WRAP PLAN DOCUMENT
FOR MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION, HEALTH CENTERS, AND WELLNESS PROGRAM BENEFITS FOR EMPLOYEES, RETIREES AND DEPENDENTS OF STATE OF MONTANA

This booklet describes the Benefits in effect as of
January 1, 2025

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.

TABLE OF CONTENTS

INTRODUCTION

Effective January 1, 2025, 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, 2025.

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:
BlueCross BlueShield of Montana
P.O. Box 660255
Dallas, TX 75266-0225

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:
VSP Vision Care
3333 Quality Dr.
Rancho Cordova, CA 95670

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 at the Department of Administration's Health Care & Benefits Division 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 General Plan Exclusions and Limitations for specific information.

The information contained in this Wrap Plan Document is only a general statement regarding FMLA, COBRA, USERRA, and QMCSO. 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-determination, pre-certification or pre-treatment review by the Plan is strongly recommended for certain services. If pre-determination, 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 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 year 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 CARE 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 Employee 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, as evidenced by the Shared Residence Affidavit;

   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; and

   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.

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 meets the criteria of an incapacitated child as provided in VERIFICATION OF DEPENDENT ELIGIBILITY REQUIREMENTS.

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 certified 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: benefits.mt.gov/forms).

For a domestic partner:

1. Declaration of Domestic Partner Relationship and Affidavit of Shared Residence forms available at benefits.mt.gov/forms; and

2. A copy of mutually-granted powers of attorney or health care powers of attorney; or

3. A copy of mutual designations of primary beneficiary in will, life insurance policies or retirement plans.

Domestic partners are automatically defaulted to a non-qualified tax dependent status.

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 Administrator 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 Administrator within thirty-one (31) days of the date the child's coverage would otherwise terminate.

4. Must submit the most recent tax return or other documentation which indicates the disabled child is a qualified tax dependent of the Participant or Retiree. Other documentation must show the Participant or Retiree provides more than 50% of the disabled child's support and maintenance.

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 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: mpera.mt.gov.

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. 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.

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 ENROLLMENT

An Employee who enrolls outside of the Initial Enrollment Period, Open Enrollment Period, or Special Enrollment Period is effective the first day of the month following the receipt of the online enrollment application. An Employee who waives coverage during their Initial Enrollment Period may not enroll Dependents other than during an Open Enrollment Period or Special Enrollment Period.

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 Participant or a 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 Participant or a Participant's covered spouse. Permanent coverage becomes effective as stated below for birth, adoption and Placement for Adoption if the Employee or Retiree completes the online enrollment 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 or Retiree completes the online enrollment 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.

   B. Establishment of domestic partnership.

2. An eligible Employee, 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. Retirees who are enrolled on the Plan, may enroll newly eligible Dependents as outlined below 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 or Retiree (must provide pre-adoption placement agreement), provided such Employee or Retiree 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

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 as of the date of 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 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 loss.

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 enrollment 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 enrollment 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 Family 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 (HCBD) 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 (QMCSO), 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 Section1908 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. On the last day of the month prior to the effective date in which the Participant becomes eligible for and has enrolled in other group health plan coverage, if the Plan is notified within sixty (60) days of the effective date of the other group health plan coverage;

4. The last day of the month for which the Participant fails to make any required contribution for coverage;

5. On the last day of the month the Plan is terminated;

6. The date the State terminates the Participant's coverage;

7. The date the Participant dies; or

8. 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 position is eliminated 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 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 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 online 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. On the last day of the month prior to the effective date in which the Dependent becomes eligible for and has enrolled in other group health plan coverage, if the Plan is notified within sixty (60) days of the effective date of the other group health plan coverage;

5. The last day of the month for which the Participant fails to make any required contribution for Dependent Coverage;

6. The date the Plan is terminated;

7. The date the State terminates the Dependent's coverage;

8. 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;

9. The date the Dependent dies;

10. 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 enrollment application and event verification documentation is submitted within sixty (60) days of the event; or

11. 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 enrollment application 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 assgined 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: Businessolver.com; P.O. Box 850512, Minneapolis, MN 55485-0512, (877) 547-6257.

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 Administrator 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 Administrator 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 (19^{th}) through the twenty-ninth (29^{th}) 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: Businessolver.com; P.O. Box 850512, Minneapolis, MN 55485-0512, (877) 547-6257.

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 Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: Businessolver.com; P.O. Box 850512, Minneapolis, MN 55485-0512, (877) 547-6257. 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 last day of the month 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 last day of the month in which 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.

OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for Employees and their enrolled Dependents through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA Continuation Coverage. For more information visit www.HealthCare.gov.

In general for a person who is still employed, if enrollment in Medicare Part A or Part B is not made when first eligible, after the Medicare initial enrollment period, there is an 8-month special enrollment period to sign up for Medicare Part A or Part B, beginning on the earlier of:

1. The month after employment ends; or

2. The month after group health plan coverage based on current employment ends.

A Covered Person who elects COBRA Continuation Coverage instead of enrolling in Medicare may result in a significant surcharge by Medicare for late enrollment in Part B and there may be a gap in coverage if enrolling for Part B at a later time. If a Covered Person elects COBRA Continuation Coverage and later enrolls for Medicare Part A or Part B before the COBRA Continuation Coverage ends, the Plan may terminate COBRA Continuation Coverage for this individual. However, if Medicare Part A and Part B is effective on or before the date of the COBRA election, COBRA Continuation coverage may not be discontinued on account of Medicare entitlement, even if enrollment is made in the other part of Medicare after the date of the election of COBRA Continuation Coverage.

If enrolling in both COBRA Continuation Coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA Continuation Coverage will pay second (secondary payer). This Plan will pay as if secondary to Medicare, even if not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to: Businessolver.com; P.O. Box 850512, Minneapolis, MN 55485-0512, (877) 547-6257., 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. For more information about the Marketplace visit www.HealthCare.gov.

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 Employer'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 Employer 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. Employee 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. Employee 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 eligibility 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 Plan Administrator 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 visions 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. The Plan provides two (2) levels of benefit determination review. The first level of benefit determination review will be completed within thirty-six (36) hours, and if needed a second level of benefit determination review will be completed within thirty-six (36) hours after the first level benefit determination.

5. **Claims for Payment Disputes for Non-Participating Emergency Air Ambulance, Emergency Use of an Emergency Room and Non-Participating Physicians and Licensed Health Care Providers While Providing Services Over Which the Covered Person Has No Control -** For providers in this category, the Plan will pay an amount equal to the Median participating fee for the same service in the same geographic area. Once payment is made by the Plan, the provider will have thirty (30) days from the date of payment to contact the Plan Supervisor and attempt to negotiate a different payment amount. Failure to contact the Plan Supervisor within such thirty (30) days will result in the amount paid by the Plan being considered payment in full for all purposes. If negotiations are attempted within thirty (30) days but cannot be resolved within that time, the provider may follow the applicable federal or state rules to seek mediation (Independent Dispute Resolution) of the fee amount. The mediators decision shall be binding on the Plan and the provider.

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:
BlueCross BlueShield of Montana
P.O. Box 660255
Dallas, TX 75266-0255

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

For Pharmacy Benefits:
BlueCross BlueShield of Montana
P.O. Box 660255
Dallas, TX 75266-0255

For Vision Benefits:
VSP Vision Care
3333 Quality Dr.
Rancho Cordova, CA 95670

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:
BlueCross BlueShield of Montana
P.O. Box 660255
Dallas, TX 75266-0255

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

For Pharmacy Benefits:
BlueCross BlueShield of Montana
P.O. Box 660255
Dallas, TX 75266-0255

For Vision Benefits:
VSP Vision Care
3333 Quality Dr.
Rancho Cordova, CA 95670

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:	BlueCross BlueShield of Montana
Address:	P.O. Box 660255 Dallas, TX 75266-0255
Phone:	(888) 901-4989
Web:	www.bcbsmt.com

Medical claims may also be submitted through any electronic claims submission system or clearinghouse to which BlueCross BlueShield of Montana 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:	VSP Vision Care
Address:	3333 Quality Dr. Rancho Cordova, CA 95670
Phone:	(800) 877-7195
Web:	vsp.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 allowable fee 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, 2025.

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: BlueCross BlueShield of Montana.

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: VSP Vision Care.

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 Third Party Administration Contract HCBD22-0161NH between the State and BlueCross BlueShield of Montana, the Third Party Administration for Dental Services Contract DOA22-0147NH between the State and Delta Dental Insurance Company, and the Third Party Administration for Vision Service Contract HCBD23-0169NH between the State and Vision Service Plan Insurance Company, 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 transplants 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.

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

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.

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 workdays 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.

BENEFIT

"Benefit" means services, supplies, and medications that are provided to a Covered Person and covered under this Wrap Plan Document as a covered expense.

BENEFIT PERIOD

"Benefit Period" refers to a time period of one year, which is either a Calendar Year or other annual period. 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.

CALENDAR YEAR

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

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”.

CONVALESCENT NURSING FACILITY

See “Skilled Nursing Facility”.

COSMETIC

“Cosmetic” means services or treatment provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical 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.

COVERED PROVIDER

“Covered Provider” means a participating or nonparticipating provider which has been recognized by the Plan Supervisor as a provider of services for Benefits described in this Wrap Plan Document. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine if a provider is covered, the Plan Supervisor looks to the nature of the services rendered, the extent of licensure and is recognized by the Plan Supervisor as a provider of services for Benefits described in the Wrap Plan Document.

Covered Providers include professional provider and facility providers including Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, audiologist, nurse specialists, naturopathic physicians, Advanced Practice Registered Nurses, physician assistants, Hospitals, and Freestanding Surgical Facilities,

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.

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.

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.

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.

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, Westaff, 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, biological product, procedure, or equipment for which the patient informed consent document utilized with the drug, device, treatment, product procedure or equipment, was reviewed and approved if federal law requires such review or approval; or

3. That the drug, device, product, equipment, 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, product, equipment, or 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, product, equipment, or 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, product, equipment, or medical treatment or procedure used in a manner outside the scope of use for which it was approved by the appropriate governmental or regulatory agency.

“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.

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.

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.

ILLNESS

"Illness" means an alteration in the body or any of its organs or parts which interrupts or disturbs the performance of a vital function, thereby causing or threatening pain or weakness to the 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, caused directly and independent of all other causes. An Injury is not caused by Illness, 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.

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.

MEDICAID

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

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

“Medically Necessary or Medical Necessity” means health care services that a Physician, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s Illness, Injury, or disease; and

3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s Illness, Injury, or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of the Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a Covered Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Participant received the services, supplies, or medications and a claim is submitted to the Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MEDICALLY NECESSARY (FOR AUTISM, ASPERGER'S DISORDER, AND PERVASIVE DEVELOPMENTAL DISORDER)

"Medically Necessary for Autism, Asperger's Disorder, and Pervasive Developmental Disorder" means any care, treatment, intervention, service, or item that is prescribed, provided or ordered by a Physician or psychologist and that will or is reasonably expected to:

1. Prevent the onset of an Illness, condition, Injury, or disability;

2. Reduce or improve the physical, mental, or developmental effects of an Illness, condition, or Injury, or disability; or

3. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

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 condition or disorder that involves a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorder or any mental health condition that occurs during pregnancy or during the postpartum period, including but not limited to, postpartum depression.

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.

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 Substance Use Disorder Treatment Facility..

PARTICIPANT

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

PHYSICIAN

"Physician" is a person licensed to practice medicine in the state where the service is provided.

"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: BlueCross BlueShield of Montana.

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: VSP Vision Care.

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.

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.

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.

"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.

SUBSTANCE USE DISORDER

"Substance Use Disorder" means the uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers

and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a licensed addiction counselor or other appropriate medical practitioner.

SUBSTANCE USE DISORDER TREATMENT CENTER

"Substance Use Disorder Treatment Center" means a treatment facility that provides a program for the treatment of an individual's Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Licensed Health Care Provider. The treatment facility must be licensed or approved as a Substance Use Disorder Treatment Center by the Department of Health and Human Services or must be licenses or approved by the state where the facility is located.

URGENT CARE

"Urgent Care" means treatment in any setting that, if delayed, could seriously jeopardize the Covered Person's life and health or ability to regain maximum function or would subject the Covered Person, in the opinion of a health care provider with knowledge of the Covered Person's medical condition, to sever pain that cannot be adequately managed without the service or treatment.

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, 2025.

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

Employer Identification Number: 81-0302402

10. PLAN SUPERVISOR FOR MEDICAL BENEFITS

Name: BlueCross BlueShield of Montana
Address: P.O. Box 660255
Dallas, TX 75266-0255

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: VSP Vision Care
Address: 3333 Quality Dr.
Cordova, CA 95670

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.

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STATE OF MONTANA

APPENDIX A

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

STATE OF MONTANA

Effective January 1, 2025

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Montana

FOR CUSTOMER SERVICE
Call 1-888-901-4989

FOR RECOMMENDED CLINICAL REVIEW
Call 1-855-313-8914 or Fax 1-866-589-8256 for Non-Behavioral Health
Call 1-855-313-8909 or Fax 1-855-649-9681 for Behavioral Health

FOR INPATIENT ADMISSIONS
Call 1-855-313-8914 or Fax 1-866-589-8256 for Non-Behavioral Health
Call 1-855-313-8909 or Fax 1-855-649-9681 for Behavioral Health

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TABLE OF CONTENTS

TABLE OF CONTENTS

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

SCHEDULE OF BENEFITS

Employee Health Benefit Plan

Group Name:	**STATE OF MONTANA**
Group Number:	**293822**
Effective Date:	**January 1, 2025**
Benefit Period:	**Calendar Year**

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

Deductible:		**In-Network**	**Out-of-Network**
	Individual:	$1,000	$1,500
Coinsurance:	**In-Network:**	**25%**	
	Out-of-Network:	**35%**	
Copayment:	**Varies**		

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

- For Emergency Services provided by an Out-of-Network provider, Benefits will be provided as if such services were provided by an In-Network provider. Nonemergency services for Mental Illness or Substance Use Disorder provided in an emergency setting will be paid the same as Emergency Services.
- Out-of-Network providers may bill the Covered Person the difference between the Allowable Fee and the provider's charge, in addition to any Deductible, Copayment and/or Coinsurance even if Recommended Clinical Review is obtained for the service, or if treatment is provided for Emergency Services.

Out of Pocket Amount:		**In-Network**	**Out-of-Network**
	Individual:	$4,000	$4,950
	Family:	$8,000	$10,900

Out of Pocket Maximum includes the Deductible and Copayments.

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Accidental Injury		
Professional Provider Services	25%	35%
Facility Services	25%	35%
Benefit includes Dental and Vision.		
Acupuncture Services	$25, No Deductible	35%
Maximum Per Benefit Period – Twenty (20) days combined with Chiropractic Benefit.		
Allergy Treatment		
Office Visits including allergy shots	$25, No Deductible	35%
Allergy Injections without Office Visit; Diagnostic testing and injections with In-Network Provider and Outpatient Professional Provider Services (except for office visit consultation and exam), apply to regular medical Benefits.	25%	35%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Ambulance – Medical Emergency Only	25%	35%
Autism Spectrum Disorders	25%	35%
Includes certain treatments associated with Autism Spectrum Disorder (ASD).		
Some Autism services, including office visits and therapy, apply to those specific Benefits listed in the Schedule of Benefits.		
Birthing Centers	25%	35%
Blue Distinction Centers (BDC) and Blue Distinction Centers Plus (BDC+)		
Specialty Care Benefits		
Transplants		
Professional Provider Services		
Outpatient	25%	Not a Benefit
Inpatient	25%	Not a Benefit
Facility Services		
Outpatient	25%	Not a Benefit
Inpatient	25%	Not a Benefit
Travel, Meals and Lodging Benefit		
The Plan will reimburse automobile mileage per allowable IRS reimbursement guidelines.	25%	Not a Benefit
Maximum Benefit Per Day – $50/Meals; $140/Lodging		
Maximum Per Transplant - $10,000		
Benefit available to the patient and one caregiver and is limited to travel to a BDC or BDC+.		
If both the donor and recipient are covered under this Plan, travel expenses incurred by each person are treated separately for each person.		
Chiropractic Services	$25, No Deductible	35%
Maximum Per Benefit Period – Twenty (20) days combined with Acupuncture Benefit.		
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 Coinsurance.		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Colonoscopies		
First Colonoscopy regardless of Diagnosis per Benefit Period	None, No Deductible	35%
Additional Colonoscopy per Benefit Period	25%	35%
Diabetic Education Benefit Maximum Per Benefit Period – Twenty (20) visits combined with Diabetic Education and Nutritional Counseling if member has not received training and education previously. Twelve (12) visits of follow-up education combined with Diabetic Education and Nutritional Counseling in subsequent years who have exhausted the initial twenty (20) visits.	None, No Deductible	35%
Diagnostic Services		
Professional Provider Services	25%	35%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services	25%	35%
Durable Medical Equipment Recommended Clinical Review from the Plan is strongly recommended for the original purchase or replacement of durable medical equipment over $2,500. Please refer to the Utilization Management section. Coverage is limited to one (1) item of equipment, for the same or similar purpose and the accessories needed to operate the item.	25%	35%
Emergency Room Care *****Nonemergency Mental Illness and Substance Use Disorder services provided by an In-Network provider or an Out-of-Network provider pay as Emergency Room Care.	25%*	25%*
Emergency Room Care not related to an Emergency Medical Condition, Accidental Injury, Mental Illness or Substance Use Disorder.	Not a Benefit	Not a Benefit
Foot Orthotics Benefit is limited to diagnosis of diabetes.	25%	35%
Hearing Coverage for Dependent Children Under Age 19 Maximum one Amplification Device per ear every 3 years or as required by an audiologist. **Refer to the section of the Schedule of Benefits entitled Office Visit.**	25%	35%
Home Health Care Maximum Per Benefit Period – 70 Visits	25%	35%
Home Infusion Therapy Services	25%	35%
Homeopathic Services		
Ancillary charges (diagnostic lab, office surgery, diagnostic miscellaneous testing, etc.)	25%	35%
Preventive Care Services performed by a Homeopathic Provider 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. **Refer to the section of the Schedule of Benefits entitled Office Visits.**	None, No Deductible	35%
Hospice Care Benefit includes Bereavement Counseling.	25%	35%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Hospital		
Professional Provider Services (when the professional provider is employed by the Hospital)		
Outpatient	25%	35%
Inpatient	25%	35%
Facility Services		
Outpatient	25%	35%
Inpatient	25%	35%
Mammograms		
Preventive	None, No Deductible	35%
Medical	None, No Deductible	35%
Maternity Services		
Professional Provider Services		
Outpatient	25%	35%
Refer to the section of the Schedule of Benefits entitled Office Visit. However, the Office Visit Copayment only applies to the initial visit. Subsequent visits are included in the charges for labor and delivery.		
Inpatient	25%	35%
Facility Services		
Outpatient	25%	35%
Inpatient	25%	35%
Medical Supplies	25%	35%
Mental Health		
Professional Provider Services		
Outpatient	25%	35%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Inpatient	25%	35%
Facility Services		
Outpatient	25%	35%
Inpatient	25%	35%
Morbid Obesity	None	35%
Maximum Per Benefit Period – Twenty (20) visits combined with Diabetic Education and Nutritional Counseling if member has not received training and education previously.		
Twelve (12) visits of follow-up education combined with Diabetic Education and Nutritional Counseling in subsequent years who have exhausted the initial twenty (20) visits.		
Refer to the section of the Schedule of Benefits entitled Office Visits.		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Naturopathic Services		
Ancillary charges (diagnostic lab, office surgery, diagnostic miscellaneous testing, etc.)	25%	35%
Preventive Care Services performed by a Naturopathic Provider	None, No Deductible	35%
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.		
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Newborn Initial Care	None, No Deductible*	35%
*Applies until the earlier of the newborn's discharge from Hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.		
Nutritional Counseling	None, No Deductible	35%
Maximum Per Benefit Period – Twenty (20) visits combined with Diabetic Education and Nutritional Counseling if member has not received training and education previously.		
Twelve (12) visits of follow-up education combined with Diabetic Education and Nutritional Counseling in subsequent years who have exhausted the initial twenty (20) visits.		
Office Visit		
Primary Care Provider (PCP)	$25, No Deductible	35%
The Copayment applies to the In-Network office visit charge only. Deductible and Coinsurance apply to services provided during the office visit.		
Specialist	$35, No Deductible	35%
The Copayment applies to the In-Network office visit charge only. Deductible and Coinsurance apply to services provided during the office visit.		
Primary Care Provider- General Practice, Family Practice, Gynecology (Osteopath only), Internal Medicine, Obstetrician/Gynecology, Pediatrics, Certified Nurse Midwife, Physician Assistant, Advanced Practice Registered Nurse, Acupuncturist, Naturopath, Homeopath, Chiropractor, Cardiac Therapist, Physical Therapist, Occupational Therapist, Speech Therapist, Psychiatry, Licensed Clinical Professional Counselor, Clinical Psychology, Psychiatric or Medical Social Worker, Mixed Group (LCSW, LCPC and LMFT), Licensed Chemical Dependency Counselor, Neuropsychologist, Child and Adolescent Psychiatry, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Licensed Social Worker.		
Deductible, Copayment and Coinsurance do not apply to Preventive Health Care services. Refer to the section entitled Preventive Health Care.		
Orthopedic Devices	25%	35%
Recommended Clinical Review from the Plan is strongly recommended for the original purchase or replacement of orthopedic devices over $2,500. Please refer to the Utilization Management section.		
Coverage is limited to one (1) item of equipment, for the same or similar purpose and the accessories needed to operate the item.		
Other Facility Services – Inpatient and Outpatient	25%	35%
Physician Medical Services	25%	35%
Preventive Health Care	Deductible, Copayment and/or Coinsurance Do Not Apply	35%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
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.		
Private Duty Nursing	25%	35%
Prostheses Benefit	25%	35%
Recommended Clinical Review from the Plan is strongly recommended for the original purchase or replacement of prosthetics over $2,500. Please refer to the Utilization Management section.		
Coverage is limited to one (1) item of equipment, for the same or similar purpose and the accessories needed to operate the item.		
Rehabilitation Therapy		
Professional Provider Services		
Outpatient	25%	35%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Inpatient	25%	35%
Facility Services		
Outpatient	25%	35%
Inpatient	25%	35%
Second and Third Surgical Opinion	None, No Deductible	35%
Skilled Nursing Facility	25%	35%
Maximum Per Benefit Period – 70 Days		
Substance Use Disorder		
Professional Provider Services		
Outpatient	25%	35%
Refer to the section of the Schedule of Benefits entitled Office Visit.		
Inpatient	25%	35%
Facility Services		
Outpatient	25%	35%
Inpatient	25%	35%
Surgery Center Services – Outpatient		
Professional Provider Services	25%	35%
Facility Services	25%	35%
Temporomandibular Joint Dysfunction (Surgical)	25%	35%
Maximum Per Lifetime - $10,000		
Recommended Clinical Review from the Plan is strongly recommended. Please refer to the Utilization Management section.		
Therapies – Outpatient	$25, No Deductible	35%
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy		
Urgent Care	$35, No Deductible	35%
Ancillary charges (diagnostic lab, office surgery, diagnostic miscellaneous testing) apply to regular medical Benefits.		
Well-Child Care Services	Deductible, Copayment and/or Coinsurance Do Not Apply	35%

PROVIDERS OF CARE FOR COVERED PERSONS

The participation or nonparticipation of providers from whom a Covered Person receives services, supplies, and medication impacts the amount the Plan will pay and the Covered Person's responsibility for payment. Professional providers and facility providers are either In-Network or Out-of-Network providers. In-Network providers include participating and PPO providers. Out-of-Network providers are nonparticipating and non-PPO providers.

Professional Providers and Facility Providers

Professional providers include, but are not limited to, Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, audiologists, Advanced Practice Registered Nurses, Physician Assistants - Certified, naturopathic physicians, chiropractors and physical therapists.

For purposes of the In-Network Office Visit Copayment Benefit, Primary Care Providers (PCPs) include general practitioners, family practitioners, internists, pediatricians, obstetricians and gynecologists, Physicians' Assistants – Certified and Advanced Practice Registered Nurses.

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

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

The Covered Person may obtain a list of In-Network Providers from the Plan Supervisor free of charge by contacting the Plan Supervisor at the number listed on the inside cover of this Summary Plan Description and/or the Blue Cross and Blue Shield Provider Finder at www.bcbsmt.com.

PPO Network Providers

The Plan Supervisor has a network of professional providers, Hospitals and surgery centers in Montana that is utilized under this Benefit Plan. Outside of the state of Montana, there are also Blue Cross and/or Blue Shield network professional providers, Hospitals and surgery centers. The Covered Person receives the In-Network Benefit when utilizing any In-Network Provider. If the Covered Person obtains services or supplies from an Out-of-Network Provider, the Out-of-Network Deductible and Coinsurance and Out of Pocket Amount will apply as indicated on the Schedule of Benefits.

The exceptions to the Benefit reduction are:

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

Any Out-of-Network Provider can bill the Covered Person for the difference between payment by the Plan and provider charges plus Deductible, Coinsurance and/or Copayment even if Recommended Clinical Review was obtained for such services. The Covered Person will be responsible for the balance of the Out-of-Network Provider's charges after payment by the Plan and payment by the Covered Person of any Deductible, Coinsurance and/or Copayment.

Additional exceptions to Benefit reductions can be found in the Federal Balance Billing and Other Protections section.

Out-of-Network Referrals

There may be circumstances under which the most appropriate treatment for the Covered Person's condition is not available through the Network. When this occurs, it is recommended the Covered Person's attending Physician contact the Plan Supervisor for an Out-of-Network referral. If the referral is not approved, and the Covered Person chooses to obtain services from an Out-of-Network provider, the Covered Person will be responsible for the Out-of-Network Deductible and Coinsurance, in addition to any difference between the Allowable Fee and the provider's billed charges.

If the Plan Supervisor approves the referral, those services will process with the In-Network Deductible, Coinsurance and/or Copayment. However, any Out-of-Network provider can bill the Covered Person for the difference between the Allowable Fee and provider charges plus Deductible, Coinsurance and/or Copayment.

How Providers are Paid by the Plan Supervisor and Covered Person Responsibility

Payment by the Plan for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the network. For an estimate of the Covered Person's cost-sharing liability for covered items or services furnished by a particular provider, visit www.bcbsmt.com or call the number on the back of the Covered Person's identification card.

An **In-Network Provider** agrees to accept the payment of the Allowable Fee from the Plan for Covered Medical Expenses, together with any Deductible, Coinsurance and/or Copayment from the Covered Person, as payment in full. Generally, the Plan will pay the Allowable Fee for a Covered Medical Expense directly to In-Network Provider.

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

OUT-OF-AREA SERVICES – THE BLUECARD PROGRAM

Out-of-Area Services

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

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

1. BlueCard® Program

Under the BlueCard® Program, when a Covered Person incurs Covered Medical Expenses within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Montana will remain responsible for fulfilling Blue Cross and Blue Shield of Montana's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its In-Network Providers.

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

a. The billed covered charges for the Covered Person's Covered Medical Expenses; or

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However,

such adjustments will not affect the price Blue Cross and Blue Shield of Montana uses for the Covered Person's claim because they will not be applied retroactively to claims already paid.

In no event shall the Employer, the Plan or the Covered Person pay more than the provider's billed charges less any applicable Deductible, Coinsurance and/or Copayment.

2. Out-of-Network Providers Outside of the Blue Cross and Blue Shield of Montana Service Area

a. Covered Person Liability Calculation

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

b. Exceptions

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

3. Blue Cross Blue Shield Global® Core

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

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

a. Inpatient Services

In most cases, if the Covered Person contacts the service center for assistance, Hospitals will not require the Covered Person to pay for covered Inpatient services, except for Deductibles, Coinsurance and Copayments. In such cases, the Hospital will submit the Covered Person's claims to the service center to begin claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a claim to receive reimbursement for Covered Medical Expenses.

b. Outpatient Services

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

c. Submitting a Blue Cross Blue Shield Global Core Claim

When the Covered Person pays for Covered Medical Expenses outside the BlueCard service area, the Covered Person must submit a claim to obtain reimbursement. For institutional and professional claims, the Covered Person should complete a Blue Cross Blue Shield Global Core International claim form and send

the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the Covered Person's claim. The claim form is available from the Plan, service center or online at www.bcbsglobalcore.com. If the Covered Person needs assistance with the Covered Person's claim submission, the Covered Person should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

UTILIZATION MANAGEMENT

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, inpatient admission and length of stay is based on Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services being rendered, during the course of care, or after care has been completed as a post-service Medical Necessity Review. If requested, services normally subject to a post-service Medical Necessity Review may be reviewed for Medical Necessity prior to the service through Recommended Clinical Review as defined below.

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

Recommended Clinical Review

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

Recommended Clinical Review is strongly recommended, the review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions of this Plan. The Plan recommends the Covered Person confirms with the provider if Recommended Clinical Review has been obtained.

To determine if a specific service or category is recommended for clinical review**,** visit the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.com for the Prior Authorization and Predetermination lists, which is updated when new services are added or when services are removed. The Covered Person can also call Blue Cross and Blue Shield of Montana Customer Service at the number on the back of the Covered Person's identification card.

Recommended Clinical Review Responsibility

The Covered Person or the Covered Person's attending provider is responsible for obtaining Recommended Clinical Review**,** in those circumstances where authorization may be recommended. If a Recommended Clinical Review is not obtained and the services are denied as not Medically Necessary, an In-Network Provider will be held responsible and will not be able to bill the Covered Person for the services.

NOTE: Out-of-state providers may not be familiar with the Recommended Clinical Review recommendations of the Plan. It is strongly recommended that the Covered Person or the Covered Person's attending provider obtain a Recommended Clinical Review. If Recommended Clinical Review is not obtained before services are received, the Covered Person may be entirely responsible for the provider's charges if the service is determined not Medically Necessary. If the services were determined to be Medically Necessary, Out-of-Network Benefits will apply. The provider may call on the Covered Person's behalf, but it is the Covered Person's responsibility to ensure that the Plan Supervisor is called.

Inpatient Admissions Recommended Clinical Review

The Covered Person or the Covered Person's attending provider may submit for Recommended Clinical Review from the Plan Supervisor for an Inpatient admission. For an elective Inpatient admission, the Covered Person or Covered Person's attending provider should call for a Recommended Clinical Review at least two working days before the Covered Person is admitted. If the admission is due to an Emergency Medical Condition and obtaining Recommended Clinical Review would delay Emergency Services, it is advised that Recommended Clinical Review should take place within two working days after admission, or as soon thereafter as reasonably possible.

If Recommended Clinical Review is not obtained for inpatient services and the services are denied as not Medically Necessary, an In-Network Provider will be held responsible and will not be able to bill the Covered Person for the services.

The Covered Person or the Covered Person's attending provider, or the Covered Person's authorized representative should obtain Recommended Clinical Review with the Plan Supervisor by calling one of the toll-free numbers shown on the back of the Covered Person's identification card. The call should be made between 8:00 a.m. and 5:00 p.m., Mountain Time, on business days. After business hours or on weekends, please call the toll-free number listed on the back of the Covered Person's identification card. The Covered Person's call will be recorded and returned the next business day. A benefits management nurse will follow up with the Covered Person's attending provider.

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

When Recommended Clinical Review of an Inpatient admission is obtained, a length of stay is assigned. The Covered Person's attending provider may seek an extension for the additional days if the Covered Person requires a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the Length of Stay/Service Review subsection of this section.

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

Maternity Care Recommended Clinical Review

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

Maternity Care

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

The Covered Person or the Covered Person's attending provider need not obtain Recommended Clinical Review from the Plan Supervisor for a length of stay less than 48 hours (or 96 hours) for Maternity Care. If the Covered Person requires a longer stay, the Covered Person, Covered Person's attending provider or Covered Person's authorized representative, should seek an extension for the additional days by obtaining Recommended Clinical Review from the Plan Supervisor.

Outpatient Service Recommended Clinical Review

To determine if a specific service or category is subject to Recommended Clinical Review visit the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.com for the Prior Authorization and Predetermination lists, which are updated when new services are added or when services are removed. The Covered Person can also call Customer Service at the number on the back of the Covered Person's identification card.

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

Preservice Recommended Clinical Review

A Preservice Recommended Clinical Review is valid for at least three months from the date the Covered Person's provider receives approval from the Plan Supervisor. Actual availability of Benefits is subject to the terms, conditions, limitations and exclusions of this Plan.

Mental Illness and Substance Use Disorder Services Recommended Clinical Review

For all Inpatient and Partial Hospitalization services related to the treatment of Mental Illness and Substance Use Disorder, the Covered Person, the Covered Person's attending physician, or Covered Person's authorized representative should request a Recommended Clinical Review from the Plan Supervisor. A Recommended Clinical Review is also suggested for the following Outpatient Services and should be submitted no later than 15 business days before the service is provided:

1. Electroconvulsive therapy;
2. Intensive Outpatient Treatment;
3. Neuropsychological testing;
4. Psychological testing;
5. Repetitive Transcranial Magnetic Stimulation;
6. Applied Behavioral Analysis (ABA).

Other Procedures/Services in an Inpatient or Outpatient Setting Recommended Clinical Review

In addition to the recommendations outlined above, the Plan also recommends a Recommended Clinical Review, submitted no later than 15 business days before the service is provided, or as soon as possible for urgent care for certain Inpatient or Outpatient procedures/services, including:

1. Air Ambulance (fixed wing and rotary) for non-emergent medical transportation;
2. Advanced Imaging (CT's, MRI's and PET scans)
3. Any procedure or service that could possibly be considered Experimental or Investigational;
4. Commercial or Private Automobile Transportation;
5. Dialysis treatment - Out-of-Network;
6. Diagnosis of Infertility (Infertility treatment not covered by the Plan)
7. Gender Identity Disorder/Gender Dysphoria Services;
8. Hemophilia;
9. High-cost injections, including but not limited to IVIG, Avastin, Rituxan, and Remicade injections;
10. Home Health Care;
11. Home Hemodialysis;
12. Hospice Services;
13. Infusion Services;
14. Medical Equipment for costs exceeding $2,500;
15. Molecular Genetic Testing;
16. Obesity Treatment (surgical benefits not covered by the Plan);
17. Orthopedic (Musculoskeletal):
    a. Artificial Intervertebral Disc;
    b. Lumbar Spinal Fusion;
18. Outpatient Rehabilitative Care (Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehab);
19. Pain Management:
    a. Spinal Cord Stimulation;
    b. Percutaneous and Implanted Nerve Stimulation and Neuromodulation;
20. Radiation Therapy;
21. Residential Treatment Facility;
22. Skilled Nursing Facility;
23. Sleep Medicine: Diagnostic attended sleep studies;
24. Surgical Procedures: Outpatient elective surgery performed at a Hospital or Ambulatory Surgical Facility (Out-of-Network Services only);
25. Surgical treatment of TMJ;

26. Surgery that could be considered cosmetic under some circumstances;
27. Transplant Evaluations and transplants;

For specific details about the Recommended Clinical Reviews for the above referenced In and Outpatient services, call Customer Service at the number on the back of the Covered Person's identification card. Updates to the list of services for Recommended Clinical Review may be confirmed by calling Customer Service.

Response to Recommended Clinical Review Requests Involving Non-Urgent Care

Except in the case of a Recommended Clinical Review request involving Urgent Care (see below), the Plan Supervisor will provide a written response to the Covered Person's Recommended Clinical Review request.

Response to Recommended Clinical Review Requests Involving Urgent Care

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

In case of a Recommended Clinical Review request involving Urgent Care, the Plan Supervisor will respond to the Covered Person's attending provider no later than 48 hours after receipt of the request, unless the Covered Person fails to provide sufficient information, in which case, the Covered Person's attending provider will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. A response will be given as soon as possible (taking into account medical exigencies) but no later than 48 hours after the initial request, or within 24 hours after the missing information is received (if the initial request is incomplete) or the end of the period for the Covered Person to provide the missing information, whichever is greater.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

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

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from the Covered Person's attending provider. The Covered Person's attending provider may be asked to provide pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan Supervisor to make a determination of coverage pursuant to the terms and conditions of this Plan.

3. **Failure to Obtain Recommended Clinical Review**

   If the Covered Person, the Covered Person's attending provider, or Covered Person's authorized representative does not obtain Recommended Clinical Review, the Plan Supervisor may conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan, the Covered Person may be responsible for the provider's charges.

Length of Stay/Service Review

Upon completion of the inpatient or emergency admission review, the Plan Supervisor will send a letter to the Covered Person, the Covered Person's attending provider, behavioral health practitioner and/or Hospital or facility with a determination on the length of service or length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient Care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage

for the length of stay/service will not be extended, except as otherwise described in the Appeal Procedure section of the Plan.

A length of stay/service review, also known as a concurrent Medical Necessity Review, is when the Covered Person, the Covered Person's attending provider, or Covered Person's authorized representative may submit a request to the Plan for continued services. If the Covered Person, the Covered Person's attending provider or Covered Person's authorized representative requests to extend care beyond the approved time limit and it is a request involving Urgent Care or an ongoing course of treatment, the Plan Supervisor will make a determination on the request as soon as possible but no later than 48 hours after it receives the urgent concurrent request, or within 48 hours after it receives the missing information (if the initial request is incomplete) and 7 business days after it receives the non-urgent concurrent request.

Care Management

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

BENEFITS

The Plan will pay for the following Covered Medical Expenses when Medically Necessary and provided by a Physician or Licensed Health Care Provider. Payment is based on the Allowable Fee and is subject to any Deductible, Copayment and/or Coinsurance and other provisions, as applicable.

The Plan will not pay for any services, supplies or medications which are not a Covered Medical Expense, or for which a Benefit maximum has been met, regardless of whether provided by an In-Network Provider or an Out-of-Network Provider. The Covered Person will be responsible for all charges for such services, supplies, or medications.

Benefits outlined in this section are subject to the Plan's applicable Medical Policies, and to the terms, conditions, limitations and exclusions in the Plan.

Accidental Injury

Services which are provided for Accidental Injury.

Acupuncture

Services provided by a licensed acupuncturist to treat Illness or Injury.

The Schedule of Benefits describes payment limitations for these services.

Advanced Practice Registered Nurses and Physician Assistants-Certified

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

Ambulance

Licensed ground and air ambulance transport required for a Medically Necessary condition to the nearest appropriate site. The Plan does not pay for Ambulance service from the facility to the patient's home or if the transport is to a lateral level or lower level of care.

Anesthesia Services

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

Coverage under this Plan does not include:

1. Hypnosis;
2. Local anesthesia or intravenous (IV) sedation that is an Inclusive Service/Procedure;
3. Anesthesia consultations before surgery that are Inclusive Services/Procedures. The Allowable Fee for the anesthesia performed during the surgery includes this anesthesia consultation; or
4. Anesthesia for extraction of teeth, except anesthesia provided at a Hospital in conjunction with dental treatment will be covered only when a nondental physical Illness or Injury exists which makes Hospital care Medically Necessary to safeguard the Covered Person's health. Dental services and treatment are not a Benefit of this Plan except:

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

Approved Clinical Trials

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

Autism Spectrum Disorder

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

Covered Medical Expenses include:

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

Blood Transfusions

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

Cardiac Rehabilitation Therapy

Charges for cardiac rehabilitation therapy are payable as specifically stated in the Schedule of Benefits.

Coverage includes charges for Medically Necessary cardiac rehabilitation services rendered by a recognized cardiac rehabilitation program.

Certified Nurse 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).

Chemotherapy

The use of anti-cancer drugs approved by the U.S. Food and Drug Administration (FDA) to reduce symptoms, prolong life or cure disease.

Chiropractic Services

Benefits include charges for Chiropractic treatment by a licensed 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.

The Schedule of Benefits describes payment limitations for these services.

Cochlear Implants

Coverage under this Benefit includes Medically Necessary services for implants, Cochlear implants, devices and related supplies, including fastenings, screws and all other hardware related to the device or implant.

Colonoscopies

Coverage under this Benefit includes Physician or Licensed Health Care Provider services, anesthesiology services, lab and facility charges related to a colonoscopy ordered for routine screening or diagnostic purposes, such as lab, tissue removal or follow-up care.

Complex Care Coordination and Transitional Care Management

Charges for services for Complex Care Coordination and Transitional 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.

Contraceptives

Services and supplies related to contraception, including but not limited to, oral contraceptives, contraceptive devices and injections.

Deductible and Coinsurance do not apply to contraceptives covered under the Preventive Health Care Benefit, whether provided during an office visit or through the Prescription Drugs Benefits. All other FDA-approved contraceptive methods, including over-the-counter methods for which the method is both FDA-approved and prescribed for a Covered Person by a Physician or Licensed Health Care Provider, are covered under the Prescription Drug Benefit.

Dental Accidental Injury

Dental services 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 when 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

Outpatient self-management training and education services for the treatment of diabetes provided by a Physician or Licensed Health Care Provider 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.

The Schedule of Benefits describes payment limitations for these services.

Diagnostic Services

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

1. X-rays and Other Radiology. Some examples of other radiology include:
   a. Computerized tomography scan (CT Scan).

   b. MRIs.
   c. Nuclear medicine.
   d. Ultrasound.

2. Laboratory Tests. Some examples of laboratory tests include:
   a. Urinalysis.
   b. Blood tests.
   c. Throat cultures.

3. Diagnostic Testing. Tests to diagnose an Illness or Injury. Some examples of diagnostic testing include:
   a. Electroencephalograms (EEG).
   b. Electrocardiograms (EKG or ECG).

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

Dialysis

Coverage under this Benefit includes charges for services and supplies related to renal dialysis done on an Outpatient basis. The Covered Person who is diagnosed with End Stage Renal Disease (ESRD) should immediately follow these steps:

1. Notify Plan Supervisor when diagnosed with ESRD by the attending Provider.
2. Notify Plan Supervisor if or when beginning dialysis treatments.
3. Enroll in Medicare Part A and Part B and use a Covered Provider that accepts Medicare patients to prevent the Covered Person from being billed for amounts in excess of the Allowable Fee.
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 and 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. **This 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.**

Durable Medical Equipment

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

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

Replacement Equipment.

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

The Plan will not pay for the following items:

1. Exercise equipment;
2. Car lifts or stair lifts;
3. Biofeedback equipment;
4. Self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition;
5. Air conditioners and air purifiers;
6. Whirlpool baths, hot tubs, or saunas;
7. Waterbeds;

8. Other equipment which is not always used to treat an Illness or Injury;
9. Deluxe equipment when Medically Necessary. The Plan has the right to decide when deluxe equipment is required. However, upon such decision, payment for deluxe equipment will be based on the Allowable Fee for standard equipment;
10. Computer-assisted communication devices;
11. Durable medical equipment required primarily for use in athletic activities;
12. Replacement of lost or stolen durable medical equipment;
13. Repair to rental equipment; and/or
14. Duplicate equipment purchased primarily for the Covered Person's convenience when the need for duplicate equipment is not medical in nature.

Recommended Clinical Review from the Plan is strongly recommended for the original purchase or replacement of durable medical equipment over $2,500. Please refer to the section entitled Utilization Management.

Emergency Room Care

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

Fertility Preservation Services

Coverage is available for Standard Fertility Preservation Services if a Medically Necessary treatment for cancer may directly or indirectly cause Iatrogenic Infertility in a Participant.

Foot Care

Charges for foot care (Podiatry) as a result of infection or diabetes when ordered by a Physician.

Gender Identity Disorder/Gender Dysphoria Services

The following services include 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 Deductible, Copayments and Coinsurance.

Certain services are excluded from coverage under the Medical Benefits Exclusion section of the Plan.

Hearing Coverage for Dependent Children Under Age 19

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

The Schedule of Benefits describes payment limitations for these services.

Home Health Care

The following Covered Medical Expenses, when prescribed by the Covered Person's attending Physician provided in the Covered Person's home by a Home Health Agency and which are part of the Covered Person's treatment plan:

1. Nursing services;
2. Home health aide services;

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

The Plan will not pay for:

1. Maintenance or Custodial Care visits.
2. Domestic or housekeeping services.
3. "Meals-on-Wheels" or similar food arrangements.
4. Visits, services, medical equipment, or supplies not approved or included as part of the Covered Person's treatment plan.
5. Services provided for the treatment of Mental Illness.
6. Services provided in a Skilled Nursing Facility.
7. 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.
8. Transportation services.

Recommended Clinical Review is strongly recommended for home health care. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

The Schedule of Benefits describes payment limitations for these services.

Home Infusion Therapy Services

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

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

NOTE: Skilled nursing services provided by a Home Health Agency will be covered under the Home Health Care Benefit.

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

Recommended Clinical Review is strongly recommended for home infusion therapy services. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Hospice Care

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

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

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

Recommended Clinical Review is strongly recommended for hospice care. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Hospital Services - Facility and Professional

Inpatient Care Services Billed by a Hospital

1. Room and Board Accommodations
    a. Room and board, which includes special diets and nursing services.
    b. Intensive care and cardiac care units which include special equipment and concentrated nursing services provided by nurses who are Hospital employees.
2. Miscellaneous Hospital Services including:
    a. Laboratory procedures.
    b. Operating room, delivery room and recovery room.
    c. Anesthetic supplies.
    d. Surgical supplies.
    e. Oxygen and use of equipment for its administration.
    f. X-ray.
    g. Intravenous injections and setups for intravenous solutions.
    h. Special diets when Medically Necessary.
    i. Respiratory therapy, chemotherapy, radiation therapy and dialysis therapy.
    j. Physical Therapy, Speech Therapy and Occupational Therapy.

Inpatient Care services are subject to the following conditions:

1. Days of care
    a. In computing the number of Inpatient Care days available, days will be counted according to the standard midnight census procedure used in most Hospitals. The day a Covered Person is admitted to a Hospital is counted, but the day a Covered Person is discharged is not. If a Covered Person is discharged on the day of admission, one day is counted.
    b. The day a Covered Person enters a Hospital is the day of admission. The day a Covered Person leaves a Hospital is the day of discharge.
2. No payment will be made for Inpatient Care provided primarily for diagnostic or therapy services.

Recommended Clinical Review is strongly recommended for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Inpatient Care Medical Services Provided and Billed by a Physician or Licensed Health Care Provider

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

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

Medical care visits are limited to one visit per day per Physician or Licensed Health Care Provider unless additional visits are Medically Necessary.

Observation Beds/Rooms

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

Outpatient Hospital Services

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

Inborn Errors of Metabolism

Treatment under the supervision of a Physician of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. Benefits include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

Infertility – Diagnosis and Treatment

Services and supplies provided for the diagnosis of Infertility.

Coverage under this Benefit includes:

The diagnosis of Infertility, including:

Medically Necessary evaluation to determine cause of Infertility.

Coverage under this Benefit does not include:

1. Procedures to restore or enhance fertility including:
    - **a.** Artificial insemination (AI) or intrauterine insemination (IUI).
    - **b.** Services, supplies, and devices related to in vitro fertilization.

Mammograms (Preventive and Medical)

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

Mastectomy

Coverage under this Benefit includes professional provider, radiology and facility charges ordered for routine screening or diagnostic purposes.

1. Services provided for treatment of an active Illness or Injury are subject to Plan provisions.
2. Risk-reducing (prophylactic) mastectomy services are subject to Recommended Clinical Review and Plan provisions.

Recommended Clinical Review is strongly recommended. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Maternity Services - Professional and Facility Providers

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

    Under federal law, Benefits may not be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or (96 hours as applicable). In any case, under federal law, plans or insurers may not require that a provider obtain

Recommended Clinical Review from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

4. Payment for any maternity services by a Physician is limited to the Allowable Fee for total maternity care, which includes prenatal care, delivery, and postpartum care.

Please refer also to the Newborn Initial Care section.

Medical Foods

Medically Necessary nutritional substances in any form that are:

1. Formulated to be consumed or administered enterally under supervision of a Physician;
2. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;
3. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
4. Essential to optimize growth, health, and metabolic homeostasis.

Medical Supplies

The following supplies for use outside of a Hospital:

1. Supplies for insulin pumps, syringes and related supplies for conditions such as diabetes;
2. Injection aids, visual reading and urine test strips, glucagon emergency kits for treatment of diabetes. One insulin pump for each warranty period is covered under the Durable Medical Equipment Benefit;
3. Sterile dressings for conditions such as cancer or burns;
4. Catheters;
5. Splints;
6. Colostomy bags and related supplies; and
7. Supplies for renal dialysis equipment or machines.
8. Dressings, sutures, casts, trusses, crutches, braces, adhesive tape, bandages, antiseptics, or other Medically Necessary medical supplies.

Medical supplies are covered only when:

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

Mental Health

Benefits provided for mental health are for the treatment of Mental Illness.

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

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

Outpatient Services

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

1. A Hospital;
2. A Physician, Licensed Health Care Provider or prescribed by a Physician;
3. A Mental Health Treatment Center;
4. A Substance Use Disorder Treatment Center;
5. A licensed psychologist;
6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. An Advanced Practice Registered Nurse;

10. Other Licensed Health Care Provider.

Outpatient Benefits must be provided to diagnose and treat a recognized Mental Illness.

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

Inpatient Services

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

1. Hospital;
2. Psychiatric Facility; or
3. Freestanding Inpatient Facility.

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

Recommended Clinical Review is strongly recommended for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Partial Hospitalization

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

1. Hospital;
2. Psychiatric Facility; or
3. Freestanding Inpatient Facility.

Recommended Clinical Review is strongly recommended for Partial Hospitalization. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Naturopathy

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

Newborn Initial Care

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

Occupational Therapy

Services must be Medically Necessary and rendered by a Licensed Health Care Provider.

Ocularist

Charges for artificial eye provided by an Ocularist.

Oophorectomy

Coverage under this Benefit includes professional provider, radiology and facility charges ordered for routine screening or diagnostic purposes.

1. Services provided for treatment of an active Illness or Injury are subject to Plan provisions.
2. Risk-reducing (prophylactic) oophorectomy services are subject to Plan provisions.

Oral Surgery

Benefits will be provided for the following:

1. Excision or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

2. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses).
3. Treatment of fractures of facial bone.
4. External incision and drainage of cellulitis (not including treatment of dental abscesses).
5. Incision of accessory sinuses, salivary glands or ducts.
6. Reduction of, dislocation of, or excision of, the temporomandibular joints.
7. Orthognathic surgery when deemed Medically Necessary per Medical Policy.

Surgical removal of complete bony impacted teeth not covered under Medical Benefits.

Orthopedic Devices/Orthotic Devices

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

The Plan Supervisor will not pay for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities except for orthotics for diabetes as specifically listed as a covered service.

Physical Therapy

Services must be Medically Necessary and rendered by a Licensed Health Care Provider.

Postmastectomy Care and Reconstructive Breast Surgery

Postmastectomy Care

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

Recommended Clinical Review is strongly recommended for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Reconstructive Breast Surgery

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

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

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

Preventive Health Care

Covered preventive services include, but are not limited to:

1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's (USPSTF) current recommendations (additional information is provided by accessing http://www.uspreventiveservicestaskforce.org); and
2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention (CDC); and

3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;

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

   a. Lactation Services

      Comprehensive lactation support and counseling, by a Licensed Health Care Provider during pregnancy and/or in the postpartum period. Professional lactation support services may be provided by a Physician, Certified Nurse Midwife, APRN or Licensed Health Care Provider. Certified Lactation Counselors and International Board-Certified Lactation Consultants services are eligible for reimbursement when services are performed under the supervision of a Physician or APRN, or Physician Assistant Certified. Claims must be filed by the supervising Physician APRN, or Physician Assistant Certified.

      In addition, Benefits are provided for the rental or purchase of one manual or electric pump, or the rental of a Hospital-grade breast pump for up to 12 months, and pump supplies. The purchase of a breast pump is limited to one per birth event

      b. Contraceptives

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

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

5. Current recommendations of the United States Preventive Task Force regarding obesity screening and counseling.

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

   Benefits shall include coverage for:

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

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

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

For more detailed information on all covered services, contact Customer Service.

Prostheses

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

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

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

A prosthesis will not be considered a replacement if the original prosthesis no longer meets the medical needs of the Covered Person due to physical changes or a deteriorating medical condition.

Coverage under this benefit does not include:

1. Prostheses required primarily for use in athletic activities;

2. Replacement of lost or stolen prostheses;
3. Duplicate prosthetic devices purchased primarily for Covered Person convenience when the need is not medical in nature; or
4. Computer-assisted communication devices.

Recommended Clinical Review is strongly recommended for the original purchase or replacement of a prosthesis if the cost is over $2,500. Refer to the section entitled Utilization Management for information regarding Recommended Clinical Review

Radiation Therapy

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

Rehabilitation – Facility and Professional

Rehabilitation Therapy and other Covered Medical Expenses, as outlined in this Benefit, billed by a Rehabilitation Facility provider or a professional provider for services provided to a Covered Person.

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

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

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

Rehabilitation Facility Inpatient Care Services Billed by a Rehabilitation Facility

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

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

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

Recommended Clinical Review is strongly recommended for Rehabilitation Facility Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

All professional services provided by a Physician who is a physiatrist or other Physician directing the Covered Person's Rehabilitation Therapy.

Outpatient Rehabilitation

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

Skilled Nursing Facility

Services of a Skilled Nursing Facility as an alternative to Hospital Inpatient Care. The Plan will not pay for Custodial Care.

NOTE: The Plan will not pay for the services of a Skilled Nursing Facility if the Covered Person remains inpatient at the Skilled Nursing Facility when a skilled level of care is not Medically Necessary.

Recommended Clinical Review is strongly recommended for Skilled Nursing Facility services. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

The Schedule of Benefits describes payment limitations for these services.

Speech Therapy

Services must be Medically Necessary and rendered by a Covered Provider.

Substance Use Disorder

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

Outpatient Services

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

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

Outpatient services are subject to the following conditions:

Services must be provided to diagnose and treat recognized Substance Use Disorder.

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

Inpatient Care Services

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

1. Hospital;
2. Freestanding Inpatient Facility; or
3. Psychiatric Facility.

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

Recommended Clinical Review is strongly recommended for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Partial Hospitalization

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

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

Recommended Clinical Review is strongly recommended for Partial Hospitalization services. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Surcharge

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

Surgical Services

Surgical Services Billed by a Professional Provider

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

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

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

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

Surgical Services Billed by a Hospital (Inpatient and Outpatient)

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

Telehealth

Medically Necessary Telehealth services are covered when provided by a Physician or Licensed Health Care Provider.

Therapies for Down Syndrome

Covered services include:

1. Habilitative Care or Rehabilitative Care that is prescribed, provided, or ordered by a licensed Physician, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the Covered Person, Habilitative Care and Rehabilitative Care includes Medically Necessary interactive therapies derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention.
2. Medically Necessary therapeutic care that is provided by a licensed speech-language pathologist a physical therapist or an occupational therapist. Visit limits do not apply.

When treatment is expected to require extended services, the Plan Supervisor may request that the treating Physician provide a treatment plan based on evidence-based screening criteria. The treatment plan will consist of the diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The Plan Supervisor may request that the treatment plan be updated every 6 months.

Therapies - Outpatient

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

Transplants

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

Blue Cross and Blue Shield of Montana contracts with Blue Distinction Centers or Blue Distinction Centers+ for certain transplant services. Blue Distinction Centers offer quality care, treatment expertise and better overall patient results. Covered Persons being considered for a transplant procedure should contact Blue Cross and Blue Shield of Montana Customer Service to discuss benefits of utilizing the Blue Distinction Centers or Blue Distinction Centers+. The Plan does not provide coverage for transplant benefits outside of the Blue Distinction Center or Blue Distinction Center+ network.

Transplant services include:

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

Payment by the Plan is subject to the following conditions:

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

The Plan will not pay for:

1. Experimental/Investigational procedures.
2. Transplants of a nonhuman organ or artificial organ implant.
3. Donor searches.
4. Transplant performed by non-Blue Distinction Centers.

Recommended Clinical Review is strongly recommended for transplants. Please refer to the section entitled Utilization Management for information regarding Recommended Clinical Review.

Voluntary Second and Third Surgical Opinion

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 Benefits. The claim must indicate that charges are for 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.

EXCLUSIONS AND LIMITATIONS

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

1. Nonsurgical treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction, anterior or internal dislocations, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances.
2. Orthodontics, except for in the case of Dental Accidental Injury.
3. All dental services, including but not limited to ridge augmentation and vestibuloplasty, whether performed by Physicians, dentists, oral surgeons and/or any other provider, except for (i) services provided as the result of a Dental Accidental Injury, (ii) services provided as a result of or to treat either a congenital defect or a cancer, or (iii) services in connection with a transplant.
4. Vision services, including but not limited to prescription, fitting or provision of eyeglasses or contact lenses, except that vision services may be covered for specific conditions in Medical Policy or as a result of an Accidental Injury. 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.
5. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.
6. 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 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 or any type, except as otherwise provided under this Plan. Medically Necessary cochlear implants are covered per Medical Policy as part of the transplant benefit.
7. Cosmetic services or complications resulting therefrom except when covered services are provided to correct a condition resulting from an Accidental Injury, a condition resulting from an Injury or to treat a congenital anomaly, as applicable in Medical Policy.
8. Any service or procedure which is determined by the Plan Supervisor to be an Inclusive Service/Procedure.
9. Any services, supplies, drugs and devices which are:
    a. Experimental/Investigational services, except any services, supplies, drugs and devices considered to be Experimental/Investigational and which are provided during a Phase I or II clinical trial, or the experimental or

research arm of a Phase III clinical trial, except for services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial. This includes services, supplies, drugs and devices under study to determine the maximum tolerated dosage(s), toxicity, safety or efficacy as compared with standard treatment, or for the diagnosis of the condition in question. The Plan has the ultimate authority and right to determine what services are Experimental/Investigational and are excluded from coverage.

b. Not accepted standard medical practice. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice.

c. Not a Covered Medical Expense.

d. Not Medically Necessary.

e. Not covered under applicable Medical Policy.

10. 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 a 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.

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

12. Reversal of an elective sterilization.

13. Vasectomy, except for covered Employee or Spouse.

14. 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.

15. Routine foot care for Covered Persons without co-morbidities, except Routine foot care is covered if a Covered Person has co-morbidities such as diabetes, including the following:

a. Removal or treatment of corns or callosities;

b. Hypertrophy, hyperplasis of the skin, or subcutaneous tissues;

c. Cutting or trimming of nails;

d. Treatment of flat feet, fallen arches, or chronic footstrain;

e. Orthotic appliances and casting for orthotic appliances, except as specifically covered;

f. Padding and strapping; or

g. Fabrication, except as specifically covered.

16. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

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

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

a. Acupressure;

b. Hypnotherapy;

c. Rolfing;

d. Holistic medicine;

e. Religious counseling;

f. Recreational counseling;

g. Mileu therapy;

h. Homeopathy;

i. Stress management;

j. Self-help programs.

19. Services provided by a massage therapist.

20. Sanitarium care, Custodial Care, rest cures, or skilled nursing care to help the Covered Person with daily living tasks. Examples include but are not limited to, help in:

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

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

21. Vitamins, except those vitamins that may be covered in Medical Policy.

22. Food supplements (except for those for inborn errors of metabolism and treatment of other Medically Necessary conditions).

23. Services, supplies, drugs and devices for the surgical treatment of any degree of obesity (bariatric surgery), whether provided for weight control or any medical condition.

24. Services, supplies, drugs and devices for weight reduction or weight control. This exclusion does not include intensive behavioral dietary counseling when services are provided by a Physician, Physician Assistant - Certified or Advanced Practice Registered Nurse.

25. Services, supplies, drugs and devices for obesity, weight reduction or control whether rendered for weight control or any other condition, except as Medically Necessary and a Benefit of this Plan.

26. Charges associated with health clubs, health spas, weight loss clubs or clinics, personal trainers, and exercise programs.

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

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

29. Services or supplies for:

    a. Intersegmental traction;
    b. All types of home traction devices and equipment;
    c. Vertebral axial decompression sessions;
    d. Surface Electromyography (EMG); the measurement of muscle electrical activity with electrodes placed on the skin over the muscle;
    e. Spinal manipulation under anesthesia;
    f. Muscle testing through computerized kinesiology machines;
    g. Balance testing through computerized dynamic posturography sensory organization test.
    h. Deluxe medical equipment including, but not limited to, durable medical equipment, prosthetics and communication devices except as included in the Durable Medical Equipment Benefit and the Prosthetic Benefit in the section entitled Benefits

30. 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.

31. Charge for elective abortion.

32. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, skilled nursing or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury.

33. 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 Telehealth Benefit.

34. 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 Benefits.

35. Charges for hair transplant procedures, wigs and artificial hairpieces or drugs which are prescribed to promote hair growth or remove hair.

36. 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.

37. Charges for non-prescription supplies or devices, except as covered under the Preventive Care Benefit.

38. 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

39. 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.

40. 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.

41. 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.

42. 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.

43. Charges for examinations for employment, licensing, insurance, school, camp, sports or adoption purposes.

44. Charges for expenses for examinations and treatment conducted for the purpose of medical research.

45. Charges for FAA and DOT Physicals.

46. 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.

47. Charges for biofeedback or orthomolecular therapy, including nutrients, vitamins and food supplements, except as specifically covered.

48. Charges for vocational rehabilitation.

49. Charges for non-Medically Necessary services, care or treatment of Gender Identity Disorder or Gender Dysphoria.

50. 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.

51. Charges for all medical examinations for firefighters in the state of Montana pursuant to § 39-71-101, MCA et. seq.

52. Purchase of O2 concentrators is not covered.

53. Physical Therapy, Occupational Therapy and Speech Therapy Treatment rendered for stuttering or for behavioral, developmental or learning disorders is excluded.

54. 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**.**

55. 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.

CLAIMS INFORMATION

How to Obtain Payment for Covered Expenses for Benefits

1. If a Covered Person obtains services from an In-Network Provider, the In-Network Provider will submit claims to the Plan Supervisor for the Covered Person. If a Covered Person obtains services from an Out-of-Network Provider, the Covered Person may be required to submit claims to the Plan. Claims for services must be submitted no later than 12 Months from the date of service. Claims must provide enough information about the services for the Plan Supervisor to determine whether or not they are a Covered Medical Expense. Submission of such information is required before payment will be made.

   Itemized bill must contain the following information:

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

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

2. Claims must be submitted to the address listed on the inside cover of this Plan. Contact the Customer Service number on the back of the Covered Person's identification card for information on how to submit a claim.

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

Family Members who live out-of-state or Covered Persons who have health care services out-of-state should use In-Network Blue Cross and Blue Shield Providers in that state. In most cases, providers will file claims directly with the

Plan Supervisor. Please refer to the BlueCard Program section. If the provider does not file the claim, the Covered Person should use the same procedures outlined in this section.

GENERAL PROVISIONS

Alternate Care

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

Treatments, services, or supplies excluded by this Plan may be reimbursable if such changes 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.

Benefit Maximums

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

Statements are Representations

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

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

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 BCBSMT (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.

Covered Person/Provider Relationship

Choosing a Provider

The choice of a Provider is solely the choice of the Covered Person's and the Plan Supervisor will not interfere with the Covered Person's relationship with any provider.

Plan Supervisor's Role

It is expressly understood that the Plan Supervisor does not itself undertake to furnish Hospital, medical or dental services, but solely to provide claims administration services to the Plan. The Plan Supervisor is not in any event liable for any act or omission of any provider or the agent or employee of such provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Any contractual relationship between a provider and the Plan Supervisor shall not be construed to mean that the Plan Supervisor is providing professional services.

Intent of Terminology

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

Provider's Role

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

Federal Balance Billing and Other Protections

This section is based upon the No Surprises Act, a federal law enacted in 2020, and effective for plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Montana law, if there is a conflict between the terms of this Federal Balance Billing and Other Protections section and the terms in the rest of this Summary Plan Description, the terms of this section will apply. However, definitions set forth in the Federal No Surprises Act Definitions provision of this section are for purposes of covered services under this section only.

Continuity of Care

If the Covered Person is under the care of an In-Network provider as defined in this Plan who stops participating in the Plan Supervisor's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), the Covered Person may be able to continue coverage for that provider's covered services at the In-Network Benefit level if one of the following conditions is met:

1. The Covered Person is undergoing a course of treatment for a serious and complex condition,
2. The Covered Person is undergoing institutional or Inpatient Care,
3. The Covered Person is scheduled to undergo nonelective surgery from the provider (including receipt of postoperative care from such provider with respect to such surgery),
4. The Covered Person is pregnant or undergoing a course of treatment for their pregnancy, or
5. The Covered Person is, or was, determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if the Covered Person is currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), or (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan Supervisor notifies the Covered Person of the provider's termination, or any longer period provided by state law. If the Covered Person is in the second or third trimester of pregnancy when the provider's termination takes effect, continuity of coverage may be extended through the postpartum period. The Covered Person has the right to appeal any decision made for a request for benefits under this provision, as explained in the Appeals section of this Plan.

Federal No Surprises Act Definitions

The definitions below apply only to this Federal Balance Billing and Other Protections section. To the extent the same terms are also defined in the Definitions section of this Plan, those terms will apply only to their use in this Plan, or this Federal Balance Billing and Other Protections section, respectively.

"Air Ambulance Services" means, for purposes of this section only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this section only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this section only,

1. A medical screening examination performed in the emergency department of a hospital or a freestanding emergency department,
2. Further medical examination or treatment the Covered Person receives at a Hospital, regardless of the department of the Hospital, or a freestanding emergency department to evaluate and treat an Emergency Medical Condition until the Covered Person's condition is stabilized; and
3. Covered services the Covered Person receives from a Non-Participating Provider during the same visit after the Covered Person's Emergency Medical Condition has stabilized unless:
    a. The Covered Person's Non-Participating Provider determines the Covered Person can travel by non-medical or non-emergency transport.
    b. The Covered Person's Non-Participating Provider has provided the Covered Person with a notice to consent form for balance billing of services; and;
    c. The Covered Person has provided informed consent for additional post stabilization care and services.

"Non-Participating Provider" means, for purposes of this section only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with BCBSMT for furnishing such item or service under the Plan.

"Non-Participating Emergency Facility" means, for purposes of this section only, with respect to a covered item or service, an emergency department of a Hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSMT for furnishing such item or service under the Plan.

"Participating Provider" means, for purposes of this section only, with respect to a covered service, a Physician or other health care provider who has a contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Member) for furnishing such item or service under the Plan, regardless of whether the provider is considered a preferred or In-Network provider for purposes of In-Network or Out-of-Network Benefits under the Plan.

"Participating Facility" means, for purposes of this section only, with respect to a covered service, a Hospital, Hospital outpatient department, critical access Hospital, ambulatory surgical center, or any other facility as otherwise required by law, that has a direct or indirect contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Member) for furnishing such item or service under the Plan, regardless of whether the provider is considered a preferred or In-Network provider for purposes of In-Network or Out-of-Network Benefits under the Plan.

"Qualifying Payment Amount" means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

"Visit" includes, for purposes of this section only, covered items and services provided as part of nonemergency services furnished by a Non-Participating Provider, regardless of whether the Non-Participating Provider is present at a Participating Facility when furnishing the covered items or services.

Federal No Surprises Act Surprise Billing Protections

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below

1. Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.

2. Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless the Member gives written consent and gives up balance billing protections).
3. Air Ambulance Services received from a Non-Participating Provider if the services would be covered if received from a Participating Provider.

Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

Cost Sharing

For nonemergency services performed by Non-Participating Providers during the Covered Person's visit at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate the Covered Person's cost-share requirements, including Deductibles, Copayments, and/or Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate the Covered Person's cost-share requirements, including Deductibles, Copayments, and/or Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward the Covered Person's In-Network Deductible and/or Out of Pocket Amount, if any.

Federal No Surprises Act Prohibition of Balance Billing

The Covered Person is protected from balance billing on included services as set forth below.

If the Covered Person receives Emergency Services from a Non-Participating Provider or Non-Participating Emergency Facility, the most the Non-Participating Provider or Non-Participating Emergency Facility may bill the Covered Person is the In-Network cost-share. The Covered Person cannot be balance billed for these Emergency Services unless the Covered Person gives written consent for services once their Emergency Medical Condition has stabilized and gives up their protections not to be balanced billed for services received after they are in a stable condition.

When the Covered Person receives covered nonemergency services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill the Covered Person is the Plan's In-Network cost-share requirements. When the Covered Person receives emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, intensivist services, or other items and services as otherwise required by law at a Participating Facility, or if the Covered Person receives services from a Non-Participating Provider if there is no Participating Provider who can furnish such service at that Participating Facility, Non-Participating Providers can't balance bill the Covered Person and may not ask the Covered Person to give up their protections not to be balance billed. If the Covered Person receives other services at Participating Facilities, Non-Participating Providers can't balance bill the Covered Person unless they give written consent and give up their protections.

If the Plan includes Air Ambulance Services as a covered service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill the Covered Person is the In-Network cost-share. The Covered Person cannot be balance billed for these Air Ambulance Services.

DEFINITIONS

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

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.

ADVANCED PRACTICE REGISTERED NURSE

Nurses who have additional professional education beyond the basic nursing degree required of a registered nurse and who are licensed as Advanced Practice Registered Nurses by the applicable state or regulatory agency in the state in which the individual performs the nursing services. Advanced Practice Registered Nurses include nurse practitioners, certified nurse-midwives, certified nurse-anesthetists and clinical nurse specialists.

ALLOWABLE FEE

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

1. Medicare RBRVS based is a system established by Medicare to pay Physicians for a "work unit." The RBRVS value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by the Plan Supervisor to Out-of-Network Providers under the Medicare RBRVS system can be considerably less than the Out-of-Network Providers' billed charge; or
2. Diagnosis-related group (DRG) methodology is a system used to classify Hospital cases into one of approximately 500 to 900 groups that are expected to have similar Hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of Hospital resources for the given DRG regardless of the actual Hospital resources used. Therefore, the amount paid by the Plan Supervisor to an Out-of-Network Provider under the DRG system can be considerably less than the Out-of-Network Providers' billed charge; or
3. Billed charge is the amount billed by the provider; or
4. Case rate methodology is an all-inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by the Plan Supervisor to Out-of-Network Providers under the case rate system can be considerably less than the Out-of-Network Providers' billed charge; or
5. Per diem methodology is an all-inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by the Plan Supervisor to Out-of-Network Providers under the per diem system can be considerably less than the Out-of-Network Providers' billed charge; or
6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by the Plan Supervisor to an Out-of-Network Provider under the flat fee per category of service system can be considerably less than the Out-of-Network Providers' billed charge; or
7. Flat fee per unit of service fixed payment amount for a unit of service. For instance, a unit of service could be the amount of "work units" customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by the Plan Supervisor to Out-of-Network Providers under the flat fee per unit system can be considerably less than the Out of-Network Providers' billed charge; or
8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or
9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or
10. The American Society of Anesthesiologists' Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a "work unit." The payment value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by the Plan Supervisor to Out-of-Network Providers under the system can be considerably less than the Out of-Network Providers' billed charge.
11. For Out-of-Network Providers in Montana, (unless otherwise required by applicable law or arrangement with the Out-of-Network Provider) the Allowable Fee is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for Out-of-Network Providers will represent an average contract rate for In-Network Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. The Plan Supervisor will utilize the

same claim processing rules and/or edits that it utilizes in processing In-Network Provider claims for processing claims submitted by Out-of-Network Providers which may also alter the Allowable Fee for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

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

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

In no event shall the Plan, the Employer, or the Covered Person pay more than the provider's billed charge regardless of whether the provider is In-Network or Out-of-Network.

In the event the Allowable Fee is less than the Out-of-Network Provider's billed charges, the Covered Person will be responsible for the difference, along with any applicable Copayment, Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the Plan's Allowable Fee for a particular service, Covered Persons may call the Customer Service number shown on the back of the Covered Person's identification card.

AMPLIFICATION DEVICE

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

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

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

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

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

Services must be provided by an appropriately certified provider.

APPROVED CLINICAL TRIAL

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

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

    a. The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;

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

BLUE CROSS AND BLUE SHIELD OF MONTANA

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

CARE-MANAGEMENT

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

CERTIFIED NURSE MIDWIFE

'Certified Nurse Midwife' means an individual who has received advanced nursing training and is authorized to use the designation 'CNM' and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

COINSURANCE

The percentage of the Allowable Fee payable by the Covered Person for Covered Medical Expenses. The applicable Coinsurance is stated in the Schedule of Benefits.

CONCURRENT CARE

Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or

Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Covered Person's condition requires the skills of separate Physicians.

CONSULTATION SERVICES

Services of a consulting Physician requested by the attending Physician. These services include discussion with the attending Physician and a written report by the consultant based on an examination of the Covered Person.

COPAYMENT

The specific dollar amount payable by the Covered Person for Covered Medical Expenses. The applicable Copayments are stated in the Schedule of Benefits.

COVERED MEDICAL EXPENSE

Expenses incurred for Medically Necessary services, supplies and medications that are based on the Allowable Fee and:

1. Covered under the Plan;
2. In accordance with Medical Policy; and
3. Provided to the Covered Person by and/or ordered by a Physician or other Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider for the diagnosis or treatment of an active Illness or Injury or in providing maternity care.

In order to be considered a Covered Medical Expense, the Covered Person must be charged for such services, supplies and medications.

CREDITABLE COVERAGE

Coverage that the Covered Person had for medical benefits under any of the following plans, programs and coverages:

1. A group health plan;
2. Health insurance coverage;

3. Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1935c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4 (Medicare);
4. Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s (Medicaid);
5. Title 10, Chapter 55, United States Code (TRICARE);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A health plan offered under Title 5, Chapter 89, of the United States Code (Federal Employee Health Benefits Program);
8. A public health plan;
9. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e); or
10. A high-risk pool in any state.

Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits.

CUSTODIAL CARE

Any service, primarily for personal comfort or convenience, that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the Covered Person's condition. Custodial Care services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable nonprofessional personnel, are to assist with Routine medical needs (e.g. simple care and dressings, administration of Routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another Hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn fetus.

EMERGENCY SERVICES

Health care items or services furnished or required to evaluate and treat an Emergency Medical Condition.

FAMILY MEMBER

A Dependent who has been enrolled by an enrolled Employee into the Plan and has been accepted as a Covered Person of the Plan.

FREESTANDING INPATIENT FACILITY

For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorder in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment Center and is licensed as a Freestanding Inpatient Facility by the the state or the regulatory agency of the state in which the Freestanding Inpatient Facility is located.

Services include medical evaluation and health supervision; Substance Use Disorder education; organized individual, group and family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up program after discharge.

For treatment of Mental Illness, it means a facility licensed by the state and specializing in the treatment of Mental Illness.

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 experience/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 sec characteristics at puberty.
   b. Persistent desire to rid oneself of the primary or secondary sexual characteristics of the other gender.
   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.

HABILITATIVE CARE

Coverage will be provided for Habilitative Care services when the Covered Person requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Other services for people with disabilities.

These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician.

HOME HEALTH AGENCY

An 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 INFUSION THERAPY AGENCY

A home infusion therapy agency means a health care facility that is licensed or accredited to provide home infusion therapy services in the state in which the services are provided.

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 Injury or provides for the facilities through arrangement or agreement with another hospitals; 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.

IATROGENIC INFERTILITY

An impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

IN-NETWORK PROVIDER

A provider who has a contract with the Plan Supervisor, Blue Cross and BlueShield of Montana, or with another Blue Cross Blue Shield Licensee/Plan in another state.

INCLUSIVE SERVICES/PROCEDURES

A portion of a service or procedure which is necessary for completion of the service or procedure or a service or procedure which is already described or considered to be part of another service or procedure.

INFUSION SUITE

An alternative to Hospital and clinic-based infusion settings where medications can be infused.

INPATIENT CARE

Care provided to a Covered Person who has been admitted to a facility as a registered bed patient and who is receiving services, supplies and medications under the direction of a Covered Provider with staff privileges at that facility. Examples of facilities to which a Covered Person might be admitted include:

1. Hospitals;
2. Hospice programs;
3. Skilled nursing facilities; or
4. Freestanding Inpatient Facilities.

INPATIENT COVERED PERSON

A Covered Person who has been admitted to a facility as a registered bed patient for Inpatient Care.

LIFE-THREATENING CONDITION

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MEDICAL POLICY

The Plan Supervisor's policy which is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. Are in accordance with any established standards of good medical practice.

Medical Policy is reviewed and modified periodically as necessary.

MENTAL HEALTH TREATMENT CENTER

A treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by a Licensed Health Care Provider. The facility must be:

1. Licensed as a Mental Health Treatment Center by the state;
2. Funded or eligible for funding under federal or state law; or
3. Affiliated with a Hospital under a contractual agreement with an established system for patient referral.

MULTIDISCIPLINARY TEAM

A group of health service providers who are either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. Members of the Multidisciplinary Team may include, but are not limited to, a licensed psychologist, licensed speech therapist, registered physical therapist, or licensed occupational therapist.

OCCUPATIONAL THERAPY

Therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of speech tasks or goal-directed activities designed to improve the functional performance of an individual.

OUT-OF-NETWORK

Providers who are not in a PPO Network.

OUT OF POCKET AMOUNT

For the Covered Person:

The total amount of applicable In-Network Deductible, Copayment and/or Coinsurance and the applicable Out-of-Network Deductible, Copayment and/or Coinsurance a Covered Person must pay for Covered Medical Expenses incurred during the Benefit Period. Once the Covered Person has satisfied the applicable Out of Pocket Amount, the Covered Person will not be required to pay the Covered Person's applicable Deductible, Copayment and/or Coinsurance for Covered Medical Expenses for the remainder of that Benefit Period. The In-Network and Out-of-Network Out of Pocket Amounts are separate, and one does not accumulate to the other.

If a Covered Person is in the Hospital on the last day of the Covered Person's Benefit Period and continuously confined through the first day of the next Benefit Period, the applicable Deductible, Copayment and/or Coinsurance for the entire Hospital stay (facility charges only) will only apply to the applicable Out of Pocket Amount of the Benefit Period in which the inpatient stay began. If the Covered Person satisfied the Out of Pocket Amount prior to that Hospital stay, no applicable Deductible, Copayment and/or or Coinsurance will be applied to that stay.

Non-covered services and amounts over the allowed amount billed by an Out-of-Network Provider do not accumulate to the Out of Pocket Amount and are the Covered Person's responsibility.

OUTPATIENT

Services or supplies provided to the Covered Person by a Covered Provider while the Covered Person is not an Inpatient Covered Person.

PARTIAL HOSPITALIZATION

A time-limited ambulatory (Outpatient) program offering active treatment which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

A Partial Hospitalization program should offer four to eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with the Covered Person.

PHYSICAL THERAPY

Treatment of an Illness or Injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and pain relief.

PPO-A PREFERRED PROVIDER ORGANIZATION

A provider or group of providers which have contracted with the Plan Supervisor to provide services to Covered Persons covered under PPO Benefit Contracts.

PPO NETWORK

A provider or group of providers which have a PPO contract with the Plan Supervisor. The Covered Person may obtain a list of PPO providers from the Plan Supervisor upon request.

QUALIFIED INDIVIDUAL (FOR AN APPROVED CLINICAL TRIAL)

A Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol for the treatment of cancer or other Life-Threatening Condition because:

1. The referring health care professional is In-Network in the clinical trial and has concluded that the Covered Person's participation in the trial would be appropriate; or
2. The Covered Person provides medical and scientific information establishing that the Covered Person's participation in the clinical trial is appropriate because the Covered Person meets the conditions described in the trial protocol.

RECOVERY CARE BED

A bed occupied in an Outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATION FACILITY

A facility, or a designated unit of a facility, licensed, certified or accredited to provide Rehabilitation Therapy including:

1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or a facility associated or co-located with a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital; and/or
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Covered Person, regardless of the category of facility licensure.

REHABILITATION THERAPY

A specialized, intense and comprehensive program of therapies and treatment services (including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy) provided by a Multidisciplinary Team for treatment of an Injury or physical deficit. A Rehabilitation Therapy program is:

1. Provided by a Rehabilitation Facility in an Inpatient Care or Outpatient setting;
2. Provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;
3. Designed to restore the Covered Person's maximum function and independence; and/or
4. Medically Necessary to improve or restore bodily function and the Covered Person must continue to show measurable progress.

REHABILITATIVE CARE

Coverage will be provided for Rehabilitative Care services when the Covered Person requires help to keep, recover or improve skills and functioning for daily living that have been lost or impaired because the Covered Person was sick, hurt or disabled. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Psychiatric rehabilitation.

These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician.

RESIDENTIAL TREATMENT CENTER

Residential Treatment Facility means an institution which is licensed as a 24-hour residential facility for Mental Illness and/or Substance Use Disorder treatment, although not licensed as a hospital; provides a multi-disciplinary treatment plan in a controlled environment, with periodic supervision of a Physician or a PhD psychologist; and provides programs such as social, psychological or rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

ROUTINE

Examinations or services provided when there is no objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any Injury or Illness.

ROUTINE PATIENT COSTS

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 participation in an Approved Clinical Trial. Routine Patient Costs do not include:

1. An investigational item, device, or service that is part of the Approved Clinical Trial;
2. An item or service provided solely to satisfy data collection and analysis needs for the Approved Clinical Trial if the item or service is not used in the direct clinical management of the Covered Person; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the Covered Person's diagnosis.

SPEECH THERAPY

Speech Therapy is the treatment of communication impairment and swallowing disorders.

STANDARD FERTILITY PRESERVATION SERVICES

Procedures consistent with established medical practices and professional guidelines, including those established by the American Society for Reproductive Medicine and the American Society of Clinical Oncology.

TELEHEALTH

The use of audio, video, or other telecommunications technology or media, including audio-only communication that is:

1. Used by a health care provider or health care facility to deliver health care services; and
2. Delivered over a secure connection that complies with state and federal laws.

Telehealth does not include delivery of health care services by means of facsimile machine or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

BlueCross BlueShield
of Montana

Blue Cross and Blue Shield of Montana
3645 Alice Street
P.O. Box 4309
Helena, MT 59604-4309

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, 2025

TABLE OF CONTENTS

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:
benefits.mt.gov/Prescription.

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 Specialty brand products	$200 Copayment	N/A	50% Copayment** (up to 34 days' supply may be available)	N/A
Tier 4 Specialty generic products	$0 Copayment	N/A	50% Copayment** (up to 34 days' supply may be available)	N/A
Tier 4 All Specialty products for Medicare Retirees only	$50 Copayment	N/A	50% Copayment** (up to 34 days' supply may be available)	N/A

Access Guidance allows the Plan to obtain copay assistance for members. This program applies to certain drugs that have manufacturer-funded copay assistance programs available. Under Access Guidance, if the drugs have copay assistance available, the amount the member pays for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, the member must remain enrolled in Navitus' program for obtaining manufacturer assistance, including co-pay assistance. Amounts paid by manufacturers on a member's behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward the member's annual Out-of-Pocket Maximum. Instead, only those payments made directly by the member will count toward the Out-of-Pocket Maximum. Once manufacturer-funded copay assistance is exhausted, the amount paid by the member will be no more than the member's benefit design. The member's copay will default to the formulary's current tiered coinsurance/copay if a drug does not qualify.

*$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.

**Tier 3 Non-preferred products do not accrue towards the Pharmacy Out-of-Pocket Maximum.

For Medicare retirees, the Centers for Medicare and Medicaid Services (CMS) restricts the amount a Medicare retiree will pay out of pocket for insulin ($35.00) and vaccinations ($0.00).

Preventive Services
The following are payable at 100% and are not subject to any Copayment: 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.
My Health Navigator Diabetes Care Program
Participants enrolled in the My Health Navigator Diabetes Care Program receive at no cost to the Participant, one (1) glucose meter per Benefit Period and clinically appropriate testing supplies (test strips and lancets). To be eligible for the My Health Navigator Diabetes Care Program, a Participant must have a diagnosis of diabetes or pre-diabetes. For additional information, see the My Health Navigator section on the Health Care & Benefits Division website at: benefits.mt.gov/Prescription/My_Health_Navigtor.
My Health Navigator Asthma Care Program
Participants enrolled in the My Health Navigator Asthma Care program receive at no cost to the Participant, if necessary, a valved holding chamber and peak flow meter. Participants may be eligible for reduced Pharmacy Copayments on some asthma drugs. To be eligible for the My Health Navigator Asthma Care Program, a Participant must have a diagnosis of asthma or breathing problems. For additional information, see the My Health Navigator section on the Health Care & Benefits Division website at: benefits.mt.gov/Prescription/My_Health_Navigtor.
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 (Prescription Drug Claim Form | Direct Member 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 and may be substantially less than the actual amount that was paid at the pharmacy. 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 70% 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* when supplied by a DME supplier.

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, 2025

deltadentalins.com

Group No: 15855

Effective Date: January 1, 2025

DENTAL PLAN COVERAGE
FOR YOUR GROUP DENTAL PROGRAM

This plan is self-funded by your employer.

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by **Delta Dental Insurance Company** (**"Delta Dental"**) and cannot modify the Contract in any way.

Claims Administered by:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, Georgia 30009
(770) 641-5100
(800) 521-2651

TABLE OF CONTENTS

GROUP HIGHLIGHTS

PLAN:
You have a Calendar Year plan and deductibles and maximums will be 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	

DEFINITIONS

Terms when capitalized in the Summary Plan Description for Dental Benefits have defined meanings, given in the section below or throughout the Summary Plan Description for Dental Benefits sections.

Approved Amount -- the maximum amount a Dentist may charge for a Single Procedure.

Benefits (In-Network or Out-of-Network) -- the amounts that Delta Dental will pay for dental services under the Contract. In-Network Benefits are those covered by the Contract and performed by a Delta Dental PPO Dentist. Out-of-Network Benefits are those covered by the Contract but performed by a Delta Dental Premier® Dentist or Non-Delta Dental Dentist.

Claim Form -- the standard form used to file a claim or request Pre-Treatment Estimate for treatment.

Contract -- the written agreement under which Benefits are provided.

Contract Allowance -- the maximum amount Delta Dental will use for calculating the Benefits for a Single Procedure. The Contract Allowance for services provided:

- by Delta Dental PPO Dentists is the lesser of the Dentist's submitted fee, the Delta Dental PPO Dentist's Fee or the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement.
- by Delta Dental Premier Dentists (who are not PPO Dentists) is the lesser of the Dentist's submitted fee, the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement or the Maximum Plan Allowance; or
- by Non-Delta Dental Dentists is the lesser of the Dentist's submitted fee or the Maximum Plan Allowance.

Contractholder -- the employer, union or other organization or group contracting to obtain Benefits.

Delta Dental PPO Dentist (PPO Dentist) -- a participating Delta Dental Dentist who agrees to accept Delta Dental's PPO Dentist's Fees as payment in full and to comply with Delta Dental's administrative guidelines. All PPO Dentists are also Delta Dental Premier Dentists. All PPO Dentists must be contracted in the Delta Dental Premier network.

Delta Dental's PPO Dentist's Fee (PPO Dentist's Fee) -- the fee outlined in the PPO Dentist Agreement. PPO Dentists agree to charge no more than this fee for treating PPO enrollees.

Delta Dental Premier® Dentist (Premier Dentist) -- a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier Dentists are PPO Dentists; however, all Premier Dentists agree to accept Delta Dental's Maximum Plan Allowance for each Single Procedure as payment in full.

Dentist -- a person licensed to practice dentistry when and where services are performed.

Dependent Enrollee -- a dependent of a Primary Enrollee or domestic partner who is eligible for Benefits under the Contract.

Effective Date -- the date the program starts. This date is given on the booklet cover.

Enrollee -- a Primary Enrollee or Dependent Enrollee enrolled to receive Benefits.

Maximum Plan Allowance (MPA) -- the maximum amount Delta Dental will 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.

Non-Delta Dental Dentist -- a Dentist who is neither a Premier nor a PPO Dentist and who is not contractually bound to abide by Delta Dental's administrative guidelines.

Open Enrollment Period -- the month of the year during which employees may change coverage for the next Contract Year.

Participating PPO Dentist Agreement (PPO Dentist Agreement) -- an agreement between a member of the Delta Dental Plans Association and a Dentist which establishes the terms and conditions under which covered services are provided under a PPO program.

Participating Dentist Agreement -- an agreement between a member of the Delta Dental Plans Association and a Dentist that establishes the terms and conditions under which services are provided.

Pre-Treatment Estimate -- an estimation of the allowable Benefits under the Contract for the services proposed, assuming the patient is eligible.

Primary Enrollee -- any employee or retiree eligible for Benefits under the Contract.

Procedure Code -- the Current Dental Terminology (CDT) number assigned to a Single Procedure by the American Dental Association.

Single Procedure -- a dental procedure that is assigned a separate CDT number.

CHOICE OF DENTIST

Delta Dental offers a choice of selecting a Dentist from our panel of PPO Dentists and Premier Dentists, or you may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists can be obtained by accessing the Delta Dental National Dentist Directory at deltadentalins.com/stateofmontana. You are responsible for verifying whether the Dentist you select is a PPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, you should always 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 you the greatest reduction in your out-of-pocket expenses, since this select group of Dentists in your area will provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the PPO Dentist.

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

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

Additional advantages of using a PPO Dentist or Premier Dentist
- The PPO Dentist and Premier Dentist must accept assignment of Benefits, meaning PPO Dentists and Premier Dentists will be paid directly by Delta Dental after satisfaction of the deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Dentist and Premier Dentist will complete the dental claim form and submit it to Delta Dental for reimbursement.

DEDUCTIBLE

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

Only the Dentist's fees you pay for covered Benefits will count toward the deductible, but you do not have to 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 will pay the Benefits for the types of dental services as described below. Delta Dental will pay 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 and/or prescribed treatments to determine generally accepted dental practices. If you receive dental services from a Dentist outside the state of **Montana**, the Dentist will be 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 will be 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. You are responsible for paying the remaining applicable percentage of any such fees, known as the "Enrollee Coinsurance". Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between Contractholder and Enrollees.

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

BENEFITS
Delta Dental will 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, Delta Dental will pay 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:

- Delta Dental will pay 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 Contractholder. 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 or 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.
- 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:

- Delta Dental will pay 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 Contractholder. See note on additional benefits during pregnancy.
- Delta Dental will not pay to replace an amalgam within 24 months of treatment if the service is provided by the same Dentist.
- Delta Dental will 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 will 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:

- Delta Dental will 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 Contractholder.
- Prosthodontic appliances and/or implants that were provided under any Delta Dental program will 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 cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Delta Dental will 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.

Limitations on Implant Benefits:

- 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 will 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 cannot be made satisfactory. Replacement of an implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Delta Dental will 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 will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be 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:

- treatment of injuries or illness covered under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

- 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.

- 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 Contractholder.

- 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 Contract, will be the responsibility of the Enrollee and not a covered Benefit.

AUTOMATED INFORMATION LINE

You may access Delta Dental's automated information line on a regular business day to obtain information on Member Eligibility and Benefits; Group Benefit Information; Claim Status or to speak to a Customer Service Representative for assistance. **AVA (866) 496-2370**

CLAIMS

Claims for Benefits must be filed on a standard Claim Form which you or your Dentist may obtain from:

Delta Dental Insurance Company
P.O. Box #1809
Alpharetta, Georgia 30023
(866) 496-2370
deltadentalins.com/stateofmontana

PRE-TREATMENT ESTIMATES

A Dentist may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Delta Dental will predetermine the amount of Benefits payable under the Contract for the listed services. Benefits will be processed according to the terms of the Contract when the treatment is performed. Pre-Treatment Estimates are valid for 60 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;

- the date the patient's coverage ends; or
- the date the PPO Dentist's or Premier Dentist's Agreement with Delta Dental ends.

GENERAL PROVISIONS

Clinical Examination
Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Delta Dental, in or near his community or residence. Delta Dental will in every case hold such information and records confidential.

Notice of Claim Forms
Delta Dental will give any Dentist or Enrollee, on request, a standard Claim Form to make claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the patient is a minor) and submitted to Delta Dental.

If the form is not furnished by Delta Dental within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Delta Dental, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Written Notice of Claim/Proof of Loss
Delta Dental must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Delta Dental within 12 months of the termination of the Contract.

Time of Payment
Claims payable under this Contract for any loss other than loss for which this Contract provides any periodic payment will be paid within 30 days after written proof loss is received. Delta Dental will notify the Primary Enrollee and his/her dentist of any additional information needed to process the claim within this 30 day period. Delta Dental will process the claim within 15 days of receipt of the additional information. If the requested information is not received within 45 days, the claim will be denied. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment will be paid monthly.

To Whom Benefits are Paid
PPO Dentists and Premier Dentists will be paid directly. Any other payments provided by the Contract will be made to the Primary Enrollee, unless the Enrollee requests when filing a proof of loss claim that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist will be payable to the Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the parent, guardian or other person actually supporting him.

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

Cancellation of Program
- on an anniversary of the Effective Date upon 60 days written notice; or
- if your employer does not pay the monthly cost of coverage upon 31 days written notice; or
- if your employer does not provide a list of who is eligible upon 60 days written notice; or
- if less than the minimum number of Primary enrollees required under the Contract reported eligible for three (3) months or more, upon 15 days written notice.

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

APPENDIX D

SUMMARY PLAN DESCRIPTION FOR VISION 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, 2025

Group Vision Care Plan

Vision Care for Life

Group Name: **STATE OF MONTANA**
Group Number: **40152225**
Effective Date: **JANUARY 1, 2024**

Provided by:
VISION SERVICE PLAN INSURANCE COMPANY

3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

vsp.com

DEFINITIONS

ANISOMETROPIA	A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.
BENEFIT AUTHORIZATION	Authorization issued by VSP identifying the individual names as a Covered Person of VSP and identifying those Plan Benefits to which a Covered Person is entitled.
COPAYMENTS	Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
COVERED PERSON	An Enrollee or Eligible Dependent who is covered under this plan.
ELIGIBLE DEPENDENT	Any legal dependent of an Enrollee of Group who meets the criteria for eligibility as established by Group.
EMERGENCY CONDITION	A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
ENROLLEE	An employee or member of Group who meets the eligibility as established by Group.
EXPERIMENTAL NATURE	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
GROUP	State of Montana has contracted with VSP for coverage under this plan to provide vision care coverage to its Enrollees and Eligible Dependents.
KERATOCONUS	A development of dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.
MEMBER DOCTOR	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.
NON-MEMBER PROVIDER	Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this plan.

PROCEDURES FOR USING THE PLAN

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or a Member Doctor. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be

obtained from VSP. If this list does not cover the geographic area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one that does.

2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

4. You pay only the Copayment (if any) to a Member Doctor for services covered by the Plan. VSP will pay the Member Doctor directly according to its agreement with the doctor.

   Note: If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown, less any applicable Copayments.

5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor. No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated in this document, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken, or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance.
   Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

6. In the event of termination of a Member Doctor's membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit the Member Doctor to continue to provider you with Plan Benefits until the services are completed or VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

BENEFIT AUTHORIZATION PROCESS

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Plan. When Covered Person requests services under this Plan, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Plan's level of coverage. Refer to the attached Schedule of Benefits for a summary of the level of coverage provided to Covered Person by Group.

BENEFITS AND COVERAGES

Through its Member Doctors, VSP provides Plan Benefits to Covered Persons, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

IMPORTANT: The benefits described below are typical services and materials available under most VSP Plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits to determine your specific Plan Benefits.

1. Eye examination. A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.

3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.

4. Contact lenses: Unless otherwise indicated on the Schedule of Benefits, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein for the current eligibility period.

   Necessary contract lenses, together with professional services will be provided as indicated on the Schedule of Benefits.

   When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professions fees and materials as shown on the Schedule of Benefits. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fess for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

5. If you elect to receive vision care services from a Member Doctor, Plan Benefits are provided subject to your payment of any applicable Copayment. If your Plan includes Non-Member Provider coverage, and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his/her full fee. VSP will reimburse you in accordance with the Schedule of Benefits, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctors services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

COPAYMENT

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet and on the Schedule of Benefits. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

EXLUSIONS AND LIMITATION OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits or may be subject to additional limitations. Covered persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

This vision service Plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the options extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses for adults.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Custom and Premium Progressive multifocal lenses.
- UV (ultraviolet) protective lenses.
- Certain limitation on low vision care.

NOT COVERED
There is not benefit for profession services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.

- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.

- Medical or surgical treatment of the eyes.

- Corrective vision treatment of an Experimental Nature.

- Costs for services and/or materials above Plan Benefit allowances indicated on the Schedule of Benefits.

- Services/materials not indicated as covered Plan Benefits on the Schedule of Benefits.

SCHEDULE OF BENEFITS

BASIC VISION PLAN

COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Exam Copayment	$10.00	$10.00
Exam Allowance (once per Frequency Period)	100% after Copayment	Up to $45.00
Additional Discount	Yes	No

COPAYMENT
A Copayment amount of $10.00 shall be payable by the Covered Person to the Member Doctor at the time of the examination.

FREQUENCY PERIOD
Once every plan year. Plan year begins January 1st.

ADDITIONAL DISCOUNT
Each Covered Person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of non-covered materials from any Member Doctor when a complete pair of prescription glasses and sunglasses including lens enhancements, are dispensed. Also, Covered Person shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any Member Doctor.*

Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.*

LIMITATIONS:

- Discounts do not apply to vision care benefits obtained from Non-Member Providers.
- 20% discount applies to complete pairs of prescription glasses and sunglasses (including lens enhancements) only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items: e.g. contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

*Professional judgement will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.

SCHEDULE OF BENEFITS

VISION HARDWARE PLAN

COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Exam Copayment	$10.00	$10.00
Exam Allowance (once per Frequency Period)	100% after Copayment	Up to $45.00
Materials Copayment	$20.00	$20.00
Basic Prescription Lenses Allowance* (one pair per Frequency Period)		
Single Vision	100% after Copayment	Up to $45.00
Lined Bifocal	100% after Copayment	Up to $55.00
Lined Trifocal	100% after Copayment	Up to $65.00
Lined Lenticular	100% after Copayment	Up to $80.00
Frames (allowance available every other calendar year)		
VSP Member Doctor	Covered up to the Plan Allowance of $150.00 after Copayment	Up to $52.00
Costco, Walmart, or Sam's Club Optical	Covered up to the Plan Allowance of $80.00 after Copayment	
Elective Contact Lenses** (contact lenses in lieu of lenses and frames)	Covered up to the Plan Allowance of $150.00 Elective Contact Lens fitting and evaluation services are covered in full once every plan year, after a maximum $55.00 Copayment.***	Up to $95.00

*Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

*Standard Progressive Lenses covered in full.

**Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses. Necessary Contact Lenses are covered in full after Copayment when provided by a Member Doctor or up to $210.00 when provided by a non-Member Provider.

**When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for one plan year.

***15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

COPAYMENT
There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to Elective Contact Lenses.

FREQUENCY PERIOD
Once every plan year. Plan year begins January 1st.

LOW VISION
Professional services for severe visual problems not corrected with regular lenses, including:

COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Supplemental Testing (included evaluation, diagnosis and prescription of vision aids where indicated)	Covered in Full	Up to $125.00
Supplemental Aids	75% of cost	75% of cost

Maximum allowable for all Low Vision benefits of $1,000.00 every two (2) years.

SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes.

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plans have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTAIL MEDICAL EYE CARE SERVICES

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the Wrap Plan Document to determine available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment by VSP. This process is referred to as Coordination of Benefits (COB).

COVERED SERVICES THROUGH A VSP MEMBER DOCTOR ONLY

Medical Eye Examinations: Covered in Full after a Copayment of $20.00
Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full
*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focuses and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be available upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included as covered Plan Benefits.

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, 2025

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").

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

Eligibility

1. Employees, Legislators and their spouses/domestic partners enrolled on the State Plan. Non-Medicare eligible Retirees and non-Medicare spouses/domestic partners covered under a Retiree's State Plan.

2. Dependents age 2 and older enrolled on the State Plan.

3. Medicare-eligible Retirees and Medicare-eligible dependents of a Retiree 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 the State 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, Vaccination Clinics, and Virtual Primary Care	$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 the State 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 PROGRAM 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, 2025

WELLNESS PROGRAM

The Employer encourages participation in its Wellness Program (the "Program") to promote health, prevent disease, and decrease overall State Plan costs. This Summary Plan Description describes the services available for Eligible Members. Eligible Members may also refer to Program communications for additional details regarding the Program.

ELIGIBILITY

Eligible Members include:

1. All Employees, Retirees, Legislators, spouses/domestic partners, and COBRA Participants over age 18 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 the 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 Requirements

Eligible Members can earn $30 per month off the required benefit contribution by completing all three Live Life Well Incentive activities between November 1 and October 31 of each year. If a covered spouse/domestic partner also completes all three Live Life Well Incentive activities, Eligible Members can earn an additional $30 per month off the required benefit contribution for dependent coverage.

To be eligible for a Live Life Well Incentive, all three activities described below must be completed.

1. Annual State-sponsored Health Screening

   Eligible Members must complete a State-sponsored Health Screening between November 1st and October 31st of the following year.

   The State-sponsored Health Screening is provided at no cost to Eligible Members once per year at all Montana Health Centers or at off-site screening events sponsored by Montana Health Centers. A schedule of off-site screening events can be found at healthcenter.mt.gov/health-screenings.

   The annual State-sponsored health screening includes a lipid panel, comprehensive metabolic panel, and complete blood count. Additional tests may be available if prescribed by a Physician or Licensed Health Care Provider, within the scope of practice of the Licensed Health Care Provider and offered by the Montana Health Center or off-site screening event. To add additional tests, Eligible Members must bring the Physician or Licensed Health Care Provider order to the State-sponsored Health Screening.

   At off-site screening events there are only three additional tests that may be performed with a Physician or Licensed Health Care Provider order: an HbA1c; a PSA; and/or a TSH thyroid test.

Appointments are required for Montana Health Center and off-site screening events. Eligible Members may visit mypremisehealth.com, call (855) 200-6822, or use the MyPremiseHealth app to make an appointment for a State-sponsored Health Screening.

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 should share health screening results or concerns with their Physician or Licensed Health Care Provider. See the Eligible Provider Visit section for more information.

2. Nicotine Free

Eligible Members must self-report Nicotine Free status or the completion of an eligible alternative between November 1 and October 31 of each year.

A. Nicotine includes cigarettes, cigars, chewing tobacco, and most vaping products.

B. Nicotine Free means:
   - An Eligible Member who has never used nicotine, has quit using nicotine, uses only FDA-approved Nicotine Replacement Therapy (NRT), or infrequently uses nicotine (less than four times per month); or
   - An Eligible Member who is currently using nicotine but has completed an eligible alternative during the program year.

C. Nicotine Use means an Eligible Member is currently using nicotine and has not completed an eligible alternative during the program year.

If the Eligible Member is not Nicotine Free, he/she must complete and self-report one eligible alternative to obtain an incentive. Alternatives include the following options:

A. Completion of 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. Completion of a nicotine education session with a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider.

3. Eligible Provider Visit

Eligible Members must complete and self-report one Eligible Provider Visit between November 1st and October 31 of each year.

An Eligible Provider Visit is an annual preventive care examination or visit with a Physician or Licensed Health Care Provider. In certain circumstances, an Eligible Provider Visit may be a telemedicine visit if approved by the member's provider. The Eligible Provider Visit may include a review of the State-sponsored Health Screening results.

More information about the Live Life Well Incentive Program including a comprehensive list of Frequently Asked Questions can be found at benefits.mt.gov/Incentive.

Healthy Weight Incentive Program

The Employer encourages participation in its Healthy Weight Incentive Program to promote health, prevent disease, and decrease overall State Plan costs.

Eligible Members may earn an annual $200 Healthy Weight Incentive for completing Weight Watchers, Healthy for Life Self-Study, or a Diabetes Prevention Program. Only these three programs are eligible.

An Eligible Member must meet the following criteria:

1. Complete the application form and return to the HCBD within 3 months of program completion. Application forms can be found at benefits.mt.gov/Live-Life-Well/Wellness-Programs/Healthy-Weight-Incentive.
2. Submit proof of 10% weight loss.
3. Submit proof of at least 4 months of program participation.
4. Submit proof of regular physical activity.

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 visit the WW (Weight Watchers) web site at weightwatchers.com/us.

Healthy For Life Self-Study

Healthy For Life (HFL) Self-Study is a one year long online program offered by the HCBD. 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 benefits.mt.gov/HealthyForLife.

Diabetes Prevention Program (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 several organizations across the state or virtually through remote events. 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.

Eligible Members may contact a DPP site in their area for details on costs, program start dates, and program location on the Diabetes Prevention Program website at dphhs.mt.gov/publichealth/Diabetes/index.

For more information about the Diabetes Prevention Program visit benefits.mt.gov/Live-Life-Well/Wellness-Programs/Weight-Management.

LIMITATIONS

Other than the benefits described in this document, the Program and Healthy Weight Incentive 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 HCBD (800) 287-8266, (406) 444-7462, TTY (406) 444-1421, or benefitsquestions@mt.gov. HCBD 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 ARE TAXABLE

Cash incentive payments earned through participation in a Wellness Program activity are taxable income to an employee. Cash awards, such as gift cards, are taxable income to an employee. Employees should consult their tax advisor with any questions on the tax consequences of cash awards.

Live Life Well Incentives that are applied towards State Plan contributions are not considered taxable income to the employee.

Adjustment of incentives obtained under the Program may be necessary due to a mistake or to comply with applicable law. If an employee is required to repay any amounts obtained under the Program due to one of these reasons and the employee 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 above and provided in 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 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.

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 HCBD for information on the Program programs and rewards at (800) 287-8266, (406) 444-7462, TTY (406) 444-1421, or benefitsquestions@mt.gov.

INCENTIVE PROGRAM NOTICE

The State Plan offers the LLW Incentive Program to all enrolled employees and their enrolled spouse/domestic partner. If you choose to participate in the LLW Incentive Program, you will be asked to complete a voluntary health risk assessment that asks questions about your health-related activities and whether you have or had certain medical conditions (e.g. cancer, diabetes, or heart disease). You will also be asked to obtain a voluntary blood test for certain conditions (e.g. cholesterol). If you choose to participate, you will receive a reduction in your bi-weekly employee contribution. If you are unable to participate in any of the health-related activities of the LLW Incentive Program, you may qualify for a reasonable accommodation to earn the incentive. To request an accommodation, contact the Health Care & Benefits Division (HCBD) at (800) 287-8266, TTY (406) 444-1421, or email benefitsquestions@mt.gov.

The information collected from your health-related activities will be used to help you understand your current health and potential risks and to offer you services.

We are required by law to maintain the privacy and security of your personally identifiable health information. For more information, review the Plan's Notice of Practices at benefits.mt.gov/_docs/Resources/Notice-of-Privacy-Practices-10.2024.pdf.

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, 2025

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, 2025 (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, 2025
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.

Section 4
Eligibility and Participation

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 to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Medical Insurance Plan coverage, provided that the Employee certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Medical Insurance Plan coverage.

  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.

Carryover Amount means unused amounts, up to the maximum amount allowed by federal law for a carryover provision, remaining in a Participant's Health FSA at the end of a Plan Year. The Carryover Amount can be carried over and used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year. Any unused amount in excess of the maximum amount allowed by federal law for a carryover provision shall be forfeited.

Claims Filing Deadline means the last day of the fourth month following the end of the Plan Year in which the claims were incurred (i.e., April 30th immediately following the end of the Plan Year). All claims must be submitted by this deadline; any remaining funds that are unclaimed will be forfeited.

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, 2024. 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 the **Carryover Amount** 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 the **Carryover Amount.** If any balance equal to or less than the **Carryover Amount** 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 the **Claims Filing Deadline**, 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 the **Claims Filing Deadline**, 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 1-668-072-7783 (رقم هاتف الصم والبكم: 117).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-866-270-3877 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester 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 [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht 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).

State of Montana Non-Discrimination Notice

Non-Discrimination Statement: 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 you need these services, contact the Customer Care Center at 866-270-3877. If you believe 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 you can file a grievance. If you need help filing a grievance the State Diversity Coordinator, is available to help you. You can file a grievance in person or by mail, fax, or email:

State Diversity Program Coordinator
Department of Administration
State Human Resources Division
125 N. Roberts
P.O. Box 200127
Helena, MT 59620
Phone: (406) 444-3871
Email: SABHRSHR@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)