is any medical condition for which a reasonable and prudent layperson, possessing average knowledge of health and medicine, would expect that failure to seek immediate medical attention would result in death, more severe or disabling medical condition(s), or continued severe pain without cessation in the absence of medical treatment. Emergency may include, but is not limited to, severe Injury, hemorrhaging, poisoning, loss of consciousness or respiration, fractures, convulsions, injuries reasonably likely to require sutures, severe acute pain, severe burns, prolonged high fever and symptoms normally associated with heart attack or stroke

“Emergency” will specifically exclude usual out-patient treatment of childhood diseases, flu, common cold, pre-natal examinations, physical examinations and minor sprains, lacerations, abrasions and minor burns, and other medical conditions usually capable of treatment at a clinic or doctor’s office during regular working hours.

For Emergency Air Ambulance services, "Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a person who possesses knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES

"Emergency Services" shall include all services provided which are related to an Emergency as defined by the Plan. Those services include, but are not limited to, Ambulance services, services of Physicians and other Licensed Health Care Providers and services for emergency rooms and other Hospital facilities.

EMPLOYEE

"Employee" means a person employed by the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer's W-2 payroll, except for Montana University System, Office of the Commissioner of Higher Education employees.

Employee does not include any employee leased from another employer including, but not limited to, those individuals defined in Internal Revenue Code Section 414(n), or an individual classified by the Employer as a contract worker or independent contractor if such persons are not on the Employer's W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as Express Services, Weststaff, and A2Z Staffing Solutions, etc.

EMPLOYER

"Employer" means the State of Montana or any affiliated entity that has adopted this Plan for its Employees and which is a "controlled group" as defined by applicable state and federal law, as amended.

ENROLLEE

"Enrollee" means an Employee of the State who is eligible and enrolled for coverage under this Plan.

ENROLLMENT DATE

"Enrollment Date" means the date a person becomes eligible for coverage under this Plan or the eligible person's effective date of coverage under this Plan, whichever occurs first.

ERISA

"ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended.

EXPERIMENTAL/INVESTIGATIONAL

"Experimental/Investigational" means:

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

2. Any drug, device, medical treatment or procedure for which the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. That the drug, device or medical treatment or procedure is under study, prior to or in the absence of any clinical trial, to determine its maximum tolerated dose, its toxicity, or its safety; or
4. That based upon Reliable Evidence, the drug, device, medical treatment or procedure is the subject of an on-going Phase I clinical trial. A Phase III clinical trial recognized by the National Institute of Health is not considered Experimental or Investigational. For chemotherapy regimens only, a Phase II clinical trial is not considered Experimental or Investigational when both of these criteria are met:
 - A. The regimen or protocol is a completed and published Phase II clinical trial which demonstrates benefits equal to or greater than existing accepted treatment protocols; and
 - B. The regimen or protocol is listed by the National Comprehensive Cancer Network and is supported by level of evidence Category 2B or higher; or
5. Based upon Reliable Evidence, any drug, device, medical treatment or procedure that the prevailing opinion among experts is that further studies or clinical trial are necessary to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or
6. Any drug, device, medical treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, Centers for Medicare and Medicaid Services (CMS), American Dental Association, American Medical Association).

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

FAMILY

"Family" means a Participant and his or her eligible Dependents as defined herein.

FMLA

"FMLA" means Family and Medical Leave Act.

GENDER IDENTITY DISORDER/ GENDER DYSPHORIA

DSM-V diagnosis in children:

1. A definite difference between experienced/expressed gender and the one assigned at birth of at least six (6) months duration. At least six (6) of the following must be present:
 - A. Persistent and strong desire to be of the other sex or insistence that they belong to the other sex.
 - B. In male children, a strong preference for cross-dressing and in female children, a strong preference for wearing typical masculine clothing and dislike or refusal to wear typical feminine clothing.

- C. Fantasizing about playing opposite gender roles in make-belief play or activities.
 - D. Preference for toys, games or activities typical of the opposite sex.
 - E. Rejection of toys, games and activities conforming to one's own sex. In male children, avoidance of rough-and-tumble play, and in female children, rejection of typically feminine toys, games and activities.
 - F. Preference for playmates of the other sex.
 - G. Dislike for sexual anatomy. Male children may hate their penis and testes, and female children may dislike urinating sitting.
 - H. Desire to acquire the primary and/or secondary sex characteristics of the opposite sex.
2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The subtypes may be ones with or without defects or defects in sexual development.

DSM-V diagnosis in adolescents and adults:

1. A definite mismatch between the assigned gender and experienced/expressed gender for at least six (6) months duration as characterized by at least two (2) or more of the following features:
- A. Mismatch between experienced or expressed gender and gender manifested by primary and/or secondary sex characteristics at puberty.
 - B. Persistent desire to rid oneself of the primary or secondary sexual characteristics of the biological sex at puberty.
 - C. Strong desire to possess the primary and/or secondary sex characteristics of the other gender.
 - D. Desire to belong to the other gender.
 - E. Desire to be treated as the other gender.
 - F. Strong feeling or conviction that he or she is reacting or feeling in accordance with the identified gender.
2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The subtypes may be ones with or without defects or defects in sexual development.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

HOSPICE

“Hospice” means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse (RN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE BENEFIT PERIOD

“Hospice Benefit Period” means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal illness, and the Covered Person is accepted into a Hospice program. The period will end the earliest of six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof will be required by the Plan Administrator before a new Hospice Benefit Period can begin.

HOSPITAL

“Hospital” means an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an emergent or Inpatient basis at the patient's expense; and
2. It is licensed as a hospital or a critical access hospital under the laws of the jurisdiction in which the facility is located; and
3. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an illness or an Injury or provides for the facilities through arrangement or agreement with another hospital; and
4. It provides treatment by or under the supervision of a Physician or osteopathic Physician with nursing services by registered nurses as required under the laws of the jurisdiction in which the facility is licensed; and
5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and
6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

“Hospital Miscellaneous Expenses” mean the actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services, regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS

“Illness” means a bodily disorder, Pregnancy, disease, physical sickness, Mental Illness, or functional nervous disorder of a Covered Person.

INCURRED EXPENSES OR EXPENSES INCURRED

“Incurred Expenses” or “Expenses Incurred” means those services and supplies rendered to a Covered Person. Such expenses will be considered to have occurred at the time or date the treatment, service or supply is actually provided.

INITIAL ENROLLMENT PERIOD

“Initial Enrollment Period” means the time allowed by this Plan for enrollment when a person first becomes eligible for coverage.

INJURY

“Injury” means physical damage to the Covered Person's body which is not caused by disease or bodily infirmity.

INPATIENT

“Inpatient” means the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT

“Intensive Care Unit” means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
2. It has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. It provides constant observation and treatment by Registered Nurses (RNs) or other highly-trained Hospital personnel.

LICENSED HEALTH CARE PROVIDER

“Licensed Health Care Provider” means any provider of health care services who is licensed or certified by any applicable governmental regulatory authority to the extent that services are within the scope of the license or certification and are not specifically excluded by this Plan.

LICENSED PRACTICAL NURSE

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

LICENSED PROFESSIONAL COUNSELOR

“Licensed Professional Counselor” means a person currently licensed in the state in which services are rendered to perform mental health counseling in a clinical setting, for Mental Illnesses.

LICENSED SOCIAL WORKER

“Licensed Social Worker” means a person holding a Masters Degree (M.S.W.) in social work and who is currently licensed as a social worker in the state in which services are rendered, and who provides counseling and treatment in a clinical setting for Mental Illnesses.

MAXIMUM LIFETIME BENEFIT

“Maximum Lifetime Benefit” means the maximum benefit payable while a person is covered under this Plan. The Maximum Lifetime Benefit will not be construed as providing lifetime coverage, or benefits for a person’s Illness or Injury after coverage terminates under this Plan.

MEDICAID

“Medicaid” means that program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.

MEDICAL POLICY AND DENTAL POLICY

“Medical Policy and Dental Policy” means the policy applied by the Plan Administrator to determine if medical or dental services, including procedures, medication, equipment, processes, and technology meet nationally accepted criteria such as the following:

- A. Final approval from the appropriate governmental regulatory agency or agencies.
- B. Conclusive scientific evidence of improved health outcome.
- C. Compliance with established standards of good medical and dental practice and established coding procedures for insurance reimbursement.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

Except for Autism and Down syndrome, “Medically Necessary” or “Medical Necessity” means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

- 1. Are to treat or diagnose an Illness or Injury; and
- 2. Are ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and
- 3. Are not primarily for the convenience of the Covered Person, Physician or other Licensed Health Care Provider; and
- 4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person and are in accordance with the Plan’s Medical Policy and Dental Policy; and
- 5. Are not of an Experimental/Investigational or solely educational nature; and
- 6. Are not provided primarily for medical or other research; and
- 7. Do not involve excessive, unnecessary or repeated tests; and

8. Are commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and
9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration (FDA) or Centers For Medicare/Medicaid Services (CMS), pursuant to that entity's program oversight authority based upon the medical treatment circumstances.

For Autism, "Medically Necessary" or "Medical Necessity" means any care, treatment, intervention, service or item that is prescribed, provided or ordered by a Physician or Psychologist and will or is reasonable 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, 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.

For Down syndrome, "Medically Necessary" or "Medical Necessity" means any care, treatment, intervention, service, or item that is prescribed, provided or order by a Physician licensed in the state of Montana, and that will or is reasonably expected to:

1. Reduce or improve the physical, mental or developmental effects of Down syndrome; or
2. 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.

MEDICARE

"Medicare" means the programs established under the "Health Insurance for the Aged Act," Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those who are eligible for Medicare Part A, Part B or Part D as a result of age, those with end-stage renal disease, or with disabilities.

MENTAL ILLNESS

"Mental Illness" means a medically recognized psychological, physiological, nervous or behavioral condition, affecting the brain, which can be diagnosed and treated by medically recognized and accepted methods, **but will not include Alcoholism, Chemical Dependency or other addictive behavior**. Conditions recognized by the Diagnostic Statistical Manual (the most current edition) will be included in this definition.

MMSERA

"MMSERA" means the Montana Military Service Employment Rights Act (MMSERA), as amended.

NAMED FIDUCIARY

"Named Fiduciary" means the Plan Administrator which has the authority to control and manage the operation and administration of the Plan.

NEWBORN

“Newborn” refers to an infant from the date of his/her birth until the initial Hospital discharge or forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean section, whichever occurs first.

OCCUPATIONAL THERAPY

“Occupational Therapy” means a program of care ordered by a Physician which is for the purpose of improving the physical, cognitive and perceptual disabilities that influence the Covered Person’s ability to perform functional tasks related to normal life functions or occupations, and which is for the purpose of assisting the Covered Person in performing such functional tasks without assistance.

ORTHODONTIC TREATMENT

“Orthodontic Treatment” means an appliance or the surgical or functional/myofunctional treatment of dental irregularities which either result from abnormal growth and development of the teeth, gums or jaws, or from Injury which requires the positioning of the teeth to establish normal occlusion.

ORTHODONTIST

“Orthodontist” means a Dentist with special training who uses braces or corrective appliances to straighten teeth, correct jaw position and improve facial balance.

ORTHOPEDIC APPLIANCE

“Orthopedic Appliance” means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

OUT-OF-POCKET MAXIMUM

“Out-of-Pocket Maximum” means the maximum dollar amount, as stated in the Schedule of Medical Benefits or Pharmacy Benefit, that any Covered Person or Family will pay in any Benefit Period for covered services, treatments or supplies.

OUTPATIENT

“Outpatient” means a Covered Person who is receiving medical care, treatment, services or supplies at a clinic, a Physician’s office, a Licensed Health Care Provider’s office or at a Hospital if not a registered bed-patient at that Hospital, Psychiatric Facility or Alcoholism and/or Chemical Dependency Treatment Facility.

PARTIAL HOSPITALIZATION

“Partial Hospitalization” means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

PARTICIPANT

“Participant” means an Employee of the State who is eligible and enrolled for coverage under this Plan.

PHYSICAL THERAPY

“Physical Therapy” means a plan of care ordered by a Physician or Licensed Health Care Provider and provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

PHYSICIAN

“Physician” means a person holding the degree of Doctor of Medicine, Dentistry or Osteopathy, or Optometry who is legally licensed as such.

“Physician” does not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

PLACEMENT OR PLACED FOR ADOPTION

“Placement” or “Placed for Adoption” means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child’s adoption. The child’s placement for adoption with such person ends upon the termination of such legal obligation.

PLAN

“Plan” means the Health Benefit Plan for Employees of the State, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

“Plan Administrator” means the State and/or its designee which is responsible for the day-to-day functions and management of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan. The Plan Administrator may employ persons or firms to process medical, prescription drug, dental or vision claims and perform other Plan-connected services. For the purposes of any applicable state legislation of a similar nature, the State will be deemed to be the Plan Administrator of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan unless the State designates an individual or committee to act as Plan Administrator of the Plan.

PLAN SUPERVISOR

“Plan Supervisor” means the person or firm employed by the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan to provide consulting services to the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan in connection with the operation of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan and any other functions, including the processing and payment of claims. The Plan Supervisor provides ministerial duties only, exercises no discretion over Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan assets and will not be considered a fiduciary as defined by State or Federal law or regulation.

The Plan Supervisor for the Medical Plan is: Allegiance Benefit Plan Management, Inc.

The Plan Supervisor for the Prescription Drug Plan is: Navitus Health Solutions.

The Plan Supervisor for the Dental Plan is: Delta Dental Insurance Company.

The Plan Supervisor for the Vision Plan is: Cigna Vision.

PREGNANCY

“Pregnancy” means a physical condition commencing with conception, and ending with miscarriage or birth.

PREVENTIVE CARE

“Preventive Care” means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, and which is not provided as a result of any Injury or Illness.

PRIMARY CARE PHYSICIAN

“Primary Care Physician” includes Family Practice, General Practice, Internal Medicine, OB/Gyn (obstetrics/gynecology), Pediatrician, Licensed Nurse Practitioner or Physician Assistant or Naturopath.

PROCEDURE BASED MAXIMUM EXPENSE or PBME

“Procedure Based Maximum Expense” or “PBME” means the maximum amount the Plan will pay under any circumstances for any treatment, service or supply or combination of any treatments, services, or supplies that comprise a procedure covered by this Plan. The PBME will apply to all charges from all providers. The PBME shall be based upon a publicly available payment schedule including Medicare allowable amounts when applicable and other similar schedules in circumstances in which Medicare allowable amounts are inapplicable or unavailable. The specific Procedure Based Maximum Expense for any treatment, service or supply shall be based upon a mathematical formula using a multiple or percentage of the payment schedules referred to above and adopted by the Plan Supervisor and the Plan. In addition, the PBME will be determined based upon the geographical location and other considerations related to each specific provider and based upon the adequacy and quality of specific services and supplies.

The PBME will apply whether a provider agrees to accept the PBME as full payment for the claim or not. Providers who agree, in writing, to accept the PBME as full payment are defined as Participating Providers. Providers who are not Participating Providers will be reimbursed based upon the lowest PBME for a geographic area as established by the Plan based upon the physical location where the Covered Person received services or supplies.

The PBME for Emergency Services will apply to both Participating Providers and non-Participating Providers, but only during the time that the medical Emergency exists and will cease to apply when the Covered Person's condition is stable and no longer emergent. When the PBME for Emergency Services ceases to apply, the PBME for the applicable additional services, if any, will apply.

PROSTHETIC APPLIANCE

“Prosthetic Appliance” means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of Covered Dental Benefit, means any device which replaces all or part of a missing tooth or teeth.

PSYCHIATRIC CARE

“Psychiatric Care,” also known as psychoanalytic care, means treatment for a Mental Illness or disorder, a functional nervous disorder, Alcoholism or drug addiction by a licensed psychiatrist, Psychologist, Licensed Social Worker or Licensed Professional Counselor acting within the scope and limitations of his/her respective license, provided that such treatment is Medically Necessary as defined by the Plan, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

“Psychiatric Facility” means a licensed institution that provides Mental Illness treatment and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

“Psychologist” means a person currently licensed in the state in which services are rendered as a psychologist and acting within the scope of his/her license.

QMCSO

“QMCSO” means Qualified Medical Child Support Order as defined by Section 609(a) of ERISA, as amended.

QUALIFIED BENEFICIARY

“Qualified Beneficiary” means an Employee, former employee or Dependent of an Employee or former employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA or Section 609(a) of ERISA in relation to QMCSO's.

“Qualified Beneficiary” will also include a child born to, adopted by or Placed for Adoption with an Employee or former employee at any time during COBRA Continuation Coverage.

REGISTERED NURSE

“Registered Nurse” means an individual who has received specialized nursing training and is authorized to use the designation of “RN” and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

RETIREE

“Retiree” means an Employee who retires under a retirement program authorized by law and eligible to continue coverage with the Employer pursuant to the terms of § 2-18-704, MCA as amended from time to time.

ROOM AND BOARD

“Room and Board” refers to all charges which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SKILLED NURSING FACILITY

“Skilled Nursing Facility” means an institution, or distinct part thereof, which meets all of the following conditions:

1. It is currently licensed as a long-term care facility or skilled nursing facility in the state in which the facility is located;
2. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders; and
3. It is certified by Medicare.

This term also applies to Incurred Expenses in an institution known as a Convalescent Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

SPECIALTY CARE PHYSICIAN

“Specialty Care Physician” includes any Physician who is practicing any branch of medicine or medical specialty other than Family Practice, General Practice, Internal Medicine, OB/Gyn (obstetrics/gynecology), Pediatrician, Licensed Nurse Practitioner or Physician Assistant or Naturopath.

SPEECH THERAPY

“Speech Therapy” means a course of treatment, ordered by a Physician, to treat speech deficiencies or impediments.

TELEMEDICINE

“Telemedicine” means the practice of medicine by electronic means, only for the purposes of diagnosis, providing medical advice and treatment to the Covered Person (patient), requiring direct contact between the Covered Person’s Licensed Health Care Provider and other Licensed Health Care Providers or entities in a different location. The Covered Person’s direct participation or physical presence is not a prerequisite for coverage if there is documentation that the consultation was conducted on behalf of the Covered Person for the purpose of diagnosing, providing medical advice or treatment to the Covered Person.

URGENT CARE FACILITY

“Urgent Care Facility” means a free-standing facility which is engaged primarily in diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention. A clinic or office located in or in conjunction with or in any way made a part of a Hospital will be excluded from the terms of this definition.

USERRA

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act, as amended.

NOTICES

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT: This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Plan Administrator for more information.

HIPAA PRIVACY AND SECURITY STANDARDS

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

“Protected Health Information” (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to the physical or mental health of an individual, health care that individual has received, or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an Employer.

“Summary Health Information” means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the ZIP Code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or plan participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Documents have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law. Such uses or disclosures may be for the purposes of Plan administration including, but not limited to, the following:
 - A. Operational activities such as quality assurance and utilization management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.
 - B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for Medical Necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.
 - C. For purposes of this certification, Plan administration does not include disclosing Summary Health Information to help the Plan Sponsor obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a Participant in; is an enrollee of or has disenrolled from the group health plan.
2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;
6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;
7. Make available the PHI required to provide an accounting of disclosures as required by the regulations;
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document or employees designated by the Plan Administrator(s) who need to know that information to perform Plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan Documents have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.
2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.
3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.
4. Report to the Plan Administrator or the Named Fiduciary of the Plan any attempted breach, or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

**WRAP PLAN DOCUMENT
FOR MEDICAL, PRESCRIPTION DRUG,
DENTAL AND VISION BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF STATE OF MONTANA
PLAN SUMMARY**

The following information, together with the information contained in this booklet, form the Wrap Plan Document.

1. PLAN NAME

The name of the Plan is the STATE OF MONTANA BENEFIT PLAN (STATE PLAN), which Wrap Plan Document describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Employees, referred to as "Participants," and the eligible Dependents of such Participants, and Retirees and their eligible Dependents.

2. PLAN BENEFITS

This Wrap Plan Document together with the Summary Plan Descriptions provide benefits for Eligible Expenses Incurred by eligible Participants for: Hospital, Surgical, Medical, Maternity, Prescription Drug, Dental, Vision and other eligible medical or dental related necessary expenses.

3. PLAN EFFECTIVE DATE

This Wrap Plan Document was established effective January 1, 1979; and restated January 1, 2020.

4. PLAN SPONSOR

Name: State of Montana
Phone: (406) 444-7462 or (800) 287-8266
Address: 100 N. Park St. Suite 320
P.O. Box 200130
Helena, MT 59620

5. PLAN ADMINISTRATOR

The Plan Administrator is the Plan Sponsor.

6. NAMED FIDUCIARY

Name: State of Montana
Phone: (406) 444-7462 or (800) 287-8266
Address: 100 N. Park St. Suite 320
P.O. Box 200130
Helena, MT 59620

7. PLAN FISCAL YEAR

The Plan fiscal year ends December 31.

8. PLAN TERMINATION

The right is reserved by the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

9. IDENTIFICATION NUMBER

Group Number: 3000900
Employer Identification Number: 81-0302402

10. PLAN SUPERVISOR FOR MEDICAL BENEFITS

Name: Allegiance Benefit Plan Management, Inc.
Address: P.O. Box 3018
Missoula, MT 59806

11. PLAN SUPERVISOR FOR PRESCRIPTION DRUG BENEFITS

Name: Navitus Health Solutions
Address: P.O. Box 999
Appleton, WI 54912-0999

12. PLAN SUPERVISOR FOR DENTAL BENEFITS

Name: Delta Dental Insurance Company
Address: 1130 Sanctuary Parkway
Alpharetta, GA 30009

13. PLAN SUPERVISOR FOR VISION BENEFITS

Name: Cigna Vision
Address: P.O. Box 997561
Sacramento, CA 95899-7561

14. ELIGIBILITY

Employees and their eligible Dependents and Retirees and their eligible Dependents of the Plan Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

15. PLAN FUNDING

The Plan is funded by contributions from the Employer and Employees.

16. AGENT FOR SERVICE OF LEGAL PROCESS

The Plan Administrator is the agent for service of legal process.

APPENDIX A

**SUMMARY PLAN DESCRIPTION
FOR MEDICAL PLAN BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF**

STATE OF MONTANA

Appendix A

Summary Plan Description
describes the Medical Plan Benefits
in effect as of January 1, 2019 and renews January 1, 2020

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**SCHEDULE OF MEDICAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS**

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN
EXCLUSIONS AND PROCEDURE BASED MAXIMUM EXPENSE (PBME)

THE BENEFIT PERIOD IS A CALENDAR YEAR

COST SHARING PROVISIONS	
DEDUCTIBLE Per Covered Person per Benefit Period	\$1,000
Deductible applies to all benefits unless specifically indicated as waived.	
BENEFIT PERCENTAGE Before satisfaction of Out-of-Pocket Maximum After satisfaction of Out-of-Pocket Maximum	75% 100%
Benefit Percentage applies to all benefits unless specifically stated otherwise.	
COPAYMENTS Copayments apply as specifically stated in this Schedule of Medical Benefits and are payable by the Covered Person. Copayments do not apply towards the Deductible but do apply towards the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments no longer apply for the remainder of the Benefit Period. Copayments apply only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other outpatient setting). Additional charges for services that are performed at the time of the visit, together with any additional charges that are incurred in conjunction with the office visit, e.g., diagnostic lab, office surgery, diagnostic miscellaneous testing, injections, are subject to the applicable Deductible and Benefit Percentage.	
OUT-OF-POCKET MAXIMUM Per Covered Person per Benefit Period Per Family per Benefit Period	\$4,000 \$8,000
Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not apply to the Medical Benefits Annual Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments apply toward the applicable Pharmacy Benefit Out-of-Pocket Maximum, except for Tier 3 and Non-Preferred Specialty Copayments. Tier 3 and Non-Preferred Specialty Copayments do not accrue to the Out-of-Pocket Maximum and will never be payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum.	

COST SHARING PROVISIONS	
NON-PARTICIPATING PROVIDERS OUTSIDE OF MONTANA	
Deductible	\$1,500
Benefit Percentage before satisfaction of Out-of-Pocket Maximum	65%
Benefit Percentage after satisfaction of Out-of-Pocket Maximum	100%
Out-of Pocket Maximum per Covered Person	\$4,950
Out-of Pocket Maximum per Family	\$10,900
<p>Non-Participating Providers Outside of Montana Deductible, Benefit Percentage and Out-of-Pocket Maximum applies to all benefits unless specifically stated otherwise and are subject to all Plan provisions, limitations and exceptions based upon the Summary Plan Description.</p>	
MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES	None
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	None
<p>PRE-CERTIFICATION/PRE-TREATMENT REVIEW: Pre-certification or Pre-treatment Review by the Plan is strongly recommended for certain services. If Pre-certification or Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted. See Hospital Admission Certification and Pre-Treatment Review for further details.</p>	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
ACCIDENTAL INJURY BENEFIT	
	75% after Deductible
ACUPUNCTURE TREATMENT	
	100% after \$25 Copayment
<p>Benefit Limits: Twenty (20) days maximum combined with Acupuncture and Chiropractor Benefit per Benefit Period</p>	
ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)	
	75% after Deductible
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY	
Inpatient Facility Services	75% after Deductible
Inpatient Professional Provider Services	75% after Deductible
Outpatient Facility Services	75% after Deductible
Office Visit Services	100% after \$25 Copayment
Outpatient Professional Provider Services (except for office visit consultation and examination)	75% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
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ALLERGY TREATMENT

Office Visit Services	100% after \$25 Copayment
Allergy Injections without Office Visit	75% after Deductible
Diagnostic Testing and Injections	75% after Deductible
Outpatient Professional Provider Services (except for office visit consultation and examination)	75% after Deductible

AMBULANCE SERVICE

Medical Emergency Only	
Air Ambulance	75% after Deductible
Ground Ambulance	75% after Deductible

AMBULATORY SURGICAL CENTER

	75% after Deductible
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AUTISM SPECTRUM DISORDER (ASD) AND/OR DOWN SYNDROME

Includes certain treatments associated with Autism Spectrum Disorder (ASD) and/or Down Syndrome for Dependent children eighteen (18) years of age or younger	75% after Deductible
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BARIATRIC SURGERY

	No Benefit
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BIRTHING CENTER

Licensed Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible

CARDIAC REHABILITATION THERAPY - OUTPATIENT

	100% after \$25 Copayment
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CHEMOTHERAPY - OUTPATIENT

Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible

CHIROPRACTIC CARE

	100% after \$25 Copayment
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Benefit Limits: Twenty (20) days Maximum combined with Acupuncture and Chiropractor Benefit per Benefit Period.

Chiropractic x-rays and any additional charges for services that are performed at the time of the visit or additional charges that are incurred in conjunction with the office visit are subject to the applicable Deductible and Benefit Percentage.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
COLONOSCOPY	
First Colonoscopy Regardless of Diagnosis Per Benefit Period	100%, Deductible Waived
Additional Colonoscopy per Benefit Period	75% after Deductible
COMPLEX CARE AND TRANSITIONAL CARE MANAGEMENT	
	100%, Deductible Waived
CONTRACEPTIVES (Including Contraceptive Management)	
Administered during office visit	100%, Deductible Waived
Self-Administered - See Pharmacy Benefit for details	
DENTAL SERVICES	
As a result of Accidental Injury	75% after Deductible
DIABETIC EDUCATION	
	100%, Deductible Waived
Benefit Limits: Three (3) visits Maximum combined with Diabetic Education and Nutritional Counseling per Benefit Period	
DIAGNOSTIC TESTS - OUTPATIENT	
Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
DIALYSIS TREATMENTS - OUTPATIENT	
	75% after Deductible
EMERGENCY ROOM SERVICES	
Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
HEARING AIDS	
	No Benefit
HEARING SCREENING (Not otherwise covered under the Preventive Care Benefit)	
	No Benefit
HOME HEALTH CARE	
	75% after Deductible
Benefit Limits: Seventy (70) days Maximum Benefit per Benefit Period.	
HOSPICE CARE	
Includes Bereavement Counseling	75% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
HOSPITAL SERVICES	
Inpatient Facility Services	75% after Deductible
Inpatient Professional Provider Services	75% after Deductible
Outpatient Facility Services	75% after Deductible
Outpatient Professional Provider Services	75% after Deductible
INFERTILITY TREATMENT	
Diagnostic testing to determine infertility	75% after Deductible
Infertility Treatment	No Benefit
INFUSION SERVICES - OUTPATIENT	
	75% after Deductible
MAMMOGRAMS	
Routine Mammograms	100%, Deductible Waived
Diagnostic Mammograms	100%, Deductible Waived
MASSAGE THERAPY	
	No Benefit
MEDICAL EQUIPMENT/SUPPLIES	
Durable Medical Equipment	75% after Deductible
Prosthetic Appliances	75% after Deductible
Orthopedic Devices	75% after Deductible
Other Medical Supplies	75% after Deductible
The Plan limits coverage to one (1) item of equipment, for the same or similar purpose and the accessories needed to operate the item.	
MENTAL ILLNESS	
Inpatient Facility Services	75% after Deductible
Inpatient Professional Provider Services	75% after Deductible
Outpatient Facility Services	75% after Deductible
Office Visit Services	100% after \$25 Copayment
Outpatient Professional Provider Services	75% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
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NATUROPATHY/HOMEOPATHIC

Office Services	100% after \$25 Copayment
Ancillary charges (diagnostic lab, office surgery, diagnostic miscellaneous testing, etc.)	75% after Deductible
Preventive Care Services performed by a Naturopathic / Homeopathic Provider	100%, Deductible Waived

Complete list of recommended preventive services can be viewed at:
<https://www.healthcare.gov/coverage/preventive-care-benefits/>.

If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures are not covered as Preventive Care and are subject to the cost sharing that applies to those specific services.

NON-AMBULANCE TRAVEL BENEFIT FOR ORGAN AND TISSUE TRANSPLANT SERVICES

	75% after Deductible
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Benefits are payable up to \$10,000 Maximum Benefit per Transplant, limited to the following:

- If driving, IRS standard mileage rate reimbursement.
- Coach airfare.
- Lodging not to exceed \$140 per day.
- Meals limited to \$50 per day per person.

This benefit is available to the patient and one care giver and is limited to travel to a contracted Center of Excellence.

NUTRITIONAL COUNSELING

	100%, Deductible Waived
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Benefit Limits: Three (3) visits Maximum combined with Diabetic Education and Nutritional Counseling per Benefit Period.

OBESITY

Non-Surgical and Non-Pharmaceutical Treatment	
Office Visit Services	100% after \$25 Copayment
Dietary and Nutritional Counseling	100%, Deductible Waived

Benefit Limits: Three (3) visits Maximum for Dietary and Nutritional Counseling when Medically Necessary (approved diagnosis code only) per Benefit Period.

OCCUPATIONAL THERAPY - OUTPATIENT

	100% after \$25 Copayment
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TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
OFFICE VISIT	
Primary Care Physician	100% after \$25 Copayment
Specialty Care Physician	100% after \$35 Copayment
Ancillary charges (diagnostic lab, office surgery, diagnostic miscellaneous testing, etc.)	75% after Deductible
Office Visit includes Telemedicine services. See Medical Benefits for details.	
ORGAN AND TISSUE TRANSPLANT SERVICES	
Center of Excellence Only	75% after Deductible
ORTHOTICS (Foot)	
	75% after Deductible
Coverage is limited to diagnosis of diabetes.	
PHYSICAL THERAPY - OUTPATIENT	
	100% after \$25 Copayment
PREGNANCY/MATERNITY SERVICES	
See Preventive Care Benefit for well-women prenatal visits	
Office Visit (if not part of a global charge)	100% after \$25 Copayment
Outpatient Facility Services (if billed as global fee)	75% after Deductible
Inpatient Facility Services	75% after Deductible
Inpatient Professional Provider Services	75% after Deductible
PRESCRIPTION DRUGS	
	See Pharmacy Benefit for Details
PREVENTIVE CARE	
	100%, Deductible Waived
Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/ .	
If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures are not covered as Preventive Care and are subject to the cost sharing that applies to those specific services.	
PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY	
Inpatient Facility Services	75% after Deductible
Inpatient Professional Provider Services	75% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
PROSTATE CANCER SCREENING, PROSTATE SPECIFIC ANTIGEN (PSA) TESTING	
	100%, Deductible Waived
RADIATION THERAPY - OUTPATIENT	
Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
RESIDENTIAL TREATMENT	
	75% after Deductible
RESPIRATORY THERAPY - OUTPATIENT	
	75% after Deductible
ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE	
	100%, Deductible Waived
Applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.	
SKILLED NURSING FACILITY	
	75% after Deductible
Benefit Limits: Seventy (70) days Maximum Benefit per Benefit Period.	
SPEECH THERAPY - OUTPATIENT	
	100% after \$25 Copayment
STERILIZATION PROCEDURES	
Female Sterilization Procedures	100%, Deductible Waived
Vasectomy	75% after Deductible
SURGERY - OUTPATIENT	
Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES	
	75% after Deductible
TMJ/JAW DISORDERS	
Surgical Treatment and Procedure	75% after Deductible
Benefit Limits: Surgical Treatment and Procedure limited to \$10,000 Maximum Lifetime Benefit	
Non-Surgical Treatment and Procedure	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
URGENT CARE FACILITY	
Office Visit Services	100% after \$35 Copayment
Ancillary charges (diagnostic lab, office surgery, diagnostic miscellaneous testing, etc.)	75% after Deductible
VISION SERVICES	
Non-routine treatment as a result of an Accidental Injury or medical condition	75% after Deductible
VOLUNTARY SECOND AND THIRD SURGICAL OPINION BENEFIT	
	100%, Deductible Waived
WEIGHT LOSS PROGRAMS	
	No Benefit
WELL-CHILD CARE - SEE PREVENTIVE CARE	
	100%, Deductible Waived

MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

Services, treatments or supplies are eligible for coverage if they meet all of the following requirements:

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider;
2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary;
3. Charges do not exceed the Eligible Expense of the Plan; and
4. They are not excluded under any provision or section of this Plan.

Treatments, services or supplies excluded by this Plan may be reimbursable if such charges are approved by the Plan Administrator prior to beginning such treatment. Prior approval is limited to medically accepted, non-experimental or investigational treatments, services, or supplies, which, in the opinion of the Plan Administrator, at the Plan Administrator's discretion, are more cost effective than a covered treatment, service or supply for the same Illness or Injury, and which benefit the Covered Person.

DEDUCTIBLE

The Deductible applies to Eligible Expenses Incurred during each Benefit Period, unless specifically waived. The Deductible applies only once for each Covered Person within a Benefit Period. **An individual Covered Person may not receive credit toward the Family Deductible for more than the Individual Annual Deductible as stated in the Schedule of Medical Benefits.**

BENEFIT PERCENTAGE

The Benefit Percentage is stated in the Schedule of Medical Benefits. The Plan will pay the Benefit Percentage of the Eligible Expense indicated.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, is stated in the Schedule of Medical Benefits and includes amounts applied toward the Deductible, amounts in excess of the Benefit Percentage paid by the Plan and all applicable Copayments for Medical Benefits. Expenses Incurred in a single Benefit Period after satisfaction of the Out-of-Pocket Maximum per Covered Person or per Family, whichever is applicable, is paid at 100% of the Eligible Expense for the remainder of the Benefit Period. **An individual Covered Person may not receive credit toward the Family Out-of-Pocket Maximum for more than the Individual Out-of-Pocket Maximum as stated in the Schedule of Medical Benefits.**

COPAYMENT

Copayments are stated in the Schedule of Medical Benefits. Copayments are first-dollar amounts that are payable for certain covered services under the Plan which are usually paid at the time the service is performed (e.g., Physician office visits or urgent care visits). These Copayments do not apply towards the Medical Benefits Deductible but apply towards the Medical Benefits Out-of-Pocket Maximum, and after the Out-of-Pocket Maximum is satisfied, Copayments no longer apply for the remainder of the Benefit Period.

MAXIMUM BENEFIT

The amount payable by the Plan may not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Medical Benefits, for any reason.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

Deductibles are applied to Eligible Expenses Incurred in the chronological order in which they are adjudicated by the Plan. Eligible Expenses Incurred are paid by the Plan in the chronological order in which they are adjudicated by the Plan. The manner in which the Deductible is applied and Eligible Expenses are paid by the Plan is conclusive and binding on all Covered Persons and their assignees.

CHANGES IN COVERAGE CLASSIFICATION

A change in coverage that decreases a benefit of this Plan becomes effective on the stated effective date of such change with regard to all Covered Persons to whom it applies.

NEW YORK STATE EXPENSES

This Plan has voluntarily elected to make public goods payments directly to the Office of Pool Administration in conformance with HCRA provisions and New York State Department of Health (Department) requirements.

MEDICAL BENEFITS

Pre-certification or Pre-treatment Review by the Plan is strongly recommended for certain services. If Pre-certification or Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted. See Hospital Admission Certification and Pre-Treatment Review for further details.

The following Medical Benefits are payable as stated in the Schedule of Medical Benefits subject to any benefit maximums specifically stated in the Schedule of Medical Benefits and all terms and conditions of this SPD.

1. Charges for services and supplies furnished by a Birthing Center.
2. Charges for the services of a licensed Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.
3. Charges are eligible for drugs intended for use in a Physicians' office or settings other than home use that are billed during the course of an evaluation or management encounter.
4. Charges for Pregnancy or maternity, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy.
5. Charges for Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) for private duty nursing.
6. Charges for midwife services by a Certified Nurse Midwife (CNM) who is a registered nurse and enrolled in either the certification maintenance program or the continuing competency assessment program through the American College of Nurse Midwives (ACNM).

"Certified Nurse Midwife" means an individual who has received advanced nursing training and is authorized to use the designation of "CNM" and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.
7. Charges for Ambulance Service to the nearest facility where Emergency care or treatment may be rendered; or from one facility to another for care. **The Plan does not pay for Ambulance Service from the facility to the patient's home or if transport is to a lateral or lower level of care.**
8. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs not available through the Pharmacy Benefit regardless of Medical Necessity and FDA approved over-the-counter female contraceptives prescribed by a Physician or Licensed Health Care Provider. **Conditions of coverage for outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Pharmacy Benefit section of the Plan.**
9. Charges for x-rays and laboratory tests.
10. Charges for radiation therapy or treatment and chemotherapy.
11. Charges for blood transfusions, blood processing costs, blood transport charges, blood handling charges, administration charges, and the cost of blood, plasma and blood derivatives. Any credit allowable for replacement of blood plasma by donor or blood insurance is deducted from the total Eligible Expense.
12. Charges for oxygen and other gases and their administration.

13. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.
14. Charges for the cost and administration of an anesthetic.
15. Charges for voluntary vasectomy for Participant and Dependent spouse only. Charges for sterilization procedures for females are covered under the Preventive Care Benefit.
16. Reasonable charges for producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Charges that exceed limits for such charges imposed by applicable law may not be deemed to be reasonable.
17. Charges for Contraceptive Management, regardless of Medical Necessity.

 "Contraceptive Management" means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation or placement of any contraceptive device. Charges for removal of contraceptive devices are covered regardless of Medical Necessity and are payable under the Preventive Care Benefit.
18. Charges for acupuncture treatment provided by a legally qualified provider practicing within the scope of his or her license. **Benefit maximums apply as stated in the Schedule of Medical Benefits.**
19. Charges for naturopathy or homeopathic treatment provided by a legally qualified provider practicing within the scope of their license.
20. Charges for allergy treatment including; office visit, diagnostic testing and injections.
21. Charges for respiratory therapy.
22. Charges for Orthotics for Covered Persons diagnosed with diabetes when prescribed by a Physician.
23. Charges for Routine Patient Costs for a Phase I, II, III, and IV Approved Clinical Trial for Qualified Individuals.

"Routine Patient Costs" include but are limited to Medically Necessary services which a Covered Person with the identical diagnosis and current condition may receive even in the absence of participating in an Approved Clinical Trial.

"Routine Patient Costs" do not include any investigational item, device or service that is part of the Approved Clinical Trial; 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; a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or an item or service customarily provided and paid for by the sponsor of an Approved Clinical Trial.

"Approved Clinical Trial" means a Phase I, II, III, and IV clinical trial that is conducted in relation to the prevention, detection, or treatment of an acutely life-threatening disease state and is not designed exclusively to test toxicity or disease pathophysiology. The Approved Clinical Trial must be:

- A. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
- B. Exempt from obtaining an investigational new drug application; or

- C. Approved or funded by:
- 1) The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services or a cooperative group or center of any of the entities described above;
 - 2) A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
 - 3) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
 - 4) 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:
 - a) Be comparable to the system of peer review of studies and investigations used by the national institutes of health; and
 - b) Provide unbiased scientific review by individuals who have no interest in the outcome of the review.

A "Qualified Individual" is a Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of an acutely life-threatening disease state and either (i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

24. Charges for services for Complex Care Coordination and Transitional Care Management, based on specific CPT Codes for those services as approved by Medicare, and are not subject to the Medical Necessity requirements of the Plan.
25. Charges for services that are related to or as a result of Telemedicine, limited to the following methods:
 - A. An interactive patient encounter between the Physician or Licensed Health Care Provider being consulted and the patient. This method requires a "live" two way video and audio transmission between the patient and the Physician or Licensed Health Care Provider, and may include one additional provider who is presenting the patient to a specialist for an opinion regarding the patient's condition.
 - B. Storing and forwarding medical documentation to a licensed Radiologist or Pathologist for the purpose of reviewing telecommunicated medical documentation at a time which is convenient to the Radiologist or Pathologist's schedule. This method does not require actual contact between the patient and the provider.

Expenses billed for the use of equipment or transmission charges to transmit the audiovisual information are not covered. Telemedicine does not include charges for teleconsultations, which involves a practitioner seeking advice from a consultant concerning a patient's condition or course of treatment.

26. Charges for the initial purchase of eyeglasses or contact lenses following cataract surgery or aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
27. Charges for artificial eye provided by an Ocularist.

ADVANCED RADIOLOGY IMAGING

Coverage includes charges for Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT) and Computed Tomography(CT) imaging or other similar advanced radiology imaging tests.

ALCOHOLISM AND/OR CHEMICAL DEPENDENCY

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary treatment including, but not limited to, group therapy.
2. Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.
3. Charges for Inpatient or Partial Hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.
4. Charges for Medically Necessary treatment, including aftercare, at an Alcoholism and/or Chemical Dependency Treatment Facility.

“Partial Hospitalization” means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

AMBULATORY SURGICAL CENTER

Coverage includes charges made by an Ambulatory Surgical Center when treatment has been rendered.

CARDIAC REHABILITATION THERAPY

Charges for cardiac rehabilitation are payable as specifically stated in the Schedule of Medical Benefits. Coverage includes charges for cardiac rehabilitation services rendered by a recognized cardiac rehabilitation program, subject to the following requirements:

1. The Covered Person must be recovering from a myocardial infarction or cardiac surgery or be suffering from angina pectoris;
2. The Covered Person must be accepted by, and have a written referral from their attending Physician to a cardiac rehabilitation program.

CHIROPRACTIC CARE

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Coverage under this benefit includes charges for Chiropractic Treatment by a legally qualified chiropractor practicing within the scope of his or her license. Services include office visits, spinal adjustments and radiology for diagnosis, evaluation and treatment planning for musculoskeletal conditions.

Services are excluded for Emergency care, Preventive Care, maintenance care of a stable condition without symptomatic complaints and radiology for therapeutic purposes.

COLONOSCOPY BENEFIT

Charges are payable as specifically stated in the Schedule of Benefits. Coverage under this benefit includes Physician, anesthesiologist, lab and facility charges related to a colonoscopy ordered for routine screening or diagnostic purposes, such as lab, tissue removal or follow-up care.

DENTAL SERVICES - ACCIDENTAL INJURY

Coverage includes charges for dental treatment required because of Accidental Injury to natural teeth. Such expenses must be Incurred within twelve (12) months of the date of accident except in the event that it is not medically feasible for service to be completed within that time frame because of the age of the Covered Person or because of the healing process of the Injury. Coverage may not in any event include charges for treatment for the repair or replacement of a denture.

DIABETIC EDUCATION BENEFIT

Benefit maximums apply as stated in the Schedule of Medical Benefits. Coverage under this benefit includes diabetic outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes. A family member who is the primary care giver may attend the training on behalf of the Covered Person with diabetes.

DIALYSIS TREATMENTS - OUTPATIENT

Coverage under this benefit includes charges for services and supplies related to renal dialysis done on an Outpatient basis.

In order to avoid or reduce liability for amounts not covered by the Plan, a Covered Person who is diagnosed with End Stage Renal Disease (ESRD) shall immediately follow these steps:

1. Notify Plan Administrator when diagnosed with ESRD by the attending Physician.
2. Notify Plan Administrator if or when beginning dialysis treatments.
3. Enroll in Medicare Part A and Part B and use a provider that accepts Medicare patients to prevent the Covered Person from being billed for amounts in excess of the benefit amounts stated in the Schedule of Medical Benefits.
4. Failure to use a provider that accepts Medicare patients may result in significant costs to the Covered Person for fees that will not be covered by the Plan.
5. Medicare Part A or Part B is considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits. **The Plan shall only pay the amount that Medicare may not have covered, even if the Covered Person did not elect to be covered under Medicare.**

GENDER IDENTITY DISORDER/GENDER DYSPHORIA SERVICES

Coverage includes charges for Medically Necessary surgical and non-surgical treatment such as:

1. Psychotherapy;
2. Continuous hormone replacement therapy and corresponding testing to monitor the safety; or
3. Surgical treatment.

Expenses for treatment of Gender Identity Disorder are covered to the same extent as would be covered if the same covered service was rendered for another medical condition. Treatment is subject to all Plan provisions including applicable Deductibles, Copayments and Benefit Percentage.

Certain services are excluded from coverage under the Medical Benefits Exclusion section of the Plan. It is important to review those exclusions.

HOME HEALTH CARE BENEFIT

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Coverage under this benefit includes charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan for the following services:

1. Part-time or intermittent nursing care by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;
2. Home health aides; and
3. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

“Home Health Care Agency” means an organization that provides skilled nursing services and therapeutic services (home health aide services, physical therapy, occupational therapy, speech therapy) on a visiting basis, in a place of residence used as the Covered Person’s home. The organization must be Medicare certified and licensed within the state in which home health care services are provided.

“Home Health Care Plan” means a program for continued care and treatment administered by a Medicare certified and licensed Home Health Care Agency, for the Covered Person who may otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility or following termination of a Hospital confinement as an Inpatient and is the result of the same related condition for which the Covered Person was hospitalized and is approved in writing by the Covered Person's attending Physician.

Home Health Care specifically excludes the following:

1. Services and supplies not included in the approved Home Health Care Plan;
2. Services of a person who ordinarily resides in the home of the Covered Person, or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services;
3. Services of any social worker;
4. Transportation services;
5. Housekeeping services; and
6. Custodial Care.

HOSPICE CARE SERVICES

Coverage includes charges made by a Hospice within any one Hospice Benefit Period for:

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services;

2. Nursing care by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a public health nurse who is under the direct supervision of a Registered Nurse;
3. Physical Therapy and Speech Therapy, when rendered by a licensed therapist;
4. Medical supplies, including drugs and biologicals and the use of medical appliances;
5. Physician's services;
6. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician; and
7. Bereavement counseling.

HOSPITAL SERVICES

Coverage includes charges made by a Hospital for:

1. Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit;
2. Medically Necessary Hospital Miscellaneous Expenses other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use for an Emergency only, Physical Therapy treatments, hemodialysis, and x-ray;
3. Nursery neonatal units, general nursing services, including Hospital Miscellaneous Expenses for services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities or premature delivery incurred by a Newborn Dependent; and
4. Therapy which has been prescribed by a speech pathologist or Physician and includes a written treatment plan with estimated length of time for therapy. **Treatment rendered for stuttering or for behavioral, developmental or learning disorders is excluded.**

INBORN ERRORS OF METABOLISM

Coverage under this benefit includes charges for treatment under the supervision of Physician for 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.

“Medical Foods” means any nutritional substances in any form that are:

1. Formulated to be consumed or administered enterally under supervision of 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.

INFUSION SERVICES - OUTPATIENT

Coverage includes charges for home and Outpatient infusion services ordered by a Physician and provided by a Home and Outpatient Infusion Therapy Organization licensed and approved within the state in which the services are provided. A "Home and Outpatient Infusion Therapy Organization" is a health care facility that provides home and Outpatient infusion therapy services and skilled nursing services. Home and Outpatient infusion therapy services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a Home and Outpatient Infusion Therapy Organization. Services also include education for the Covered Person, the Covered Person's care giver, or a family member. Home and Outpatient infusion therapy services include pharmacy, supplies, equipment and skilled nursing services when billed by a Home and Outpatient Infusion Therapy Organization. **Skilled nursing services billed by a Home Health Care Agency are covered under the Home Health Care Benefit.**

MAMMOGRAM BENEFIT

Coverage under this benefit includes professional provider, radiology and facility charges related to a mammogram ordered for routine screening or diagnostic purposes.

MEDICAL EQUIPMENT/SUPPLIES

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Coverage includes charges for Durable Medical Equipment, Orthopedic Appliances, Prosthetic Appliances and other medical equipment as follows:

1. Rental, up to the purchase price, of a wheelchair, Hospital bed, respirator or other Durable Medical Equipment required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less. If there is a known medical reason to rent rather than purchase Durable Medical Equipment, then rental is allowed up to the purchase price;
2. Purchase of Orthopedic Appliances or Prosthetic Appliances including, but not limited to, artificial limbs, eyes, larynx;
3. Replacement or repair of Durable Medical Equipment, Orthopedic Appliances, Prosthetic Appliances;
4. Medical supplies such as dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies; and
5. Rental of oxygen (O2) concentrators. Purchase of O2 concentrators is not covered.

Diabetic supplies are eligible for coverage as specifically stated under the Pharmacy Benefit of this Plan.

MENTAL ILLNESS

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment including, but not limited to, group therapy;
2. Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States;
3. Charges for Inpatient or Partial Hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical illness or Injury by this Plan; and

4. Charges for Medically Necessary treatment at a Psychiatric Facility.

“Partial Hospitalization” means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

OBESITY / NUTRITIONAL COUNSELING

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Charges for treatment rendered by a registered dietician or other Licensed Healthcare Provider for individuals with medical conditions that require a special diet. Such conditions include, but may not be limited to; diabetes mellitus, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, hyperlipidemias and obesity (approved diagnosis code only) when Medically Necessary.

OCCUPATIONAL THERAPY - OUTPATIENT

Coverage includes charges for Occupational Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Occupational Therapy must be ordered by a Physician and rendered by a licensed occupational therapist. **Treatment rendered for stuttering or for behavioral, developmental or learning disorders is excluded.**

ORGAN AND TISSUE TRANSPLANT SERVICES

Coverage includes charges in connection with non-Experimental or non-Investigational organ or tissue transplant procedures, subject to the following conditions:

1. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education or such similar criteria, and must not be affiliated in any way with the Physician who is performing the actual surgery;
2. If the donor is covered under this Plan, Eligible Expenses Incurred by the donor are considered for benefits to the extent that such expenses are not payable by the recipient's plan;
3. If the recipient is covered under this Plan, Eligible Expenses Incurred by the recipient are considered for benefits. Eligible Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, are considered for payment to the extent that such expenses are not payable by the donor's plan. In no event are benefits payable in excess of the benefit maximums available to the recipient;
4. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person are treated separately for each person; and
5. The cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, are considered for payment.

PHYSICAL THERAPY - OUTPATIENT

Coverage includes charges for Physical Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Physical Therapy must be ordered by a Physician or Licensed Health Care Provider and rendered by a licensed physical therapist. **Treatment rendered for stuttering or for behavioral, developmental or learning disorders is excluded.**

PREVENTIVE CARE

“Preventive Care” means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, and which is not provided as a result of any Injury or Illness.

Coverage under this benefit includes the following routine services, subject to the following limitations:

1. Routine Wellness care for children and adults for the following:
 - A. Routine physical examinations by a Physician or Licensed Health Care Provider, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician or Licensed Health Care Provider and associated routine testing provided or ordered at the time of the examination; and
 - B. Routine immunizations according to the schedule of immunizations which is recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention.
2. Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at: <https://www.healthcare.gov/coverage/preventive-care-benefits/>.
3. Women’s Preventive Care for the following:
 - A. Well-women annual visits for women 18 years of age and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits as medically appropriate.
 - B. Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
 - C. Human papillomavirus (HPV) DNA testing.
 - D. Annual counseling on sexually transmitted infections (STI’s) and human immune-deficiency virus (HIV) screening for all sexually active women.
 - E. All Food and Drug Administration approved prescription contraceptives and female over-the-counter contraceptives when prescribed by a Physician or Licensed Health Care Provider, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Self-administered contraceptives are available only through the Pharmacy Benefit as outlined in the Pharmacy Benefit section of this Plan.
 - F. Breast feeding support, supplies, and counseling, including comprehensive lactation support and counseling by a trained provider during Pregnancy and/or in the postpartum period, and costs for breast feeding equipment and related supplies.
 - G. Annual screening and counseling for interpersonal and domestic violence.
4. Office visit charges only if the primary purpose of the office visit is to obtain a recommended Preventive Care service identified above.

Expenses payable under this Preventive Care Benefit are not subject to the Medical Necessity provisions of this Plan. Charges for Preventive Care that involve excessive, unnecessary or duplicate tests are specifically excluded. Charges for treatment of an active illness or injury are subject to the Plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

PREVENTIVE/PROPHYLACTIC MASTECTOMY OR OOPHORECTOMY

Coverage includes charges for a preventive/prophylactic mastectomy or oophorectomy regardless of Medical Necessity for treatment of individuals at high risk of developing breast cancer when any ONE of the following criteria is met:

Individuals with a personal history of cancer as noted below:

1. Individuals with a personal history of breast cancer when any ONE of the following criteria is met:
 - A. Diagnosed at age forty-five (45) or younger;
 - B. Diagnosed at age fifty (50) or younger with at least one close blood relative* with breast cancer at any age;
 - C. Diagnosed with two breast primaries (includes bilateral disease or cases where there are two or more clearly separate ipsilateral primary tumors) when the first breast cancer diagnosis occurred prior to age fifty (50);
 - D. Diagnosed at age sixty (60) or younger with a triple negative breast cancer;
 - E. Diagnosed at age fifty (50) or younger with a limited family history (e.g., fewer than two first- or second degree female relatives or female relatives surviving beyond forty-five (45) years in the relevant maternal and/or paternal lineage);
 - F. Diagnosed at any age and there are at least two close blood relatives* with breast cancer diagnosed at any age;
 - G. Diagnosed at any age and there is at least one close blood relative* with breast cancer at age fifty (50) or younger;
 - H. Diagnosed at any age and there are at least two close blood relatives* with pancreatic cancer or prostate cancer (Gleason score ≥ 7) at any age;
 - I. Diagnosed at any age with one or more close blood relatives* with epithelial ovarian cancer, fallopian tube, or primary peritoneal cancer;
 - J. Close male blood relative* with breast cancer;
 - K. An individual of Ashkenazi Jewish descent;
 - L. Development of invasive lobular or ductal carcinoma in the contralateral breast after electing surveillance for lobular carcinoma in situ of the ipsilateral breast;
 - M. Lobular carcinoma in situ confirmed on biopsy;
 - N. Lobular carcinoma in situ in the contralateral breast;
 - O. Diffuse indeterminate microcalcifications or dense tissue in the contralateral breast that is difficult to evaluate mammographically and clinically;

- P. A large and/or ptotic, dense, disproportionately-sized contralateral breast that is difficult to reasonably match the ipsilateral cancerous breast treated with mastectomy and reconstruction.
- 2. Personal history of epithelial ovarian, fallopian tube, or primary peritoneal cancer;
- 3. Personal history of pancreatic cancer or prostate cancer (Gleason score ≥ 7) at any age with two or more close blood relatives* with breast, ovarian, pancreatic cancer, or prostate cancer (Gleason score ≥ 7) at any age;
- 4. Personal history of pancreatic cancer at any age with Ashkenazi Jewish ancestry and one or more close blood relatives* with breast, ovarian, pancreatic cancer, or prostate cancer (Gleason score ≥ 7) at any age;
- 5. Personal history of male breast cancer.

Individuals with no personal history of breast or epithelial ovarian cancer when any ONE of the following is met:

- 1. Known breast risk cancer antigen (BRCA1 or BRCA2), or PTEN mutation confirmed by genetic testing;
- 2. Close blood relative* with a known BRCA1, BRCA2 or PTEN mutation;
- 3. First- or second-degree blood relative* meeting any of the above criteria for individuals with a personal history of cancer;
- 4. Third-degree blood relative with breast and/or epithelial ovarian/fallopian tube/primary peritoneal cancer with two or more close blood relatives* with breast and/or ovarian cancer (with at least one close blood relative with breast cancer prior to age fifty (50));
- 5. History of treatment with thoracic radiation;
- 6. Atypical ductal or lobular hyperplasia, especially if combined with a family history of breast cancer;
- 7. Dense, fibronodular breasts that are mammographically or clinically difficult to evaluate, several prior breast biopsies for clinical and/or mammographic abnormalities, and strong concern about breast cancer risk.

*A close blood relative/close family member includes first-, second-, and third-degree relatives on the same side of the family.

A first-degree relative is defined as a blood relative with whom an individual shares approximately 50% of his/her genes, including the individual's parents, full siblings, and children.

A second-degree relative is defined as a blood relative with whom an individual shares approximately 25% of his/her genes, including the individual's grandparents, grandchildren, aunts, uncles, nephews, nieces and half-siblings.

A third-degree relative is defined as a blood relative with whom an individual shares approximately 12.5% of his/her genes, including the individual's great-grandparents and first-cousins.

PROSTATE CANCER SCREENING, PROSTATE SPECIFIC ANTIGEN (PSA) TESTING

Charges are payable as specifically stated in the Schedule Medical of Benefits. Coverage under this benefit includes annual routine examination for the detection of prostate cancer, including a prostate-specific antigen (PSA) test.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

Coverage includes charges for reconstructive breast surgery subsequent to any Medically Necessary mastectomy or preventive/prophylactic mastectomy covered under this Plan, limited to charges for the following:

1. Reconstruction of the breast(s) upon which the mastectomy was performed, including implants;
2. Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants; and
3. Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry.

Specifically excluded from this benefit are expenses for the following:

1. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;
2. Breast augmentation procedures unrelated to producing a symmetrical appearance;
3. Implants for the non-affected breast unrelated to producing a symmetrical appearance; and
4. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

RESIDENTIAL TREATMENT

Coverage includes charges made by a Residential Treatment Facility for treatment of Mental Illness or for treatment of Alcoholism and/or Chemical Dependency, provided the Alcoholism and/or Chemical Dependency Treatment Facility and program meet ASAM level 3.5 or higher criteria. Residential care Room and Board charges are covered in lieu of Inpatient Room and Board charges provided the patient would meet criteria for an Inpatient admission.

“Residential Treatment Facility” means an institution which:

1. Is licensed as a 24-hour residential facility for Mental Illness and Chemical Dependency and/or Alcoholism treatment, although not licensed as a hospital;
2. Provides a multi-disciplinary treatment plan in a controlled environment, with periodic supervision of a Physician or a Ph.D. psychologist; and
3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE

Routine Newborn Inpatient Nursery/Physician Care including the following services:

1. Routine Nursery Care includes room, board and Hospital Miscellaneous Expenses for a Newborn Dependent child, including circumcision; and
2. Routine Physician Care includes charges for services of a Physician for a Newborn Dependent child while Inpatient as a result of the child's birth, including circumcision.

SKILLED NURSING FACILITY

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Coverage includes charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility during the convalescent confinement. Only charges in connection with convalescence from the Illness or Injury for which the Covered Person was Hospital-confined may be eligible for benefits. These expenses include:

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services;
2. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees; and
3. Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent confinement, but no other supplies.

SPEECH THERAPY - OUTPATIENT

Coverage includes charges made by a licensed speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders. The Plan will provide benefits for Speech Therapy when all of the following criteria are met:

1. There is a documented condition or delay in development that can be expected to improve with therapy within a reasonable time.
2. Treatment is rendered for a condition that is the direct result of a diagnosed neurological, muscular, or structural abnormality affecting the organs of speech.
3. Therapy has been prescribed by the speech language pathologist or Physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all above conditions are met.

Charges for Speech Therapy are not covered under the following conditions:

1. Treatment when improvement would normally be expected to occur without intervention.
2. Treatment is rendered for stuttering.
3. Treatment is rendered for behavioral or learning disorders.

SPINAL SURGERY BENEFIT

Spine surgery in the absence of one (1) of the following conditions or diagnoses shall be subject to, and require proof of, a minimum of three (3) consecutive months of unsuccessful conservative therapy within the six (6) months immediately prior to the scheduled date of surgery:

1. Acute trauma.
2. Tumor.
3. Infection.
4. Cauda equina syndrome.
5. Severe disease and rapidly progressing neurologic deficit.
6. Situation where the patient risks permanent neurological or functional deficit if not operated on urgently.

Conservative therapies are non-operative treatments such as physical therapy, epidural injections, non-steroidal anti-inflammatory medications, chiropractic care and other recommended regimens by a Physician.

Benefits of all spine surgeries shall be covered based upon published national current best practices guidelines, such as by the North American Spine Society (NASS guidelines) or by the International Society for the Advancement of Spine Surgery (ISASS guidelines), as applied to the specific surgical procedure recommended. This includes, but is not limited to, all requirements or guidelines for prior conservative treatments, including the above, before surgery is performed.

None of the requirements above will be waived, except by written request of the attending surgeon with two (2) unanimous, concurrent, independent board certified spine surgeon reviews, either by a neurosurgeon or by an orthopedic spine surgeon. At least one (1) of the reviews must be done by a surgeon outside the attending surgeon's background (e.g., a neurosurgeon must have at least one (1) review by an orthopedic spine surgeon). The review must state that the non-operative treatment requirements of this Plan or recommended guideline are not medically appropriate for the specific patient's diagnosis and condition, as reported in the records submitted.

SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES

Coverage under this benefit includes charges for implants, devices and related supplies, including fastenings, screws and all other hardware related to the device or implant.

SURGICAL PROCEDURES

Coverage includes charges for Surgical Procedures.

For non-Participating Providers, when two or more Surgical Procedures occur during the same operative session, charges are considered as follows:

1. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, 100% of the Eligible Expense are considered for the Major Procedure; and 50% of the Eligible Expense are considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services are reimbursed at the contracted or negotiated rate; and

2. When an incidental procedure is performed through the same incision, only the Eligible Expense for the Major Procedure may be considered. Examples of incidental procedures are: excision of a scar, appendectomy at the time of other abdominal surgery, lysis of adhesions, etc.

When an assisting Physician is required to render technical assistance during a Surgical Procedure, the charges for such services are limited to 25% of the primary surgeon's Eligible Expense for the Surgical Procedure. When an assisting non-physician is required to render technical assistance during an operation, charges for such services are limited to 10% of the surgeon's Eligible Expense for the Surgical Procedure.

TMJ/JAW DISORDERS

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Coverage includes charges in connection with any surgical treatment for temporomandibular joint (TMJ) dysfunction including, but not limited to: correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia. Coverage does not include Expenses Incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.

URGENT CARE FACILITY

Coverage includes charges made by an Urgent Care Facility when treatment has been rendered.

VISION SERVICES - ACCIDENTAL INJURY OR MEDICAL CONDITION

Coverage includes charges for vision treatment as a result of Accidental Injury or medical condition.

EXPERIMENTAL COVERAGE

Treatment that would otherwise be considered Experimental/Investigational will be covered only if the proposed Experimental/Investigational treatment has been reviewed by four (4) unrelated, independent board certified Physicians actively practicing within the same specialty as the attending Physician and the four (4) reviewing Physicians have unanimously agreed that:

1. As a result of the rarity of the disease or condition, there is no United States FDA-approved regimen of treatment;
2. All United States FDA-approved regimens of treatment have been attempted within the twelve (12) month period immediately prior to the date the proposed experimental treatment is to commence without any significant clinical improvement in the disease or condition;
3. The proposed course of treatment is medically indicated and is considered the standard of care in the United States for the disease or condition being treated based upon published reports and articles in the authoritative medical and scientific literature including, but not limited to, the following:
 - A. The written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, treatment, device or procedure; and
 - B. The informed consent documents used by the treating facility or of another facility studying substantially the same drug, treatment, device or procedure; and
4. To a reasonable degree of medical certainty, there is a likelihood that the proposed treatment will clinically improve the condition being treated; and
5. That the patient is not considered to be terminal regardless of the treatment proposed or attempted; or
6. The treatment has been recognized by the National Comprehensive Cancer Network (NCCN) as the only available treatment that has demonstrated efficacy of the condition in question.

VOLUNTARY SECOND AND THIRD SURGICAL OPINION BENEFIT

Charges are covered as follows:

1. Legally qualified Physician for a second opinion consultation if non-emergency, elective surgery is recommended by the Covered Person's attending Physician. The Physician rendering the second opinion regarding the Medical Necessity of such surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who is performing the actual surgery; and
2. Legally qualified Physician for a third consultation, if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such opinion, and must not be affiliated in any way with the consulting Physician, or with the Physician who is performing the actual surgery.

Expenses Incurred under this benefit are not subject to any Copayment or Deductible. Physician charges are payable at 100% of the Eligible Expense. Ancillary charges are payable as stated in the Schedule of Medical Benefits. The claim must indicate that charges are for a Second or Third Surgical Opinion. Claims that do not indicate Second or Third Surgical Opinion are considered under the Medical Benefits Section of the Plan, subject to all Plan conditions, exclusions, and limitations.

HOSPITAL ADMISSION CERTIFICATION

The Plan strongly recommends, but does not require, for Inpatient hospital admissions that the Covered Person pre-certify the Inpatient stay or notify the Plan of an Emergency admission.

Pre-certification, Plan notification and case management are designed to:

1. Provide information regarding coverage before receiving treatment, services, or supplies;
2. Provide information about benefits regarding proposed procedures or alternate treatment plans;
3. Assist in determining out-of-pocket expenses and identify possible ways to reduce them;
4. Help avoid reductions in benefits which may occur if the services are not Medically Necessary or the setting is not appropriate; and
5. If appropriate, assign a case manager to work with the Covered Person and the Covered Person's providers to design a treatment plan.

A benefit determination on a claim will be rendered only after the claim has been submitted to adjudicate whether it is eligible for coverage under the terms and conditions of the Plan. If it is determined not to be eligible, the Covered Person will be responsible to pay for all charges that are determined to be ineligible.

Therefore, although not required, pre-certification and Plan notification of Emergency admissions is strongly recommended to obtain coverage information prior to incurring the charges.

PRE-ADMISSION CERTIFICATION REVIEW

The Plan recommends that prior to admission for any non-emergency Illness or Injury, and within seventy-two (72) hours after admission for any Emergency Illness or Injury, the Covered Person or the Covered Person's attending physician call the designated utilization management company retained by the Plan Sponsor in connection with this Plan for a pre-admission certification review.

To pre-certify, call Allegiance Care Management (the utilization management company) at (800) 342-6510 for pre-admission certification review.

Most certifications occur over the phone. Once a final decision is made regarding the request for certification, a notice of pre-certification is sent to the physician, to the Covered Person, to the Plan Supervisor and to the hospital.

NOTE: PRE-CERTIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT OF THE CLAIM(S). ELIGIBILITY FOR CLAIM PAYMENTS IS DETERMINED AT THE TIME CLAIMS ARE ADJUDICATED SINCE THE AMOUNT OF BENEFIT COVERAGE, IF ANY, IS SUBJECT TO ALL PLAN PROVISIONS INCLUDING, BUT NOT LIMITED TO, MEDICAL NECESSITY, PATIENT ELIGIBILITY, DEDUCTIBLES, CO-PAYMENTS AND ANY PLAN LIMITATIONS OR MAXIMUMS IN EFFECT WHEN THE SERVICES ARE PROVIDED. PROVIDERS AND COVERED PERSONS ARE INFORMED AT THE TIME CLAIMS ARE PRE-CERTIFIED THAT PRE-CERTIFICATION OF A COURSE OF TREATMENT BY THE PLAN DOES NOT GUARANTEE PAYMENT OF CLAIMS FOR THE SAME.

CONTINUED STAY CERTIFICATION

Charges for Inpatient hospital services for days in excess of any days previously certified by Allegiance Care Management (the utilization management company) are subject to all terms, conditions and exclusions of the Plan, and must be certified by Allegiance Care Management.

Certification for additional days may be obtained in the same manner as the pre-admission certification.

EMERGENCY NOTIFICATION/CERTIFICATION

The Covered Person or their representative may notify Allegiance Care Management (the utilization management company) regarding any Emergency Hospital Admission within seventy-two (72) hours immediately following admission.

To notify the Plan of an Emergency admission, call Allegiance Care Management (the utilization management company) at (800) 342-6510 for Emergency admission certification.

MATERNITY NOTIFICATION

The Covered Person or representative may notify Allegiance Care Management (the utilization management company) at **(877) 792-7827** when Pregnancy is diagnosed or as soon after as possible, in order to participate Allegiance Maternity Management Program. Notification is encouraged within the first trimester. Access to the Allegiance Maternity Management Program is available to the Covered Person through the entire term of the Pregnancy. Only Covered Persons who notify the utilization management company and participate in the Allegiance Maternity Management Program during the first and/or second trimester are eligible for the related incentive.

PRE-TREATMENT REVIEW

Pre-treatment Review by the Plan is strongly recommended for certain services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.

Pre-treatment Review is the process of verifying the eligibility of services to determine if reimbursement is available under Plan provisions. Although benefits may not be available under this Plan, Pre-treatment Review is strongly recommended before incurring expenses for any Inpatient or Outpatient service, medication, supply or ongoing treatment for:

1. Surgeries:
 - A. Spinal fusions or any other back surgery involving implantable devices;
 - B. Reduction Mammoplasty;
 - C. Blepharoplasty;
 - D. Uvulopalato-pharyngoplasty (UPPP).
2. Organ or Tissue Transplants.
3. Infertility. **(Not Covered under this Plan)**
4. Medical Equipment for costs exceeding \$2,500.
5. Outpatient dialysis.
6. Infusion services.
7. Obesity treatment.
8. Bariatric Surgery benefits. **(Not Covered under this Plan)**
9. Cancer treatments.
10. Commercial or Private Automobile Transportation.
11. Outpatient Rehabilitative Care (Benefits in excess of 30 visits per twelve months).
12. Surgery that could be considered Cosmetic under some circumstances.
13. Any procedure or service that could possibly be considered Experimental or Investigational.
14. Surgical treatment of TMJ.
15. Home Health Care services.
16. Residential Treatment Facility.
17. Preventive/Prophylactic Mastectomy/Oophorectomy.
18. Chronic pain program. **(Some restrictions apply)**
19. Hemophilia.

20. Advanced Imaging. Employee may request pre-treatment review for PET Scan for cancer.
21. Skilled Nursing Facility.
22. Speech Therapy.
23. Gender Identity Disorder/Gender Dysphoria Services.

To obtain Pre-treatment Review from the Plan, submit the following to the Plan Supervisor at P.O. Box 3018, Missoula, MT 59806-3018 or via facsimile at (866) 201-0522:

1. A complete description of the procedure(s) or treatment(s) for which review is requested;
2. A complete diagnosis and all medical records regarding the condition that supports the requested procedure(s) or treatment(s) including, but not limited to, informed consent form(s), all lab and/or x-rays, or diagnostic studies;
3. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding CPT or HCPCS codes;
4. The attending Physician's prescription, if applicable;
5. A Physician's referral letter, if applicable;
6. A letter of Medical Necessity;
7. A written treatment plan; and
8. Any other information deemed necessary to evaluate the request for Pre-treatment Review.

Upon receipt of all required information, the Plan provides a written response to the written request for Pre-treatment Review of services.

THE BENEFITS QUOTED ARE NOT A GUARANTEE OF PAYMENT. FINAL DETERMINATION AS TO BENEFITS PAID IS MADE AT THE TIME THE CLAIM IS SUBMITTED FOR PAYMENT WITH REVIEW OF NECESSARY MEDICAL RECORDS AND OTHER INFORMATION.

MEDICAL EXPENSE SELF AUDIT BONUS

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

In the event a self-audit results in elimination or reduction of charges, an amount up to fifty (50%) percent of identified overcharge, up to one-thousand (\$1,000) dollars on overcharge of fifty (\$50) dollars or more of the amount eliminated or reduced, will be paid directly to the Employee as a bonus, provided the savings are accurately documented and satisfactory evidence of a reduction in charges is submitted to Allegiance Benefit Plan Management (e.g. a copy of the incorrect bill and a copy of the corrected billing). The bonus only applies to charges which have been submitted to and paid by the Plan and for which an erroneous charge was paid by the Plan. Erroneous charges corrected by the Plan during the claims adjudication process are not eligible for this bonus.

This self-audit is a bonus in addition to the benefits of this Plan. The Covered Person must indicate on the corrected billings "This is a claim for the Medical Expense Self Audit Bonus" in order to receive the bonus.

This bonus is not payable for charges in excess of the Eligible Expense, regardless of whether the charges are reduced.

MEDICAL BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Medical Benefits in addition to the following Medical Benefit Exclusions:

1. Charges for routine medical examinations, routine health check-ups or preventive immunizations not necessary for the treatment of an Injury or Illness, except as specifically listed under the Preventive Care Benefit.
2. Charges in connection with the care or treatment of, surgery performed for, or as the result of, a Cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury or an Illness, or when rendered to correct a congenital anomaly.**
3. Charges for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a covered benefit of this Plan.
4. Charges for Elective Abortion.
5. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury.
6. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician, except as specifically covered under the Telemedicine Benefit.
7. Charges for Licensed Health Care Providers' fees for any treatment which is not rendered by or in the physical presence of a Licensed Health Care Provider, except as specifically covered under the Telemedicine Benefit.
8. Special duty nursing services are excluded:
 - A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or
 - B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.
9. Charges in connection with eye refractions, the purchase or fitting of eyeglasses or contact lenses. **This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery or aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.**
10. Charges in connection with hearing aids, or such similar aid devices, including, but not limited to: exams for the purpose of fitting a hearing aid; any device, service or treatment for hearing loss; or any device, service or treatment for the purpose of improving or assisting hearing by directing or amplifying sound in the ear canal whether the ears are absent or deformed from trauma, surgery, disease or congenital defect, or Illness or Injury, or any tinnitus masking device, and all bone assisted hearing devices of any type.

11. Charges for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes, except as specifically listed as a covered service.
12. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, or any other assisted reproductive technique.
13. Charges for recreational counseling, religious counseling, milieu therapy, hypnotherapy, holistic medicine, homeopathy, stress management or self-help programs. Refer to EAP Benefit for counseling services. Contact (888) 750-0512 or eap@mt.gov for further information.
14. Charges resulting from or in connection with the reversal of a sterilization procedure.
15. Charges in connection with services or supplies provided for the surgical treatment of obesity and weight reduction, including bariatric surgery or any other weight reduction surgery or procedure and weight loss medications regardless of Medical Necessity, and regardless of other condition, diagnosis or co-morbidity, are specifically excluded.
16. Charges for chiropractic treatment which are not related to an actual Illness or Injury or which exceed the maximum benefit as stated in the Schedule of Medical Benefits.
17. Charges for orthotics or rolfing, except for orthotics for diabetes as specifically listed as a covered service.
18. Charges for hair transplant procedures, wigs and artificial hairpieces or drugs which are prescribed to promote hair growth or remove hair.
19. Charges for any surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism.
20. Charges related to Custodial Care.
21. Charges for artificial organ implant procedures.
22. Charges for non-prescription supplies or devices, except as covered under the Preventive Care Benefit.
23. Charges for services of a doula, direct-entry midwife or lay midwife, or the practice of direct-entry midwifery. A direct-entry midwife is one practicing midwifery and licensed pursuant to state in which services are being performed pursuant to § 37-27-101 et seq, MCA.

"Direct-entry midwife" means a person who advises, attends, or assists a woman during Pregnancy, labor, natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.
24. Charges for complications that directly result from acting against medical advice, non-compliance with specific physician's orders or leaving an Inpatient facility against medical advice.
25. Charges for equipment including, but not limited to, motorized wheelchairs or beds, that exceed the patient's needs for everyday living activities as defined by the Americans with Disabilities Act as amended from time to time, unless Medically Necessary by independent review and not primarily for personal convenience.
26. Charges for specialized computer equipment including, but not limited to, Braille keyboards and voice recognition software, unless determined to be Medically Necessary by independent review, and not primarily for personal convenience.

27. Charges for nutrition-based therapy for alcoholism or drug addiction.
28. Charges for health care services to treat co-dependency.
29. Charges for immunizations, medications and other preventive treatments that are recommended because of increased risk due to type of employer or travel including, but not limited to, immunizations, medications and/or other preventive treatments for malaria and yellow fever.
30. Charges for examinations for employment, licensing, insurance, school, camp, sports or adoption purposes.
31. Charges for expenses for examinations and treatment conducted for the purpose of medical research.
32. Charges for FAA and DOT Physicals.
33. Charges for the following (known as a "Never Event") when the condition is a result of patient confinement or surgery:
 - A. Removal of an object left in the body during surgery;
 - B. Catheter-associated urinary tract infection;
 - C. Pressure ulcers;
 - D. Vascular catheter-associated infection;
 - E. Infection inside the chest after coronary artery bypass graft surgery;
 - F. Hospital acquired injuries such as fractures, dislocations, intracranial injuries, crushing injuries and burns; and
 - G. Treatment, amputation or removal of the wrong body part or organ.
34. Charges for services for massage or massage therapy, except as provided by a Chiropractor or Physical Therapist.
35. Charges for routine foot care, including the following:
 - A. Removal or treatment of corns or callosities,
 - B. Hypertrophy, hyperplasia of the skin, or subcutaneous tissues;
 - C. Cutting or trimming of nails;
 - D. Treatment of flat feet, fallen arches, or chronic foot strain;
 - E. Orthotic appliances and casting for orthotic appliances, except as specifically covered;
 - F. Padding and strapping; or
 - G. Fabrication, except as specifically covered.
36. Charges for health clubs, health spas, personal trainers and exercise programs, whether or not approved or prescribed by a licensed provider.

37. Charges for Autism Spectrum Disorder, as defined, related services provided in a public school setting and paid for by the public school are specifically excluded.
38. Charges for biofeedback or orthomolecular therapy, including nutrients, vitamins and food supplements, except as specifically covered.
39. Charges for vocational rehabilitation.
40. Charges for legally ordered services, including services which are required by a court order or as a condition of parole or probation, unless subsequently found to be Medically Necessary.
41. Charges related to any services, care or treatment for sexual dysfunction including; medications, surgery, medical, counseling or Psychiatric Care, or treatment.
42. Charges for voice modification; suction assisted lipoplasty of the waist; blepharoplasty; facial reconstruction or facial feminization surgery; hair removal or other non-Medically Necessary services, care or treatment of Gender Identity Disorder or Gender Dysphoria.
43. Charges for treatment of Gender Identity Disorder/Gender Dysphoria when the services are for reversal of a prior gender reassignment surgery or reversal of a prior surgery to revise secondary sex characteristics.
44. Charges for all medical examinations for firefighters in the state of Montana pursuant to § 39-71-101, MCA et. seq.

APPENDIX B

**SUMMARY PLAN DESCRIPTION
FOR PRESCRIPTION DRUG BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF**

STATE OF MONTANA

Appendix B

Summary Plan Description
describes the Pharmacy Plan Benefits
in effect as of January 1, 2019 and renews January 1, 2020

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PHARMACY BENEFIT

Prescription drug charges are payable only through the Plan’s Pharmacy Benefit Manager (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. **The PBM shall provide separate information for details regarding Network pharmacies, Preferred Brand prescriptions, formulary listings and Specialty Drugs upon enrollment for coverage under this Plan.**

Additional information regarding the Prescription Drug Benefits is available at:
www.benefits.mt.gov/rx.

COST SHARING PROVISIONS

Pharmacy Deductible per Benefit Period

Per Covered Person None
 Per Family None

Pharmacy Out-of-Pocket Maximum per Benefit Period

Per Covered Person \$1,800
 Per Family \$3,600

Pharmacy Copayments do not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments apply toward the applicable Pharmacy Benefit Out-of-Pocket Maximum. Pharmacy Benefits are payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum for the remainder of the Benefit Period, except for Tier 3 and Non-Preferred Specialty Copayments . Tier 3 and Non-Preferred Specialty Copayments do not accrue to the Pharmacy Out-of-Pocket Maximum and will never be payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum.

Copayment per Prescription				
	Preferred Pharmacy Retail 1 to 34 days' supply	Preferred Pharmacy Retail 35 to 90 days' supply	Non-Preferred Pharmacy Retail Member Submit 1 to 10 days' supply	Preferred Pharmacy Mail Order up to 90 days' supply
\$0 Preventive products*	No charge	No charge	No charge	No charge
Tier 1 Preferred generics and some lower cost brand products	\$15 Copayment	\$30 Copayment	\$15 Copayment	\$30 Copayment
Tier 2 Preferred brand products and some high cost non-preferred generics	\$50 Copayment	\$100 Copayment	\$50 Copayment	\$100 Copayment

Copayment per Prescription				
	Preferred Pharmacy Retail 1 to 34 days' supply	Preferred Pharmacy Retail 35 to 90 days' supply	Non-Preferred Pharmacy Retail Member Submit 1 to 10 days' supply	Preferred Pharmacy Mail Order up to 90 days' supply
Tier 3** Non-preferred products (may include some high cost non-preferred generics)	50% Copayment	50% Copayment	50% Copayment	50% Copayment
Tier 4 Speciality products	\$200 Copayment	N/A	50% Copayment** (up to 34 days' supply may be available)	N/A
Tier 4 Speciality products for Medicare Retirees only	\$50 Copayment	N/A	50% Copayment** (up to 34 days' supply may be available)	N/A
<p>The Plan offers a CoPay Max Program for certain specialty drugs included in the specialty tier and dispensed through the specialty pharmacy, Lumicera. This program manages expenses for eligible specialty medications, while also lowering the Plan's overall cost if Copayment assistance is available. Under the program, speciality medications are subject to a 30% Copayment. However, the program will cap a member's total payment at \$0 after the utilization of available Copayment assistance. Only the amount paid out-of-pocket will apply to the Out-of-Pocket Maximum. If a speciality drug does not qualify, or is removed from the program, Copayment will default to the Tier 4 Copayment indicated in the Copayment per Prescription table.</p>				
<p>*\$0 Preventive products apply to certain preventive medications (as defined by the Affordable Care Act (ACA)) and select medications. See the formulary for a listing of covered products.</p>				
<p>**Tier 3 Non-preferred products do not accrue towards the Pharmacy Out-of-Pocket Maximum.</p>				
Preventive Services				
<p>The following are payable at 100% and are not subject to any Copayment:</p> <ol style="list-style-type: none"> 1. Prescribed generic female contraceptives or brand if generic is unavailable; 2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and 3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the ACA which may be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. 4. Vaccines available through the PBM's Vaccine Program. 				

Mandatory Generic
If there is a generic alternative for the prescription drug, and the Covered Person chooses a brand name instead, regardless of how the prescription is written, the Covered Person shall pay the difference in cost between the generic and brand name medication plus the applicable brand Copayment amount.
Hometown Diabetes Care
Participants enrolled in the Hometown Diabetes Care program receive at no cost to the Participant, one (1) glucose meter per Benefit Period, 100 glucose test strips per month for Participants using insulin or 50 strips for Participants not using insulin, and discounted pricing for additional strips and other diabetic supplies. To be eligible for the Hometown Diabetes Care program, a Participant must have a diagnosis of diabetes or pre-diabetes. For additional information, see the Hometown MTm brochure on the Health Care and Benefits Division website at: http://benefits.mt.gov/Prescription/HomeTown-MTm .
Hometown Asthma Care
Participants enrolled in the Hometown Asthma Care program receive at no cost to the Participant, a valved holding chamber, peak flow meter, if necessary, and two (2) one-hour appointments with a certified Asthma Educator per Benefit Period. Participants may be eligible for reduced Pharmacy Copayments on some asthma drugs. To be eligible for the Hometown Asthma Care Program, a Participant must have a diagnosis of asthma or breathing problems. For additional information, see the Hometown MTm brochure on the Health Care and Benefits Division website at: http://benefits.mt.gov/Prescription/HomeTown-MTm .
When Primary Coverage exists Under Another Plan
If primary coverage exists under another plan, charges for prescription drugs must be submitted to the primary carrier first. Once the PBM receives a copy of the drug receipt or explanation of benefits showing the total charges and amounts paid for eligible prescription drugs from the primary carrier, if applicable, this Plan may reimburse the Participant for the remainder of Eligible Expenses, not subject to the applicable Copayments. In order to receive reimbursement, the drug receipt must be submitted to the PBM.

COVERAGE

Coverage for prescription drugs only includes those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. Contraceptives and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider. **Contraceptive Management is covered under the Preventive Care Benefit of this Plan.**
2. Diabetic supplies, including calibration liquid, insulin, lancet devices, lancets, blood glucose meters, pen needles, syringes, and blood glucose and ketone test strips.
3. Smoking deterrents prescribed by a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider.
4. Select over-the-counter (OTC) medications that offer a lower cost alternative and OTC medications listed as an A or B recommendation as a Preventive Service covered under the ACA, only when prescribed by a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider. ACA medications may be viewed at: <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

5. Legend vitamins (oral only); Prenatal agents used in Pregnancy; therapeutic agents used for specific deficiencies and conditions; and hemopoetic agents used to treat anemia.
6. Legend fluoride products (oral only): Dental or pediatric.

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:

PBM Network Prescriptions: Available only through a retail pharmacy that is part of the PBM Network. The pharmacy bills the Plan directly for the part of the prescription cost that exceeds the Copayment (Copayment amount must be paid to pharmacy at time of purchase). **The prescription identification card is required for this option.**

Member Submit Prescriptions: Available only if the prescription identification card may not be used because a pharmacy is not part of the PBM Network, or the prescription identification card is not used at a Network pharmacy. **Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the PBM, along with a reimbursement form (Direct Reimbursement). The PBM shall reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement may not exceed what the PBM would have reimbursed for a Network Prescription.**

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. **The mail order pharmacy bills the Plan directly for prescription costs that exceed the Copayment.**

Specialty Drugs: These medications are generic or non-generic drugs classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty drugs should be obtained from a preferred specialty pharmacy. **A list of specialty drugs and preferred specialty pharmacies may be obtained from the PBM or Plan Supervisor.**

DRUG OPTIONS

The drug options available are:

Formulary Generic: Those drugs and supplies listed in the most current edition of the Physicians' Desk Reference or by the PBM Program as generic drugs. Drugs that are new to the market are reviewed by the Pharmacy and Therapeutics Committee for possible addition to the formulary approximately six (6) months after entering the market.

Preferred Brand: Non-generic drugs and supplies listed as "Preferred Brand" by the PBM Program as stated in a written list provided to Covered Persons and updated from time to time.

Non-Preferred Brand: Copyrighted or patented brand name drugs (Non-Generic) which are not recognized or listed as Preferred Brand drugs or supplies by the PBM Program. On limited occasions a Generic may be included when specific regulatory or market place circumstances exist.

PRESCRIPTION COPAYMENT

“Copayment” means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of service. Copayments are specifically stated in this section. Copayments are not payable by the Plan and do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments apply towards the applicable Pharmacy Out-of-Pocket Maximum, and after satisfaction of the Out-of-Pocket Maximum, Copayments no longer apply for the remainder of the Benefit Period.

SUPPLY LIMITS

Supply is limited to 90 days for PBM Network and Mail Order Prescriptions. Schedule II and Schedule III drug classification Prescriptions and Specialty Prescriptions are limited to 34 days’ supply. Non-Preferred Pharmacy Prescriptions are limited to a 10 days’ supply.

Prescription drug refills are not allowed until 75% for Retail refills and 70% for Mail Order refills of the prescribed day supply is used.

The amount of certain medications are limited to promote safe, clinically appropriate drug usage. Any additional prescribed supply exceeding any clinically appropriate limits will be reviewed for Medical Necessity. A current list of applicable quantity limits can be obtained by contacting the PBM at the number listed on the Participant’s identification card.

STEP THERAPY PROGRAM

A protocol that requires the member to try a preferred formulary medication before approving a more expensive preferred product or non-formulary product.

PRIOR AUTHORIZATION

Approval is required by the PBM for a select drug before authorizing coverage for the medication. Unless otherwise indicated by the PBM, the prior authorization must be in writing from the provider. Determinations for prior authorizations are at the discretion of the PBM.

EXCLUSIONS

Prescription drugs or supplies in the following categories are specifically excluded:

1. Drugs prescribed for Cosmetic only indications including, but not limited to: photo-aged skin products (e.g., Renova), hair growth agents or hair removal agents (e.g., Propecia, Vaniqa) and injectable Cosmetics (e.g., Botox Cosmetic).
2. Drugs prescribed for dermatology: Agents used in the treatment of acne and/or for Cosmetic purposes for Covered Persons thirty-five (35) years or older or depigmentation products used for skin conditions requiring a bleaching agent, unless Prior Authorization has been obtained.
3. Legend homeopathic drugs.
4. Fertility agents, oral, vaginal and injectable.
5. Drugs prescribed for erectile dysfunction.
6. Drugs prescribed for weight management.
7. Allergen injectable.

8. Serums, toxoids.
9. Legend vitamins and legend fluoride products, except as specifically covered.
10. Over-the-counter equivalents and non-legend medications (OTC), except as specifically covered.
11. Durable Medical Equipment*
12. Experimental or Investigational drugs.
13. Abortifacient drugs.

*Eligible for coverage under the Medical Benefits, subject to all requirements and exclusions of this Plan.

APPENDIX C

**SUMMARY PLAN DESCRIPTION
FOR DENTAL BENEFITS PLAN
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF**

STATE OF MONTANA

Appendix C

Summary Plan Description
describes the Dental Benefits
in effect as of January 1, 2019 and renews January 1, 2020

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GROUP HIGHLIGHTS

PLAN:

The dental plan is a Calendar Year plan, and deductibles and maximums are based upon a Calendar Year, which is January 1st through December 31st.

BENEFITS:		
	In-Network	Out-of-Network
Diagnostic & Preventive Benefits:	100%	100%
Basic Benefits:	80%	80%
Major Benefits:	50%	50%
Implant Benefits:	50%	50%
DEDUCTIBLES:		
Per Enrollee per Calendar Year:	\$50	
Per Family per Calendar Year:	\$150	
Diagnostic and Preventive Benefits are not subject to the deductible.		
MAXIMUM AMOUNTS:		
Per Enrollee per Calendar Year:	\$1,800	
Lifetime for Implant Benefits:	\$1,500	

CHOICE OF DENTIST

Delta Dental offers a choice of dentists from the Delta Dental panel of PPO Dentists and Premier Dentists or Enrollees may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists may be obtained by accessing the Delta Dental National Dentist Directory at deltadentalins.com/stateofmontana. Enrollees are responsible for verifying whether the Dentist they select is a PPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, Enrollees are advised to confirm with the dentist's office that a listed Dentist is still a contracted PPO Dentist or a Premier Dentist.

PPO Dentist

The PPO program potentially allows Enrollees the greatest reduction in their out-of-pocket expenses, since this select group of Dentists provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the PPO Dentist.

Premier Dentists

The Premier Dentists, which include specialists (endodontists, periodontists or oral surgeons), have not agreed to the features of the PPO program; however, Enrollees may still receive dental care at a lower cost than if they select a Non-Delta Dental Dentist.

Non-Delta Dental Dentist

If a Dentist is a Non-Delta Dental Dentist, the amount charged to Enrollees may be above that accepted by the PPO or Premier Dentists. Non-Delta Dental Dentists may balance bill for the difference between the Maximum Plan Allowance and the Non-Delta Dental Dentist's Approved Amount. For a Non-Delta Dental Dentist, the Approved Amount is the dentist's submitted charge.

Maximum Plan Allowance (MPA)

The maximum amount Delta Dental may reimburse for a covered procedure. Delta Dental establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of participating Dentist.

Additional advantages of using a PPO Dentist or Premier Dentist

- The PPO Dentist and Premier Dentist are required to accept assignment of Benefits, meaning PPO Dentists and Premier Dentists are paid directly by Delta Dental after satisfaction of the deductible and coinsurance, and the Enrollee is not required to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Dentist and Premier Dentist shall complete the dental claim form and submit it to Delta Dental for reimbursement.

DEDUCTIBLE

The dental plan features a deductible. This is an amount Enrollees shall pay out-of-pocket before Benefits are paid by the dental plan. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees Enrollees pay for covered Benefits count toward the deductible, but Enrollees do not pay a deductible for Diagnostic and Preventive Benefits.

MAXIMUM AMOUNT

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis or a lifetime basis.

BENEFITS, LIMITATIONS & EXCLUSIONS

Delta Dental pays the Benefits for the types of dental services as described below. Delta Dental pays Benefits only for covered services. These services must be provided by a Dentist and must be necessary and customary under generally accepted dental practice standards. Delta Dental may use dental consultants to review treatment plans, diagnostic materials or prescribed treatments to determine generally accepted dental practices. If you receive dental services from a Dentist outside of the State of Montana, the Dentist is reimbursed according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

If a comprehensive dental procedure includes component or interim procedures that are performed at the same time as the comprehensive procedure, the component or interim procedures are considered to be part of the comprehensive procedure for purposes of determining the benefit payable under the Contract. If the Dentist bills separately for the comprehensive procedure and each of its component or interim parts, the total benefit payable for all related charges is limited to the maximum benefit payable for the comprehensive procedure.

Enrollee Coinsurance

Delta Dental's provision of Benefits is limited to the applicable percentage of Dentist's fees shown on the Group Highlights page. Enrollees are responsible for paying the remaining applicable percentage of any such fees, known as the "Enrollee Coinsurance". The State of Montana (State) has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the State and Enrollees.

If the Dentist discounts, waives or rebates any portion of the Enrollee Coinsurance to the Enrollee, Delta Dental is only obligated to provide as Benefits the applicable percentages of the Dentist's fees reduced by the amount of such fees that is discounted, waived or rebated.

BENEFITS

On the State's behalf, Delta Dental shall pay or otherwise discharge the percentage of Contract Allowance shown on the Group Highlights page for the following covered services:

- Diagnostic: procedures to assist the Dentist in choosing required dental treatment.

- Preventive: prophylaxis (cleaning, periodontal cleaning in the presence of gingival inflammation is considered to be periodontal (a Basic Benefit) for payment purposes) and topical application of fluoride solutions.
- Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
- Palliative: treatment to relieve pain.

Basic Benefits :

- Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).
- General Anesthesia or IV Sedation: when administered by a Dentist for covered oral surgery or selected endodontic and periodontal surgical procedures.
- Endodontics: treatment of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth, periodontal maintenance.
- Restorative: posterior composite, synthetic porcelain, plastic restorations (fillings), amalgam fillings and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- Other Basic Service: space maintainers.

Major Benefits:

- Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.
- Crowns, Inlays/Onlays and Cast Restorations: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations.
- Prosthodontics: procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges.

Implant Benefits:

Implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

Note on additional benefits during pregnancy - When an Enrollee is pregnant, on the State's behalf, Delta Dental pays for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

LIMITATIONS

Limitations on Diagnostic and Preventive Benefits:

- On the State's behalf, Delta Dental pays for routine oral examinations and cleanings (including periodontal cleanings) no more than twice in any Calendar Year while the person is an Enrollee under any Delta Dental program or dental care program provided by the State. Note that periodontal

cleanings are covered as a Basic Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.

- Full-mouth x-rays and panoramic x-rays are limited to once every five (5) years while the person is an Enrollee under any Delta Dental program.
- Topical application of fluoride solutions is limited to twice in a Calendar Year for Enrollees under age 19.
- Delta Dental may not pay to replace an amalgam within 24 months of treatment if the service is provided by the same Dentist.
- Sealants are limited to once per tooth in a lifetime for permanent molars through age 15 if they are without cavities or restorations on the occlusal surface.
- Bitewing x-rays are provided twice in a Calendar Year for each Enrollee.

Limitations on Basic Benefits (coinsurance applies):

- On the State's behalf, Delta Dental pays for periodontal cleanings no more than four (4) times in any Calendar Year while the person is an Enrollee under any Delta Dental program or dental care program provided by the State. See note on additional benefits during pregnancy.
- Delta Dental may not pay to replace synthetic porcelain or plastic restorations (fillings) within 24 months of treatment if the service is provided by the same Dentist.
- Delta Dental may not pay to replace prefabricated stainless steel restorations within 60 months of treatment if the service is provided by the same Dentist.
- Delta Dental limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a Major Benefit.
- Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional benefits during pregnancy.

Limitations on Major Benefits (coinsurance applies):

- Delta Dental may not pay to replace any crowns, inlays/onlays or cast restorations which the Enrollee received in the previous five (5) years under any Delta Dental program or any program of the State.
- Prosthodontic appliances and/or implants that were provided under any Delta Dental program may be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture may not be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program may be made if Delta Dental determines it is unsatisfactory and may not be made satisfactory. Delta Dental may pay for the removal of an implant once for each tooth during the Enrollee's lifetime.
- Delta Dental limits payment for dentures to a standard partial or complete denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means. Dentures and replacement dentures that were provided under any Delta Dental program may be replaced only after five (5) years have passed

Limitations on Implant Benefits (coinsurance applies):

- The maximum amount payable for each Enrollee during the Enrollee's lifetime is shown on the Group Highlights page.
- Implants Benefits are subject to all terms and conditions in this Contract.
- Implants that were provided under any Delta Dental program may be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture may not be made satisfactory. Replacement of an implant supported prosthesis not provided under a Delta Dental program may be made if Delta Dental determines it is unsatisfactory and may not be made satisfactory. Delta Dental may pay for the removal of an implant once for each tooth during the Enrollee's lifetime.

Limitations on All Benefits - Optional Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- a crown where a filling would restore the tooth;
- a precision denture/partial where a standard denture/partial could be used; or
- an inlay/onlay instead of an amalgam restoration.

If you receive Optional Services, Benefits are based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee is responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

EXCLUSIONS

Delta Dental does not pay Benefits for:

- Cosmetic surgery or dentistry for purely cosmetic reasons.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), unless the service is provided to a newborn or adopted dependent child for treatment of a medically diagnosed congenital defect.
- Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. For example: equilibration, periodontal splinting, occlusal adjustment.
- Any Single Procedure started prior to the date the person became covered for such services under this program.
- Prescribed drugs, medication, pain killers or experimental procedures, services, or supplies.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.
- Services or supplies covered by any other health plan of the State.
- Medical procedures, services or supplies.
- Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws).
- Services for any disturbances of the temporomandibular (jaw) joints.

- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the plan, are the responsibility of the Enrollee and not a covered Benefit.

THIS BOOKLET CONSTITUTES ONLY A SUMMARY OF THE DENTAL SERVICE PLAN. THE COMPLETE PLAN MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

APPENDIX D

**SUMMARY PLAN DESCRIPTION
FOR VISION PLAN BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF**

STATE OF MONTANA

Appendix D

Summary Plan Description
describes the Vision Benefits
in effect as of January 1, 2019 and renews January 1, 2020



**Cigna Vision
State of Montana
E1 - Standard PPO Exam Only Plan**

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	In-Network Benefit	Out-of-Network Benefit	Frequency Period **
Exam Copay	\$10	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to \$45	12 months
** Your Frequency Period begins on January 1 (Calendar year basis)			
Definitions: Copay: the amount you pay towards your exam. Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance. Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.			
<ul style="list-style-type: none"> To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders. If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses. 			
In-Network Coverage Includes: <ul style="list-style-type: none"> One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses. 			
Healthy Rewards® - Vision Network Savings Program: <ul style="list-style-type: none"> When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details. 			
What's Not Covered: <ul style="list-style-type: none"> Orthoptic or vision training and any associated supplemental testing Medical or surgical treatment of the eyes Any eye examination, or any corrective eyewear, required by an employer as a condition of employment Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related Charges in excess of the usual and customary charge for covered Services Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy Experimental or non-conventional treatment or device Claims submitted and received in-excess of twelve (12) months from the original Date of Service 			

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor



There are three ways to find a quality eye doctor in your area:

1. Log into myCigna.com, "Review My Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click Cigna Vision Directory, under Additional Directories.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.

2. Schedule an appointment

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:

- Go to **Cigna.com** and go to Forms, Vision Forms
- Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Benefits are underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company. Any benefit information displayed is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. Participating providers are independent contractors solely responsible for your routine vision examinations and products.

"Cigna" is a registered service mark, and the "Tree of Life" logo, "Cigna Vision" and "CG Vision" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries, including Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company, and not by Cigna Corporation. In Arizona and Louisiana, the Cigna Vision product is referred to as CG Vision. Healthy Rewards® - Vision Network Savings Program powered by Cigna Vision is a discount program, not an insured benefit.



DISCRIMINATION IS AGAINST THE LAW

Vision coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



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Summary of Benefits Cigna Health and Life Insurance Company



Cigna Vision State of Montana C1 - Standard PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	In-Network Benefit	Out-of-Network Benefit	Frequency Period **
Exam Copay	\$10	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to \$45	12 months
Materials Copay	\$20	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	Up to \$45 Up to \$55 Up to \$65 Up to \$80	12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	Up to \$130 Covered 100%	Up to \$95 Up to \$210	12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to \$130	Up to \$52	24 months
** Your Frequency Period begins on January 1 (Calendar year basis)			
Definitions: Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses). Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance. Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance. Materials: eyeglass lenses, frames, and/or contact lenses.			
<ul style="list-style-type: none"> To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders. If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses. 			
In-Network Coverage Includes: <ul style="list-style-type: none"> One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses; One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms) <ul style="list-style-type: none"> Polycarbonate lenses for children under 19 years of age Oversize lenses Rose #1 and #2 solid tints Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles. Progressive lenses covered up to bifocal lens amount with 20% savings on the difference; 			



- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakia; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:

- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription eyeglasses, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log into myCigna.com,"Review My Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click Cigna Vision Directory, under Additional Directories.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.



2. Schedule an appointment

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:

- Go to **Cigna.com** and go to Forms, Vision Forms
- Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Benefits are underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company. Any benefit information displayed is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. Participating providers are independent contractors solely responsible for your routine vision examinations and products.

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DISCRIMINATION IS AGAINST THE LAW

Vision coverage

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Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

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Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



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APPENDIX E

**SUMMARY PLAN DESCRIPTION
FOR THE MONTANA HEALTH CENTER BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF**

STATE OF MONTANA

**Appendix E
Summary Plan Description
describes the Montana Health Center Benefits
in effect as of January 1, 2019 and Renews January 1, 2020**

MONTANA HEALTH CENTER BENEFITS

Montana Health Center benefits apply when care, treatment, or services are provided by a contracted provider to Employees, Legislators, and non-Medicare eligible Retirees and their non-Medicare eligible spouses/domestic partners and dependent children age two and older who are covered under the State Plan ("Participants"). Participants may also wish to refer to program communications for additional details regarding the Incentive Program.

The Coordination of Benefits provision will not apply to services provided at a Montana Health Center.

Eligibility

1. Employees, non-Medicare eligible Retirees, Legislators and spouses/domestic partners enrolled on the State Plan.
2. Dependents age 2 and older enrolled on the State Plan.
3. Medicare-eligible Retirees and their Medicare-eligible dependents may only use the Montana Health Centers for flu shots and health screenings.
4. Other terms and conditions for Eligibility are as described in the section, Eligibility Provisions, of the Wrap Document for the State Plan.

Note: Montana Health Center locations include Anaconda, Billings, Butte, Helena and Missoula. Please contact the Health Care & Benefits Division (HCBD) for more information at (800) 287-8266, (406) 444-7462, TTY (406) 444-1421, or benefitsquestions@mt.gov.

Medical Services

Montana Health Center services are primary health care services for minor acute care, preventive care, wellness services, chronic disease management, and health coaching services payable as shown in the Schedule of Benefits below.

Services provided at a Montana Health Center are not subject to a deductible, and will not be applied to the deductible or maximum out-of-pocket amounts that may be applicable under the medical benefits of this Plan.

SCHEDULE OF BENEFITS

DEDUCTIBLE, PER PLAN YEAR	
Per Participant	None
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR	
Per Participant	None
COVERED CHARGES	PARTICIPANT PAYS
Routine Well Care	\$0
Office visits / minor office visit procedures	\$0
Laboratory Services	\$0
Immunizations	\$0
Health Coaching and Wellness Services	\$0
All Other Covered Montana Health Center Services including Off-site Health Screening Events and Flu Shot Clinics	\$0
Maximum Benefit Amount Per Plan Year	Unlimited

General Limitations and Exclusions:

The following services are not available at a Montana Health Center:

1. **Before covered.** Care, treatment or supplies incurred before a person was covered under this Plan.
2. **Chronic Pain Management Services**, for pain that lasts beyond the term of an injury or painful stimulus including but not limited to pain from a chronic or degenerative disease, and pain from an unidentified cause.
3. **Excluded.** Charges excluded or limited by the Plan design as stated in this document.
4. **Excluded under Medical.** Services that are excluded under medical Plan Exclusions.
5. **Allergy Injections.**
6. **Obstetrics**, to include all services typically provided during Pregnancy (prenatal period), childbirth and the postnatal period.
7. **Occupational illness or injury.** Services related to the management of work related injuries or conditions, including an independent medical evaluation, a return to work status determination, or a determination of whether an Injury or condition relates to or arose from the individual's employment. This exclusion will not apply to the initial treatment for minor injuries or occupational diseases that may have occurred or arisen in the workplace.
8. **Radiology procedures** except as ordered by a Montana Health Center physician and provided by a Montana Health Center contracted radiology provider.
9. **Services outside the scope of the license** for a family practice physician, general practitioner, or mid-level provider, as determined by the laws of the state in which the services are provided.

APPENDIX F
SUMMARY PLAN DESCRIPTION
FOR WELLNESS PLAN BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF

STATE OF MONTANA

Appendix F
Summary Plan Description
describes the Wellness Plan Benefits
in effect as of January 1, 2019 and Renews January 1, 2020

WELLNESS PROGRAM

The Employer encourages participation in its Wellness Program (the “Program”) to promote health and prevent disease. This Summary Plan Description describes the services available for Employees “Eligible Members”, and the eligible Dependents of such Eligible Members, and Retirees and their eligible Dependents for this Program. Eligible Members may also wish to refer to Program communications for additional details regarding the Program.

ELIGIBILITY

1. All Employees, Retirees, Legislators, spouses/domestic partners and COBRA Participants enrolled on the State Plan.
2. Dependents age 18 and older enrolled on the State Plan may obtain a State-sponsored health screening and participate in wellness programs, but are not eligible for an incentive.

BENEFIT COVERAGE

Coverage under the Program is administered by the Health Care & Benefits Division (HCBD), the Program Administrator.

The Program offers certain activities for Eligible Members to complete to be eligible for an incentive. Some of these activities may be related to a health condition. If an Eligible Member is unable to participate in an activity because of a health condition, the Eligible Member may request reasonable accommodation. See the Reasonable Alternative Section for more information. Participation in the Program is voluntary.

Live Life Well Incentive Program

To be eligible for an incentive from the Live Life Well Incentive Program, all three of the activities described below must be completed.

1. Annual State-sponsored Health Screening

Complete a State-sponsored Health Screening between November 1 and October 31 each Live Well Incentive Program year.

The Program offers an annual State-sponsored health screening which will include a lipid panel, comprehensive metabolic panel, and complete blood count. Additional tests may be available if prescribed by the Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and offered by the Montana Health Center. The screenings are provided at no cost to Eligible Members and are offered once per year at the Montana Health Center's in Anaconda, Billings, Butte, Helena and Missoula.

If an Eligible Member is unable to attend a screening at one of the Montana Health Centers, off-site screenings are available around the state and a list of events can be found at <http://healthcenter.mt.gov/Health-Screenings>. At off-site screening events there are three additional tests that may be performed if prescribed by the Eligible Member's healthcare provider: an HbA1c; a PSA; and/or a thyroid test.

Appointments are required for both Montana Health Center and off-site screening events. Visit www.carehere.com or call (855) 200-6822 for additional detail on State-sponsored health screenings.

The annual State-sponsored health screening results provide information related to current health and potential risks, and may also be used for participation in the Program. Eligible Members are encouraged to share health screening results or concerns with the Physician or Licensed Health Care Provider.

2. Nicotine Free

Nicotine status must be self-reported between November 1 and October 31 each Live Well Incentive Program year at: www.myactivehealth.com/som.

If the Eligible Member is not nicotine free, he/she must complete one nicotine free alternative and self-report completion of such activity. Alternatives include:

- A. Complete a Nicotine Cessation Program:
 - Montana Health Center behavioral health coach (Medicare-eligible Retirees and their spouses or dependents are not eligible). Call (855) 200-6822.
 - Montana Tobacco Quit Line health coach: Call (800) QUITNOW; or
- B. Complete a nicotine education session with the Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider.

3. Next Step Activity

Complete and self-report one eligible activity between November 1 and October 31 each Live Well Incentive Program year.

- Visit the HCBBD website for a complete list of eligible Next Step activities at: <http://benefits.mt.gov/NextStepIncentive>
- Self-report ONE completed activity at: www.myactivehealth.com/som

For more information about the Live Life Well Incentive Program visit <http://benefits.mt.gov/Incentive>.

Healthy Weight Incentive Programs

WW (formerly Weight Watchers)

WW is a company that offers wellness and weight loss based on scientifically-proven weight management strategies. There is a cost associated with this program.

The WW program is offered in several different formats. Studio workshops (Traditional meetings), Studio Workshops at Work (At-Work Meetings), and WW Digital (Online) are all options. Anyone may begin this program at any time.

For more information, please contact WW (Weight Watchers), <https://www.weightwatchers.com/us/>

Healthy For Life Self-Study

Healthy For Life (HFL) Self-Study is a one year long online program offered by the Health Care & Benefits Division (HCBBD). There is no cost associated with this program.

Developed by a registered dietitian, HFL closely mirrors the Diabetes Prevention Program structure. This program is designed to reduce the impact of many chronic diseases connected to body weight and improve quality of life. It is for those who are ready to make the commitment necessary to find their best health outcomes and body size.

Participants will watch 1-hour recorded webinars once per week for 16 weeks, and then once per month for 6 months. After viewing each recorded webinar, participants must fill out the associated survey. This provides proof that the plan is followed according to the required timeline and that webinars have actually been watched. There are associated activities participants are asked to complete between each class. The self-study program uses previously recorded webinars along with program materials to offer an on-demand,

internet-based program. This program is best for those who are highly self-motivated, as it will be up to the member to translate the information given for self-study use. Anyone may begin the program at any time.

For more information about the HFL Program visit <http://benefits.mt.gov/HealthyForLife>.

Diabetes Prevention Programs (DPP)

The Montana DPP is a one year long public health program that supports healthy lifestyle changes for adults who are at risk for developing type 2 diabetes. Trained lifestyle coaches deliver the program through group meetings at 19 organizations across the state. There may be a cost associated with the program.

There are prerequisites for participation in this program. Adults are eligible to participate in the DPP if they are overweight, have medical clearance and have one or more of the following risk factors:

- Pre-diabetes
- High blood pressure
- High LDL cholesterol, low HDL cholesterol, or high triglycerides
- Had gestational diabetes mellitus (GDM) or delivered a baby >9 lbs.
-

People who have completed this year-long program gain confidence and learn new life skills. You will attend 1-hour group classes for a 16-week series of nutrition and physical activity classes and then 6 monthly classes. You will learn how to make better food choices, be more active, and manage stress or other challenges to help you lose weight.

Please contact a DPP site in your area for details on costs, program start dates, and more! Find a Diabetes Prevention Program in Montana by going to the Diabetes Prevention Program website at: <http://mtdphhs.maps.arcgis.com/apps/MapSeries/index.html?appid=ef83beb03a024113956dc37bf139510a>.

For more information about the Diabetes Prevention Program visit <http://benefits.mt.gov/Live-Life-Well/Wellness-Programs/Weight-Management>.

LIMITATIONS

Other than the benefits described in this document, the Program offers no other medical benefits. Specifically, no benefits are payable for preventive screening tests, physical exams, or any other expense that would be covered by another group health plan or health insurance policy for which the Employer sponsors.

REASONABLE ALTERNATIVE

If the Eligible Member is unable to meet a standard of the Program or needs reasonable accommodation to participate in a Program activity, options may be available for an alternative program or different means to earn the incentive. The Eligible Member should contact HCB (800) 287-8266, (406) 444-7462, TTY (406) 444-1421, or benefitsquestions@mt.gov. HCB will work with the Eligible Member (and the Physician or Licensed Health Care Provider, if applicable) to design a program with reasonable accommodations to earn an incentive.

The Eligible Member may complete the Program alternative at any time during the applicable incentive year and still receive the entire incentive amount available for that Plan Year. Once the Program alternative is completed, the Eligible Member will receive any amount that would have been available if the original requirements had been met.

If the Eligible Member can demonstrate that achieving the stated requirements or the Program alternative is unreasonably difficult to achieve or inadvisable to attempt due to a medical condition, the Eligible Member must provide supporting documentation from the Physician or Licensed Health Care Provider within thirty

(30) days. Eligible Members who cannot achieve the original requirements or the Program alternative because of a medical issue will be given a waiver or a different option to qualify.

PROGRAM INCENTIVES

Eligible Members can earn \$30 per month off their required benefit contribution by completing all three Live Life Well Incentive Program activities between each November 1 and October 31. If a covered spouse/domestic partner also completes all three Live Life Well Incentive Program activities, Eligible Members can earn an additional \$30 per month off their required benefit contribution for dependent coverage.

Eligible members can earn an annual two-hundred dollar (\$200) incentive for completion and participation in one of the Healthy Weight Incentive Programs.

Note: Cash awards, such as gift cards, are taxable to the Eligible Member as income. The Eligible Member should consult his or her tax advisor with any questions on the tax consequences of cash awards.

Adjustment of incentives obtained under the Program may be necessary due to a mistake or to comply with applicable law. If the Eligible Member is required to repay any amounts obtained under the Program due to one of these reasons and the Eligible Member does not return the benefits, future benefits may be offset to recover the amount owed.

CLAIMS REVIEW PROCEDURE

If the Eligible Member believes the Eligible Member or an enrolled spouse/domestic partner was denied benefits, the Eligible Member has specific rights and responsibilities for appealing the denial. This section describes how to appeal a denial.

Each Eligible Member participating in the Program must complete the qualifying activities for each sub-program of the Program within the specified time and in accordance with the rules stated above and in written materials. Incentives will not be awarded to an Eligible Member who does not comply with the instructions provided in the annual Program materials. If the Eligible Member does not complete all qualifying activities to obtain an incentive for the sub-program(s) that the Eligible Member elects to participate in, the Eligible Member will not receive the incentive. HCBD will provide written notice of the incentive awarded prior to the beginning of the each Plan Year. The Eligible Member has the right to appeal if the Eligible Member feels he/she has earned the incentive and the incentive was not awarded.

If the Eligible Member or his/her covered spouse/domestic partner were not awarded the incentive and the Eligible Member believes it should have been awarded, the Eligible Member should submit in writing to HCBD, benefitsquestions@mt.gov, that he/she was not awarded the incentive and the reason he/she believes it should have been awarded.

The Eligible Member may request a review up to 180 days after the incentive should have been awarded (January 1st of each Plan Year). The Eligible Member must submit the request as soon as reasonably possible. The Eligible Member may also request copies of all relevant documentation.

The Plan Sponsor's review will take into account all comments, documents, records and other information related to the claim. The decision on the appeal will be independent from the decision to award (or not award) the incentive and, therefore determined by an individual or individuals who were not involved with that initial decision. The decision on appeal will be made within sixty (30) days after receipt of the request for review.

After review, the Plan Sponsor will provide a written notice that includes the following:

- The reason for the decision;
- References to the specific requirement that was not achieved;

- A statement that the Eligible Member may request copies of all relevant documents, free of charge; and
- A description of additional appeal rights, if any, and a statement that the Eligible Member has the right to bring a civil action under applicable law, once the Eligible Member has exhausted all rights of appeal.

NON-DISCRIMINATION FOR STATE OF MONTANA

State of Montana complies with applicable Federal civil rights laws, state and local laws, rules, policies and executive orders and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana does not exclude people or treat them differently because of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If the Eligible Member needs these services, contact the Customer Care Center at 855-999-1062. If the Eligible Member believes that State of Montana has failed to provide these services or discriminated in another way on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status the Eligible Member can file a grievance. If the Eligible Member needs help filing a grievance, John Pavao, State Diversity Coordinator, is available to help. The Eligible Member can file a grievance in person or by mail, fax, or email:

John Pavao
 State Diversity Program Coordinator
 Department of Administration
 State Human Resources Division
 125 N. Roberts
 P.O. Box 200127
 Helena, MT 59620
 Phone: (406) 444-3984
 Email: jpavao@mt.gov

The Eligible Member can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201
 (800) 368-1019, (800) 537-7697 (TDD)

COBRA CONTINUATION COVERAGE

If the Eligible Member qualifies for COBRA Continuation Coverage, the Program will be provided at the Eligible Member's cost to each qualified beneficiary who elects to continue coverage on the Program. The cost for each qualified beneficiary is the full cost of the Program plus an additional 2% for administration

and will be due on the date the incentive benefit is incurred. For more information, contact Allegiance at (406) 721-2222.

AMENDMENT AND TERMINATION

The Plan Sponsor reserves the sole discretionary right to modify, amend, or terminate the Program at any time and from time to time. The Eligible Member will be notified of any modification to, amendment of, or the termination of the Program.

FUNDING

The Program is self-funded by the Employer.

GENERAL PLAN ADMINISTRATION

Contact HCBP for information on the Program programs and rewards at (800) 287-8266, (406) 444-7462, TTY (406) 444-1421, or benefitsquestions@mt.gov.

PRIVACY STANDARDS

The Program Administrator is required by law to maintain the privacy and security of the Eligible Member's personally identifiable health information. Although the Plan and the Employer may use aggregated information it collects to design a program based on identified health risks in the workplace, the Plan will never disclose any personal information either publicly or to the Employer, except as necessary to respond to a request for a reasonable accommodation needed to participate in the Program, or as expressly permitted by law. Medical information that is provided in connection with the Program will not be provided to supervisors or managers and may never be used to make decisions regarding employment.

Health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Program, and the Eligible Member will not be asked or required to waive the confidentiality of health information as a condition of participating in the Program or receiving an incentive. Anyone who receives information for purposes of providing services as part of the Program will abide by the same confidentiality requirements. The only individual(s) who will receive personally identifiable health information is the Program Administrator in order to provide services under the Program.

In addition, all medical information obtained through the Program will be maintained separate from personnel records, information stored electronically will be encrypted, and no information provided as part of the Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information provided in connection with the Program, we will notify the Eligible Member immediately.

Contact HCBP at (800) 287-8266, (406) 444-7462, TTY (406) 444-1421, or benefitsquestions@mt.gov for a copy of the Plan's privacy notice or go to: www.benefits.mt.gov/Portals/59/Documents/hipaa%20notice.pdf.

APPENDIX G

THE FLEXIBLE BENEFITS PLAN FOR EMPLOYEES AND DEPENDENTS OF

STATE OF MONTANA

The Flexible Benefit Plan and Summary Plan Description for the State of Montana are included as part of the Wrap Plan Document.

The terms of the Wrap Plan Document are not applicable to the Flexible Benefit Plan and Summary Plan Description.

If any conflict arises between the Wrap Plan Document and the Flexible Benefit Plan and Summary Plan Description, the terms of the Flex Plan Document and Summary Plan Description will control first, followed by the Wrap Plan Document.

Appendix G

Flex Plan Document and
Flex Summary Plan Description
describes the Flexible Benefits Plan
in effect as of January 1, 2019 and renews January 1, 2020

Flexible Benefit Plan for the Employees of the State of Montana

Plan Document and Summary Plan Description

Effective September 1, 1997
Amended and Restated Effective January 1, 2019

This Benefit Plan Document and Summary Plan Description for the State of Montana are included as part of the Wrap Document. The terms of the Wrap Plan Document are not applicable to this Benefit Plan Document and Summary Plan Description. If any conflict arises between the Wrap Plan Document and this Benefit Plan Document and Summary Plan Description, the terms of this Benefit Plan Document and Summary Plan Description will control first, followed by the Wrap Plan Document.

Summary Plan Description

This Plan Document also constitutes a Summary Plan Description.

Administration services provided by:



ASIFlex, 201 W. Broadway, Suite 4-C, Columbia, MO 65203

Website: asiflex.com

Customer Service: 800-659-3035

Claims Fax: 877-879-9038

Customer Service Hours: 6 am - 6 pm MT on Monday - Friday; 8 am – noon MT on Saturday

Section 1 Introduction

1.1 Establishment of the Plan

The State of Montana (the “Employer”) originally established the State of Montana Flexible Benefit Plan (the “Plan”) effective September 1, 1997. The Employer hereby amends and restates the Plan effective January 1, 2019 (the “Effective Date”).

1.2 Purpose of the Plan

This Plan allows an Employee to participate in the following Benefit Options:

- **Premium Only Plan (POP)** to make pre-tax Salary Reduction Contributions to pay the Employee’s share of the premium or contribution for the State of Montana Benefit Plan.
- **Health Flexible Spending Account (Health FSA)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Health Care Expenses.
- **Dependent Care Assistance Program (DCAP)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Dependent Care Expenses.

1.3 Legal Status

This Plan is intended to qualify as a “cafeteria plan” under the Code §125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The **Health FSA** is intended to qualify as a self-insured health reimbursement plan under Code §105, and the Health Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees’ gross income under Code §105(b).

The **DCAP** is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees’ gross income under Code §129(a).

Although reprinted within this document, the **Health FSA** and the **DCAP** are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The **Health FSA** is also a separate plan for purposes of applicable provisions of COBRA and HIPAA.

1.4 Capitalized Terms

Many of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this document or in other relevant Sections. When reading the provisions of the Plan, please refer to the Glossary at the end of this document.

Becoming familiar with the terms defined there will provide a better understanding of the procedures and Benefits described.

**Section 2
General Information**

Name of the Cafeteria Plan	State of Montana Flexible Benefit Plan
Name of Employer	State of Montana
Address of Plan	100 North Park Avenue, Suite 320, Helena, MT 59601
Plan Administrator	State of Montana
Plan Sponsor and its IRS	State of Montana
Employer Identification Number	81-0302402
Named Fiduciary & Agent for Service of Legal Process	State of Montana
Type of Administration	The Plan is administered by the Plan Administrator with Benefits provided in accordance with the provisions of the State of Montana Benefit Plan. It is not financed by an insurance company and Benefits are not guaranteed by a contract of insurance. The State of Montana may hire a third party to perform some of its administrative duties such as claim payments and enrollment.
Plan Number	501
Benefit Option Year	The twelve-month period ending December 31.
Plan Effective Date	Original effective date was September 1, 1997; Amended and restated effective date is January 1, 2019
Claims Administrator	Application Software Inc., dba ASIFlex, 201 W. Broadway, Suite 4-C, Columbia, MO 65203; 800-659-3035
Plan Renewal Date	January 1

Internal Revenue Code and Other Federal Compliance

It is intended that this Plan meet all applicable requirements of the Internal Revenue Code of 1986 (the "Code") and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine the appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained.

In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this Section.

Section 3
Benefit Options and Method of Funding

3.1 Benefits Offered

Each Employee may elect to participate in one or more of the following Benefits:

- **Premium Only Plan (POP)** as described in Schedule A.
- **Health Flexible Spending Account (Health FSA)** as described in Schedule B.
- **Dependent Care Assistance Program (DCAP)** as described in Schedule C.

Benefits under the Plan shall not be provided in the form of deferred Compensation.

3.2 Employer and Participant Contributions

- **Employer Contributions.** The Employer may, but is not required to, contribute to any of the Benefit Options. There are no Employer Contributions for the **POP** under this Plan; however, if the Participant elects the **POP** as described in Schedule A, the Employer may contribute toward the State of Montana Benefit Plan as provided in the respective plan or policy of the Employer.
- **Participant Contributions.** The Employer shall withhold from a Participant's Compensation by Salary Reduction on a pre-tax basis, or with after-tax deductions, an amount equal to the Contributions required for the Benefits elected by the Participant under the Salary Reduction Agreement. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected.

3.3 Computing Salary Reduction Contributions

- **Salary Reductions per Pay Period.** The Participant's Salary Reduction is an amount equal to:
 - The annual election for such Benefits payable on a semi-monthly basis in the Period of Coverage;
 - An amount otherwise agreed upon between the Employer and the Participant; or
 - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)
- **Salary Reductions Following a Change of Elections.** If the Participant changes his or her election under the **POP**, **Health FSA** or **DCAP**, as permitted under the Plan, the Salary Reductions will be, for the Benefits affected, calculated as follows:
 - An amount equal to:
 - The new annual amount elected pursuant to the Method of Timing and Elections section below;
 - Less the aggregate Contributions, if any, for the period prior to such election change;
 - Payable over the remaining term of the Period of Coverage commencing with the election change;
 - An amount otherwise agreed upon between the Employer and the Participant; or
 - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)
- **Salary Reductions Considered Employer Contributions for Certain Purposes.** Salary Reductions to pay for the Participant's share of the Contributions for Benefit Options elected for purposes of this Plan and the Code are considered Employer Contributions.

- **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the required Contributions necessary for Benefit Options elected up to the date of termination, the Employer will either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.
- **After-Tax Contributions for POP.** After-tax Contributions for the State of Montana Benefit Plan will be paid outside of this Plan.

3.4 Funding This Plan

- **Benefits Paid from General Assets.** All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer nor the Plan Administrator to maintain any fund or to segregate any amount for the Participant's benefit. Neither the Participant, nor any other person, shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire a third party administrator to perform some of its administrative duties such as claims payments and enrollment.
- **Participant Bookkeeping Account.** While all Benefits are to be paid from the general assets of the Employer, the Employer will keep a bookkeeping account in the name of each Participant. The bookkeeping account is used to track allocation and payment of Plan Benefits. The Plan Administrator will establish and maintain under each Participant's bookkeeping account a subaccount for each Benefit Option elected by each Participant.
- **Maximum Contributions.** The maximum Contributions that may be made under this Plan for the Participant are the total of the maximums that may be elected for the **POP** as described in Schedule A, **Health FSA** as described in Schedule B, and the **DCAP** as described in Schedule C.

<p>Section 4 Eligibility and Participation</p>
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4.1 Eligibility to Participate

An individual is eligible to participate in this Plan if such individual meets the definition of Employee as set forth in the Glossary.

Eligibility requirements to participate in the individual Benefit Options may vary from the eligibility requirements to participate in this Plan.

4.2 Required Valid Enrollment Process

To participate in the **Benefit Option(s)**, an Employee must complete a Valid Enrollment Process by the deadline designated by the Plan Administrator. If an Employee fails to timely complete a Valid Enrollment Process, the Employee is deemed to have elected cash and will not be allowed to change such election until the next Open Enrollment unless the Employee experiences an event permitting an election change mid-year.

The Employee may begin participation on the 1st of the month coincident with or next following the date on which the Employee has met the Plan's eligibility requirements or in accordance with the Enrollment requirements each year.

4.3 Termination of Participation

A Participant will terminate participation in this Plan upon the earlier of:

- The expiration of the Period of Coverage for which the Employee has elected to participate unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating;
- The termination of this Plan; or
- The end of the month in which the Employee ceases to be an Employee because of retirement, termination of employment, layoff, reduction in hours, or any other reason. Eligibility may continue beyond such date for purposes of COBRA coverage, where applicable as set forth in the respective Schedule attached hereto, as may be permitted by the Plan Administrator on a uniform and consistent basis, but not beyond the end of the current Plan Year. Additionally, participants retiring from employment or were terminated due to a reduction in force can choose to prepay the remainder of the participant's annual **Health FSA** pretax contributions out of the Participant's final paycheck.

False or Fraudulent Claims. The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits.

Termination of participation in this Plan will automatically revoke the Participant's participation in the elected Benefit Options, according to the terms thereof.

4.4 Rehired Employees

If a Participant terminates employment with the Employer for any reason, including, but not limited to, disability, retirement, layoff, leave of absence without pay, or voluntary resignation, and then is rehired within the same Plan Year and within 31 days or less of the date of termination of employment, the Employee will be reinstated with the same per pay period elections that the Participant had prior to termination. If the Employer rehires a former Participant within the same Plan Year but more than 30

days following termination of employment and the Participant is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire.

4.5 Eligibility Rules Regarding the Health FSA

An Employee enrolled in a Health Savings Account (HSA) is not eligible to enroll in the **Health FSA**.

4.6 FMLA Leaves Of Absence

Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under FMLA then to the extent required by FMLA, the Participant will be entitled to continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. For example, the Employer will continue to pay its share of the Contribution to the extent the Participant opts to continue coverage. In the event of unpaid FMLA leave, a Participant may elect to continue such Benefits.

If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contribution:

- With after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or
- With pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on FMLA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

A Participant whose coverage ceased under any of the aforementioned plans will be entitled to elect whether to be reinstated in such plans at the same coverage level as in effect before the FMLA leave with increased Contributions for the remaining Period of Coverage, or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for his or her Contributions will be equal to the amount withheld prior to the period of FMLA leave.

Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as **DCAP** Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on leave not qualified as an FMLA leave of absence, as described below. If such policy permits a Participant to discontinue Contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

4.7 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by after-tax Contributions while on leave or with catch-up Contributions after the leave ends, as may be determined by the Plan Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

4.8 Death

A Participant's beneficiaries or representative of the Participant's estate, may submit claims for expenses that the Participant incurred through the end of the month in which the Participant ceases to be eligible for the Plan due to death. A Participant may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Plan Administrator or its designee may designate the Participant's Spouse, another Dependent, or representative of the estate. Claims incurred by the Participant's Spouse or any other of the Participant's qualified Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement.

4.9 COBRA

Under the COBRA rules, as discussed in the attached Schedules B and C, where applicable, the Participant's Spouse and Dependents may be able to continue to participate under the **Health FSA** through the end of the Period of Coverage in which the Participant dies. The Participant's Spouse and Dependents may be required to continue making Contributions to continue their participation.

4.10 USERRA

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Employer will continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid USERRA leave, a Participant may elect to continue such Benefits during the leave.

If the Participant elects to continue coverage while on USERRA leave, then the Participant may pay his or her share of the Contribution with:

- After-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or
- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on USERRA leave for any reason, including for non-payment of

Contributions, the Participant will be entitled to re-enter such Benefit upon return from such leave on the date of such resumption of employment and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of anything to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to Benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.

Section 5

Method of Timing and Elections

5.1 Initial Election

An Employee must complete a Valid Enrollment Process within 31 days of becoming eligible to enroll in the Benefit Options.

Unless otherwise specified by the Employer, an Employee who first becomes eligible to participate in the Plan mid-year will commence participation on the 1st day of the month coinciding with or after the date the Employee completes a Valid Enrollment Process within the election period set forth therein.

Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit Option. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable Benefit Options.

5.2 Open Enrollment

During each Open Enrollment Period, the Plan Administrator shall provide a Valid Enrollment Process to each Employee who is eligible to participate in the Plan. The Valid Enrollment Process shall enable the Employee to elect to participate in the Benefit Options for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Employee must complete a Valid Enrollment Process to the Plan Administrator on or before the last day of the Open Enrollment Period.

If an Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year.

5.3 Failure to Elect

If an Employee fails to complete a Valid Enrollment Process within the time described in the Elections paragraphs as discussed immediately above, then the Employee will be deemed to have elected to receive his or her entire Compensation in cash. Where the Employer provides for an automatic election for the **POP**, the Employee will have also agreed to a Salary Reduction for such Employee's Contribution to the **POP**.

Such Employee may not enroll in the Plan:

- Until the next Open Enrollment Period; or

- Until an event occurs that would justify a mid-year election change as described in the Irrevocability of Election and Exceptions section below.

Section 6 Irrevocability of Elections and Exceptions

6.1 Irrevocability of Elections

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates, except as described in this Section.

The rules regarding irrevocability of elections and exceptions are quite complex. The Plan Administrator will interpret these rules in accordance with prevailing IRS guidance.

6.2 Procedure for Making New Election If Exception to Irrevocability Applies

- **Timing for Making New Election if Exception to Irrevocability Applies.** A Participant may make a new election within 60 days of the occurrence of an event described in section 6.4 below (other than a birth or adoption), if the election under the new Valid Enrollment Process is made on account of and corresponds to the event. A Participant may make a new election within 91 days of the occurrence of a birth or adoption, if the election under the new Valid Enrollment Process is made on account of and corresponds to the birth or adoption of a dependent. A Change in Status, as defined below, that automatically results in ineligibility in the State of Montana Benefit Plan shall automatically result in a corresponding election change, whether or not requested.
- **Effective Date of New Election.** For the **POP**, elections made pursuant to this Section shall be effective on the date of eligibility for benefits. For the **Health FSA** and **DCAP**, elections made pursuant to this Section shall be effective on the 1st of the month following or coinciding with the Plan Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in "Certain Judgments, Decrees and Orders" or for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only.
- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Valid Enrollment Process or other document.
- **Effect on Maximum Benefits.** Any change in an election affecting annual Contributions to the **Health FSA** or **DCAP** also will change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:

- Any Contributions made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election; to
- The total Contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Benefit Option; reduced by
- All reimbursements made during the entire Period of Coverage.

6.3 Change in Status Defined

A Participant may make a new election that corresponds to a gain or loss of eligibility and coverage under this Plan or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence of a Change in Status. A Change in Status is any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- **Legal Marital Status.** A change in a Participant's legal marital status including marriage, death of a Spouse, divorce, legal separation or annulment;
- **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the **DCAP**, a change in the number of Qualifying Individuals as defined in Code §21(b)(1);
- **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse or Dependents:
 - A termination or commencement of employment;
 - A strike or lockout;
 - A commencement of or return from an unpaid leave of absence;
 - A change in worksite; or
 - If the eligibility conditions of this Plan or another employee benefit plan of the Participant, Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes, or ceases to be, eligible under this Plan or another employee benefit plan;
- **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular Benefit; and
- **Change in Residence.** A change in the place of residence of the Participant, Spouse or Dependent(s).

6.4 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Benefit Option.

The following rules shall apply to all Benefit Options except where expressly limited below.

- **Open Enrollment Period.** A Participant may change an election during the Open Enrollment Period.
- **Termination of Employment.** A Participant's election will terminate upon termination of employment as described in the Eligibility and Participation section above.
- **Leave of Absence.** A Participant may change an election upon a leave of absence as described in the Eligibility and Participation section above.
- **Change in Status.** *(Applies to the POP and Health FSA as limited below, and DCAP as limited below.)* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change corresponds with a gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer, referred to as the general consistency requirement.

A Change in Status that affects eligibility for coverage also includes a Change in Status that results in an increase or decrease in the number of an Employee's family members who may benefit from the coverage.

The Plan Administrator, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status: ○ **Loss of Spouse or Dependent Eligibility.** For a Change in Status involving a Participant's divorce, annulment or legal separation, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health coverage for:

- The Spouse involved in the divorce, annulment, or legal separation;
- The deceased Spouse or Dependent; or
- The Dependent that ceased to satisfy the eligibility requirements.

Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

- **Gain of Coverage Eligibility under Another Employer's Plan.** When a Participant, Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of that Participant's Spouse or Dependent, a Participant may elect to terminate or decrease coverage for that individual only if coverage for that individual

becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained

or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

- **Special Consistency Rule for DCAP Benefits.** With respect to the **DCAP**, the Participant may change or terminate the Participant's election upon a Change in Status if:
 - Such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an Employer's plan; or
 - The election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129.
- **HIPAA Special Enrollment Rights** (*Applies to the POP only*). If the Participant, the Participant's Spouse or Dependent is entitled to special enrollment rights under a group health plan as required by HIPAA, then the Participant may revoke a prior election for group health plan coverage and make a new election provided that the election change corresponds with such HIPAA special enrollment right. As more specifically defined by HIPAA, a special enrollment right will arise in the following circumstances:
 - The Participant, Spouse or Dependent declined to enroll in group health plan coverage because the Participant, the Participant's Spouse or Dependent had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted; or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;
 - The Participant acquired a new Dependent as a result of marriage, birth, adoption or placement for adoption; or
 - The Employee or Dependents who are eligible but did not enroll for coverage when initially eligible and:
 - The Employee or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
 - The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change due to birth, adoption, or placement for adoption of a new Dependent child may, subject to the group health plan, be effective retroactively for up to 30 days.

- **Certain Judgments, Decrees and Orders.** *(Applies to the **POP** and **Health FSA**, but does not apply to the **DCAP**).* If a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody, including a Qualified Medical Child Support Order (QMCSO) requires accident or health coverage, including an election for **Health FSA** Benefits for a Participant’s Dependent child, a Participant may:
 - Change an election to provide coverage for the Dependent child provided that the order requires the Participant to provide coverage; or
 - Change an election to revoke coverage for the Dependent child if the order requires that another individual provide coverage under that individual’s plan and such coverage is actually provided.

- **Medicare and Medicaid.** *(Applies to the **POP** and **Health FSA** as limited below, but does not apply to the **DCAP**).* If a Participant, Spouse or Dependent is enrolled in a Benefit under this Plan and becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the Health Plan covering the person, and the **Health FSA** coverage may be cancelled but not reduced. However, such cancellation will not be effective to the extent that it would reduce future contributions to the **Health FSA** to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Further, if a Participant, Spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the **Health FSA** coverage.

- **Change in Cost.** *(Applies to the **POP** and **DCAP** as limited below, but does not apply to the **Health FSA**).* For purposes of this Section, “similar coverage” means coverage for the same category of Benefits for the same individuals.
 - **Insignificant Cost Changes.** The Participant is required to increase his or her elective Contributions to reflect insignificant increases in the required Contribution for the Benefit Options, and to decrease the elective Contributions to reflect insignificant decreases in the required Contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically make this increase or decrease in affected Participants’ elective Contributions on a prospective basis.

 - **Significant Cost Increases.** If the Plan Administrator determines that the cost charged to an Employee for a Benefit significantly increases during a Period of Coverage, the Participant may:
 - Make a corresponding prospective increase to elective Contributions by increasing Salary Reductions;

 - Revoke the election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Option that provides similar coverage; or

- Terminate coverage going forward if there is no other Benefit Option available that provides similar coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant.

- **Significant Cost Decreases.** If the Plan Administrator determines that the cost of any Benefit (such as the premium for the Health Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes:
 - Participants enrolled in that Benefit Option may make a corresponding prospective decrease in their elective contributions by decreasing Salary Reductions;
 - Participants who are enrolled in another benefit package option may change their election on a prospective basis to elect the Benefit Option that has decreased in cost; or
 - Employees who are otherwise eligible may elect the Benefit Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant.
- **Limitation on Change in Cost Provisions for DCAP Benefits.** The above “Change in Cost” provisions apply to **DCAP** Benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee.
- **Change in Coverage.** (*Applies to the **POP** and **DCAP**, but not to the **Health FSA***). The definition of “similar coverage” applied in the Change of Cost provision above also applies here.
 - **Significant Curtailment.** Coverage under a Plan is deemed to be “significantly curtailed” only if there is an overall reduction in coverage provided under the Plan to constitute reduced coverage generally. If coverage is “significantly curtailed,” Participants may elect coverage under a Benefit Option that provides similar coverage. In addition, if the coverage curtailment results in a “Loss of Coverage” as defined below, Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a curtailment is “significant,” and whether a Loss of Coverage has occurred in accordance with prevailing IRS guidance.
 - **Definition of Loss of Coverage.** For purposes of this Section, a “Loss of Coverage” means a complete loss of coverage. In addition, the Plan Administrator in its sole discretion and on a uniform and consistent basis, may treat the following as a Loss of Coverage:
 - A substantial decrease in the health care providers available under the Benefit Package Plan;

- A reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
 - Any other similar fundamental loss of coverage.
- **Addition or Significant Improvement of a Benefit Option.** If during a Period of Coverage, the Plan adds a new Benefit Option or significantly improves an existing Benefit Option, the Plan Administrator may permit the following election changes:
- Participants who are enrolled in a Benefit Option other than the newly-added or significantly improved Benefit Option that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Option and instead elect the newly added or significantly improved Benefit Option; and
 - Employees who are otherwise eligible may elect the newly added or significantly improved Benefit Option on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Option.
- **Loss of Coverage under Another Group Health Coverage.** A Participant may prospectively change an election to add group health coverage for the Participant, Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including, but not limited to, the following:
- A children’s health insurance program (CHIP) under Title XXI of the Social Security Act;
 - A health care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization;
 - A state health benefits risk pool; or
 - A foreign government group health plan, subject to the terms and limitations of the applicable Benefit Option.
- **Change in Coverage under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan, including a plan of the Employer or a plan of the Spouse’s or Dependent’s employer, so long as:
- The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or

- The Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan.

The Plan Administrator, on a uniform and consistent basis, will decide whether a requested change is because of, and corresponds with, a change made under the other employer plan.

- **Enrollment in a Group Health Plan that Offers Minimal Essential Coverage or in a Health Care Exchange or Marketplace.** An Employee may make a **prospective** election change that is on account of and corresponds with a change to his/her **POP** election, so long as:

- The Employee's employment status changes from an expectation to work 30 hours or more per week to an expectation to work less than 30 hours per week (even if that change fails to make the Employee ineligible for Employer-sponsored group health plan coverage); AND the Employee enrolls in a group health plan that offers minimal essential coverage (as defined by the Affordable Care Act) with a new coverage effective date no later than the first day of the second month following the month that includes the date the original coverage is revoked; or
- The Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or the Employee seeks to enroll in a Marketplace during the Marketplace's annual open enrollment period; AND the Employee enrolls in the Marketplace with a new coverage effective date no later than the day immediately following the last day the original coverage is revoked.

No such changes shall be made retroactively.

- **Change in Dependent Care Service Provider.** A Participant may make a prospective election change that corresponds with a change in the dependent care service provider. For example:

- If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and
- If the Participant terminates a dependent care service provider because a relative or other person becomes available to take care of the child at no charge, the Participant may cancel coverage.

A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described this Section.

6.5 Election Modifications Required by Plan Administrator

The Plan Administrator may require, at any time, any Participant or class of Participants to amend their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to:

- Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or another cafeteria plan;
- Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of Benefits hereunder than would otherwise be recognized;
- Maintain the qualified status of Benefits received under this Plan; or
- Satisfy any of the Code's nondiscrimination requirements or other limitations applicable to the Employer's qualified Plans.

In the event that Contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section 7 Claims and Appeals

7.1 Claims under the Plan

If a claim for reimbursement under the **Health FSA** or **DCAP** is wholly or partially denied, or if the Participant is denied a Benefit under the Plan regarding the Participant's coverage under the Plan, then the claims procedure described below will apply.

7.2 Notice from ASI

If a claim is denied in whole or in part, ASI will notify the Participant in writing within 30 days of the date that ASI received the claim. This time may be extended for an additional 15 days for matters beyond the control of the ASI, including cases where a claim is incomplete. ASI will provide written notice of any extension, including the reason(s) for the extension and the date a decision by ASI is expected to be made. When a claim is incomplete, the extension notice will also specifically describe the required information, and will allow the Participant at least 45 days from receipt of the notice to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided. Notification of a denied claim will include:

- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take to appeal ASI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim. **7.3 First Level Appeal to ASI**

If a claim is denied in whole or in part, the Participant, or the Participant's authorized representative, may request a review of the adverse benefits determination upon written application to ASI. The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 180 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

7.4 ASI Action on Appeal

ASI, within a reasonable time, but no later than 30 days after receipt of the request for review, will decide the appeal. ASI may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

- Appropriate information on the steps to take to appeal ASI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

7.5 Second and Final Level Appeal to the Plan Administrator

If the decision on review affirms ASI's initial denial, the Participant may request a review of the adverse appeal determination upon written application to the Plan Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse appeal determination must be made in writing within 60 days after receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

7.6 Plan Administrator Action on Appeal

The Plan Administrator, within a reasonable time, but no later than 30 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason(s) for the decision on review;
- The specific Plan provision(s) on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- A statement regarding the right to bring suit, where applicable.

7.7 Appeal Procedure for Eligibility or Salary Reduction Issues

If the Participant is denied a Benefit under the Plan due to questions regarding the Participant's eligibility or entitlement for coverage under the Plan or regarding the amount the Participant owes, the Participant may request a review upon written application to the Plan Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 180 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The Plan Administrator, within a reasonable time, but no later than 30 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- Appropriate information on the steps to take to appeal the Plan Administrator's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

If the decision on review affirms the Plan Administrator's initial denial, the Participant may request a review of the adverse appeal determination upon written application to the Plan Administrator. The Second and Final Level of Appeals Procedures described above will apply.

Section 8
Plan Administration

8.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out in accordance with the terms of the Plan document and for the exclusive benefit of persons entitled to participate in this Plan and without discrimination among them.

8.2 Powers of the Plan Administrator

The Plan Administrator shall have such powers and duties as may be necessary or appropriate to discharge its functions hereunder. The Plan Administrator shall have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters hereunder. The Plan Administrator shall have the following discretionary authority:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan (provided that the Committee shall exercise such exclusive power with respect to an appeal of a claim);
- To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- To prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- To furnish each Employee and Participant with such reports in relation to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide Benefits under this Plan;
- To receive, review and keep on file such reports and information concerning the Benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

- To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and Benefit consultants;
- To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- To secure independent medical or other advice and require such evidence as deemed necessary to decide any claim or appeal; and
- To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

8.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the Participant's direction, information or election as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by the Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

8.4 Outside Assistance

The Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as the Plan Administrator shall deem advisable. The Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligations of the Employer and the Plan Administrator.

8.5 Insurance Contracts

The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan; and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer Contributions toward such insurance.

8.6 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for its own gross negligence, misconduct or willful breach of this Plan.

8.7 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

8.8 Inability to Locate Payee

If the Plan Administrator is unable to make payment to the Participant or another person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of the Participant or such other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to the Participant or such other person shall be forfeited one year after the date any such payment first became due.

8.9 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the Participant's account, or the amount of Benefits paid or to be paid to the Participant or another person, the Plan Administrator shall, to the extent administratively possible and otherwise permissible under Code §125 or the regulations issued thereunder, correct by making the appropriate adjustments of such amounts as necessary to credit the Participant's account or such other person's account or withhold any amount due to the Plan or the Employer from Compensation paid by the Employer.

Section 9 Amendment or Termination of the Plan

9.1 Permanency

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in the paragraphs below.

9.2 Right to Amend

The Employer reserves the right to merge or consolidate the Plan and to make any amendment or restatement to the Plan from time-to-time, including those which are retroactive in effect. Such amendments may be applicable to any Participant.

Any amendment or restatement shall be deemed to be duly executed by the Employer when signed by its President or a Vice President, and attested by its Secretary or Assistant Secretary.

9.3 Right to Terminate

The Employer reserves the right to discontinue or terminate the Plan in whole or in part at any time without prejudice. This Plan may be terminated by the Employer.

Section 10 General Provisions

10.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Schedules B and C and then by the Employer.

10.2 No Contract of Employment

Nothing contained in the Plan shall be construed as a contract of employment with the Employer or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any Employee, with or without cause.

10.3 Compliance with Federal Mandates

To the extent applicable for each Benefit Option, the Plan will provide Benefits in accordance with the requirements of all federal mandates, including USERRA, COBRA, and HIPAA. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

10.4 Verification

The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as an Employee or Dependent. If the Participant does not supply the requested information within the applicable time limits or provide a release for such information, the Participant will not be entitled to Benefits under the Plan.

10.5 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Employer, any of its employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provide herein or as provided by law.

10.6 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

10.7 Governing Law

This Plan is intended to be construed, and all rights and duties hereunder are governed, in accordance with the laws of the State of Montana, except to the extent such laws are preempted by any federal law.

10.8 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

10.9 Captions

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

10.10 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the IRS to the extent this Plan Document or any Schedule contains advice relating to a federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of avoiding any penalties that may be imposed on the Participant or any other person or entity under the Internal Revenue Code or promoting, marketing or recommending to another party any transaction or matter addressed herein.

10.11 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer make any commitment or guarantee that any amounts paid to the Participant or for the Participant's benefit under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the Participant's obligation to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.12 Indemnification of Employer

If the Participant receives one or more payments or reimbursements under this Plan on a pre-tax Salary Reduction basis, and such payments do not qualify for such treatment under the Code, the Participant shall indemnify and reimburse the Employer for any liability the Employer may incur for failure to

withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Section 11

HIPAA Privacy and Security

11.1 Provision of Protected Health Information to Employer

For purposes of this Section, Protected Health Information (PHI) shall have the meaning as defined in HIPAA. PHI means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

Members of the Employer's workforce have access to the individually identifiable health information of Plan Participants for administrative functions of the **Health FSA**, plus any other Benefit Option which might be subject to the privacy and security provisions of HIPAA (hereinafter referred to collectively as the Plan). When this health information is provided to the Employer, it is PHI. HIPAA and its implementing regulations restrict the Employer's ability to use and disclose PHI. The Employer shall have access to PHI from the Plan only as permitted under this Section or as otherwise required or permitted by HIPAA.

11.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Employer information on whether the individual is participating in the Plan.

11.3 Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

Summary Health Information means information:

- That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and
- From which the required information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit ZIP code.

11.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification described below, the Plan may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan Administration Purposes.

Plan Administration Purposes means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan Administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

11.5 Conditions of Disclosure for Plan Administration Purposes

Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it, the Employer shall:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other for employee benefit plan of the Employer;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance with HIPAA's privacy and security requirements;
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- Ensure that the adequate separation between the Plan and the Employer (i.e., the “firewall”), required in 45 CFR §504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents, including subcontractors, to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

11.6 Adequate Separation between Plan and Employer

The Employer shall designate such employees of the Employer who need access to PHI in order to perform Plan administration functions that the Employer performs for the Plan such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals. No other persons shall have access to PHI. These specified employees, or classes of employees, shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan.

In the event that any of these designated employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer’s employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

11.7 Certification of Plan Sponsor

The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.5.

11.8 Organized Health Care Arrangement

The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit Option under a covered health plan under 45 CFR §160.103 provided by Employer.

Glossary

Capitalized terms used in the Plan have the following meanings:

Benefit or Benefits means the Benefit Options offered under the Plan.

Benefit Option means a qualified benefit under Code §125(f) that is offered under this Cafeteria Plan, or an option for coverage under an underlying accident or health plan.

Cafeteria Plan means the State of Montana Benefit Plan as set forth herein and as amended from time to time.

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

Code means the Internal Revenue Code of 1986, as amended.

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to: any Salary Reduction election under this Plan; any Salary Reduction election under any other cafeteria plan; any compensation reduction under any Code §132(f)(4) plan; and any salary deferral elections under any Code §§401(k), 408(k) or 457(b) Plan or arrangement.

Contribution means the amount contributed to pay for the cost of Benefits as calculated under the Benefit Options.

DCAP means Dependent Care Assistance Program.

Dependent means any individual who is a tax dependent of the Participant as defined in Code §§105(b) and 152, with the following exceptions:

- For purposes of accident or health coverage (to the extent funded under the **POP** and for purposes of the **Health FSA**):
 - A dependent is defined as in Code §§105(b) and 152, determined without regard to §152 subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and
 - Any child whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year) is treated as a dependent of both parents; and
- For purposes of the **DCAP**, a dependent means a Qualifying Individual.

Notwithstanding the foregoing, the **Health FSA** Component will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

Dependent Care Assistance Program means the dependent care assistance program component established by Employer under the Plan. It allows the Participant to use pre-tax dollars to pay for the care of the Participant's eligible Dependents while the Participant is at work.

Dependent Care Expenses has the meaning described in the **DCAP** Schedule below.

Earned Income means all income derived from wages, salaries, tips, self-employment, and other compensation (such as disability or wage continuation Benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include: any amounts received pursuant to any **DCAP** established under Code §129; or any other amounts excluded from earned income under Code §32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

Effective Date of the restatement of this Plan shall be January 1, 2019. The original effective date of the Plan is September 1, 1997.

Employee means an individual who is eligible to be enrolled in the State's group medical plan; and has been employed by the Employer for 1 or more days, counting the Participant's employment commencement date as the first day. Legislators are considered employees for the purpose of participating in **POP** during the time in which the legislator is receiving a paycheck during the legislative session; legislators are not eligible to participate in the **Health FSA** or the **DCAP**.

The following classes of employees cannot participate in the State of Montana Benefit Plan:

- Former employees;
- Leased employees (as defined by §414 (n) of the Code);
- Contract workers and independent contractors;
- Temporary employees, casual employees, and employees hired short-term to meet specific needs of the Employer whether or not such persons are on the Employer's W-2 payroll;
- Individuals paid by a temporary or other employment or staffing agency;
- Self-employed individuals; and

Employer means the State of Montana.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Health Care Expenses has the meaning defined in the **Health FSA** Schedule below.

Health Flexible Spending Account means the health flexible spending account component established by the Employer under the Plan. It allows a Participant to use pre-tax dollars to pay for most health and dental expenses not reimbursed under other programs.

Health FSA means Health Flexible Spending Account.

Health Plan means the health benefit plan sponsored by the Employer.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HSA means a Health Savings Account established under Code §223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

Open Enrollment Period with respect to a Plan Year means a period as described by the Plan Administrator preceding the Plan Year during which Participants may make Benefit elections for the Plan Year.

Participant means a person who is an Employee and who is participating in this Plan in accordance with the provisions of the Eligibility and Participation Section. Participants include: (a) those that elect to receive Benefits under this Plan, and enroll for Salary Reductions to pay for such Benefits; and (b) those that elect instead to receive their full salary in cash and have not elected the **Health FSA** or **DCAP**.

Period of Coverage means the Plan Year, with the following exceptions: for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in the Eligibility and Participation Section; and for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in the Eligibility and Participation Section.

PHI means Protected Health Information.

Plan means the State of Montana Benefit Plan, as set forth herein and as amended from time to time.

Plan Administrator means the State of Montana.

Plan Year means the twelve-month period ending December 31.

POP means the Premium Only Plan.

Premium Only Plan means the Benefit Option in which an Employee can elect to participate and have Contributions for the State of Montana Benefit Plan paid on a pre-tax basis.

Protected Health Information (PHI) means information that is created or received by the State of Montana Benefit Plan and relates to the past, present, or future physical, mental health or condition of a Participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.

QMCSO means a Qualified Medical Child Support Order, as defined in ERISA §609(a).

Qualifying Dependent Care Services has the meaning described in the **DCAP** Schedule below.

Qualifying Individual means:

- A tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1);
- A tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of selfcare and who has the same principal place of abode as the Participant for more than half of the year; or
- A Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code §21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code §152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefit Options.

Spouse means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a Spouse under the Code). Notwithstanding the above, for purposes of the **DCAP**, the term "Spouse" shall not include: an individual legally separated from the Participant under a divorce or separate maintenance decree; or an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

State of Montana Benefit Plan includes the offerings listed in Schedule A in which an Employee can elect to participate.

Student means an individual who, during five or more calendar months during the Plan Year, is a fulltime student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly held.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Valid Enrollment Process means the agreement, form(s) or Internet web site, which Employees use to elect one or more Benefit Options. The agreement and/or forms spell out the procedures used for allowing an Employee to participate in this Plan and will allow the Employee to elect Salary Reductions to pay for any Benefit Options offered under this Plan.

Appendix A
Exclusions – Medical Expenses That Are Not Reimbursable From the Health FSA

The Plan Document contains the general rules governing what expenses are reimbursable under the **Health FSA**. This Appendix A, as referenced in the Plan Document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the **Health FSA** -- that is, expenses that are *not* reimbursable, even if such expenses meet the definition of “medical care” under Code §§213(d) and 106(f) and may otherwise be reimbursable under the regulations governing health flexible spending accounts:

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee’s or Dependent’s inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for Benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, etc.
- Uniforms or special clothing.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code §§213(d) and 106(f).

- Any item that is not reimbursable under Code §§213(d) and 106(f) due to the rules in Prop. Treas. Reg. §1.125-2, Q-7(b)(4) or other applicable regulations.

Schedule A
Premium Only Plan

Unless otherwise specified, terms capitalized in this Schedule A shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

A.1 Benefits

If the Employee is an enrolled participant in the Benefit Option(s) and timely submits an executed Valid Enrollment Process, the Employee can either:

- Option A: Elect Benefits under the **POP** by electing to contribute his or her share for the State of Montana Benefit Plan on a pre-tax basis; or
- Option B: Elect no Benefits under the **POP** and to contribute his or her share, if any, for the State of Montana Benefit Plan with after-tax deductions outside of this Plan.

If the Employee is an enrolled participant in the State of Montana Benefit Plan and does not timely submit an executed Valid Enrollment Process, the Employee will be deemed to have elected Option A.

Benefits elected under Option A will be funded by the Participant's Contributions as provided in the Eligibility and Participation section in the Plan Document.

To determine when a Valid Enrollment Process will be considered timely submitted, see the Method and Timing of Elections section in the Plan Document.

Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section in the Plan Document, such election is irrevocable for the duration of the Period of Coverage to which it relates.

A.2 State of Montana Benefit Plan

The only benefits that are offered under the **Premium Only Plan** are benefits under the State of Montana Benefit Plan listed below:

- Medical plan;
- Prescription drug plan;
- Dental plan; and
- Vision plan.

A.3 Benefit Contributions

The annual Contribution for the **POP** is equal to the amount as set by the Employer, which may or may not be the same amount charged under the State of Montana Benefit Plan.

A.4 Medical Benefits Provided Under the State of Montana Benefit Plan

Medical benefits will be provided by the State of Montana Benefit Plan (State Plan), not this Plan. The types and amounts of medical benefits, the requirements for participation, and other terms and conditions of coverage and benefits of the State Plan are set forth in the documents relating to that plan. No changes can be made under this Plan with respect to such State Plan if such changes are not permitted under the applicable State Plan.

All claims to receive benefits under the State Plan shall be subject to and governed by the terms and conditions of the State Plan and the rules, regulations, policies and procedures adopted in accordance therewith, as may be amended from time to time.

A.5 COBRA

To the extent required by COBRA, the Participant, Spouse and Dependent, as applicable, whose coverage terminates under the State Plan because of a COBRA qualifying event and who is a qualified beneficiary as defined under COBRA, shall be given the opportunity to continue the same coverage that the Participant, Spouse or Dependent had under the State Plan the day before the qualifying event for the periods prescribed by COBRA, on a self-pay basis. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Schedule B
Health Flexible Spending Account

Unless otherwise specified, terms capitalized in this Schedule B shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

B.1 Benefits

An Employee can elect to participate in the **Health FSA** by electing to receive Benefits in the form of reimbursements for Health Care Expenses. If elected, the Benefit Option will be funded by Participant Contributions on a pre-tax Salary Reduction basis as provided in the Employer and Participant Contributions section in the Plan Document.

Unless an exception applies as described in the Irrevocability of Elections and Exceptions section, such election is irrevocable for the duration of the Period of Coverage to which it relates.

A Participant who has an election for the **Health FSA** that is in effect on the last day of a Plan Year cannot make contributions to or receive contributions from anyone else for an HSA for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's **Health FSA** is \$0 as of the last day of that Plan Year. For this purpose, a Participant's **Health FSA** balance is determined on a cash basis – that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

B.2 Benefit Contributions

The annual Contribution for a Participant's **Health FSA** is equal to the annual Benefit amount elected by the Participant.

B.3 Eligible Health Care Expenses

Under the **Health FSA**, a Participant may receive reimbursement for Health Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred.** A Health Care Expense is incurred at the time the medical care or service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the medical care.
- **Health Care Expenses.** Health Care Expenses means expenses incurred by a Participant, or the Participant's Spouse or Dependent(s) covered under the **Health FSA** for medical care, as defined in Code §§213(d) and 106(f), other than expenses that are excluded by this Plan, but only to the extent that the Participant or other person incurring the expense is not reimbursed through any other accident or health plan.

- **Expenses That Are Not Reimbursable.** Insurance premiums are not reimbursable from the **Health FSA**. Other expenses that are not reimbursable are listed in Appendix A to the Plan Document.

B.4 Maximum and Minimum Benefits

- **Maximum Reimbursement Available; Uniform Coverage Rule.** The maximum dollar amount elected by the Participant for reimbursement of Health Care Expenses incurred during a Period of Coverage, reduced by prior reimbursements during the Period of Coverage, shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's **Health FSA**. Notwithstanding the foregoing, no reimbursements will be available for Health Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided below.
- **Payment** shall be made to the Participant in cash as reimbursement for Health Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section have been satisfied.
- **Maximum and Minimum Dollar Limits.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Health Care Expenses incurred in any Period of Coverage shall be no greater than the federally allowed maximum. The maximum annual benefit amount shall be set by the Employer and communicated to the employees through the use of the enrollment system or enrollment election forms. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Health Care Expenses incurred in any Period of Coverage shall be \$120.00. Reimbursements due for Health Care Expenses incurred by the Participant's Spouse or Dependent(s) shall be charged against the Participant's **Health FSA**.
- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Valid Enrollment Process or another document.
- **No Proration.** If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.
- **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual Contributions to the **Health FSA** will also change the maximum reimbursement benefits for the balance of the Period of Coverage commencing on the election change effective date. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding:
 - The aggregate Contribution for the period prior to such election change;
 - to

- The total Contribution for the remainder of such Period of Coverage to the **Health FSA**; reduced by
- All reimbursements made during the entire Period of Coverage.
- **FMLA Leave.** Any change in an election for FMLA leave will change the maximum reimbursement benefits in accordance with FMLA or the regulations governing cafeteria plans.
- **Monthly Limits on Reimbursing OTC Drugs.** Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's **Health FSA** in a single calendar month, even assuming that the drug otherwise meets the requirements of this Section, including that it is for medical care under Code §§213(d) and 106(f). Stockpiling is not permitted.

B.5 Establishment of Account

The Plan Administrator will establish and maintain a **Health FSA** with respect to each Participant who has elected to participate in the **Health FSA**, but will not create a separate fund or otherwise segregate assets for this purpose. The account established hereto will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts.** A Participant's **Health FSA** will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.
- **Debiting of Accounts.** A Participant's **Health FSA** will be debited during each Period of Coverage for any reimbursement of Health Care Expenses incurred during the Period of Coverage.
- **Available Amount Not Based on Credited Amount.** The amount available for reimbursement of Health Care Expenses is the amount as calculated according to the "Maximum Reimbursement Available" paragraph of this Section above. It is not based on the amount credited to the **Health FSA** at a particular point in time.

B.6 Use It or Lose It Rule; Forfeiture Of Account Balance

- **Use It or Lose It Rule.** If any balance in excess of \$500 remains in the Participant's **Health FSA** for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance in excess of \$500. If any balance less than \$500 remains in the Participant's **Health FSA** for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall be carried over to reimburse the Participant for Health Care Expenses incurred during the subsequent Plan Year so long as the Participant is still eligible to participate in the Plan.

- **Use of Forfeitures.** All forfeitures under this Plan shall be used as follows:
 - First, to offset any losses experienced by Employer during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the Contributions paid by such Participant through Salary Reductions;
 - Second, to reduce the cost of administering the **Health FSA** during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and
 - To provide increased Benefits or compensation to all Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.
- **Unclaimed Benefits.** Benefit payments that remain unclaimed by the close of the Plan Year following the Period of Coverage in which the Health Care Expense was incurred shall be forfeited and applied as described above.

B.7 Reimbursement Procedure

- **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Health Care Expenses, or the Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.
- **Claims Substantiation.** A Participant who has elected to receive Health Care Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting an application to the Plan Administrator by no later than 120 days immediately following the end of the applicable plan year, setting forth:
 - The person or persons on whose behalf Health Care Expenses have been incurred;
 - The nature and date of the expenses incurred;
 - The amount of the requested reimbursement;
 - A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source; and

- Other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Health Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Participant's **Health FSA** for a Plan Year or other Period of Coverage, no claim for reimbursement may be made by check unless and until the aggregate claim for reimbursement is at least \$25. If the **Health FSA** is accessible by an electronic payment card, the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with the most current IRS guidance.

- **Claims Denied.** For appeal of claims that are denied, see the Appeals Procedure in the Plan Document.
- **Claims Ordering; No Reprocessing.** All claims for reimbursement will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it from amounts attributable to a different Plan Year or Period of Coverage.

B.8 Reimbursements After Termination; Limited COBRA Continuation

The Participant will not be able to receive reimbursements for Health Care Expenses incurred after participation terminates. However, such Participant, or the Participant's estate, may claim reimbursement for any Health Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant, or the Participant's estate, files a claim within 120 days from the date of termination.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and such Participant's Spouse and Dependent(s), whose coverage terminates under the **Health FSA** because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that the Participant had under the **Health FSA** the day before the qualifying event, subject to all conditions and limitations under COBRA. The Contributions for such continuation coverage will be equal to the cost of providing the same coverage to an active employee taking into account all costs incurred by the Employee and the Employer plus a 2% administration fee. Specifically, an individual will be eligible for COBRA continuation coverage only if the Participant's remaining available amount is greater than the Participant's remaining Contribution payments at the time of the qualifying event, taking into account all claims submitted before the date of the qualifying event. Such individual will be notified if the individual is eligible for COBRA continuation coverage.

If COBRA is elected, COBRA coverage will be subject to the most current COBRA rules. COBRA will be available only for the remainder of the Plan Year in which the qualifying event occurs. Such COBRA coverage for the **Health FSA** will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Coverage may terminate sooner if the Contributions for a Period of Coverage are not received by the due date established by the Plan Administrator for that Period of Coverage.

Continuation coverage is only granted after the Plan Administrator has received the Contributions for that period of coverage.

Contributions for coverage for **Health FSA** Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation, as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year, where COBRA coverage arises either:

- Because the Employee ceases to be eligible because of a reduction of hours; or
- Because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage.

For all other individuals (for example, Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for **Health FSA** Benefits shall be paid on an after-tax basis, unless permitted otherwise by the Plan Administrator, in its discretion and on a uniform and consistent basis, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

B.9 Qualified Reservist Distribution

If a Participant meets all of the following conditions, the Participant may elect to receive a qualified reservist distribution from the **Health FSA**:

- The Participant's Contributions to the **Health FSA** for the Plan Year as of the date the qualified reservist distribution is requested exceeds the reimbursements the Participant has received from the **Health FSA** for the Plan Year as of that date.
- The Participant is ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.
- The Participant has provided the Plan Administrator with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.
- The Participant is ordered or called to active military duty on or after April 1, 2009, or the Participant's period of active duty begins before April 1, 2009 and continues on or after the date.
- During the period beginning on the date of the Participant's order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant submits a qualified reservist distribution election form to the Plan Administrator.

Amount of Qualified Reservist Distribution. If the above conditions are met, the Participant will receive a distribution from the **Health FSA** equal to his or her Contributions to the **Health FSA** for the Plan Year as of the date of the distribution request, minus any reimbursements received for the Plan Year as of that date.

No Reimbursement for Expenses Incurred After Distribution Request. Once a Participant requests a qualified reservist distribution, the Participant forfeits the right to receive reimbursements for Health Care Expenses incurred during the period that begins on the date of the distribution request and ends on the last day of the Plan Year. The Participant may, however, continue to submit claims for Health Care Expenses that were incurred before the date of the distribution request (even if the claims are submitted after the date of the qualified reservist distribution), so long as the total dollar amount of the claims does not exceed the amount of the **Health FSA** election for the Plan Year, minus the sum of the qualified reservist distribution and the prior **Health FSA** reimbursements for the Plan Year.

Tax Treatment of a Qualified Reservist Distribution. If the Participant receives a qualified reservist distribution, it will be included in his or her gross income and will be reported as wages on the Participant's Form W-2 for the year in which it is paid.

B.10 Named Fiduciary

The Plan Administrator is the Named Fiduciary for the **Health FSA**.

B.11 Coordination of Benefits

Health FSAs are intended to pay Benefits solely for Health Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the **Health FSA** shall not be considered a group health plan for coordination of benefits purposes, and the **Health FSA** shall not be taken into account when determining benefits payable under any other plan.

Schedule C
Dependent Care Assistance Program

Unless otherwise specified, terms capitalized in this Schedule C shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

C.1 Benefits

An Employee can elect to participate in the **DCAP** to receive Benefits in the form of reimbursements for Dependent Care Expenses. If elected, the Benefit Option will be funded by the Participant on a pre-tax Salary Reduction basis. Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section above, such election is irrevocable for the duration of the Period of Coverage to which it relates.

C.2 Benefit Contributions

The annual Contribution for a Participant's **DCAP** Benefits is equal to the annual Benefit amount elected by the Participant, subject to the Maximum Benefits paragraph below.

C.3 Eligible Dependent Care Expenses

Under the **DCAP**, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred.** A Dependent Care Expense is "incurred" at the time the Qualifying Dependent Care Service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.
- **Dependent Care Expenses.** Dependent Care Expenses means expenses that are considered to be:
 - Employment-related expenses under Code §21(b)(2) relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse; and
 - Expenses for incidental household services, if incurred by the Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other Plan.

If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the **DCAP** can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Schedule.

- **Qualifying Individual.** A Qualifying Individual is:
 - A tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1);

A tax dependent of the Participant as defined in Code §152, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

- A Participant's Spouse, as defined in Code §152, who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

In the case of divorced or separated parents, a child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code §152(e).

- **Qualifying Dependent Care Services.** Qualifying Dependent Care Services means services that both:
 - Relate to the care of a Qualifying Individual that enable the Participant and Spouse to remain gainfully employed after the date of participation in the **DCAP** and during the Period of Coverage; and

- Are performed:

- In the Participant's home; or

- Outside the Participant's home for:

- The care of a Participant's Dependent who is under age 13; or

- The care of any other Qualifying Individual who regularly spends at least 8 hours per day in the Participant's household.

In addition, if the expenses are incurred for services provided by a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services, then the facility must comply with all applicable state and local laws and regulations.

- **Exclusions.** Dependent Care Expenses do not include amounts paid to or for:
 - An individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or Participant's Spouse;

- A Participant's Spouse; ○ A Participant's child, as defined in Code §152(f)(I), who is under 19 years of age at the end of the year in which the expenses were incurred; and

- A Participant's Spouse's child, as defined in Code §152 (a)(i), who is under 19 years of age at the end of the year in which the expenses were incurred.

C.4 Maximum and Minimum Benefits

- **Maximum Reimbursement Available and Statutory Limits.** The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's **DCAP** less amounts debited to the Participant's **DCAP** pursuant to the Maximum Contribution paragraph below.

Payment shall be made to the Participant as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section have been satisfied.

No reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the year to date amount of Participant Contributions to the **DCAP** for the Period of Coverage or applicable statutory limit.

- **Maximum Dollar Limits.** The maximum dollar limit for a Participant is the smallest of the following amounts:
 - The Participant's Earned Income for the calendar year;
 - The Earned Income for the calendar year of the Participant's Spouse who:
 - Is not employed during a month in which the Participant incurs a Dependent Care Expense; and
 - Is either physically or mentally incapable of self-care or a full-time Student shall be deemed to have Earned Income in the amount of \$250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of \$500 per month); or
 - \$5,000 for the calendar year, if:
 - The Participant is married and files a joint federal income tax return; or
 - The Participant is married, files a separate federal income tax return, and meets the following conditions:
 - The Participant maintains as his or her home a household that constitutes, for more than half of the taxable year, the principal abode of a Qualifying Individual;
 - The Participant furnishes over half of the cost of maintaining such household during the taxable year; and

➤ During the last six months of the taxable year, the Participant's Spouse is not a member of such household; or

- The Participant is single or is the head of the household for federal income tax purposes.

\$2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

- **Minimum Dollar Limits.** The minimum annual Benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be \$120.00.
- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Valid Enrollment Process or another document.
- **No Proration.** If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.
- **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual Contributions to the **DCAP** component will also change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change effective date. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:
 - The aggregate Contribution for the period prior to such election change; to
 - The total Contribution for the remainder of such Period of Coverage to the **DCAP**; reduced by
 - All reimbursements made during the entire Period of Coverage.

C.5 Establishment of Account

The Plan Administrator will establish and maintain a **DCAP** with respect to each Participant who has elected to participate in the **DCAP**, but will not create a separate fund or otherwise segregate assets for this purpose. The account so established will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts.** A Participant's **DCAP** will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.
- **Debiting of Accounts.** A Participant's **DCAP** will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.
- **Available Amount is Based on Credited Amount.** The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's **DCAP**, less any prior reimbursements. A Participant's **DCAP** may not have a negative balance during a Period of Coverage.

C.6 Unused Year End Balance

- **Use It or Lose It Rule.** If any balance remains in the Participant's **DCAP** after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during the subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.
- **Use of Forfeiture.** All forfeitures shall be used by the Plan in the following ways:
 - To offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participant through Salary Reduction;
 - To reduce the cost of administering the **DCAP** during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and
 - To provide increased Benefits or Compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, and consistent with applicable regulations.
- **Unclaimed Benefits.** Any **DCAP** Benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be applied as described above.

C.7 Reimbursement Procedure

- **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses or the Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the

extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.

- **Claims Substantiation.** A Participant who has elected to receive **DCAP** Benefits for a Period of Coverage may apply for reimbursement by completing, signing, and returning an application to the Plan Administrator by no later than than 120 days immediately following the end of the applicable plan year, setting forth:
 - The person or persons on whose behalf Dependent Care Expenses have been incurred;
 - The nature and date of the expenses incurred;
 - The amount of the requested reimbursement;
 - The name of the person, organization or entity to whom the expense was or is to be paid;
 - A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source;
 - The Participant's certification that he or she has no reason to believe that the reimbursement refunded, added to other reimbursements to date will exceed the limit herein; and
 - Other such details about the expenses that may be requested by the Plan Administrator.

The Participant shall include bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claims for reimbursement may be made until the aggregate claim for reimbursement is at least \$25.

- **Claims Denied.** For appeals of claims that are denied, see the Appeals Procedure in the Plan Document.

C.8 Reimbursements After Termination

If a Participant's employment terminates, the Participant may submit for reimbursement Dependent Care Expenses incurred after the date of termination up to the amount of the Participant's remaining **DCAP** Benefits.

C.9 DCAP Participant vs. Claiming the Dependent Care Tax Credit

Employees often have the choice between participating in their employer's **DCAP** on a Salary Reduction basis or taking a Dependent Care Tax Credit under Code §21. Employees cannot take advantage of both tax benefit options. Employees with questions regarding which option is best should consult with an accountant.

Language Assistance – General Taglines

State of Montana is required by federal law to provide the following information.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-270-3877 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-270-3877 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-270-3877 (TTY : 711)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-270-3877 (TTY:711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-270-3877 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-270-3877 (ATS : 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-270-3877 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-270-3877 (TTY: 711)번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-270-3877 (رقم هاتف الصم والبكم: 117).

เรียน: หากคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-866-270-3877 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistanstjenester tilgjengelige for deg. Ring 1-866-270-3877 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-270-3877 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-270-3877 (телетайп: 711).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-270-3877 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-270-3877 (TTY: 711).

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John Pavao
State Diversity Program Coordinator
Department of Administration
State Human Resources Division
125 N. Roberts
P.O. Box 200127
Helena, MT 59620
Phone: (406) 444-3984
Email: jpavao@mt.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)