PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION

for the

MONTANA ASSOCIATION OF COUNTIES HEALTH CARE TRUST
(MACoHCT)

This booklet describes the Plan Benefits in effect as of December 1, 2023

Claims Processed By:

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
P.O. Box 1966
Missoula, MT 59806-1966

Missoula Area Phone Number: (406) 721-2222
Toll-Free Number: (888) 883-3233
# TABLE OF CONTENTS

**INTRODUCTION** ........................................................................................................... 1

**PARTICIPATING PROVIDER BENEFIT** ........................................................................... 2
  **NON-PARTICIPATING BENEFIT EXCEPTION** ............................................................. 2
  **CONTINUITY OF CARE** ............................................................................................ 2

**REVISED MEDICAL PLAN SCHEDULE OF BENEFITS** ............................................... 3

**BASIC MEDICAL PLAN SCHEDULE OF BENEFITS** ....................................................... 12

**HIGH DEDUCTIBLE HEALTH PLAN SCHEDULE OF BENEFITS** ................................ 21

**PHARMACY BENEFIT** ................................................................................................... 29
  **REVISED MEDICAL PLAN COST SHARING PROVISIONS** ....................................... 29
  **BASIC MEDICAL PLAN COST SHARING PROVISIONS** ............................................ 30
  **HIGH DEDUCTIBLE HEALTH PLAN COST SHARING PROVISIONS** ......................... 31
  **COVERAGE** ............................................................................................................. 31
  **SERVICE OPTIONS** ................................................................................................ 32
  **DRUG OPTIONS** ...................................................................................................... 32
  **COPAYMENT** .......................................................................................................... 33
  **PRIMARY COVERAGE UNDER ANOTHER PLAN** .................................................... 33
  **SUPPLY LIMITS** ..................................................................................................... 33
  **PRIOR AUTHORIZATION** ........................................................................................ 34
  **SPECIALTY PHARMACY COPAY ASSISTANCE PROGRAM** .................................... 34
  **EXCLUSIONS** ......................................................................................................... 34
  **NON-FORMULARY EXCLUSION** ............................................................................. 35

**SCHEDULE OF DENTAL BENEFITS** ............................................................................. 36

**SCHEDULE OF VISION BENEFITS** ............................................................................. 37

**MEDICAL BENEFIT DETERMINATION REQUIREMENTS** ............................................. 38
  **ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES** ............................................. 38
  **DEDUCTIBLE** .......................................................................................................... 38
  **NEW MEMBER GROUP OR SUB-ENTITY CARRYOVER** ........................................ 38
  **NEW GROUP EXTENDED BENEFIT PERIOD** .......................................................... 38
  **BENEFIT PERCENTAGE** ........................................................................................ 39
  **OUT-OF-POCKET MAXIMUM** .................................................................................. 39
  **MAXIMUM BENEFIT** .............................................................................................. 39
  **APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT** .................. 39
  **CHANGES IN COVERAGE CLASSIFICATION** ......................................................... 39
  **NEW YORK STATE EXPENSES** .............................................................................. 39

**MEDICAL BENEFITS** .................................................................................................... 40
  **ACUPUNCTURE TREATMENT** .................................................................................. 43
  **ADVANCED RADIOLOGY IMAGING** ......................................................................... 43
  **ALCOHOLISM AND/OR CHEMICAL DEPENDENCY** ................................................. 43
  **AMBULATORY SURGICAL CENTER** .......................................................................... 44
  **AUTISM SPECTRUM DISORDER BENEFIT** ............................................................ 44
  **BARIATRIC SURGERY BENEFIT** .............................................................................. 45
  **CHIROPRACTIC CARE** ........................................................................................... 46
  **COLONOSCOPY BENEFIT** ....................................................................................... 46
  **DENTAL SERVICES** ................................................................................................. 46
  **DIABETIC EDUCATION BENEFIT** .......................................................................... 47
<table>
<thead>
<tr>
<th>SERVICES</th>
<th>47</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIALYSIS TREATMENTS - OUTPATIENT</td>
<td>47</td>
</tr>
<tr>
<td>DIETICIAN SERVICES</td>
<td>48</td>
</tr>
<tr>
<td>EYE EXAMINATION FOR REFRACTORY CONDITIONS AND RETINAL SCREENING</td>
<td>48</td>
</tr>
<tr>
<td>GENDER IDENTITY DISORDER/GENDER DYSPHORIA SERVICES</td>
<td>48</td>
</tr>
<tr>
<td>HEARING AIDS AND EXAMINATION</td>
<td>48</td>
</tr>
<tr>
<td>HOME HEALTH CARE BENEFIT</td>
<td>48</td>
</tr>
<tr>
<td>HOSPICE CARE SERVICES</td>
<td>49</td>
</tr>
<tr>
<td>HOSPITAL SERVICES</td>
<td>49</td>
</tr>
<tr>
<td>INBORN ERRORS OF METABOLISM</td>
<td>50</td>
</tr>
<tr>
<td>INFUSION SERVICES - OUTPATIENT</td>
<td>50</td>
</tr>
<tr>
<td>MAMMOGRAM BENEFIT</td>
<td>50</td>
</tr>
<tr>
<td>MASSAGE THERAPY</td>
<td>50</td>
</tr>
<tr>
<td>MEDICAL EQUIPMENT/SUPPLIES</td>
<td>51</td>
</tr>
<tr>
<td>MENTAL ILLNESS</td>
<td>51</td>
</tr>
<tr>
<td>MORBID OBESITY ELIGIBLE EXPENSES</td>
<td>51</td>
</tr>
<tr>
<td>OCCUPATIONAL THERAPY - OUTPATIENT</td>
<td>52</td>
</tr>
<tr>
<td>ORGAN AND TISSUE TRANSPLANT SERVICES</td>
<td>53</td>
</tr>
<tr>
<td>PHYSICAL THERAPY - OUTPATIENT</td>
<td>53</td>
</tr>
<tr>
<td>PREVENTIVE CARE</td>
<td>53</td>
</tr>
<tr>
<td>PREVENTIVE/PROPHYLACTIC MASTECTOMY</td>
<td>54</td>
</tr>
<tr>
<td>PROPHYLACTIC OOPHORECTOMY/HYSTERECTOMY</td>
<td>54</td>
</tr>
<tr>
<td>RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT</td>
<td>55</td>
</tr>
<tr>
<td>REHABILITATION/CARDIAC THERAPY</td>
<td>55</td>
</tr>
<tr>
<td>RESIDENTIAL TREATMENT FACILITY</td>
<td>56</td>
</tr>
<tr>
<td>ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE</td>
<td>56</td>
</tr>
<tr>
<td>SKILLED NURSING FACILITY</td>
<td>57</td>
</tr>
<tr>
<td>SPEECH THERAPY - OUTPATIENT</td>
<td>57</td>
</tr>
<tr>
<td>SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES</td>
<td>57</td>
</tr>
<tr>
<td>SURGICAL PROCEDURES</td>
<td>58</td>
</tr>
<tr>
<td>URGENT CARE FACILITY</td>
<td>58</td>
</tr>
</tbody>
</table>

EXPERIMENTAL COVERAGE ........................................................ 59

MEDICAL EXPENSE AUDIT BONUS .................................................. 60

ACCIDENTAL INJURY BENEFIT ..................................................... 61

HOSPITAL ADMISSION CERTIFICATION ........................................ 62
| PRE-ADMISSION CERTIFICATION REVIEW | 62 |
| CONTINUED STAY CERTIFICATION | 62 |
| EMERGENCY NOTIFICATION/CERTIFICATION | 63 |
| CASE MANAGEMENT PROGRAM | 63 |
| MATERNITY NOTIFICATION | 63 |

PRE-TREATMENT REVIEW .......................................................... 64

MEDICAL BENEFIT EXCLUSIONS .................................................. 66

DENTAL BENEFIT DETERMINATION REQUIREMENTS .......................... 69
| ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES | 69 |
| DEDUCTIBLE AND BENEFIT PERCENTAGE | 69 |
| MAXIMUM BENEFIT PAYABLE | 69 |
| EXPENSES INCURRED | 69 |
| PREDETERMINATION OF BENEFITS | 69 |

DENTAL BENEFITS ........................................................................ 71
INTRODUCTION

MACoHCT Administration: (406) 443-8102
MACoHCT Claims: (888) 883-3233
www.mtcounties.org/hct

Effective December 1, 2023, Montana Association of Counties restates the benefits, rights and privileges which will pertain to Member Groups and Sub-Entities, their eligible Employees, Elected County Officials referred to as “Participants,” and the eligible Dependents of such Participants, as defined, and which benefits are provided through a trust established by the Plan Sponsor and referred to as the “Plan.” This booklet describes the Plan in effect as of December 1, 2023.

Coverage provided under this Plan for Employees 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.

Montana Association of Counties Health Care Trust (the Plan Sponsor) has retained the services of an independent Plan Supervisor, experienced in claims processing, to handle health claims. The Plan Supervisor for the Plan is:

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

Please read this booklet carefully before incurring any medical expenses. For specific questions regarding coverage or benefits, please refer to this Plan Document/Summary Plan Description which is available for review in the Personnel Office, at the office of the Plan Supervisor, or call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions concerning the Plan.

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

The information contained in this Plan Document/Summary Plan Description 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-certification or Pre-treatment Review by the Plan is strongly recommended for certain services. If Pre-certification or Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.
PARTICIPATING PROVIDER BENEFIT

This Plan provides benefits through a group of Participating Providers. Using Participating Providers offers cost-saving advantages because a Covered Person pays only a percentage of the scheduled fee for services provided.

A Covered Person who uses a Non-Participating Provider will pay more and may result in balance billing.

To determine if a provider qualifies as a Participating Provider under this Plan, please consult Allegiance’s website at [www.askallegiance.com](http://www.askallegiance.com) to access links for directories of Participating Providers.

The Benefit Percentages for benefits may vary depending on the type of service and provider rendering the service or treatment. If a Non-Participating Provider is chosen over a Participating Provider, the Benefit Percentage will be lower (as stated in the following Schedule of Medical Benefits), unless one of the Non-Participating Benefit Exceptions stated below applies.

NON-PARTICIPATING BENEFIT EXCEPTION

When a covered service is rendered by a Non-Participating Provider, charges will be paid as if the service were rendered by a Participating Provider under any of the following circumstances:

1. Charges for an Emergency, as defined by this Plan, limited to only those emergency medical procedures necessary to treat and stabilize an eligible Injury or Illness and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time to a Participating Hospital, clinic or other facility, or discharged.

2. Charges which are incurred as a result of and related to confinement in or use of a Participating Hospital, clinic or other facility only for Non-Participating Provider services and providers over whom or which the Covered Person does not have any choice in or ability to select.

3. Charges for Emergency use of an Air Ambulance.

CONTINUITY OF CARE

In the event a provider that a Covered Person is currently receiving services, treatment or care of an Illness or Injury for any of the following terminates its network affiliation, the Plan will pay the provider at the Participating Provider benefit level and allowable amount for a period of up to ninety (90) days after the date the provider terminates its Participating Provider affiliation:

1. Pregnancy in the second or third trimester or postpartum care;

2. Continuation of treatment for a chronic or acute medical condition;

3. Active care at an Inpatient facility;

4. A disabling, degenerative, congenital or life threatening Illness;

5. Ongoing treatment of a terminal illness or serious medical condition; or

6. A Mental Illness or Alcohol and/or Chemical Dependency condition.

To be eligible for this benefit, call the customer service number listed on the Participant’s identification card.
REVISED MEDICAL PLAN SCHEDULE OF BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

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

THE BENEFIT PERIOD IS A PERIOD FOR EACH MEMBER GROUP OR SUB-ENTITY AS DEFINED IN APPENDIX A

REVISED MEDICAL PLAN BENEFITS ARE SUBJECT TO THE DEDUCTIBLE, BENEFIT PERCENTAGE AND OUT-OF-POCKET MAXIMUM PROVISIONS OF THIS PLAN ACCORDING TO THE MEDICAL PLAN OPTION SELECTED BY EACH INDIVIDUAL MEMBER GROUP OR SUB-ENTITY.

### REVISED MAJOR MEDICAL PLAN OPTIONS

Plan Year, Benefit Period and Open Enrollment Period are defined in Appendix A for each Member Group or Sub-Entity

<table>
<thead>
<tr>
<th>Deductible (Embedded) per Covered Person / Family per Benefit Period</th>
<th>Benefit Percentage</th>
<th>Out-of-Pocket Maximum (Embedded) per Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500 / $1000</td>
<td>80%</td>
<td>$1500 / $3000</td>
</tr>
<tr>
<td>$1000 / $2000</td>
<td>80%</td>
<td>$3000 / $6000</td>
</tr>
<tr>
<td>$2000 / $4000</td>
<td>80%</td>
<td>$4000 / $8000</td>
</tr>
<tr>
<td>$1500 / $3000</td>
<td>80%</td>
<td>$3000 / $6000</td>
</tr>
<tr>
<td>$3000 / $6000</td>
<td>80%</td>
<td>$5000 / $10000</td>
</tr>
</tbody>
</table>

The Deductible applies to all benefits unless specifically indicated as waived. The Benefit Percentage applies after Deductible is satisfied and applies to all benefits unless specifically stated otherwise. After satisfaction of Out-of-Pocket Maximum the Benefit Percentage will be 100% for the remainder of the Benefit Period. Out-of-Pocket Maximum includes amounts applied toward the Deductible and Eligible Expenses in excess of the Benefit Percentage.

### TYPE OF SERVICE / LIMITATIONS

<table>
<thead>
<tr>
<th>BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM ALL PROVIDERS</th>
</tr>
</thead>
</table>

#### ACCIDENTAL INJURY BENEFIT

| 100%, Deductible Waived |

**Benefit Limits:** $500 Maximum Benefit per Accidental Injury. Expenses must be incurred within 90 days of the date of Accidental Injury.

#### ACUPUNCTURE TREATMENT

| 100%, Deductible Waived |

**Benefit Limits:** 25 Combined Maximum Number of Treatments per Benefit Period for Chiropractic Care, Acupuncture Treatment and Massage Therapy. Treatment includes all services provided during a calendar day.

PBME does not apply to Non-Participating Providers.
<table>
<thead>
<tr>
<th>TYPE OF SERVICE / LIMITATIONS</th>
<th>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>ALCOHOLISM AND/OR CHEMICAL DEPENDENCY</td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Facility Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Provider Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Office Visit Services first 3 per Benefit Period</td>
<td>100%, Deductible Waived*</td>
</tr>
<tr>
<td>Office Visit Services exceeding 3 per Benefit Period</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Inpatient Milieu Therapy</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>*The Deductible is waived only for those charges billed for the office visit evaluation and management services, which may include clinical management, therapy or counseling. The Deductible applies to all other charges.</td>
<td></td>
</tr>
<tr>
<td>ALLERGY TREATMENT (Includes diagnostic testing and injections)</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>AMBULANCE SERVICE</td>
<td></td>
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<tr>
<td>Air Ambulance (All Providers)</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Ground Ambulance (All Montana and Non-Montana Participating Providers)</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>AUTISM SPECTRUM DISORDER BENEFIT</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>BARIATRIC SURGERY</td>
<td>80% after Deductible</td>
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<tr>
<td>Benefits are available only if criteria is met. Please refer to the Bariatric Surgery Benefit for further details.</td>
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<tr>
<td>BIRTHING CENTER</td>
<td></td>
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<tr>
<td>Facility Services</td>
<td>80% after Deductible</td>
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<tr>
<td>Professional Provider Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>CARDIAC REHABILITATION THERAPY - INPATIENT AND OUTPATIENT</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>CHEMOTHERAPY - OUTPATIENT</td>
<td></td>
</tr>
<tr>
<td>Facility Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM ALL PROVIDERS</td>
<td></td>
</tr>
<tr>
<td>CHIROPRACTIC CARE</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Benefit Limits: 25 Combined Maximum Number of Treatments per Benefit Period for Chiropractic Care, Acupuncture Treatment and Massage Therapy. Treatment includes all services provided during a calendar day, except for x-rays. $50 Maximum Benefit per treatment.</td>
<td></td>
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<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
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<tr>
<td>CHIROPRACTIC X-RAYS</td>
<td>80%, Deductible Waived</td>
</tr>
<tr>
<td>Benefit Limits: $100 Maximum Benefit per Benefit Period</td>
<td></td>
</tr>
<tr>
<td>CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) MACHINE AND RELATED SUPPLIES</td>
<td>80%, Deductible Waived</td>
</tr>
<tr>
<td>COLONOSCOPY</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Routine Colonoscopy</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Colonoscopy</td>
<td></td>
</tr>
<tr>
<td>CONTRACEPTIVES (Including Contraceptive Management)</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Prescription Contraceptives Obtained Through County Health Department</td>
<td></td>
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<tr>
<td>Administered during Office Visit</td>
<td></td>
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<tr>
<td>See Pharmacy Benefit for details if obtained from a Pharmacy.</td>
<td></td>
</tr>
<tr>
<td>COVID-19 VACCINE</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>DENTAL SERVICES (Accidental Injury and medical conditions)</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>DEPARTMENT OF TRANSPORTATION (DOT) EXAMS</td>
<td>100% of billed charges, Deductible Waived</td>
</tr>
<tr>
<td>DIABETIC EDUCATION</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>DIABETIC BLOOD GLUCOSE MONITORS</td>
<td>80%, Deductible Waived</td>
</tr>
<tr>
<td>This benefit only includes the monitor itself and does not include the related supplies which are eligible under the Pharmacy Benefit, subject to the applicable Prescription Drug Deductible and Copayments.</td>
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</tr>
<tr>
<td>DIABETIC INSULIN PUMPS AND SUPPLIES</td>
<td>80%, Deductible Waived</td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
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<tr>
<td><strong>DIAGNOSTIC SERVICES - INPATIENT AND OUTPATIENT</strong></td>
<td></td>
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<tr>
<td>Facility and Professional Provider Services first $600 per Benefit Period</td>
<td>80%, Deductible Waived</td>
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<tr>
<td>Facility and Professional Provider Services exceeding $600 per Benefit Period</td>
<td>80% after Deductible</td>
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<tr>
<td><strong>DIALYSIS TREATMENTS - OUTPATIENT</strong></td>
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<td></td>
<td>80% after Deductible</td>
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<tr>
<td><strong>DIETICIAN SERVICES (Eligible for individuals diagnosed with Cancer)</strong></td>
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<td></td>
<td>100% after Deductible</td>
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<tr>
<td><strong>EMERGENCY ROOM SERVICES</strong></td>
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<td></td>
<td>80% after Deductible</td>
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<tr>
<td><strong>EYE EXAMINATION FOR REFRACTORY CONDITIONS AND RETINAL SCREENING</strong></td>
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<td></td>
<td>80% after Deductible</td>
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<tr>
<td>Benefit Limits: 1 Exam per Benefit Period</td>
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<tr>
<td><strong>HEARING AIDS AND EXAM BENEFIT</strong></td>
<td></td>
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<td></td>
<td>80%, Deductible Waived</td>
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<tr>
<td>Benefit Limits: $2,000 Maximum Benefit once every 5 Benefit Periods. Applies to all related charges, including repairs and replacements.</td>
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<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
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<tr>
<td><strong>HEARING SCREENING (Not otherwise covered under Preventive Care)</strong></td>
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<tr>
<td></td>
<td>No Benefit</td>
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<tr>
<td><strong>HOME HEALTH CARE</strong></td>
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<td></td>
<td>80% after Deductible</td>
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<tr>
<td><strong>HOSPICE CARE (Includes bereavement counseling provided as part of Hospice Care)</strong></td>
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<td></td>
<td>80% after Deductible</td>
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<tr>
<td><strong>HOSPITAL SERVICES</strong></td>
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<tr>
<td>Inpatient Facility Services</td>
<td>80% after Deductible</td>
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<tr>
<td>Inpatient Professional Provider Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Outpatient Professional Provider Services</td>
<td>80% after Deductible</td>
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<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
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<td>-----------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
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<tr>
<td>INFERTILITY SERVICES</td>
<td></td>
</tr>
<tr>
<td>Diagnostic testing to determine infertility</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td>No Benefit</td>
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<tr>
<td>INFUSION SERVICES - OUTPATIENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after Deductible</td>
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<tr>
<td>MAMMOGRAMS</td>
<td></td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Diagnostic Mammograms</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>MASSAGE THERAPY</td>
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<tr>
<td></td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td><strong>Benefit Limits</strong>: 25 Combined Maximum Number of Treatments per Benefit Period for Chiropractic Care, Acupuncture Treatment and Massage Therapy. Treatment includes all services provided during a calendar day.</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td>MEDICAL EQUIPMENT/SUPPLIES</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (other than Diabetic monitors, pumps and supplies)</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Prosthetic Appliances</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Orthopedic Devices</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Other Medical Supplies</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>MENTAL ILLNESS</td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Facility Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Provider Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Office Visit Services first 3 per Benefit Period</td>
<td>100%, Deductible Waived*</td>
</tr>
<tr>
<td>Office Visit Services exceeding 3 per Benefit Period</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>*The Deductible is waived only for those charges billed for the office visit evaluation and management services, which may include clinical management, therapy or counseling. The Deductible applies to all other charges.</td>
<td></td>
</tr>
<tr>
<td>NATUROPATHY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on Place of Service</td>
</tr>
</tbody>
</table>
## TYPE OF SERVICE / LIMITATIONS

<table>
<thead>
<tr>
<th>TYPE OF SERVICE / LIMITATIONS</th>
<th>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM ALL PROVIDERS</strong></td>
<td></td>
</tr>
</tbody>
</table>

### NON-AMBULANCE TRAVEL BENEFIT
- Benefits are payable up to $5,000 Maximum Lifetime Benefit, limited to the following:
  - Coach airfare.
  - If driving, IRS standard mileage rate reimbursement.
  - Meals limited to $50 per day per person.
  - Lodging not to exceed $125 per day.

This benefit is available to the patient and one companion, limited to travel to a contracted Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable).

### NUTRITIONAL COUNSELING (Only when related to Morbid Obesity and not otherwise covered under Preventive Care)
- 80% after Deductible

### OCCUPATIONAL THERAPY - OUTPATIENT
- 80% after Deductible

### OFFICE VISIT

<table>
<thead>
<tr>
<th>Primary Care Physician (PCP)</th>
<th>80%, Deductible Waived</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Care Physician (SCP)</td>
<td>80%, Deductible Waived</td>
</tr>
</tbody>
</table>

The Deductible is waived only for those charges billed for the office visit evaluation and management services performed in the physical presence of the provider in an office, clinic or other Outpatient setting which may include clinical management, history, examinations, medical decision making, counseling or coordination of care. The Deductible will apply to all other charges associated with the office visit.

### ORGAN AND TISSUE TRANSPLANT SERVICES (Limited to a Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable)
- 80% after Deductible

### ORTHOTICS (Foot)
- 80%, Deductible Waived

**Benefit Limits:** $400 Maximum Benefit every 3 Benefit Periods

PBME does not apply to Non-Participating Providers.

### PHYSICAL THERAPY - OUTPATIENT
- 80% after Deductible
<table>
<thead>
<tr>
<th>TYPE OF SERVICE / LIMITATIONS</th>
<th>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREGNANCY/MATERNITY SERVICES</td>
<td>See Preventive Care Benefit for well-women prenatal visits.</td>
</tr>
<tr>
<td>Office Visit (if not part of a global fee)</td>
<td>See Office Visit</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services (if billed as global fee)</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>PRESCRIPTION DRUGS</td>
<td>See Pharmacy Benefit for Details</td>
</tr>
<tr>
<td>PREVENTIVE CARE</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Covered Services:</td>
<td></td>
</tr>
<tr>
<td>♦ Well-Child Care</td>
<td></td>
</tr>
<tr>
<td>♦ Physical examinations</td>
<td></td>
</tr>
<tr>
<td>♦ Pelvic examination and pap smear</td>
<td></td>
</tr>
<tr>
<td>♦ Laboratory and testing</td>
<td></td>
</tr>
<tr>
<td>♦ Hearing and vision screening</td>
<td></td>
</tr>
<tr>
<td>♦ Mammogram</td>
<td></td>
</tr>
<tr>
<td>♦ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE)</td>
<td></td>
</tr>
<tr>
<td>♦ Cardiovascular screening blood tests</td>
<td></td>
</tr>
<tr>
<td>♦ Colorectal cancer screening tests</td>
<td></td>
</tr>
<tr>
<td>♦ Vaccinations and Immunizations recommended by Physician</td>
<td></td>
</tr>
<tr>
<td>♦ BRCA1 and BRCA2 when medically indicated</td>
<td></td>
</tr>
<tr>
<td>♦ Nutritional counseling</td>
<td></td>
</tr>
<tr>
<td>♦ Well Women Preventive Care subject to Plan limitations on sterilization procedures</td>
<td></td>
</tr>
<tr>
<td>♦ Tobacco cessation education up to 8 visits per Benefit Period</td>
<td></td>
</tr>
<tr>
<td>♦ Skin cancer screening</td>
<td></td>
</tr>
<tr>
<td>Complete list of recommended preventive services can be viewed at:</td>
<td></td>
</tr>
<tr>
<td><a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
<td></td>
</tr>
<tr>
<td>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 will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| PREVENTIVE/PROPHYLACTIC MASTECTOMY                                    |                                                                            |
| Inpatient Facility Services                                          | 80% after Deductible                                                      |
| Inpatient Professional Provider Services                             | 80% after Deductible                                                      |</p>
<table>
<thead>
<tr>
<th>TYPE OF SERVICE / LIMITATIONS</th>
<th>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTIVE/PROPHYLACTIC OOPHORECTOMY/HYSTERECTOMY</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Benefits are available only if criteria is met. Please refer to the Preventive/prophylactic Oophorectomy/Hysterectomy Benefit for further details.</td>
<td></td>
</tr>
<tr>
<td><strong>RADIATION THERAPY - OUTPATIENT</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>RESIDENTIAL TREATMENT FACILITY</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80%, Deductible Waived</td>
</tr>
<tr>
<td><strong>RESPIRATORY THERAPY - OUTPATIENT</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE</strong></td>
<td></td>
</tr>
<tr>
<td>(Applies until the earlier of the Newborn’s discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>SKILLED NURSING FACILITY</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>SPEECH THERAPY - OUTPATIENT</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>STERILIZATION PROCEDURES</strong></td>
<td></td>
</tr>
<tr>
<td>Female Sterilization Procedures</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>Based on place of service and type of provider</td>
</tr>
<tr>
<td><strong>SURGERY - OUTPATIENT</strong></td>
<td></td>
</tr>
<tr>
<td>Facility Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Benefit Limits:</strong> Maximum Benefit per Implant for the following:</td>
<td></td>
</tr>
<tr>
<td>$40,000 for Orthopedic Implants</td>
<td></td>
</tr>
<tr>
<td>$60,000 for Cardiac Implants (except for LVAD and RVAD)</td>
<td></td>
</tr>
<tr>
<td>$85,000 for Cochlear Implants</td>
<td></td>
</tr>
<tr>
<td>$200,000 for LVAD / RVAD Implants</td>
<td></td>
</tr>
<tr>
<td>Benefit limits apply to all providers.</td>
<td></td>
</tr>
<tr>
<td>Benefit limits apply to any implantable device and all supplies associated with that implantable device.</td>
<td></td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM ALL PROVIDERS</td>
<td></td>
</tr>
<tr>
<td>TELEMEDICINE</td>
<td>80%, Deductible Waived</td>
</tr>
<tr>
<td>For further details regardless Recuro Health consultations, please consult <a href="http://www.recursohealth.com">www.recursohealth.com</a> or call (855) 673-2876.</td>
<td></td>
</tr>
<tr>
<td>TMJ/JAW DISORDERS</td>
<td>No Benefit</td>
</tr>
<tr>
<td>URGENT CARE FACILITY</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>WEIGHT LOSS PROGRAMS (Commercial or franchise)</td>
<td>No Benefit</td>
</tr>
<tr>
<td>WIG (Loss of hair as a result of medical treatment or Alopecia)</td>
<td>80%, Deductible Waived</td>
</tr>
</tbody>
</table>
BASIC MEDICAL PLAN SCHEDULE OF BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

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

THE BENEFIT PERIOD IS A PERIOD FOR EACH MEMBER GROUP OR SUB-ENTITY AS DEFINED IN APPENDIX A

<table>
<thead>
<tr>
<th>BASIC MEDICAL PLAN OPTIONS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Dollar Benefit (Before Deductible)</td>
<td>Deductible (Embedded) per Covered Person / Family per Benefit Period</td>
<td>Benefit Percentage</td>
<td>Out-of-Pocket Maximum (Embedded) per Benefit Period</td>
</tr>
<tr>
<td>$300</td>
<td>Waived</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
<td>$2000 / $4000</td>
<td>70%</td>
<td>$4000 / $8000</td>
</tr>
</tbody>
</table>

Eligible Expenses that would otherwise be subject to the Deductible and/or Out-of-Pocket Maximum are payable at 100% under the First Dollar Benefit up to a maximum of $300 per Benefit Period. Once the first $300 of Eligible Expenses has been exhausted during the same Benefit Period, any remaining Eligible Expenses are subject to the Deductible and/or Out-of-Pocket Maximum. After satisfaction of the Deductible, any remaining Eligible Expenses are payable at the Benefit Percentage stated below. The amount payable by the Plan will not exceed any Maximum Benefit as stated in the Schedule of Medical Benefits, for any reason. Prescription drugs are not covered under this benefit.

Out-of-Pocket Maximum includes amounts applied toward the Deductible and Eligible Expenses in excess of the Benefit Percentage.

<table>
<thead>
<tr>
<th>COST SHARING PROVISIONS</th>
<th>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST DOLLAR BENEFIT (Before Deductible)</td>
<td></td>
</tr>
<tr>
<td>Eligible Expenses that would otherwise be subject to the Deductible and/or Out-of-Pocket Maximum are payable at 100% under the First Dollar Benefit up to a maximum of $300 per Benefit Period. Once the first $300 of Eligible Expenses has been exhausted during the same Benefit Period, any remaining Eligible Expenses are subject to the Deductible and/or Out-of-Pocket Maximum. After satisfaction of the Deductible, any remaining Eligible Expenses are payable at the Benefit Percentage stated below. The amount payable by the Plan will not exceed any Maximum Benefit as stated in the Schedule of Medical Benefits, for any reason. Prescription drugs are not covered under this benefit.</td>
<td></td>
</tr>
<tr>
<td>DEDUCTIBLE (Embedded)</td>
<td></td>
</tr>
<tr>
<td>Per Covered Person per Benefit Period</td>
<td>$2,000</td>
</tr>
<tr>
<td>Per Family per Benefit Period</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

The Deductible applies to all benefits unless specifically indicated as waived.
### Basic Medical Plan Schedule of Benefits

#### COST SHARING PROVISIONS

<table>
<thead>
<tr>
<th>BENEFIT PERCENTAGE</th>
<th>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before satisfaction of Out-of-Pocket Maximum</td>
<td>70%</td>
</tr>
<tr>
<td>After satisfaction of Out-of-Pocket Maximum</td>
<td>100%</td>
</tr>
</tbody>
</table>

The Benefit Percentage applies after Deductible is satisfied and applies to all benefits unless specifically stated otherwise.

#### OUT-OF-POCKET MAXIMUM (Embedded)

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefit Limit per Covered Person per Benefit Period</th>
<th>Benefit Limit per Family per Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,000</td>
<td>$8,000</td>
<td></td>
</tr>
</tbody>
</table>

Includes the Deductible and Eligible Expenses in excess of the Benefit Percentage.

#### TYPE OF SERVICE / LIMITATIONS

<table>
<thead>
<tr>
<th>TYPE OF SERVICE / LIMITATIONS</th>
<th>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCIDENTAL INJURY BENEFIT</td>
<td>100%, Deductible Waived</td>
</tr>
</tbody>
</table>

**Benefit Limits:** $300 Maximum Benefit per Accidental Injury. Expenses must be incurred within 90 days of the date of Accidental Injury.

**ACUPUNCTURE TREATMENT**

<table>
<thead>
<tr>
<th>Benefit Limits: 25 Combined Maximum Number of Treatments per Benefit Period for Chiropractic Care, Acupuncture Treatment and Massage Therapy. Treatment includes all services provided during a calendar day.</th>
</tr>
</thead>
</table>

**PBME does not apply to Non-Participating Providers.**

**ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)**

| Benefit Limit | 70% after Deductible |

**ALCOHOLISM AND/OR CHEMICAL DEPENDENCY**

| Inpatient and Outpatient Facility Services | 70% after Deductible |
| Inpatient and Outpatient Professional Provider Services | 70% after Deductible |
| Office Visit Services first 3 per Benefit Period | 100%, Deductible Waived* |
| Office Visit Services exceeding 3 per Benefit Period | 70% after Deductible |
| Inpatient Milieu Therapy | 70% after Deductible |

*The Deductible is waived only for those charges billed for the office visit evaluation and management services, which may include clinical management, therapy or counseling. The Deductible applies to all other charges.
<table>
<thead>
<tr>
<th>TYPE OF SERVICE / LIMITATIONS</th>
<th>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM ALL PROVIDERS</strong></td>
<td></td>
</tr>
<tr>
<td>ALLERGY TREATMENT (Includes diagnostic testing and injections)</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>AMBULANCE SERVICE</td>
<td></td>
</tr>
<tr>
<td>Air Ambulance (All Providers)</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Ground Ambulance (All Montana and Non-Montana Participating Providers)</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>AUTISM SPECTRUM DISORDER BENEFIT</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>BARIATRIC SURGERY</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Benefits are available only if criteria is met. Please refer to the Bariatric Surgery Benefit for further details.</td>
<td></td>
</tr>
<tr>
<td>BIRTHING CENTER</td>
<td></td>
</tr>
<tr>
<td>Facility Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>CARDIAC REHABILITATION THERAPY - INPATIENT AND OUTPATIENT</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>CHEMOTHERAPY - OUTPATIENT</td>
<td></td>
</tr>
<tr>
<td>Facility Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>CHIROPRACTIC CARE</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Benefit Limits: 25 Combined Maximum Number of Treatments per Benefit Period for Chiropractic Care, Acupuncture Treatment and Massage Therapy. Treatment includes all services provided during a calendar day, except for x-rays. $50 Maximum Benefit per treatment.</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td>CHIROPRACTIC X-RAYS</td>
<td>70%, Deductible Waived</td>
</tr>
<tr>
<td>Benefit Limits: $100 Maximum Benefit per Benefit Period</td>
<td></td>
</tr>
<tr>
<td>CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) MACHINE AND RELATED SUPPLIES</td>
<td>70%, Deductible Waived</td>
</tr>
<tr>
<td>COLONOSCOPY</td>
<td></td>
</tr>
<tr>
<td>Routine Colonoscopy</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Diagnostic Colonoscopy</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM ALL PROVIDERS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>CONTRACEPTIVES (Including Contraceptive Management)</strong></td>
<td></td>
</tr>
<tr>
<td>Prescription Contraceptives Obtained Through County Health Department</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Administered during Office Visit</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>See Pharmacy Benefit for details if obtained from a Pharmacy.</td>
<td></td>
</tr>
<tr>
<td><strong>COVID-19 VACCINE</strong></td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td><strong>DENTAL SERVICES (Accidental Injury and medical conditions)</strong></td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>DEPARTMENT OF TRANSPORTATION (DOT) EXAMS</strong></td>
<td>100% of billed charges, Deductible Waived</td>
</tr>
<tr>
<td><strong>DIABETIC EDUCATION</strong></td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td><strong>DIABETIC BLOOD GLUCOSE MONITORS</strong></td>
<td>70%, Deductible Waived</td>
</tr>
<tr>
<td>This benefit only includes the monitor itself and does not include the related supplies which are eligible under the Pharmacy Benefit, subject to the applicable Prescription Drug Deductible and Copayments.</td>
<td></td>
</tr>
<tr>
<td><strong>DIABETIC INSULIN PUMPS AND SUPPLIES</strong></td>
<td>70%, Deductible Waived</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC SERVICES - INPATIENT AND OUTPATIENT</strong></td>
<td>70%, Deductible Waived</td>
</tr>
<tr>
<td><strong>DIALYSIS TREATMENTS - OUTPATIENT</strong></td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>DIETICIAN SERVICES (Eligible for individuals diagnosed with Cancer)</strong></td>
<td>100% after Deductible</td>
</tr>
<tr>
<td><strong>EMERGENCY ROOM SERVICES</strong></td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>EYE EXAMINATION FOR REFRACTORY CONDITIONS AND RETINAL SCREENING</strong></td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>Benefit Limits:</strong> 1 Exam per Benefit Period</td>
<td></td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM ALL PROVIDERS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>HEARING AIDS AND EXAM BENEFIT</strong></td>
<td>70%, Deductible Waived</td>
</tr>
<tr>
<td>Benefit Limits: $2,000 Maximum Benefit once every 5 Benefit Periods. Applies to all related charges, including repairs and replacements.</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td><strong>HEARING SCREENING (Not otherwise covered under Preventive Care)</strong></td>
<td>No Benefit</td>
</tr>
<tr>
<td><strong>HOME HEALTH CARE</strong></td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>HOSPICE CARE (Includes bereavement counseling provided as part of Hospice Care)</strong></td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>HOSPITAL SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Outpatient Professional Provider Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>INFERTILITY SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnostic testing to determine infertility</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td>No Benefit</td>
</tr>
<tr>
<td><strong>INFUSION SERVICES - OUTPATIENT</strong></td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>MAMMOGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Diagnostic Mammograms</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td><strong>MASSAGE THERAPY</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Benefit Limits: 25 Combined Maximum Number of Treatments per Benefit Period for Chiropractic Care, Acupuncture Treatment and Massage Therapy. Treatment includes all services provided during a calendar day.</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
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</tr>
<tr>
<td>--------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>MEDICAL EQUIPMENT/SUPPLIES</strong></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (other than Diabetic monitors, pumps and supplies)</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Prosthetic Appliances</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Orthopedic Devices</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Other Medical Supplies</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>MENTAL ILLNESS</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Facility Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Provider Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Office Visit Services first 3 per Benefit Period</td>
<td>100%, Deductible Waived*</td>
</tr>
<tr>
<td>Office Visit Services exceeding 3 per Benefit Period</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>*The Deductible is waived only for those charges billed for the office visit evaluation and management services, which may include clinical management, therapy or counseling. The Deductible applies to all other charges.</td>
<td></td>
</tr>
<tr>
<td><strong>NATUROPATHY</strong></td>
<td></td>
</tr>
<tr>
<td>Based on Place of Service</td>
<td></td>
</tr>
<tr>
<td><strong>NON-AMBULANCE TRAVEL BENEFIT</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits are payable up to $5,000 Maximum Lifetime Benefit, limited to the following:</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Coach airfare.</td>
<td></td>
</tr>
<tr>
<td>If driving, IRS standard mileage rate reimbursement.</td>
<td></td>
</tr>
<tr>
<td>Meals limited to $50 per day per person.</td>
<td></td>
</tr>
<tr>
<td>Lodging not to exceed $125 per day.</td>
<td></td>
</tr>
<tr>
<td>This benefit is available to the patient and one companion, limited to travel to a contracted Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable).</td>
<td></td>
</tr>
<tr>
<td><strong>NUTRITIONAL COUNSELING (Only when related to Morbid Obesity and not otherwise covered under Preventive Care)</strong></td>
<td>70% after Deductible</td>
</tr>
<tr>
<td><strong>OCCUPATIONAL THERAPY - OUTPATIENT</strong></td>
<td></td>
</tr>
<tr>
<td>70% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>OFFICE VISIT</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Specialty Care Physician (SCP)</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM ALL PROVIDERS</strong></td>
<td></td>
</tr>
<tr>
<td>ORGAN AND TISSUE TRANSPLANT SERVICES (Limited to a Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable)</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>ORTHOTICS (Foot)</td>
<td>70%, Deductible Waived</td>
</tr>
<tr>
<td>Benefit Limits: $400 Maximum Benefit every 3 Benefit Periods</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td>PHYSICAL THERAPY - OUTPATIENT</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>PREGNANCY/MATERNITY SERVICES</td>
<td>See Preventive Care Benefit for well-women prenatal visits.</td>
</tr>
<tr>
<td>Office Visit (if not part of a global fee)</td>
<td>See Office Visit</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services (if billed as global fee)</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>PRESCRIPTION DRUGS</td>
<td>See Pharmacy Benefit for Details</td>
</tr>
</tbody>
</table>
## Basic Medical Plan Schedule of Benefits

<table>
<thead>
<tr>
<th>Type of Service / Limitations</th>
<th>Benefit Percentage for All Montana and Non-Montana Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>100%, Deductible Waived</td>
</tr>
</tbody>
</table>

### Covered Services:
- Well-Child Care
- Physical examinations
- Pelvic examination and pap smear
- Laboratory and testing
- Hearing and vision screening
- Mammogram
- Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE)
- Cardiovascular screening blood tests
- Colorectal cancer screening tests
- Vaccinations and Immunizations recommended by Physician
- BRCA1 and BRCA2 when medically indicated
- Nutritional counseling
- Well Women Preventive Care subject to Plan limitations on sterilization procedures
- Tobacco cessation education up to 8 visits per Benefit Period
- Skin cancer screening

Complete list of recommended preventive services can be viewed at: [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

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

### Preventive/Prophylactic Mastectomy

<table>
<thead>
<tr>
<th>Inpatient Facility Services</th>
<th>70% after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>70% after Deductible</td>
</tr>
</tbody>
</table>

### Preventive/Prophylactic Oophorectomy/Hysterectomy

<table>
<thead>
<tr>
<th>Inpatient Facility Services</th>
<th>70% after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>70% after Deductible</td>
</tr>
</tbody>
</table>

Benefits are available only if criteria is met. Please refer to the Preventive/prophylactic Oophorectomy/Hysterectomy Benefit for further details.

### Radiation Therapy - Outpatient

<table>
<thead>
<tr>
<th></th>
<th>70% after Deductible</th>
</tr>
</thead>
</table>

### Residential Treatment Facility

<table>
<thead>
<tr>
<th></th>
<th>70%, Deductible Waived</th>
</tr>
</thead>
</table>

### Respiratory Therapy - Outpatient

<table>
<thead>
<tr>
<th></th>
<th>70% after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>(Applies until the earlier of the Newborn’s discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.)</td>
<td></td>
</tr>
<tr>
<td>SKILLED NURSING FACILITY</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>SPEECH THERAPY - OUTPATIENT</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>STERILIZATION PROCEDURES</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Female Sterilization Procedures</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>Based on place of service and type of provider</td>
</tr>
<tr>
<td>SURGERY - OUTPATIENT</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Facility Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: Maximum Benefit per Implant for the following:</td>
<td></td>
</tr>
<tr>
<td>$40,000 for Orthopedic Implants</td>
<td></td>
</tr>
<tr>
<td>$60,000 for Cardiac Implants (except for LVAD and RVAD)</td>
<td></td>
</tr>
<tr>
<td>$85,000 for Cochlear Implants</td>
<td></td>
</tr>
<tr>
<td>$200,000 for LVAD / RVAD Implants</td>
<td></td>
</tr>
<tr>
<td>Benefit limits apply to all providers.</td>
<td></td>
</tr>
<tr>
<td>Benefit limits apply to any implantable device and all supplies associated with that implantable device.</td>
<td></td>
</tr>
<tr>
<td>TELEMEDICINE</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>For further details regardless Recuro Health consultations, please consult <a href="http://www.recurohealth.com">www.recurohealth.com</a> or call (855) 673-2876.</td>
<td></td>
</tr>
<tr>
<td>TMJ/JAW DISORDERS</td>
<td>No Benefit</td>
</tr>
<tr>
<td>URGENT CARE FACILITY</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>WEIGHT LOSS PROGRAMS (Commercial or franchise)</td>
<td>No Benefit</td>
</tr>
<tr>
<td>WIG (Loss of hair as a result of medical treatment or Alopecia)</td>
<td>70%, Deductible Waived</td>
</tr>
</tbody>
</table>
HIGH DEDUCTIBLE HEALTH PLAN SCHEDULE OF BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

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

THE BENEFIT PERIOD IS A PERIOD FOR EACH MEMBER GROUP OR SUB-ENTITY AS DEFINED IN APPENDIX A

HIGH DEDUCTIBLE HEALTH PLAN BENEFITS ARE SUBJECT TO THE DEDUCTIBLE, BENEFIT PERCENTAGE AND OUT-OF-POCKET MAXIMUM PROVISIONS OF THIS PLAN ACCORDING TO THE MEDICAL PLAN OPTION SELECTED BY EACH INDIVIDUAL MEMBER GROUP OR SUB-ENTITY.

<table>
<thead>
<tr>
<th>HIGH DEDUCTIBLE HEALTH PLAN OPTIONS</th>
<th>Benefit Limits are for Services Received from All Providers</th>
<th>Benefit Percentage for All Montana and Non-Montana Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (Embedded) per Covered Person / Family per Benefit Period</td>
<td>Benefit Percentage</td>
<td>Out-of-Pocket Maximum (Embedded) per Benefit Period</td>
</tr>
<tr>
<td>$3000 / $6000</td>
<td>100%</td>
<td>$3000 / $6000</td>
</tr>
<tr>
<td>$4000 / $8000</td>
<td>100%</td>
<td>$4000 / $8000</td>
</tr>
<tr>
<td>$5000 / $10000</td>
<td>100%</td>
<td>$5000 / $10000</td>
</tr>
<tr>
<td>$6000 / $12000</td>
<td>100%</td>
<td>$6000 / $12000</td>
</tr>
<tr>
<td>$7000 / $14000</td>
<td>100%</td>
<td>$7000 / $14000</td>
</tr>
</tbody>
</table>

The Deductible applies to all benefits unless specifically indicated as waived. The Benefit Percentage applies after Deductible is satisfied and applies to all benefits unless specifically stated otherwise. After satisfaction of Out-of-Pocket Maximum the Benefit Percentage will be 100% for the remainder of the Benefit Period. Out-of-Pocket Maximum includes amounts applied toward the Deductible and Eligible Expenses in excess of the Benefit Percentage.

<table>
<thead>
<tr>
<th>TYPE OF SERVICE / LIMITATIONS</th>
<th>BENEFIT LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCIDENTAL INJURY BENEFIT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: $500 Maximum Benefit per Accidental Injury. Expenses must be incurred within 90 days of the date of Accidental Injury.</td>
<td></td>
</tr>
<tr>
<td>ACUPUNCTURE TREATMENT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: 25 Combined Maximum Number of Treatments per Benefit Period for Chiropractic Care, Acupuncture Treatment and Massage Therapy. Treatment includes all services provided during a calendar day.</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>ALCOHOLISM AND/OR CHEMICAL DEPENDENCY</td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Office Visit Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Inpatient Milieu Therapy</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>ALLERGY TREATMENT (Includes diagnostic testing and injections)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>AMBULANCE SERVICE</td>
<td></td>
</tr>
<tr>
<td>Air Ambulance (All Providers)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Ground Ambulance (All Montana and Non-Montana Participating Providers)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>AUTISM SPECTRUM DISORDER BENEFIT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>BARIATRIC SURGERY</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefits are available only if criteria is met. Please refer to the Bariatric Surgery Benefit for further details.</td>
<td></td>
</tr>
<tr>
<td>BIRTHING CENTER</td>
<td></td>
</tr>
<tr>
<td>Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>CARDIAC REHABILITATION THERAPY - INPATIENT AND OUTPATIENT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>CHEMOTHERAPY - OUTPATIENT</td>
<td></td>
</tr>
<tr>
<td>Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>CHIROPRACTIC CARE</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: 25 Combined Maximum Number of Treatments per Benefit Period for Chiropractic Care, Acupuncture Treatment and Massage Therapy. Treatment includes all services provided during a calendar day, except for x-rays. $50 Maximum Benefit per treatment.</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CHIROPRACTIC X-RAYS</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: $100 Maximum Benefit per Benefit Period</td>
<td></td>
</tr>
<tr>
<td>CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) MACHINE AND RELATED SUPPLIES</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>COLONOSCOPY</td>
<td></td>
</tr>
<tr>
<td>Routine Colonoscopy</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Diagnostic Colonoscopy</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>CONTRACEPTIVES (Including Contraceptive Management)</td>
<td></td>
</tr>
<tr>
<td>Prescription Contraceptives Obtained Through County Health Department</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Administered during Office Visit</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>See Pharmacy Benefit for details if obtained from a Pharmacy.</td>
<td></td>
</tr>
<tr>
<td>COVID-19 VACCINE</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>DENTAL SERVICES (Accidental Injury and medical conditions)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>DEPARTMENT OF TRANSPORTATION (DOT) EXAMS</td>
<td>100% of billed charges, Deductible Waived</td>
</tr>
<tr>
<td>DIABETIC EDUCATION</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>DIABETIC BLOOD GLUCOSE MONITORS</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>This benefit only includes the monitor itself and does not include the related supplies which are eligible under the Pharmacy Benefit, subject to the applicable Prescription Drug Deductible and Copayments.</td>
<td></td>
</tr>
<tr>
<td>DIABETIC INSULIN PUMPS AND SUPPLIES</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>DIAGNOSTIC SERVICES - INPATIENT AND OUTPATIENT</td>
<td></td>
</tr>
<tr>
<td>Facility and Professional Provider Services first $600 per Benefit Period</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Facility and Professional Provider Services exceeding $600 per Benefit Period</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>DIALYSIS TREATMENTS - OUTPATIENT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>DIETICIAN SERVICES (Eligible for individuals diagnosed with Cancer)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>EMERGENCY ROOM SERVICES</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>EYE EXAMINATION FOR REFRACTORY CONDITIONS AND RETINAL SCREENING</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: 1 Exam per Benefit Period</td>
<td></td>
</tr>
<tr>
<td>HEARING AIDS AND EXAM BENEFIT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: $2,000 Maximum Benefit once every 5 Benefit Periods. Applies to all related charges, including repairs and replacements.</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td>HEARING SCREENING (Not otherwise covered under Preventive Care)</td>
<td>No Benefit</td>
</tr>
<tr>
<td>HOME HEALTH CARE</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>HOSPICE CARE (Includes bereavement counseling provided as part of Hospice Care)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>HOSPITAL SERVICES</td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Outpatient Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>INFERTILITY SERVICES</td>
<td></td>
</tr>
<tr>
<td>Diagnostic testing to determine infertility</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td>No Benefit</td>
</tr>
<tr>
<td>INFUSION SERVICES - OUTPATIENT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>MAMMOGRAMS</td>
<td></td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Diagnostic Mammograms</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MASSAGE THERAPY</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: 25 Combined Maximum Number of Treatments per Benefit Period for Chiropractic Care, Acupuncture Treatment and Massage Therapy. Treatment includes all services provided during a calendar day.</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td>MEDICAL EQUIPMENT/SUPPLIES</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (other than Diabetic monitors, pumps and supplies)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Prosthetic Appliances</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Orthopedic Devices</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Other Medical Supplies</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>MENTAL ILLNESS</td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Office Visit Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>NATUROPATHY</td>
<td></td>
</tr>
<tr>
<td>NON-AMBULANCE TRAVEL BENEFIT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefits are payable up to $5,000 Maximum Lifetime Benefit, limited to the following:</td>
<td></td>
</tr>
<tr>
<td>Coach airfare.</td>
<td></td>
</tr>
<tr>
<td>If driving, IRS standard mileage rate reimbursement.</td>
<td></td>
</tr>
<tr>
<td>Meals limited to $50 per day per person.</td>
<td></td>
</tr>
<tr>
<td>Lodging not to exceed $125 per day.</td>
<td></td>
</tr>
<tr>
<td>This benefit is available to the patient and one companion, limited to travel to a contracted Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable).</td>
<td></td>
</tr>
<tr>
<td>NUTRITIONAL COUNSELING (Only when related to Morbid Obesity and not otherwise covered under Preventive Care)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>OCCUPATIONAL THERAPY - OUTPATIENT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>OFFICE VISIT</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Specialty Care Physician (SCP)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>ORGAN AND TISSUE TRANSPLANT SERVICES (Limited to a Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>ORTHOTICS (Foot)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: $400 Maximum Benefit every 3 Benefit Periods</td>
<td></td>
</tr>
<tr>
<td>PBME does not apply to Non-Participating Providers.</td>
<td></td>
</tr>
<tr>
<td>PHYSICAL THERAPY - OUTPATIENT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>PREGNANCY/MATERNITY SERVICES See Preventive Care Benefit for well-women prenatal visits.</td>
<td></td>
</tr>
<tr>
<td>Office Visit (if not part of a global fee)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services (if billed as global fee)</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>PRESCRIPTION DRUGS</td>
<td>See Pharmacy Benefit for Details</td>
</tr>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>PREVENTIVE CARE</strong></td>
<td>100%, Deductible Waived</td>
</tr>
</tbody>
</table>

**Covered Services:**
- Well-Child Care
- Physical examinations
- Pelvic examination and pap smear
- Laboratory and testing
- Hearing and vision screening
- Mammogram
- Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE)
- Cardiovascular screening blood tests
- Colorectal cancer screening tests
- Vaccinations and Immunizations recommended by Physician
- BRCA1 and BRCA2 when medically indicated
- Nutritional counseling
- Well Women Preventive Care subject to Plan limitations on sterilization procedures
- Tobacco cessation education up to 8 visits per Benefit Period
- Skin cancer screening

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

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

<table>
<thead>
<tr>
<th><strong>PREVENTIVE/PROPHYLACTIC MASTECTOMY</strong></th>
<th>100% after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PREVENTIVE/PROPHYLACTIC OOPHORECTOMY/HYSTERECTOMY</strong></th>
<th>100% after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Inpatient Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
</tbody>
</table>

Benefits are available only if criteria is met. Please refer to the Preventive/prophylactic Oophorectomy/Hysterectomy Benefit for further details.

<table>
<thead>
<tr>
<th><strong>RADIATION THERAPY - OUTPATIENT</strong></th>
<th>100% after Deductible</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>RESIDENTIAL TREATMENT FACILITY</strong></th>
<th>100% after Deductible</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>RESPIRATORY THERAPY - OUTPATIENT</strong></th>
<th>100% after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF SERVICE / LIMITATIONS</td>
<td>BENEFIT PERCENTAGE FOR ALL MONTANA AND NON-MONTANA PARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>(Applies until the earlier of the Newborn’s discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.)</td>
<td></td>
</tr>
<tr>
<td>SKILLED NURSING FACILITY</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>SPEECH THERAPY - OUTPATIENT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>STERILIZATION PROCEDURES</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>Female Sterilization Procedures</td>
<td>Based on place of service and type of provider</td>
</tr>
<tr>
<td>Vasectomy</td>
<td></td>
</tr>
<tr>
<td>SURGERY - OUTPATIENT</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Facility Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>Benefit Limits: Maximum Benefit per Implant for the following:</td>
<td></td>
</tr>
<tr>
<td>$40,000 for Orthopedic Implants</td>
<td></td>
</tr>
<tr>
<td>$60,000 for Cardiac Implants (except for LVAD and RVAD)</td>
<td></td>
</tr>
<tr>
<td>$85,000 for Cochlear Implants</td>
<td></td>
</tr>
<tr>
<td>$200,000 for LVAD / RVAD Implants</td>
<td></td>
</tr>
<tr>
<td>Benefit limits apply to all providers.</td>
<td></td>
</tr>
<tr>
<td>Benefit limits apply to any implantable device and all supplies associated with that implantable device.</td>
<td></td>
</tr>
<tr>
<td>TELEMEDICINE</td>
<td>100%, Deductible Waived</td>
</tr>
<tr>
<td>For further details regardless Recuro Health consultations, please consult <a href="http://www.recurohealth.com">www.recurohealth.com</a> or call (855) 673-2876.</td>
<td></td>
</tr>
<tr>
<td>TMJ/JAW DISORDERS</td>
<td>No Benefit</td>
</tr>
<tr>
<td>URGENT CARE FACILITY</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td>WEIGHT LOSS PROGRAMS (Commercial or franchise)</td>
<td>No Benefit</td>
</tr>
<tr>
<td>WIG (Loss of hair as a result of medical treatment or Alopecia)</td>
<td>100% after Deductible</td>
</tr>
</tbody>
</table>
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 Pharmacy Benefit Manager (PBM) will provide separate information for details regarding Network pharmacies, Preferred Brand prescriptions and Specialty Drugs upon enrollment for coverage under this Plan.

If the Physician authorizes a generic drug and the Covered Person requests a Preferred or Non-Preferred Brand, the Covered Person must pay the difference as well as the Copayment amount.

REVISED MEDICAL PLAN COST SHARING PROVISIONS

Pharmacy Deductible per Benefit Period

| Per Covered Person | $50 |

Pharmacy Deductible applies to all prescription drug charges payable through the Plan’s PBM unless specifically indicated as waived. After satisfaction of the Pharmacy Deductible, Pharmacy Copayments apply as stated in this section.

Pharmacy Out-of-Pocket Maximum per Benefit Period

| Per Covered Person | $1,550 |

Out-of-Pocket Maximum includes the Pharmacy Deductible and any applicable Pharmacy Copayments. Pharmacy Benefits are payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum for the remainder of the Benefit Period.

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Retail PBM Network 30-Day Supply</th>
<th>Retail PBM Network or Mail Order 90-Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$25</td>
<td>$62.50</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$50</td>
<td>$125</td>
</tr>
<tr>
<td>Specialty</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Patient Assurant Program (PAP)</td>
<td>$25</td>
<td>$62.50</td>
</tr>
</tbody>
</table>

Note: A current list of eligible insulin products under the PAP can be obtained by contacting the PBM at the number listed on the Participant’s identification care.

The following are payable at 100% and are not subject to any Deductible or Copayment:

1. Prescribed generic contraceptives or brand if generic is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider;
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 Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/; and
4. Colonoscopy bowel preparation products prescribed by a Physician or Licensed Health Care Provider.
BASIC MEDICAL PLAN COST SHARING PROVISIONS

Medical Benefit applies to claims for prescriptions. Once the Medical Deductible is satisfied, claims for prescriptions will be subject to the Medical Benefit Percentage of the contract cost until satisfaction of the Medical Out-of-Pocket Maximum. After satisfaction of the Medical Out-of-Pocket Maximum, claims for prescriptions will be reimbursed at 100% of the contract cost for the remainder of the Benefit Period for Retail and Mail Order prescriptions. Reimbursements will not exceed the contract cost.

<table>
<thead>
<tr>
<th>Prescriptions may be purchased at a discounted rate from network pharmacies.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail PBM Network 30-Day Supply</strong></td>
</tr>
<tr>
<td>Patient Assurant Program (PAP) $25 Copayment</td>
</tr>
</tbody>
</table>

Note: A current list of eligible insulin products under the PAP can be obtained by contacting the PBM at the number listed on the Participant’s identification care.

The following are payable at 100% and are not subject to any Deductible or Copayment:

1. Prescribed generic contraceptives or brand if generic is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider;
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 Affordable Care Act which can be viewed at: [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/); and
4. Colonoscopy bowel preparation products prescribed by a Physician or Licensed Health Care Provider.
HIGH DEDUCTIBLE HEALTH PLAN COST SHARING PROVISIONS

Medical Benefit applies to claims for prescriptions. Once the Medical Deductible is satisfied, claims for prescriptions will be subject to the Medical Benefit Percentage of the contract cost until satisfaction of the Medical Out-of-Pocket Maximum. After satisfaction of the Medical Out-of-Pocket Maximum, claims for prescriptions will be reimbursed at 100% of the contract cost for the remainder of the Benefit Period for Retail and Mail Order prescriptions. Reimbursements will not exceed the contract cost.

| DISCOUNT PHARMACY PLAN COMBINED WITH MEDICAL PLAN.  
Medical Deductible and Benefit Percentage Applies |
| Prescriptions may be purchased at a discounted rate from network pharmacies. |
| | |
| Retail PBM Network 30-Day Supply | Retail PBM Network or Mail Order 90-Day Supply |
| Patient Assurant Program (PAP) $25 Copayment | Patient Assurant Program (PAP) $75 Copayment |

Note: A current list of eligible insulin products under the PAP can be obtained by contacting the PBM at the number listed on the Participant’s identification care.

The following are payable at 100% and are not subject to any Deductible or Copayment:

1. Prescribed generic contraceptives or brand if generic is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider;
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 Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/; and
4. Colonoscopy bowel preparation products prescribed by a Physician or Licensed Health Care Provider.

COVERAGE

Coverage for prescription drugs will include only 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. Self-administered contraceptives and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider. **Contraceptive Management, injectable contraceptives and contraceptive devices are covered under the Preventive Care Benefit of this Plan. Self-administered and injectable contraceptives can be obtained at a Montana County Health Department and re reimbursable under the Medical Plan.**
2. Legend vitamins (oral only): Hematopoietic agents used to treat anemia.
3. Legend pediatric fluoride(oral only) through nineteen (19) years of age.
4. Diabetic supplies, including syringes, needles, swabs, blood test strips, blood glucose calibration solutions, urine tests, lancets and lancet devices.
5. Smoking deterrents prescribed by a Physician or Licensed Health Care Provider and only if covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.
6. 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 Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

7. Colonoscopy bowel preparation products prescribed by a Physician or Licensed Health Care Provider.

8. Compounded prescriptions containing at least one ingredient that is a Federal Legend Drug. Compounded prescriptions exceeding $300 require prior authorization.

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 will bill the Plan directly for that 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 cannot be used because a pharmacy is not part of the PBM Network, or the prescription identification card is not used at a PBM pharmacy. Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the Pharmacy Benefit Manager (PBM), along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM’s discounted cost of the prescription drug. Reimbursement will 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 pharmacy will bill the Plan directly for prescription costs that exceed the Copayment.

**Specialty Drug(s):** 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 must 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:

**Generic:** Those drugs and supplies listed in the most current edition of the Physicians Desk Reference or by the PBM Program as generic drugs.

**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.
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 do apply towards the applicable Pharmacy Out-of-Pocket Maximum and after satisfaction of the Out-of-Pocket Maximum, Copayments will no longer apply for the remainder of the Benefit Period.

PRIMARY COVERAGE UNDER ANOTHER PLAN

When primary coverage exists under another Plan, including Medicare Part D, charges for prescription drugs may be reimbursed by the Plan as specifically stated in this section, subject to the following conditions:

1. Charges for prescription drugs must be submitted to the primary carrier first.

2. The prescription drug receipt and explanation of benefits from primary carrier showing the total charges and amounts paid for eligible prescription drugs, along with a reimbursement form must be submitted to MACoHCT Claims Office. This Plan will reimburse the Participant for the remainder of Eligible Expenses subject to the Copayments stated in this section.

3. The pharmacy indicates either generic or brand on the prescription drug receipt.

4. The primary coverage information has been previously submitted to the Plan.

Charges for prescription drugs are not eligible if the above conditions are not met.

SUPPLY LIMITS

Supply is limited to thirty (30) days for Retail PBM Network and ninety (90) days for Retail PBM Network or Mail Order Prescriptions. Supply is limited to thirty (30) days for all oncology prescriptions for Retail PBM Network and Mail Order.

The following Prescriptions are limited as stated:

<table>
<thead>
<tr>
<th>Type of Medication</th>
<th>Supply Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate-Release (IR) Opioid Products (new utilizers)</td>
<td>Coverage limited up to 7 days for patients who are new to therapy (based on history of an opioid prescription).</td>
</tr>
<tr>
<td>Extended-Release (ER) Opioid Products (new utilizers)</td>
<td>An immediate-release product must be utilized before an extended release product will be covered.</td>
</tr>
<tr>
<td>Extended-Release and Immediate-Release Opioid Products (new/existing utilizers)</td>
<td>Coverage limited up to 90 morphine milligram equivalents (MME) per day.</td>
</tr>
</tbody>
</table>

Opioid Product Supply Limits: Coverage is limited up to 90 morphine milligram equivalents (MME) per day (based on a 30- or 90-day supply) and may accumulate across opioid products to help avoid duplicate therapy and high doses.

If a patient is taking more than one opioid product, the limit may be exceeded even if the quantity of each individual product is less than the limit. If a prescriber decides that different quantity of medication is right for the patient, a prior authorization may be requested by contacting CVS Caremark.
Note: Opioid pain medications used to treat cancer pain are not subject to quantity limits noted above.

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.

PRIOR AUTHORIZATION

Certain drugs require approval before the drug can be dispensed. A current list of drugs that require Prior Authorization can be obtained by contacting the PBM at the number listed on the Participant’s identification card.

SPECIALTY PHARMACY COPAY ASSISTANCE PROGRAM

Specialty Non-EHB Drugs are those prescription drugs that have been designated by the Pharmacy Benefit Manager, Express Scripts, as “Specialty Non-EHB Drugs” and are therefore covered by the special rules of the SaveOnSP program (the “Program”). The Plan has implemented a specialty pharmacy copay assistance program that applies to prescription drug coverage under all coverages except the High Deductible Health Plans (HDHPs). Certain specialty pharmacy drugs are considered non-essential health benefits under our non-HDHP coverages and the cost of such drugs does not apply toward satisfying the Deductible or Out-of-Pocket Maximum for those coverages. In addition, the Copayment for such drugs is intended to be set to the maximum amount that the applicable manufacturer offers in copay assistance. The Program is designed with the intent that the Covered Person may apply for reimbursement for the entire Copayment cost from the manufacturer, which is expected to result in no cost to the Covered Person. If the Covered Person chooses not to participate in the Program and submit the necessary manufacturer reimbursement applications, the Covered Person will bear the full Copayment cost for such drugs. A list of Specialty Non-EHB Drugs can be obtained by calling SaveOnSP at (800) 683-1074.

EXCLUSIONS

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

1. Cosmetic only indications including, but not limited to, photo-aged skin products (Renova); hair growth or hair removal agents (Propecia, Vaniqa); and injectable Cosmetics (Botox Cosmetic).
2. Dermatology: Agents used in the treatment of acne and/or for Cosmetic purposes for Covered Persons twenty-six (26) years or older or depigmentation products used for skin conditions requiring a bleaching agent.
3. Legend homeopathic drugs.
4. Fertility agents, oral, vaginal and injectable.
5. Impotence treatments.
6. Weight management.**
7. Allergens.
8. Serums, toxoids and vaccines.
9. Legend vitamins and legend fluoride products, except as specifically covered.
10. Over-the-counter equivalents and non-legend medications (OTC), except as specifically covered.
11. Durable Medical Equipment.*
12. Experimental or Investigational drugs.

13. Growth hormones. **

14. Diabetic pumps and pump supplies.*

15. Abortifacient drugs.

16. Compounded pharmaceuticals containing bulk chemicals.

17. Gene therapy and all gene therapy medications.*

18. COVID-19 home tests.

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

**Eligible for coverage subject to review for Medical Necessity.

NON-FORMULARY EXCLUSION

Certain drugs may be excluded by the Plan’s Pharmacy Benefit Manager (PBM). Those exclusions are based upon the PBM’s clinical research regarding the efficacy of the drug as compared to other similar drugs, the availability of the drug, and clinical prescribing rules. Drugs excluded under this basis may be covered if a request for Prior Authorization is made, or if a denial of coverage for the drug is appealed under the claims and appeals procedures of this Plan.
SCHEDULE OF DENTAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND LIMITATIONS

THE BENEFIT PERIOD IS A PERIOD FOR EACH MEMBER GROUP OR SUB-ENTITY AS DEFINED IN APPENDIX A

DEDUCTIBLE

Deductible Per Covered Person per Benefit Period ........................................ $25

DENTAL EXPENSES

Type A (Preventive Care) Dental Expenses
Deductible ........................................................................................................... Applies
Benefit Percentage ........................................................................................... 100%

Type B (Basic Care) Dental Expenses
Deductible ........................................................................................................... Applies
Benefit Percentage ........................................................................................... 80%

Type C (Major Restorative) Dental Expenses
Deductible ........................................................................................................... Applies
Benefit Percentage ........................................................................................... 50%

Orthodontic Treatment (up to nineteen (19) years of age only)
Deductible ........................................................................................................... Applies
Benefit Percentage ........................................................................................... 50%

MAXIMUM BENEFIT PER BENEFIT PERIOD PER COVERED PERSON (Type A, B and C) ... $ 1,600

MAXIMUM LIFETIME BENEFIT ORTHODONTIC TREATMENT PER COVERED PERSON ...... $1,000
SCHEDULE OF VISION BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

THE BENEFIT PERIOD IS A PERIOD FOR EACH MEMBER GROUP OR SUB-ENTITY AS DEFINED IN APPENDIX A

DEDUCTIBLE

Deductible Per Covered Person per Benefit Period ................................................. None

BENEFIT PERCENTAGE .............................. 100% of Eligible Expenses up to the Maximum Benefit

VISION EXAMINATION (applicable for spectacle lenses or contacts lenses)
Exam limited to one exam per Benefit Period, up to Maximum Benefit .................. $100

MATERIALS
Limited to one pair of glasses (frames and lenses) or contact lenses, but not both, per Benefit Period
Maximum Benefit ................................................................. $350
MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

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

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider; and

2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary; and

3. Charges do not exceed the Eligible Expense of the Plan; and

4. They are not excluded under any provision or section of this Plan.

Treatments, services or supplies excluded by this Plan may be reimbursable if such charges are approved by MACoHCT 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 MACoHCT, are more cost effective than a covered treatment, service or supply for the same Illness or Injury, and which benefit the Covered Person.

DEDUCTIBLE

The Deductible is stated in the Schedule of Medical Benefits and applies to Eligible Expenses Incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period. Also, if members of a Family have satisfied individual Deductible amounts that collectively equal the Deductible per Family, as stated in the Schedule of Medical Benefits, during the same Benefit Period, no further Deductible will apply to any member of that Family during that Benefit Period. An individual Covered Person cannot receive credit toward the Family Deductible for more than the Individual Deductible as stated in the Schedule of Medical Benefits.

NEW MEMBER GROUP OR SUB-ENTITY CARRYOVER

This Plan will be a continuum for a new Member Group or Sub-Entity whose benefit period under the prior health benefit plan or insurance coverage commences earlier than the renewal period under this Plan, as approved by MACoHCT. In such circumstances, charges which accumulated toward satisfying the Deductible, coinsurance or Out-of-Pocket Maximum under the prior health benefit plan or insurance coverage of the Member Group or Sub-Entity during the Benefit Period in which the Member Group or Sub-Entity became effective under this Plan, will apply towards satisfaction of the Medical Deductible and Out-of-Pocket Maximum for the Medical Plan Option selected by the Member Group or Sub-Entity during the same Benefit Period. Credits will be given only upon receipt of documented proof of such full or partial satisfaction of Deductible or Out-of-Pocket Maximum under the prior health benefit plan or insurance coverage. However, such credit of Deductible or Out-of-Pocket Maximum will not exceed the Medical Deductible and Out-of-Pocket Maximum Option selected by the Member Group or Sub-Entity under this Plan.

NEW GROUP EXTENDED BENEFIT PERIOD

Only if approved by MACoHCT, the Benefit Period may be extended or reduced for those Member Groups or Sub-Entities who commence participation earlier or later than either standard renewal period of this Plan. In such circumstances, the Benefit Period will be extended or reduced by the number of months beginning on the date participation commences and ending on the last day of the applicable standard renewal period. The Medical Deductible, Out-of-Pocket Maximum and any of the Plan’s benefit limits will be extended or reduced through this period. This will not apply to the Pharmacy Deductible and Out-of-Pocket Maximum.
BENEFIT PERCENTAGE

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

OUT-OF-POCKET MAXIMUM

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

MAXIMUM BENEFIT

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

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

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

CHANGES IN COVERAGE CLASSIFICATION

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

NEW YORK STATE EXPENSES

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

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

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

1. Charges for services and supplies furnished by a Birthing Center.

2. Charges for the services of a licensed Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.

   Charges are eligible for drugs intended for use in a Physicians’ office or settings other than home use that are billed during the course of an evaluation or management encounter. However, specifically identified oral or injectable drugs, except for contraceptives, that can be self-administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit Manager’s Specialty Pharmacy. These drugs are excluded from coverage under Medical Benefits. The list of drugs can be obtained from the Plan Supervisor.

3. Charges for Pregnancy or maternity, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy. The Plan also provides a maternity management service that assists in early identification, intervention and management of Pregnancy at no additional cost to Employees and their covered Dependents. For additional information on this service, call Allegiance Maternity Management at (877) 792-7827 or MACoHCT Claims at (888) 883-3233.

4. Charges for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) or Licensed Vocational Nurses (LVNs) for private duty nursing.

5. Charges for midwife services by a Certified Nurse Midwife (CNM) who is a Registered Nurse and enrolled in either the certification maintenance program or the continuing competency assessment program through the American College of Nurse Midwives (ACNM).

6. Charges for Ambulance Service to the nearest facility where Emergency care or treatment can be rendered; or from one facility to another for care; or from a facility to the patient’s home when Medically Necessary.

7. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs not available through the Pharmacy Benefit regardless of Medical Necessity and FDA approved over-the-counter female contraceptives prescribed by a Physician or Licensed Health Care Provider. However, specifically identified oral or injectable drugs, except for contraceptives, that can be self-administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit Manager’s Specialty Pharmacy. These drugs are excluded from coverage under Medical Benefits. The list of drugs can be obtained from the Plan Supervisor.

   Conditions of coverage for Outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Pharmacy Benefit section of the Plan.

8. Charges for x-rays and laboratory tests.
9. Charges for radiation therapy or treatment and chemotherapy. However, any oral or injectable drug, except for contraceptives, that can be administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit, unless there is a documented medical reason for administration of the drug in an office or outpatient setting.

10. Charges for blood transfusions, blood processing costs, blood transport charges, blood handling charges, administration charges, and the cost of blood, plasma and blood derivatives. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Eligible Expense. Charges for autologous blood storage are not covered unless blood is used during surgery.

11. Charges for oxygen and other gases and their administration.

12. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.

13. Charges for the cost and administration of an anesthetic.

14. Charges for voluntary vasectomy for Participants and Dependent spouse only. Charges for sterilization procedures for females are covered under the Preventive Care Benefit.

15. Reasonable charges for producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Charges that exceed limits for such charges imposed by applicable law will not be deemed to be reasonable.


17. Charges for naturopathy including office visits and laboratory services performed or ordered by a licensed naturopath. However, charges for herbal and vitamin supplements are specifically excluded.

18. Charges for wigs if hair loss is due to medical treatment or Alopecia.

19. Charges for allergy treatment, including office visit, diagnostic testing and injections.

20. Charges for respiratory therapy or pulmonary therapy.

21. Charges for Orthotics that are custom made or custom fitted and made of rigid or semi-rigid material. **Benefit maximums apply as stated in the Schedule of Medical Benefits.**

22. Charges for Routine Patient Costs for a Phase I Approved Clinical Trial for Qualified Individuals.

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

Routine Patient Costs do not include any investigational item, device, or service that is part of the Approved Clinical Trial; an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; a service that is clearly inconsistent with widely accepted and established standards of care for the individual’s diagnosis; or an item or service customarily provided and paid for by the sponsor of an Approved Clinical Trial.
“Approved Clinical Trial” means a Phase I clinical trial that is conducted in relation to the prevention, detection, or treatment of an acutely life-threatening disease state and is not designed exclusively to test toxicity or disease pathophysiology. The Approved Clinical Trial must be:

A. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;

B. Exempt from obtaining an investigational new drug application; or

C. Approved or funded by:

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

2) A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;

3) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or

4) The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:

a) Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

b) Provide unbiased scientific review by individuals who have no interest in the outcome of the review.

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

23. Charges for services that are related to or as a result of Telemedicine, but limited to the following methods:

A. An interactive patient encounter between the Physician or Licensed Health Care Provider being consulted and the patient. This method requires a “live” two way video and audio transmission between the patient and the Physician or Licensed Health Care Provider, and may include one additional provider who is presenting the patient to a specialist for an opinion regarding the patient’s condition.

B. Storing and forwarding medical documentation to a licensed Radiologist or Pathologist for the purpose of reviewing telecommunicated medical documentation at a time which is convenient to the Radiologist or Pathologist’s schedule. This method does not require actual contact between the patient and the provider.

Expenses billed for the use of equipment or transmission charges to transmit the audiovisual information are not covered.

Telemedicine does not include charges for teleconsultations, which involves a practitioner seeking advice from a consultant concerning a patient’s condition or course of treatment.

24. Charges for the initial purchase of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary surgical procedure to the eye, cataract surgery or for aphakic patients, soft lenses or sclera shells intended for use as corneal bandages.
25. Charges for an abortion, only if carrying the fetus to full term would seriously endanger the life of the mother. However, abortion services in any jurisdiction where the services are illegal by the law of that jurisdiction are excluded regardless.


27. Charges for gene therapy.

28. Charges for Department of Transportation (DOT) examinations. Charges are payable as specifically stated in the applicable Schedule of Benefits.

**ACUPUNCTURE TREATMENT**

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

Coverage under this benefit includes charges for acupuncture treatment provided by a legally qualified provider practicing within the scope of his or her license.

**ADVANCED RADIOLOGY IMAGING**

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

**ALCOHOLISM AND/OR CHEMICAL DEPENDENCY**

Coverage under this benefit includes charges for the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary treatment including, but not limited to, group therapy.

2. Well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.

3. Inpatient or Partial Hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.

4. Medically Necessary treatment, including aftercare, at an Alcoholism and/or Chemical Dependency Treatment Facility.

5. Charges for Milieu Therapy. Milieu Therapy means residential, therapeutic, experiential treatment on an Inpatient basis. Coverage includes charges for Milieu therapy provided all of the following conditions are met:

   A. Treatment is done on an Inpatient basis for Alcoholism and Chemical Dependency Treatment;

   B. Covered Person is at least twelve (12) years of age and under nineteen (19) years of age;

   C. Milieu Therapy treatment must be subsequent to an Inpatient stay for Chemical Dependency;

   D. Must have exhausted all other conservative treatment prior to Milieu Therapy.
AMBULATORY SURGICAL CENTER

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

AUTISM SPECTRUM DISORDER BENEFIT

Charges under this benefit are payable as specifically stated in the Schedule of Benefits. Coverage is provided to a child who is diagnosed with one of the following disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic Disorder;
2. Aspergers Disorder; or
3. Pervasive Developmental Disorder not otherwise specified.

Coverage includes any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician or Psychologist licensed in this state 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, 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.

Coverage includes the following specific services:

1. Habilitative or rehabilitative care that is prescribed, provided, ordered by a licensed Physician or licensed Psychologist 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 child. Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including Applied Behavior Analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

   “Applied Behavior Analysis” means discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention, which can only be provided by an individual who is licensed by the Behavior Analyst Certification Board or is certified by the Montana Department of Public Health and Human Services as a family support specialist with an Autism endorsement.

2. Medications prescribed by a Physician;
3. Psychiatric or Psychological care; and
4. Therapeutic care that is provided by a Speech-Language Pathologist, Audiologist, Occupational Therapist, or Physical Therapist.

The Plan may require a treatment plan from the treating Physician every six (6) months. The treatment plan must be based on evidence-based screening criteria. The treatment plan must contain a diagnosis, proposed treatment by type and frequency, anticipated duration of treatment, anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary.
BARIATRIC SURGERY BENEFIT

Coverage includes charges for Bariatric Surgery only when surgery has been authorized by the Plan. Request for authorization must include:

1. Recommendation from the attending Physician for bariatric surgery; and

2. Medical records from the attending Physician for the twelve (12) month period prior to authorization for surgery, which must include documentation of active participation in a weight loss program for at least six (6) consecutive months within the twelve months prior to authorization for surgery and at least three (3) office visits specifically relating to weight loss during the six (6) month period; and

3. A nutritional and mental evaluation and approval for bariatric surgery from the bariatric facility; and


Coverage under this benefit includes charges for bariatric surgery, including Gastric Bypass Surgery (Roux-en-Y), Gastric Sleeve Surgery (Vertical Sleeve Gastrectomy) or other medical policy standard technique, directly related pre-surgical assessment and or counseling, directly related post-surgical follow-up care and complications as a result of bariatric surgery.

Bariatric Surgery is considered Medical Necessary for the treatment of clinically severe obesity for selected adults (18 years and older) who meet the following criteria:

1. Body Mass Index (BMI) of greater than or equal to 40 kg/meter squared OR a BMI greater than or equal to 35 kg/meters squared with at least one of the following co-morbid conditions that are generally expected to be reversed or improved by bariatric treatment:
   
   A. Hypertension
   B. Dyslipidemia
   C. Insulin dependent or oral medication dependent diabetes
   D. Coronary heart disease
   E. Sleep apnea
   F. Severe Musculoskeletal dysfunction
   G. Gastric Esophageal Reflux Disorder
   H. Cardiomyopathy
   I. Pickwickian syndrome

2. A documented two-year history of morbid obesity that meets the above criteria. When medical records are requested, a letter of support and/or explanation is helpful but alone will not be considered sufficient documentation to make a Medical Necessity determination.

3. The patient must have actively participated in a documented weight loss program which has been directed and monitored by a Physician for a minimum of six (6) consecutive months within the twelve (12) consecutive months prior to application requesting coverage for bariatric surgery.

4. The patient must undergo and successfully complete a pre-surgical evaluation and participate in a post-operative follow-up. The patient must receive a positive assessment of surgery risk-benefit from all evaluating staff members of the pre-surgery program.

Body Mass Index (BMI) is calculated by dividing a person’s weight (in kilograms) by his/her height squared (in meters).
Charges incurred for weight reduction, weight loss, the treatment of obesity and the treatment of clinically severe obesity are excluded for the following:

1. Except covered under Morbid Obesity Eligible Expenses, non-surgical treatment of weight gain, weight reduction or weight maintenance including, but not limited to, vitamins or food supplements.

2. Bariatric surgery procedures that are not considered Medically Necessary or that are not listed above.

3. Any charges for which all of the conditions of the Bariatric Surgery Benefit of this Plan have not been met.

4. Any redo or revision of a prior bariatric surgical procedure, unless the indication for surgery is to treat or manage a diagnosis or condition unrelated to further weight loss.

5. A second bariatric surgical procedure, whether or not the first procedure was performed while covered under this Plan or not. This exclusion does not apply to adjustments that are Medically Necessary following bariatric surgery.

CHIROPRACTIC CARE

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

Coverage under this benefit includes charges for chiropractic Treatment by a legally qualified chiropractor practicing within the scope of his or her license. Services include office visits, spinal adjustments and radiology for diagnosis, evaluation and treatment planning for musculoskeletal conditions. Services are excluded for Emergency care, Preventive Care, maintenance care of a stable condition without symptomatic complaints and radiology for therapeutic purposes.

COLONOSCOPY BENEFIT

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

DENTAL SERVICES

Coverage includes charges for dental care and treatment, including the services of an oral surgeon or licensed Dentist and eligible Hospital services, provided such services are rendered for the following conditions:

1. Excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination;

2. Surgical procedures required to correct accidental injuries to teeth and the jaw, including the initial repair or replacement of such damaged teeth. Such expenses must be incurred within six (6) months from the date of the accident, except in the event that it is medically impossible 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;

3. Excision of exostoses of the jaws and hard palate;

4. Treatment of fractures of the facial bones;

5. Excision of accessory sinuses, salivary glands and ducts; or

6. Reductions, dislocations and excisions of the temporomandibular joint.
7. Medically Necessary corrective treatments for birth defects including cleft palate and cleft lip.

Hospital Eligible Expenses Incurred in conjunction with covered oral surgery will be payable on the same basis as any other claim.

This Plan will be primary for any charges covered under this Plan that may also be covered under the Dental Benefits covered under this Plan.

DIABETIC EDUCATION BENEFIT

Coverage under this benefit includes diabetic Outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes. A family member who will be the primary care giver may attend the training on behalf of the Covered Person with diabetes.

DIAGNOSTIC SERVICES INPATIENT AND OUTPATIENT SERVICES

Coverage under this benefit includes the following services when ordered by a Physician or Licensed Health Care Provider for the investigation of an Illness or Injury, regardless of where such services are rendered, including inpatient and outpatient Hospital services:

1. Diagnostic testing;
2. X-rays; and
3. Laboratory and tissue diagnostic examinations including, but not limited to, electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.

DIALYSIS TREATMENTS - OUTPATIENT

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

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

1. Notify Plan Administrator when diagnosed with ESRD by the attending Physician.
2. Notify Plan Administrator if or when beginning to receive dialysis treatments.
3. Enroll in Medicare Parts A and B and use a provider that accepts Medicare patients to prevent the Covered Person from being billed for amounts in excess of the benefit amounts stated above.
4. Failure to use a provider that accepts Medicare patients may result in significant costs to the Covered Person for fees that will not be covered by the Plan.
5. Medicare Part A or Part B 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. This means that the Plan will only pay the amount that Medicare would not have covered, even if the Covered Person does not elect to be covered under Medicare.

Pre-treatment Review is required for Outpatient Renal Dialysis. Failure to obtain Pre-treatment Review may result in significant out-of-pocket expenses not covered by the Plan.
DIETICIAN SERVICES

Coverage under this benefit includes charges for prescribed treatment rendered by a registered dietician for individuals diagnosed with cancer. Such treatment must be ordered by a Physician as Medically Necessary.

EYE EXAMINATION FOR REFRACTORY CONDITIONS AND RETINAL SCREENING

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

Coverage includes charges for an eye examination for refractory conditions and retinal screening.

GENDER IDENTITY DISORDER/GENDER DYSPHORIA SERVICES

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

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

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

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

HEARING AIDS AND EXAMINATION

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

Coverage includes charges in connection with the fitting and purchase of hearing aids, including hearing examinations, hearing aids and related services and supplies. Services must be rendered by a licensed audiologist. Charges for batteries are excluded.

HOME HEALTH CARE BENEFIT

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

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

Home Health Care specifically excludes the following:

1. Services and supplies not included in the approved Home Health Care Plan.
2. Services of a person who ordinarily resides in the home of the Covered Person.
3. Services of any medical social services.
4. Transportation services.
5. Housekeeping services.
6. Custodial Care.
7. "Meals on Wheels" or any other food arrangements.
8. Services for Mental Illness.
9. Services provided in a Skilled Nursing Facility or nursing home.

HOSPICE CARE SERVICES

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

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services.
2. Nursing care by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), a public health nurse who is under the direct supervision of a Registered Nurse.
3. Physical Therapy and Speech Therapy, when rendered by a licensed therapist.
4. Medical supplies, including drugs and biologicals and the use of medical appliances.
5. Physician's services.
6. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
7. Bereavement counseling provided as part of a Hospice Care.

HOSPITAL SERVICES

Coverage includes charges made by a Hospital for:

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

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

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

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

INFUSION SERVICES - OUTPATIENT

Coverage includes charges for home and Outpatient infusion services ordered by a Physician and provided by a Home and Outpatient Infusion Therapy Organization licensed and approved within the state in which the services are provided. Home and Outpatient infusion therapy services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a Home and Outpatient Infusion Therapy Organization. Services also include education for the Covered Person, the Covered Person’s care giver, or a family member. Home and Outpatient infusion therapy services include pharmacy, supplies, equipment and skilled nursing services when billed by a Home and Outpatient Infusion Therapy Organization.

Skilled nursing services billed by a Home Health Care Agency are covered under the Home Health Care Benefit.

A "Home and Outpatient Infusion Therapy Organization" is a health care facility that provides home and Outpatient infusion therapy services and skilled nursing services.

MAMMOGRAM BENEFIT

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

MASSAGE THERAPY

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

Coverage under this benefit includes charges for massage therapy provided by a legally qualified massage therapist practicing within the scope of his or her license.
**MEDICAL EQUIPMENT/SUPPLIES**

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

1. Rental, up to the purchase price, of a wheelchair, Hospital bed, respirator or other Durable Medical Equipment required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less. If there is a known medical reason to rent rather than purchase Durable Medical Equipment, then rental is allowed up to the purchase price.

2. Purchase of Orthopedic Devices or Prosthetic Appliances including, but not limited to, artificial limbs, eyes, larynx.

3. Replacement or repair of Durable Medical Equipment, Orthopedic Devices, Prosthetic Appliances.

4. Medical supplies such as dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies.

   Diabetic supplies are only eligible for coverage as stated under the Pharmacy Benefit of this Plan. Diabetic blood glucose monitors and diabetic insulin pumps are eligible as Durable Medical Equipment.

5. Adhesive tape, bandages, antiseptics or other over-the-counter first aid supplies only upon prior approval of the Plan. Approval will be based on guidelines of cost effectiveness and Medical Necessary treatment of an Illness or Injury as determined by MACoHCT.

**MENTAL ILLNESS**

Coverage under this benefit includes charges for the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment including, but not limited to, group therapy.

2. Well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.

3. Inpatient or Partial Hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.


**MORBID OBESITY ELIGIBLE EXPENSES**

Coverage is available for the medical management treatment of Morbid Obesity when all of the following conditions are met:

1. Treatment of Morbid Obesity requires Pre-treatment Review by the Plan. Request for Pre-treatment Review must include a treatment plan proposed by the provider that includes the individual’s height, weight and BMI on the date treatment begins, the goal weight and medical records indicating the Covered Person’s willingness to cooperate in managing their obesity (i.e., following a diet, taking prescribed medications); and

2. The Covered Person meets one of the following criteria:

   A. Has a Body Mass Index (BMI) of 30 or greater; or
B. Has a Body Mass Index (BMI) of 27 to 29 combined with at least one of the following comorbid conditions:

1) Sleep apnea;
2) Pickwickian syndrome;
3) Congestive heart failure;
4) Cardiomyopathy;
5) Insulin dependent diabetes;
6) Severe Musculoskeletal dysfunction;
7) Dyslipidema; or
8) Hypertension.

3. Charges incurred for gastric bypass, stomach stapling, gastroplasty and similar surgical procedures regardless of the diagnosis, except as specifically covered under the "Bariatric Surgery Benefit".

Coverage under this benefit includes charges for treatment of Morbid Obesity for the following services:

1. Licensed Health Care Providers including, but not limited to, dieticians.
2. Prescription Drugs that are FDA approved for the management of weight loss due to Morbid Obesity.
3. Nutritional counseling.
4. Office visits and associated lab work ordered by the provider.

“Morbid Obesity” is defined as a body mass index (BMI) of 30 or above. BMI is calculated by dividing a person's weight (kilograms) by his or her height squared (in meters).

The treatment plan and goals will be subject to review at least every six (6) months from the date of the initial approval and more often if deemed necessary by MACoHCT. In order for benefits to continue, a weight loss of 24-48 pounds, which is equivalent to a weight loss of 1-2 pounds per week, must be documented. Weight loss of less than 24 pounds will result in termination of benefits for medical management weight loss.

After the Covered Person has reached the specified goal weight recorded in the treatment plan, benefits will no longer be provided for maintenance or follow-up programs, even if weight is gained after initial goal weight has been reached. It will be the responsibility of the Covered Person to notify the MACoHCT Claims Office when goal weight is achieved at which time the medical records will be reviewed. The treatment plan and goals will be reviewed in six (6) month intervals from the date of the initial approval. If the Covered Person is not meeting the criteria stated above for benefits to continue, benefits for the medical management of their Morbid Obesity will no longer be covered by the Plan.

The following services or charges are specifically excluded from coverage under this Plan:

1. Treatment of weight gain, weight reduction or weight maintenance except for treatment of Morbid Obesity as defined by this Plan.
2. Commercial or franchise weight loss programs.
3. Gastric bypass, stomach stapling, gastroplasty and similar surgical procedures regardless of the diagnosis, except as specifically covered under the Bariatric Surgery Benefit.

OCCUPATIONAL THERAPY - OUTPATIENT

Coverage includes charges for Occupational Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Occupational Therapy must be rendered by a licensed occupational therapist.
ORGAN AND TISSUE TRANSPLANT SERVICES

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

1. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician’s findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

2. If the donor is covered under this Plan, Eligible Expenses Incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient’s plan.

3. If the recipient is covered under this Plan, Eligible Expenses Incurred by the recipient will be considered for benefits. Eligible Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, will be considered for payment to the extent that such expenses are not payable by the donor’s plan. In no event will benefits be payable in excess of the benefit limits still available to the recipient.

4. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.

5. The cost of securing an organ from a cadaver or tissue bank, including the surgeon’s charge for removal of the organ and a Hospital’s charge for storage or transportation of the organ, will be considered for payment.

PHYSICAL THERAPY - OUTPATIENT

Coverage includes charges for Physical Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Physical Therapy must be rendered by a licensed physical therapist.

PREVENTIVE CARE

Charges are payable as specifically stated in the Schedule of Medical Benefits for Preventive Care.

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

1. Routine Wellness care for children and adults for the following:
   A. Routine physical examinations by a Physician or Licensed Health Care Provider, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician or Licensed Health Care Provider and associated routine testing provided or ordered at the time of the examination; and
   B. Routine immunizations according to the schedule of immunizations which is recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention.

2. Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE).

3. Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.
4. Office visit charges only if the primary purpose of the office visit is to obtain a recommended Preventive Care service identified above.

5. Women’s Preventive Care for the following:
   A. Well-women annual visits for women 18 years of age and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits as medically appropriate.
   B. Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
   C. Human papillomavirus (HPV) DNA testing.
   D. Annual counseling on sexually transmitted infections (STI) and human immune-deficiency virus (HIV) screening for all sexually active women.
   E. All Food and Drug Administration approved prescription contraceptives and female over-the-counter contraceptives when prescribed by a Physician or Licensed Health Care Provider, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Self-administered contraceptives are available only through the Pharmacy Benefit as outlined in the Pharmacy Benefit section of this Plan.
   F. Breast feeding support, supplies, and counseling, including comprehensive lactation support and counseling by a trained provider during Pregnancy and/or in the postpartum period, and costs for breast feeding equipment and related supplies.
   G. Annual screening and counseling for interpersonal and domestic violence.

6. Skin cancer screening.

Expenses payable under this Preventive Care Benefit will not be subject to the Medical Necessity provisions of this Plan. Charges for Preventive Care that involve excessive, unnecessary or duplicate tests are specifically excluded.

Charges for treatment of an active Illness or Injury are subject to the Plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

PREVENTIVE/PROPHYLACTIC MASTECTOMY

Coverage includes charges for a preventive/prophylactic mastectomy if the preventive/prophylactic mastectomy is medically indicated based upon an independent medical review.

PROPHYLACTIC OOPHORECTOMY/HYSTERECTOMY

Charges for the following services are payable the same as if services were Medically Necessary, subject to the applicable criteria.

1. A prophylactic bilateral oophorectomy for a women who meets one of the following criteria:
   A. Has a personal history of breast cancer, which is estrogen receptor positive and/or progesterone receptor positive and who is premenopausal; or
   B. Has a BRCA 1 or BRCA 2 mutation or Lynch syndrome II mutation; or
Medical Benefits

C. Has two or more first degree relatives or one first degree relative and one or more second degree relative with a history of ovarian cancer.

2. A prophylactic hysterectomy only when performed in conjunction with an oophorectomy for a woman who meets one of the following criteria:
   A. Has Lynch Syndrome II Mutation;
   B. Meets one of the criteria for a prophylactic bilateral oophorectomy and who, after risk/benefit discussion with their Physician, chooses to have a prophylactic hysterectomy in conjunction with an oophorectomy.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

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

1. Reconstruction of the breast(s) upon which the mastectomy was performed, including implants;

2. Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants;

3. Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry.

Specifically excluded from this benefit are expenses for the following:

1. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;

2. Breast augmentation procedures unrelated to producing a symmetrical appearance;

3. Implants for the non-affected breast unrelated to producing a symmetrical appearance;

4. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

REHABILITATION/CARDIAC THERAPY

Coverage includes charges for Rehabilitation/Cardiac Therapy. Rehabilitation/Cardiac Therapy will be payable as follows if the treatment is necessary to improve or restore bodily function and such therapy is ordered and prescribed by a Physician. Rehabilitation/Cardiac Therapy services are subject to periodic review by the claims processor:

1. Outpatient benefits include:
   A. Therapy services provided while the Covered Person is not a registered bed patient of a rehabilitation unit;
   B. Services of a licensed psychologist, registered physical therapist or licensed occupational therapist;
C. Services of a legally qualified speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders. The Plan will provide benefits for Speech Therapy when all of the following criteria are met:

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

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

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

2. Inpatient benefit includes services provided while the Covered Person is a registered bed patient of a Hospital or rehabilitation unit. Therapy must be provided by a multi-disciplinary team under the direction of a physiatrist.

RESIDENTIAL TREATMENT FACILITY

Coverage includes charges made by a Residential Treatment Facility for treatment of Mental Illness or for treatment of Alcoholism and/or Chemical Dependency, provided the Alcoholism and/or Chemical Dependency Treatment Facility and program meet ASAM level 3.3 or higher criteria. Residential care Room and Board charges are covered in lieu of Inpatient Room and Board charges provided the patient would meet criteria for an Inpatient admission.

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

ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE

Coverage includes charges for Routine Newborn Inpatient Nursery/Physician Care including the following services:

1. Routine Nursery Care includes room, board and Hospital Miscellaneous Expenses for a Newborn Dependent child, including circumcision.

2. Routine Physician Care includes charges for services of a Physician for a Newborn Dependent child while Inpatient as a result of the child's birth, including circumcision.

Coverage also includes charges for circumcision performed on an Outpatient basis within six (6) months following birth.
SKILLED NURSING FACILITY

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

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

2. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians’ fees.

3. Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent confinement, but no other supplies.

SPEECH THERAPY - OUTPATIENT

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

1. There is a documented condition or delay in development that can be expected to improve with therapy within a reasonable time.

2. Treatment is rendered for a condition that is the direct result of a diagnosed neurological, muscular, or structural abnormality affecting the organs of speech.

3. Therapy has been prescribed by the speech language pathologist or Physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all above conditions are met.

4. Treatment is rendered for stuttering due to a neurological disorder.

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

1. Treatment when improvement would normally be expected to occur without intervention.

2. Treatment is rendered for behavioral or learning disorders.

SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES

Charges for surgical implants and/or devices and related supplies are payable as specifically outlined in the Schedule of Benefits, subject to all terms and conditions of this Plan. Coverage under this benefit includes charges for implants, devices and related supplies, including fastenings, screws and all other hardware related to the device or implant.
SURGICAL PROCEDURES

Coverage includes charges for Surgical Procedures.

When two or more Surgical Procedures occur during the same operative session, charges will be considered as follows:

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

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

When an assisting Physician is required to render technical assistance during a Surgical Procedure, the charges for such services will be limited to 20% of the primary surgeon's Eligible Expense for the Surgical Procedure. When an assisting non-physician is required to render technical assistance during an operation, charges for such services will be limited to 10% of the surgeon’s Eligible Expense for the Surgical Procedure.

URGENT CARE FACILITY

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

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

1. As a result of the rarity of the disease or condition, there is no United States FDA approved regimen of treatment;

2. All United States FDA approved regimens of treatment have been attempted within the twelve (12) month period immediately prior to the date the proposed experimental treatment is to commence without any significant clinical improvement in the disease or condition;

3. The proposed course of treatment is medically indicated and is considered the standard of care in the United States for the disease or condition being treated based upon published reports and articles in the authoritative medical and scientific literature including, but not limited to, the following:
   A. The written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, treatment, device or procedure; and
   B. The informed consent documents used by the treating facility or another facility studying substantially the same drug, treatment, device or procedure; and

4. To a reasonable degree of medical certainty, there is a likelihood that the proposed treatment will clinically improve the condition being treated; and

5. That the patient is not considered to be terminal regardless of the treatment proposed or attempted; or

6. The treatment has been recognized by the National Comprehensive Cancer Network (NCCN) as the only available treatment that has demonstrated efficacy of the condition in question.
MEDICAL EXPENSE AUDIT BONUS

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

In the event a self-audit results in elimination or reduction of charges, fifty percent (50%) of the amount eliminated or reduced will be paid directly to the Employee as a bonus, provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the MACoHCT Claims Office (e.g. a copy of the incorrect bill and a copy of the corrected billing). The bonus shall only apply to charges which have been submitted to and paid by the Plan, and for which an erroneous charge was paid by the Plan. Erroneous charges corrected by the Plan during the claims adjudication process are not eligible for this bonus.

Rewards are subject to the following:

A minimum reward of $25 (on overcharge of $50)
A maximum reward of $1,000 (on overcharge of $2,000 or more).

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

MACoHCT PO Box 1966
Missoula, MT 59806-1966
ACCIDENTAL INJURY BENEFIT

(Expenses not eligible under this benefit may be considered under the Medical Benefits of this Plan)

Except for the High Deductible Health Plan, Eligible Expenses Incurred under this benefit are not subject to the Deductible. Charges in connection with an Accidental Injury are payable at 100% of the Eligible Expense, up to the maximum benefit stated in the Schedule of Medical Benefits. Any portion of the charges exceeding the maximum benefit will be considered under the Medical Benefits Section of the Plan, subject to all Plan conditions, exclusions and limitations. Services and supplies must be ordered by a Physician and furnished within a ninety-day period beginning with the date the Covered Person sustained those injuries.

Charges for the following are covered under this benefit when furnished for medical care to the Covered Person for Accidental Injuries including, but not limited to:

1. Services and supplies (including Room and Board) furnished by a Hospital for medical care in that Hospital.
2. Physicians’ services for surgical procedures and other medical care.
3. Oral surgery and dental examinations performed by doctors of dental surgery and ordered by a doctor of medicine.
4. Surgical dressings.
5. X-ray and laboratory examinations.
6. Private duty professional nursing services by a Registered Nurse (RN), a Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN).
7. Casts, splints, trusses, braces and crutches.
8. Ambulance service for local travel to the nearest facility capable of treating the Injury.

Chiropractic Care Services are specifically excluded under this benefit.
HOSPITAL ADMISSION CERTIFICATION

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

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

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

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

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

PRE-ADMISSION CERTIFICATION REVIEW

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

To pre-certify, call the utilization management company at (800) 342-6510 or MACoHCT claims at (888) 883-3233 for pre-admission certification review.

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

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

CONTINUED STAY CERTIFICATION

Charges for Inpatient hospital services for days in excess of any days previously certified by the cost containment company are subject to all terms, conditions and exclusions of the Plan, and should be certified by the Plan’s utilization management company.

Certification for additional days should be obtained in the same manner as the pre-admission certification.
EMERGENCY NOTIFICATION/CERTIFICATION

The Covered Person, or his or her representative, should notify the utilization management company for the Plan regarding any Emergency Hospital Admission within seventy-two (72) hours immediately following admission.

To notify the Plan of an Emergency admission, call the utilization management company at (800) 342-6510 or call MACoHCT claims at (888) 883-3233.

CASE MANAGEMENT PROGRAM

This Program is administered through Allegiance Care Management and provides support to Covered Persons to ensure the best possible outcome of a condition which will help to reduce costs to the Plan. Allegiance Care Management will make several attempts to contact an individual identified as needing case management. While participation in case management is voluntary, declining to participate or declining to continue participating in case management services when requested by the Program will result in a penalty. Upon notification from Allegiance Care Management of an individual who has opted out of case management services, all claims will be processed according to the Plan, subject to an additional $2,500 in Deductible for the applicable Benefit Period. However, charges applied to the penalty will not apply towards the Out-of-Pocket Maximum.

Reviews regarding case management determinations must be submitted to MACoHCT Claims at P.O. Box 1966, Missoula, MT 59806-1966 or for further information call MACoHCT Claims at (888) 883-3233.

MATERNITY NOTIFICATION

The Covered Person or her representative should notify the utilization management company at (877) 792-7827 when Pregnancy is diagnosed or as soon after as possible, in order to participate in the Allegiance Maternity Management Program. Notification is encouraged within the first trimester and is free of charge.
PRE-TREATMENT REVIEW

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

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

1. Surgeries:
   A. Spinal fusions or any other back surgery involving implantable devices;
   B. Reduction Mammaplasty;
   C. Blepharoplasty;
   D. Uvulapalato-pharyngoplasty (UPPP).

2. Organ or Tissue Transplants.

3. Infertility (not covered).

4. Medical Equipment for costs exceeding $5,000.

5. Outpatient dialysis.

6. Infusion services.


10. Commercial or Private Automobile Transportation (limits apply).

11. Outpatient Rehabilitative Care (Benefits in excess of 30 visits per twelve months).

12. Surgery that could be considered Cosmetic under some circumstances (not covered).

13. Any procedure or service that could possibly be considered Experimental or Investigational (not covered).


15. Home Health Care services.


17. Preventive/Prophylactic Mastectomy/Oophorectomy/Hysterectomy.

18. Gender Identity Disorder/Gender Dysphoria Services.


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

1. A complete description of the procedure(s) or treatment(s) for which review is requested;

2. A complete diagnosis and all medical records regarding the condition that supports the requested procedure(s) or treatment(s) including, but not limited to, informed consent form(s), all lab and/or x-rays, or diagnostic studies;

3. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding CPT or HCPCS codes;

4. The attending Physician’s prescription, if applicable;

5. A Physician’s referral letter, if applicable;

6. A letter of Medical Necessity;

7. A written treatment plan; and

8. Any other information deemed necessary to evaluate the request for Pre-treatment Review.

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

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

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

1. Charges for routine medical examinations, routine health check-ups or preventive immunizations not necessary for the treatment of an Injury or Illness, except as specifically listed as a covered benefit.

2. Charges in connection with the care or treatment of, surgery performed for, or as the result of, a Cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury or an Illness, or when rendered to correct a congenital anomaly.**

3. Charges for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a covered benefit of this Plan.

4. Charges for elective abortions. However, abortion services in any jurisdiction where the service is illegal by the law of that jurisdiction are excluded regardless.

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

6. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician, except as specifically covered for Telemedicine.

7. Charges for Licensed Health Care Providers' fees for any treatment which is not rendered by or in the physical presence of a Licensed Health Care Provider, except as specifically covered for Telemedicine.

8. Charges for special duty nursing services are excluded:
   A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or
   B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.

9. Charges in connection with eye refractions, the purchase or fitting of eyeglasses or contact lenses, except as specifically listed as a covered service.

10. Charges in connection with hearing aids, supplies and tinnitus maskers, except as specifically listed as a covered expense.

11. Charges for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes, except as specifically listed as a covered service.

12. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, or any other assisted reproductive technique.
13. Charges for marital counseling, family counseling, recreational counseling, medical social services, visual educational therapy, transitional therapy or hypnotherapy.

14. Charges resulting from or in connection with the reversal of a sterilization procedure.

15. Charges in connection with services or supplies provided for the treatment of obesity and weight reduction, except as specifically listed as a covered benefit and as identified in the Bariatric Surgery Benefit and Morbid Obesity Eligible Expenses.

16. Charges for chiropractic treatment which are not related to an actual Illness or Injury or which exceed the maximum benefit as stated in the Schedule of Medical Benefits.

17. Charges for acupressure, homeopathy, herbal and vitamin supplements, holistic medical procedures or rolfing.

18. Charges for corrective shoes or other supportive devices for the feet, any routine foot care including, but not limited to, surgical procedures and treatment involving corns, calluses, hypertrophy, hyperplasia of the skin or subcutaneous tissues, the cutting or trimming of nails, fallen arches, flat feet, chronic foot strain or symptomatic complaints of the feet.

19. Charges for hair transplant procedures, wigs and artificial hairpieces, or drugs which are prescribed to promote hair growth or remove hair, except as specifically listed as a covered service.

20. Charges related to any services, care or treatment for sexual dysfunction including related drugs, medications, surgery, medical, counseling or Psychiatric Care or treatment.

21. 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.

22. Charges related to Custodial Care.

23. Charges for artificial organ implant procedures.

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

25. Charges for specifically identified oral or injectable drug that can be self-administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit’s Specialty Pharmacy. These drugs are excluded for coverage under the Medical Benefits. The list of drugs can be obtained from the Plan Supervisor or can be found on the MACoHCT website.

26. Charges for services of a 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, MCA, et seq.

“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.

27. Charges for marijuana for any reason.

28. 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.

29. Charges for batteries needed for operation or maintenance of equipment such as CPAP machines and nebulizers.
30. Charges for equipment including, but not limited to, motorized wheelchairs or beds, that exceeds the patient’s needs for every day 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.

31. 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.

32. Charges for detoxification services or Outpatient therapy under court order or as condition of parole, except when Medically Necessary and as ordered by a Physician.

33. Charges for nutrition-based therapy for Alcoholism or drug addiction.

34. Charges for health care services to treat alcohol or drug co-dependency.

35. 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. This exclusion does not apply to Department of Transportation (DOT) examinations.

36. Charges for examinations for employment, licensing, insurance, school, camp, sports or adoption purposes, except for Department of Transportation (DOT) examinations.

37. Charges for court ordered examinations or treatment, except when Medically Necessary and as ordered by a Physician.

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

39. 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; or
   G. Treatment, amputation or removal of the wrong body part or organ.

40. Charges for voice modification; suction assisted lipoplasty of the waist; blepharoplasty; facial reconstruction or facial feminization surgery; hair removal or other non-Medically Necessary services, care or treatment of Gender Identity Disorder or Gender Dysphoria.

41. 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.

42. Charges for COVID-19 home tests. Coverage is provided as outlined under the "Pharmacy Benefit".
DENTAL BENEFIT DETERMINATION REQUIREMENTS

Dental Benefits are available only to those Participants whose Member Group or Sub-Entity has opted for this coverage and who have individually completed an enrollment form requesting coverage and the premium has been paid. If a Participant elects this coverage, election for Dental Benefits may be voluntarily terminated only during the Open Enrollment Period or Special Enrollment Period. If Dental benefits are voluntarily terminated during the Open Enrollment Period or Special Enrollment Period, there will be a two (2) year waiting period before the coverage can be reinstated. All general Plan provisions apply to this Plan.

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

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

1. They are administered, ordered or provided by a Dentist, Denturist, Dental Hygienist or other Licensed Health Care Provider covered by the Plan; and

2. They are Dentally Necessary for the diagnosis and treatment of a dental condition or dental disease unless otherwise specifically included as a benefit; and

3. Charges for such services, treatments and supplies do not exceed the Eligible Expense of the Plan. If two or more procedures are separately suitable for the correction of a specific condition, the Eligible Expense will be based upon the least expensive procedure; and

4. They are not excluded under any provision or section of this Plan.

DEDUCTIBLE AND BENEFIT PERCENTAGE

The Deductible applies to Eligible Expenses Incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period.

The Benefit Percentage is stated in the Schedule of Dental Benefits. After satisfaction of the Deductible, the Plan will pay the Benefit Percentage of the Eligible Expense indicated.

MAXIMUM BENEFIT PAYABLE

The Maximum Benefit per Benefit Period as specified in the Schedule of Dental Benefits is the maximum amount that may be paid by the Plan for Eligible Expenses Incurred by each individual Covered Person in each Benefit Period as indicated in the Schedule of Dental Benefits.

EXPENSES INCURRED

For a dental appliance, or modification of a dental appliance, an expense is considered Incurred at the time the impression is made. For a crown, bridge or gold restoration an expense is considered Incurred at the time the tooth or teeth are prepared. For root canal therapy an expense is considered Incurred at the time the pulp chamber is opened. All other expenses are considered Incurred at the time a service is rendered or a supply furnished.

PREDETERMINATION OF BENEFITS

Charges that are expected to exceed five hundred dollars ($500) may be predetermined by having the Dentist complete the Predetermination of Benefits portion of the claim form and listing the procedures he/she is recommending, including an estimate of charges for the procedures and submit the claim form to the Plan Supervisor for Predetermination of Benefits payable.
Upon the Plan’s receipt of the Predetermination of Benefits request, the Plan Supervisor will determine the eligibility of the Covered Person and determine the coverage available under the Plan for the recommended dental procedures. After determining the benefits payable under the Plan, the Plan Supervisor will return the claim form to the Dentist. A copy of the predetermination of benefits will also be mailed to the covered Employee, informing the Employee of the amount of benefits estimated to be covered by the Plan for the recommended dental procedures.

A PREDETERMINATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF PLAN BENEFITS IS SUBJECT TO PLAN PROVISIONS AND ELIGIBILITY AT THE TIME SERVICES ARE PERFORMED OR CHARGES ARE INCURRED.
DENTAL BENEFITS

TYPE A (PREVENTIVE CARE) EXPENSES

The following general dental expenses will be considered “Type A” for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Oral Examination (including prophylaxis--scaling and cleaning of teeth), but not more than twice in any Benefit Period.

2. Topical application of sodium fluoride or stannous fluoride, limited to once per Benefit Period.

3. Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment; also other dental x-rays, but not more than one full mouth x-ray or series in any three (3) Benefit Periods and not more than two (2) sets of supplementary bitewing x-rays in any Benefit Period.

4. Space maintainers, used to maintain the present position of a tooth, but not to move the tooth.

5. Sealants for Dependent children under age nineteen (19) but not more than one treatment per permanent tooth per lifetime.


TYPE B (BASIC CARE) EXPENSES

The following general dental expenses will be considered “Type B” for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Extractions, including extractions related to orthodontia for a Dependent child under age nineteen (19).

2. Oral surgery.

3. Restorative Services: Provides amalgam, synthetic porcelain and plastic restorations for treatment of decay (one restoration per surface; benefits may be paid for restorations placed on the same surface once each eighteen months) except the maximum fee payable for restoration of primary teeth is the charge for a stainless steel crown.

4. Sedative fillings.

5. General anesthesia or conscious intravenous (IV) sedation when Medically Necessary and administered in connection with oral surgery or other Covered Dental Benefits.

6. Treatment, including periodontal surgery of diseased periodontal structures for periodontal and other diseases affecting such structures.

7. Endodontic treatment, including root canal therapy.

8. Injection of antibiotic drugs.

TYPE C (MAJOR RESTORATIVE) EXPENSES

The following general dental expenses will be considered “Type C” for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Gold fillings, inlays, onlays or crowns (including precision attachments for dentures).
2. Initial installation of fixed bridgework (including crowns and inlays to form abutments) to replace one or more natural teeth extracted.
3. Replacement of an existing partial denture or fixed bridgework by a new fixed bridgework, or the addition of teeth to an existing fixed bridgework.
4. Initial installation of partial or full removable dentures (including adjustments for the six (6) month period following installation) to replace one or more natural teeth extracted.
5. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or the addition of teeth to an existing partial denture.
6. Repair or recementing of crowns, inlays, bridgework or dentures; or relining of dentures.
7. Dental implants.
8. Appliances to reduce or prevent pain or damage from buxism (grinding of the teeth) or occlusion.

ORTHODONTIC TREATMENT (Up to nineteen (19) years of age only)

The following expenses will be considered Orthodontic for reimbursement purposes and will be payable as stated in the Schedule of Dental Benefits and subject to any separate Maximum Lifetime Benefit applicable to Orthodontic Treatment:

1. Treatment for a diagnosed malocclusion.
2. Cephalometric X-ray once in any two (2) Benefit Periods.
3. One set of study models per Covered Person.
4. Initial placement of braces or appliances, ongoing treatment adjustment, removal and follow-up related to said initial placement.
5. Orthodontic extractions.

If Orthodontic Treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received.

DENTAL BENEFIT LIMITATIONS

Charges for the replacement of existing dentures or removable or fixed bridgework will be considered an eligible expense only if the existing appliance is not serviceable and cannot be repaired.
DENTAL BENEFIT EXCLUSIONS

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

1. Charges for dental services or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by a Participant's employer, to the extent that the expenses have been paid by another applicable portion of this Plan or any other insurance or employee benefit plan.

2. Charges for treatment which is not rendered by or in the presence of a Dentist or other Licensed Health Care Provider covered by the Plan except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if the treatment is rendered under the supervision or the direction of the Dentist.

3. Charges for dentures, crowns, inlays, onlays, bridgework or other appliances which are not Dentally Necessary and performed solely or primarily for Cosmetic or personal reasons, personal comfort, convenience, or beautification items, including charges for personalization or characterization of dentures.

4. Charges for facility, Ambulatory Surgery Center and Hospital charges.

5. Charges for local anesthesia administered in conjunction with covered dental services or procedures, when billed separately (unbundled) from the charge for the Covered Service or procedure.

6. Charges for the replacement of a lost, missing, or stolen appliance device or for an additional (spare) appliance.

7. Charges for any services or supplies which are for Orthodontic Treatment, including orthodontic extractions, except as specifically provided for by the Plan.

8. Charges for root canal therapy for which the pulp chamber was opened before the individual became a Covered Person.

9. Charges for oral hygiene and dietary instructions.


11. Charges for fixed bridges for Covered Persons under sixteen (16) years of age.

12. Charges for root canals on primary teeth.

13. Replants, transplants or any treatment rendered on such teeth.


15. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature including, but not limited to, correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia.

16. Charges for any services, supplies or appliances which are not specifically listed as a benefit of this Plan.

17. Charges for broken or missed appointments.

18. Charges for infection control (OSHA) fees or claim filing.
19. Charges for non-dental services such as training, education, instructions or educational materials, even if they are performed or provided by a dental service provider.

20. Charges for hypnosis, prescribed drugs, premedications, nitrous oxide or any euphoric drugs.

21. Charges for biopsies or oral pathology, except as specifically provided for under Covered Dental Services.
VISION BENEFITS

Vision Benefits are available only to those Participants whose Member Group or Sub-Entity has opted for this coverage and who have individually completed an enrollment form requesting coverage and the premium has been paid. If a Participant elects this coverage, election for Vision Benefits may be voluntarily terminated only during the Open Enrollment Period or Special Enrollment Period. If Vision Benefits are voluntarily terminated during the Open Enrollment Period Special Enrollment Period, there will be a two (2) year waiting period before the coverage can be reinstated. All general Plan provisions apply to this Plan.

PAYMENT OF BENEFITS

If a Covered Person, while covered for Vision Benefits, incurs charges for Covered Vision Care Services, benefits are payable under the Plan up to the maximums stated in the Schedule of Vision Benefits.

COVERED VISION CARE SERVICES

Covered Vision Care Services are those Expenses Incurred in connection with the following Vision Care Services:

1. Vision Examination - Vision examination by an ophthalmologist (or other Physician licensed to perform vision examinations and prescribe lenses) or optometrist to evaluate the health and visual status of the eyes.

2. Necessary Contact Lenses - When deemed necessary by the Physician, the Expenses Incurred for the evaluation, fitting and materials for the dispensing of contact lenses will be provided, in lieu of frames and lenses, but in no event more frequently than once per Benefit Period up to the maximum stated in the Schedule of Vision Benefits. The vision examination will be payable as stated in the Schedule of Vision Benefits. Contact Lenses are necessary for any of the following conditions:
   A. Following cataract surgery;
   B. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
   C. Certain conditions of Anisometropia; or
   D. Keratoconus.

3. Elective Contact Lenses - When a Covered Person chooses contact lenses for reasons other than those conditions for Necessary Contact Lenses, the Expenses Incurred for the evaluation, fitting and materials for contact lenses for the dispensing of contact lenses will be provided, in lieu of frames and lenses, but in no event more frequently than every Benefit Period up to the maximum stated in the Schedule of Vision Benefits. The vision examination will be payable as stated in the Schedule of Vision Benefits.

4. Frames up to the maximum stated in the Schedule of Vision Benefits.

5. Scratch, coating, photosensitive, photosun, photochromatic or anti-reflective lens coating up to the maximum stated in the Schedule of Vision Benefits.

6. Prescription sunglasses when obtained in lieu of prescription glasses or contacts up to the maximum stated in the Schedule of Vision Benefits.
EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

1. Services or supplies for which the Covered Person is entitled to benefits under any other section of the Plan or as provided under any other section of the Plan.

2. Drugs or any other medication not administered for the purpose of a vision examination.

3. Medical or surgical treatment of the eye.

4. Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonia lenses and tonography.

5. Two pair of eyeglasses in lieu of bifocals.


7. Services rendered or ordered while not covered for Vision Benefits.

8. Services or supplies not prescribed as necessary by a licensed Physician, optometrist or optician.

9. Replacement of lenses or frames which are lost or broken except at the normal intervals indicated.

10. Services required by an employer as a condition of employment.

11. Oversize frames or lenses.
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 could 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

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

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 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.

12. Charges for services, treatment or supplies not considered legal in the United States.

13. Charges for travel Expenses Incurred by any person for any reason, except as specifically covered under the Non-Ambulance Travel Benefit.

14. 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.

15. Charges in connection with any non-surgical treatment for temporomandibular joint dysfunction or any related diagnosis.

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 carried or sponsored by a Member Group or Sub-Entity.

19. Charges for incidental supplies or common first aid supplies such as, but not limited to, adhesive tape, bandages, antiseptics, analgesics, etc., except as specifically listed as a covered benefit.

20. Charges for dental braces or corrective shoes.

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.
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 will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan(s), will not exceed 100% of the Allowable Expense. Only the amount paid by this Plan will be charged against the Plan maximums.

If the Covered Person is a member or Dependent of a member of a Health Maintenance Organization (HMO) which has primary responsibility for the Covered Person’s medical care, this Plan will not provide reimbursement for any expenses which would have been covered by the HMO if the Covered Person had used HMO facilities and personnel.

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 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 Plan Document/Summary Plan Description are subject to this provision.

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 will be 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 will be 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 will be equal to the secondary plan’s chosen limits for non-contracted providers.

“Plan” as used herein means any plan providing benefits or services for or by reason of medical, 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; or

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans; or

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision; or

4. A licensed Health Maintenance Organization (HMO); or

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. Individual automobile insurance coverage on an automobile leased or owned by the Member Group or Sub-Entity or any responsible third-party tortfeasor.

“Plan” will be 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 the 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.
Coordination of Benefits

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, Part B and Part D 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. This means that this Plan will only pay the amount that Medicare would not have covered, even if the Covered Person does not elect to be covered under Medicare. Also, failure to enroll in Medicare Part B or Part D when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment in Part B or Part D.

1. For Working Aged

A covered Employee who is eligible for Medicare Part A, Part B or Part D 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, Part B or Part D as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

A covered Dependent, eligible for Medicare Part A, Part B or Part D 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, Part B or Part D as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

2. For Retired Persons

Medicare is primary and this Plan will be secondary for the covered Retiree if he/she is an individual who is enrolled in Medicare Part A, Part B or Part D as a result of age or disability and retired.

Medicare is primary and this Plan will be secondary for the covered Retiree's Dependent spouse who is enrolled in Medicare Part A, B or D if both the covered Retiree and his/her covered Dependent spouse are enrolled in Medicare Part A, Part B or Part D as a result of age or disability and retired.

Medicare is primary for the Retiree's Dependent spouse when the Retiree is not enrolled for Medicare Part A, Part B or Part D as a result of age and the Retiree’s Dependent spouse is enrolled in Medicare Part A, Part B or Part D as a result of age or disability.

3. For Covered Persons who are Disabled

For plans with fewer than 100 Employees, Medicare is primary and this Plan will be secondary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability.

For plans with 100 Employees or more, this Plan is primary and Medicare will be 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.

For plans with 100 Employees or more, this Plan is secondary and Medicare will be 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 stated below*, for Employees or Retirees and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above, the Covered Person has no dialysis for a period of twelve (12) consecutive months and:

A. Then resumes dialysis, at which time this Plan will again become primary for a period of thirty (30) months; or

B. The Covered Person undergoes a kidney transplant, at which time this Plan will again become 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 will continue to be primary and this Plan will be secondary.

**COORDINATION WITH MEDICAID**

If a Covered Person is also entitled to and covered by Medicaid, this Plan will always be primary and Medicaid will always be secondary coverage.

**COORDINATION WITH TRICARE/CHAMPVA**

If a Covered Person is also entitled to and covered under TRICARE/CHAMPVA, this Plan will always be primary and TRICARE/CHAMPVA will always be secondary coverage. TRICARE coverage will include 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 will always be primary and the VA will always be secondary for non-service connected medical claims. For these claims, this Plan will make payment to the VA as though this Plan was making payment secondary to Medicare.
PROCEDURES FOR CLAIMING BENEFITS

Claims must be submitted to the Plan within twelve (12) months after the date services or treatments are received or completed. Non-electronic claims may be submitted on any approved 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 Necessity of the treatment or service being provided and sufficient to enable the Plan Supervisor to adjudicate the claim pursuant to the terms and conditions of the Plan.

When completed, the claim must be sent to the Plan Supervisor:

MACoHCT Claims
PO Box 1966
Missoula, MT 59806-1966

Toll-Free: (888) 883-3233
Missoula Area: (406) 721-2222

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

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

In the event a Member Group or Sub-Entity discontinues its coverage, the Covered Person or Dependent must submit their claims within twelve (12) months from the date of service in order to receive reimbursement or payment. All coverage ends at midnight on the day coverage is terminated.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL RECEIVED BY MACOHCT.

The Plan will have the right, in its sole discretion and at its own expense, to require a claimant to undergo a medical 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 and other relevant records it deems necessary to properly adjudicate the claim.

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims will be 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 Plan. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims decisions will be made within the time periods stated below. 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 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. The Plan will recognize this Authorized Representative when the Plan 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 HIS OR HER HEALTHCARE PROVIDER; HOWEVER, THE PLAN WILL ONLY PAY BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THIS PLAN.

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 could 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, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

There are no 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 Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the 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 Plan Document/Summary Plan Description which, the Plan recommends be utilized before a Covered Person obtains medical care.

3. Post-Service Claims - A Post-Service Claim is any claim for a medical benefit under the 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, and for which medical treatment has been obtained prior to submission of the claim(s).

In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan’s receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but 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 Plan, a decision by the Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the Plan’s benefit maximums is not an Adverse Benefit Determination.) The Plan will 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 Plan’s receipt of the request. The appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially-prescribed period.
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 network 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 claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim denial will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific 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 Plan Supervisor at the address or telephone number shown on the claim denial.

**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 Plan 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 Plan which was not initially provided and forward it to the 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 Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).**

1. **First Level of Benefit Determination Review**

   The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within fifteen (15) days following the date the 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 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 MACoHCT Board of Trustees will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the MACoHCT Board of Trustees who is neither the original decisionmaker nor the decisionmaker’s subordinate. The MACoHCT Board of Trustees cannot give deference to the initial benefit determination. The MACoHCT Board of Trustees may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the MACoHCT Board of Trustees will consult with a health care professional with appropriate training who was neither the medical 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 will provide a written or electronic notice of the final benefit determination, which contains 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**

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 must 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 Supervisor will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.
The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

**APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM**

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific 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 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 Plan 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 Plan which was not initially provided and forward it to the 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 Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. **First Level of Benefit Determination Review**

   The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within thirty (30) days following the date the 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 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 MACoHCT Board of Trustees will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the MACoHCT Board of Trustees who is neither the original decisionmaker nor the decisionmaker’s subordinate. The MACoHCT Board of Trustees cannot give deference to the initial benefit determination. The MACoHCT Board of Trustees may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the MACoHCT Board of Trustees will consult with a health care professional with appropriate training who was neither the medical 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 will 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 at each level of review.

All claim payments are based upon the terms contained in the Plan Document/Summary Plan Description, on file with the Plan Administrator and the Plan Supervisor. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan 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

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 must 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 Supervisor will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

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

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.
ELIGIBILITY PROVISIONS

EMPLOYEE ELIGIBILITY

An eligible Employee under this Plan is defined by each Montana Association of Counties Health Care Trust (MACoHCT) Member Group or Sub-Entity.

An Employee becomes eligible under this Plan for each classification of Employee as stated in the MACoHCT Participation and Affiliation Agreement and in the MACoHCT Employee Eligibility Form provided by the MACoHCT Member Group or Sub-Entity to the Plan.

An Employee is not eligible while on active military duty if that duty exceeds a period of thirty-one (31) consecutive days.

EMPLOYEE ELIGIBILITY FOR TETON COUNTY

An eligible Employee includes a person who is employed by Teton County, a Member Group or Sub-Entity, on a continuing basis who is regularly scheduled to work at least seventy-five (75) hours per month.

However, an eligible Employee includes only a person who is employed by a Member Group as a permanent, temporary, or seasonal employee as defined in the General Definitions section of this Plan and who has been determined to be eligible for Health Benefits by the Member Group under contract or policy.

Part-time workers scheduled to work less than seventy-five (75) hours per month, short-term workers and student interns are not eligible for coverage.

An Employee is not eligible while on active military duty if that duty exceeds a period of thirty-one (31) consecutive days.

ELECTED COUNTY OFFICIAL ELIGIBILITY

An eligible County Elected Official is a person whose service with the Member Group, also known as “Member Entities”, is as a result of an election to an official governmental office as required by Montana law, or as a result of appointment to such an official governmental office to serve out the remainder of an unexpired term of an elected official who has resigned or been removed from an official governmental office, as allowed by Montana law. A person will be considered a County Elected Official only during the legal term of office for any such official governmental office. Elected officials, supervisors, trustees, and commissioners of special districts, known as “Affiliate Entities”, are not eligible for coverage.

WAITING PERIOD

With respect to an eligible Employee, coverage under the Plan will not start until the Employee completes a Waiting Period or Administrative Period.

The Waiting Period is the period of time commencing on the Enrollment Date and ending on the last day of the month following the Enrollment Date (date of eligibility), unless a different period is required pursuant to a collectively bargained contract or the Employer’s personnel policy, which shall be stated in the MACoHCT Employee Eligibility Form.

The Administrative Period commences starting from the end of the Measurement Period. If elected, coverage under this section shall continue for a period of time equal to the Measurement Period, provided the Participant remains employed by the Employer, but regardless of the number of hours worked, paid leave, FMLA or jury duty time off during that time period. This period of time is the Coverage Period and shall be stated in the MACoHCT Eligibility Form provided by the MACoHCT Member Entity, Affiliate Entity or Sub-Entity to the Plan.

No Waiting Period or Administrative Period will exceed ninety (90) days for any class of Employee.
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 has been assigned by the Employer, and who is either:

1. The Participant’s legal spouse, according to the marriage laws of the state where the marriage was first solemnized or established. Proof of legal marriage must be furnished to the Plan Administrator upon request, including a copy of signed Affidavit.

   An eligible Dependent does not include a spouse or domestic partner who is legally separated or divorced from the Participant and has a court order or decree stating such from a court of competent jurisdiction.

2. The Participant’s domestic partner, provided all of the following “Required Eligibility Conditions” are met:

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

   B. The Participant and domestic partner are competent to enter into a contract; and

   C. The Participant and domestic partner are not legally married to, nor the domestic partner of, any other person; and

   D. The Participant and domestic partner are not related by marriage; and

   E. The Participant 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

   F. The Participant and domestic partner have entered into the domestic partner relationship voluntarily, willingly and without reservation; and

   G. The Participant and domestic partner have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:

       1) Living together as a couple;

       2) Mutual support of each other;

       3) Mutual caring and commitment to each other;

       4) Mutual fidelity;

       5) Mutual responsibility for each other’s welfare; and

       6) Joint responsibility for the necessities of life.

   H. The Participant and domestic partner have been living together as a couple for at least twelve (12) months prior to the date of the Affidavit; and

   I. The Participant and domestic partner intend to continue the domestic partner relationship indefinitely, with the understanding that the relationship is terminable at the will of either partner.
3. The Participant's or domestic partner'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 with the Participant or the Participant’s domestic partner and for whom as part of such placement the Participant 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 the Participant’s domestic partner has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant’s child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to MACoHCT upon request, and additional proof may be required from time to time.

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

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

Each Employee will become eligible for Dependent Coverage on the latest of:

1. The date the Employee becomes eligible for Participant coverage; or

2. The date on which the Employee first acquires a Dependent.

RETIREE ELIGIBILITY

Retirees of Member Groups or Sub-Entities and their eligible Dependents shall be eligible under this Plan if the Retiree satisfies one of the following conditions:

1. The retired person was an eligible covered Employee under this Plan on the day immediately before the date of retirement and retired pursuant to the terms of the Public Employees Retirement laws or is eligible for coverage pursuant to the terms of 2-18-704, MCA, as amended from time to time; or

2. The retired person was an eligible covered Employee under this Plan on the day immediately before the date of retirement, was not eligible for retirement under the terms of 2-18-704, MCA, but was eligible for retirement under the terms and conditions of the employment policies and practices of the Member Group or Sub-Entity with which the person was employed on the day immediately before retirement.

Medicare eligible Retirees and their covered Dependent spouses or domestic partners may be eligible to enroll for coverage under the MACoHCT Group Medicare Advantage Plan, subject to the eligibility rules of such plan. Coverage under this Plan will terminate on the date the Medicare eligible Retiree or his/her Dependent spouse or domestic partner becomes eligible for coverage under the MACoHCT Group Medicare Advantage Plan. However, Dependent children of a Medicare eligible Retiree are not eligible for coverage under the MACoHCT Group Medicare Advantage Plan and may continue coverage under this Plan. A Dependent spouse or domestic partner of a Medicare eligible Retiree who does not meet the eligibility rules under the MACoHCT Group Medicare Advantage Plan may continue coverage under this Plan until the date he/she becomes eligible for coverage under the MACoHCT Group Medicare Advantage Plan. Once coverage for a Medicare eligible Retiree or a Dependent spouse or domestic partner of a Medicare eligible Retiree has been elected under the MACoHCT Group Medicare Advantage Plan, eligibility under this Plan may not be reinstated, unless the Retiree becomes rehired and is eligible for coverage again as an active Employee. If coverage under the MACoHCT Group Medicare Advantage Plan is elected for any Medicare eligible Retiree or covered spouse or domestic partner, Dental or Vision benefits may be continued in the same manner in which they were provided prior to becoming covered under the MACoHCT Group Medicare Advantage Plan.
Retirees and their eligible Dependents who are not eligible for coverage under the MACoHCT Group Medicare Advantage Plan and who elect to continue coverage under this Plan may also elect to change coverage options at the time of retirement to any coverage option offered by the Member Group. The coverage option for eligible Dependents must be the same as the Retiree.
**EFFECTIVE DATE OF COVERAGE**

All coverage under the Plan will commence 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**

Participant coverage under the Plan will become effective on the first day immediately after the Employee satisfies the applicable eligibility requirements and Waiting Period or Administrative Period as stated in the MACoHCT Employee Eligibility Form provided by the MACoHCT Member Group or Sub-Entity to the Plan. If these requirements are met, the Employee must be offered coverage or an opportunity to waive coverage even if the offer is after the date coverage should become effective, regardless of the time that has elapsed, provided that the reason coverage was not offered before the end of the Waiting Period or Administrative period was as a result of an administrative error on the part of the Employer, Plan Administrator or Plan Supervisor.

An eligible Employee who declines Participant coverage under the Plan during the Initial Enrollment Period will be able to become covered later in only during Open Enrollment Period and Special Enrollment Period.

A variable hour Employee will remain covered during the Coverage Period, regardless of the number of hours worked and applicable leave, as long as the individual remains employed by the Member Group or Sub-Entity. At the end of the Coverage Period, if the individual remains employed as a variable hour Employee and meets the eligibility requirements as stated in the MACoHCT Employee Eligibility Form during the Coverage Period, the individual will remain covered for a period of time equal to the original Coverage Period.

“Coverage Period” is the maximum period of time variable hour Employees can be covered under the Plan as active Employees after completion of a Measurement Period as defined by each Montana Association of Counties Health Care Trust (MACoHCT) Member Group or Sub-Entity.

**DEPENDENT COVERAGE**

Each Participant who requests Dependent Coverage on the Plan’s enrollment platform will become covered for Dependent Coverage as follows:

1. On the Participant’s effective date of coverage, if application for Dependent Coverage is made on the same enrollment platform used by the Participant to enroll for coverage. This subsection applies only to Dependents who are eligible on the Participant’s effective date of coverage.

2. In the event a Dependent is acquired after the Participant’s effective date of coverage as a result of a legal guardianship or in the event that a Participant is required to provide coverage as a result of a valid court order, or if the Dependent is acquired as a result of operation of law, Dependent Coverage will begin on the first day of the month following the Plan’s receipt of an enrollment form and copy of said court order, if applicable.

**OPEN ENROLLMENT PERIOD**

The “Open Enrollment Period” is a period during which an Employee and the Employee’s eligible Dependents, who are not covered under this Plan, may request Participant or Dependent coverage. Coverage must be requested on the Plan’s enrollment platform.

The Open Enrollment Period for Member Groups or Sub-Entities as defined by MACoHCT for Plans that renew in January is October 1 through December 15 of each year.

The Open Enrollment Period for Member Groups or Sub-Entities as defined by MACoHCT for Plans that renew in July is May 1 through July 15 of each year.
Coverage requested during any Open Enrollment Period will begin on the first day of the month immediately following the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

In addition to other enrollment times allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below.

Coverage will become effective on the date of the event if the Employee makes a special enrollment request, verbally or in writing, within thirty (30) days of any special enrollment event and application along with supporting documentation for such coverage is made on the Plan’s enrollment platform within sixty (60) days of the event.

1. An eligible Employee who is not enrolled and eligible Dependents, including step children, who are acquired under the following specific events may enroll and become covered:
   A. Marriage to the Employee; or
   B. Birth of the Employee’s child; or
   C. Adoption of a child by the Employee, provided the child is under the age of 19; or
   D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

2. A Participant may enroll eligible Dependents, including step children, who are acquired under the following specific events:
   A. Marriage to the Participant; or
   B. Birth of the Participant’s child; or
   C. Adoption of a child by the Participant, provided the child is under the age of 19; or
   D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.
   E. Establishment of domestic partnership.

3. The spouse or domestic partner of a Participant, or the spouse or domestic partner of a Retiree who is covered at the time of the Special Enrollment event, may enroll and will become covered under the following specific events:
   A. Marriage to the Participant or Retiree; or
   B. Birth of the Participant’s or Retiree’s child; or
   C. Adoption of a child by the Participant or Retiree, provided the child is under the age of 19; or
   D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.
   E. Establishment of domestic partnership.
4. A Retiree who is covered at the time of a special enrollment event may enroll his/her eligible Dependents, including step children who are acquired under the circumstances below:

   A. Marriage to the Retiree; or
   B. Birth of the Retiree’s child; or
   C. Adoption of a child by the Retiree, provided the child is under the age of 19; or
   D. Placement for Adoption with the Retiree, provided such 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 19.

5. The following individuals may enroll and become covered when coverage under another health care plan or health insurance is terminated due to loss of eligibility or if employer contributions to the other coverage have been terminated (Loss of Coverage), subject to the following:

   A. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
   B. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.
   C. If an eligible Dependent of a Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.

Further, Loss of Coverage means only one of the following:

   A. COBRA Continuation Coverage under another plan and the maximum period of COBRA Continuation Coverage under that other plan has been exhausted; or
   B. Group or insurance health coverage that has been terminated as a result of termination of employer contributions* towards that other coverage; or
   C. Group or insurance health coverage (includes other coverage that is Medicare) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:
      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 the Health Maintenance Organization (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 eligibility for 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.
6. The following individuals may waive coverage under the Plan due to gain of eligibility of coverage subject to the below. Any waiver request and required substantiating documentation must be received within sixty (60) days of the Special Enrollment event except for the gain of Medicaid coverage which must be received within ninety (90) days after the event:

A. If the eligible Employee gains other coverage, the eligible Employee who gained coverage and any eligible Dependents of the eligible Employee may waive coverage.

B. If an eligible Dependent gains other coverage, the eligible Employee and any eligible Dependents of the eligible Employee may waive coverage.

C. If the eligible Retiree or their eligible Dependent gains other coverage they may waive coverage.

7. Individuals may enroll and become covered 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. A request for enrollment must be made either verbally or in writing within sixty (60) days after this special enrollment event, and written application for such coverage must be made within ninety (90) days after such event.

B. 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.

C. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

D. If an eligible Dependent of a Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.

8. 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 shall be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (CHIP or Medicaid). A request for enrollment, either verbal or in writing, must be made within sixty (60) days after this special enrollment event, and written application for such coverage must be made in writing within ninety (90) days after such event.

For any Special Enrollment event, the Participant may also elect to change Coverage Options to any Coverage Option offered by the Member Group or Sub-Entity. The Coverage Option for the Dependent must be the same as the Participant.

CHANGE IN STATUS

If a Covered Dependent under this Plan becomes an eligible Employee of a Member Group or Sub-Entity, he/she may continue his/her coverage as a Dependent and/or elect to be covered as a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of a Member Group or Sub-Entity, but is eligible to be covered as a Dependent under another Employee/Participant, he/she may elect to continue his/her coverage uninterrupted as a Dependent, provided there is no break in coverage. Written notice from the Member Group or Sub-Entity must be made within thirty (30) days immediately following the date coverage would otherwise terminate.

A Change in Status will not be deemed to be a break or termination of coverage and will not operate to reduce or increase any benefits. The Deductible and Out-of-Pocket Maximum accumulations, to which the Covered Person was entitled before the Change in Status, as well as all accrued Plan maximums, will carry over to the continued coverage. However, the amounts carried forward to the new coverage due to a Change in Status will not exceed the Deductible or Out-of-Pocket Maximum amounts applicable to the new coverage.
QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

Pursuant to Section 609(a) of ERISA, the Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified in accordance with ERISA's requirements, to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required.

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 MACoHCT to meet the qualification requirements as outlined under “Procedures For Notifications and Determinations” of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and

2. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and

3. Specify each period to which such order applies.

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

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

1. MACoHCT 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, MACoHCT 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 MACoHCT 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.
TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant coverage will automatically terminate immediately 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 Participant's employment terminates; or
2. On the last day of the month in which the Participant ceases to be eligible for coverage; or
3. The date the Participant fails to make any required contribution for coverage; or
4. The date the Plan is terminated; or
5. The date the Member Group or Sub-Entity terminates the Participant's coverage; or
6. The date the Participant dies; or
7. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form and substantiating documentation due to a Special Enrollment Event for the Participant; or
8. For variable hour Employees on the last day of the Coverage Period, unless at the expiration of the Coverage Period, the Participant is otherwise eligible as the result of a subsequent Measurement Period or as a result of being reclassified as a full-time Employee.

RETIREE TERMINATION

Coverage for all Retirees and Dependents of Retirees will cease on the earliest of time as indicated below, unless Retiree is eligible for and elects COBRA Continuation Coverage:

1. On the last day of the month for which premiums are discontinued;
2. On the last day of the month in which the Member Group or Sub-Entity terminates coverage for active Employees under the Plan;
3. On the last day of the month in which the Member Group or Sub-Entity no longer employs any Employee, as defined by the Plan;
4. The date the Plan is terminated;
5. The date the Member Group or Sub-Entity terminates coverage under this Plan;
6. On the last day of the month in which the Dependent ceases to be an eligible Dependent of the Retiree;
7. The date the Member Group or Sub-Entity discontinues Retiree benefits;
8. On the last day of the month in which the Retiree dies; or
9. The date the Medicare eligible Retiree or spouse or domestic partner of a Medicare eligible Retiree becomes covered under the MACoHCT Group Medicare Advantage Plan.
REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of termination of employment or reduction in hours 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 or reduction in hours will become eligible for reinstatement of coverage on the date of renewed eligibility. Coverage will be reinstated for the Employee and eligible Dependents on the date of renewed eligibility, if covered on the date of termination, provided that application for such coverage is made on the Plan’s enrollment platform within thirty (30) days after the date of renewed eligibility. Reinstatement of Coverage is subject to the following:

1. Credit will 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 will apply.

If renewed eligibility occurs under any circumstances other than as stated in this subsection, enrollment for coverage for the Employee and his/her Dependents will be treated as if initially hired for purposes of eligibility and coverage under this Plan.

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

TEMPORARY LAYOFF/ LEAVE OF ABSENCE

A Participant whose Active Service ceases as a result of a layoff or any county approved leave of absence, including FMLA leave and Worker’s Compensation Injury leave, may remain covered as an Employee in Active Service until the earliest of the following dates:

1. The date the Participant fails to make any required contribution for coverage;

2. The date the Participant otherwise cancels his or her coverage or terminates participation in MACoHCT;

3. The date the Participant exhausts twelve (12) weeks of unpaid leave in a twelve (12) month period; or

4. In the event that the Participant qualifies for Family Medical Leave Act Leave in excess of twelve (12) weeks in a twelve (12) month period, the date the Participant no longer qualifies for FMLA leave.

Pursuant to 7-32-2113, MCA, a deputy sheriff may remain covered as an Employee in Active Service for up to one (1) year for a deputy sheriff whose Active Service ceases as a result of Injury in the line of duty and the deputy sheriff is unable to perform the deputy sheriff’s duties as a result of the Injury.

DEPENDENT TERMINATION

Each Covered Person, whether Participant or Dependent, is responsible for notifying MACoHCT, 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 will automatically terminate immediately 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 by the Plan; or
2. On the last day of the month in which the Participant's coverage terminates under the Plan; or  

3. On the last day of the month in which the Participant ceases to be eligible for Dependent Coverage; or  

4. The date the Participant fails to make any required contribution for Dependent Coverage; or  

5. The date the Plan is terminated or with respect to any Dependent’s benefit of the Plan, the date of termination of such benefit; or  

6. The date the Member Group or Sub-Entity terminates the Dependent's coverage; or  

7. On the last day of the month in which the Participant dies; or  

8. On the last day of the month in which the Plan receives the Plan’s Health Coverage Waiver Form for the Dependent whose coverage is to be terminated due to a Special Enrollment Event; or  

9. The date the Participant and domestic partner terminate their domestic partner relationship as evidenced by a signed Affidavit of Termination of Domestic Partnership.

DEPENDENT MEDICAL COVERAGE AFTER EMPLOYEE’S DEATH

If an Employee is covered under this Plan when he/she dies, any of his or her Dependents who are covered at that time will continue to be eligible for coverage under the Plan in accordance with the following requirements:

1. Coverage for the surviving Dependent spouse domestic partner of a covered Employee who is eligible to receive the retirement benefits accrued by the deceased employee will continue until the earliest of the following:
   
   A. The last day for which the spouse or domestic partner and/or Participant has made any required contributions; or
   
   B. The date the Member Group or Sub-Entity ceases to participate in MACoHCT.
   
   C. The date the surviving Dependent spouse or domestic partner becomes eligible for coverage under the MACoHCT Group Medicare Advantage Plan.

2. Coverage for surviving Dependent children who are eligible to receive retirement benefits accrued by the deceased Employee will continue until the earliest of the following:
   
   A. The date the Dependent becomes a Participant in or becomes 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;
   
   B. The date the Dependent becomes eligible for insurance or other coverage by virtue of the employment of a surviving parent or legal guardian;
   
   C. The last day for which the Dependent and/or Member Group or Sub-Entity has made any required contributions; or
   
   D. The date the Member Group or Sub-Entity ceases to participate in MACoHCT.

The Dependent benefits available after the Employee dies will be those in effect for that Employee’s Dependents on the day prior to his or her death.
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 will receive written notice at least thirty (30) days before the coverage is rescinded.
CONTINUATION COVERAGE AFTER TERMINATION

Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Employees 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 Montana Association of Counties Health Care Trust (MACoHCT), 721D Skyway Drive, Helena Montana 59602; (406) 443-8102. MACoHCT is responsible for administering COBRA Continuation Coverage.

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 following the date of the 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 Member Group or Sub-Entity of the following Qualifying Events within sixty (60) days after the date the event occurs.

The Member Group or Sub-Entity must notify MACoHCT 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 Member Group or Sub-Entity must notify MACoHCT 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.
Failure by the Member Group or Sub-Entity to provide the notice required by this subsection may result in the Plan denying COBRA eligibility and/or the Eligible Employer being liable to the Plan or the former Covered Person for medical claims incurred by the Covered person after the Qualifying Event.

**ELECTION OF COVERAGE**

When MACoHCT is notified of a Qualifying Event, MACoHCT 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 MACoHCT 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 MACoHCT, 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 MACoHCT. The premium required under the provisions of COBRA is as follows:

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).

2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.

3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:
   
   A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce or legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.
   
   B. If the second Qualifying Event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Member Group or Sub-Entity 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 MACoHCT.
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 MACoHCT 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. MACoHCT 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: MACoHCT, 721D Skyway Drive, Helena Montana 59602.

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, MACoHCT must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: MACoHCT, 721D Skyway Drive, Helena Montana 59602 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, Part B or Part D of Medicare, whichever occurs earlier.

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

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

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

WHEN COBRA CONTINUATION COVERAGE ENDS

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

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance.
2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A, Part B or Part D).
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 MACoHCT.
4. On the date the Employer ceases to provide any group health plan coverage to any Employee.

5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.

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

7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

**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). Certain plans may pay as if secondary to Medicare, even if not enrolled in Medicare.


**QUESTIONS**

Any questions about COBRA Continuation Coverage should be directed to MACoHCT 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](http://www.dol.gov/ebsa). For more information about the Marketplace visit [www.HealthCare.gov](http://www.HealthCare.gov).

**INFORM THE PLAN OF ADDRESS CHANGES**

In order to protect the Employee’s family’s rights, the Employee should keep MACoHCT 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 MACoHCT.
CONTINUATION COVERAGE FOR DOMESTIC PARTNERS

Continuation Coverage under this section does not confer any rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Domestic partners and their enrolled Dependent children may continue coverage beyond the time coverage would ordinarily have ended due to a Continuation Coverage Event. Continuation Coverage under this provision will begin on the first day following the date coverage terminates.

Continuation Coverage Events for covered domestic partners and their enrolled children, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:

1. The termination (other than by reason of gross misconduct) of the Participant’s employment.
2. The reduction in hours of the Participant’s employment.
3. Death of the Participant or Retiree.
4. Termination of domestic partnership.
5. A covered Dependent child of a domestic partner ceases to be a Dependent as defined by the Plan.

A Domestic Partner or enrolled child of a domestic partner has sixty (60) days from the date coverage would otherwise be lost to notify the Plan Administrator that he or she elects to Continue Coverage for Domestic Partners under the Plan. Failure to elect continuation within that period will cause coverage to end.

Continuation Coverage for Domestic Partners and their enrolled children will cease on the earliest of the following:

1. On the date the Domestic Partner or enrolled child of a domestic partner becomes covered under another group health plan or health insurance, unless the other group health plan contains a provision excluding or limiting coverage for a Pre-existing Condition applicable to a condition of the Domestic partner or enrolled child of a domestic partner under this Plan. However, if the exclusionary period does not apply due to prior Creditable Coverage, Continuation Coverage for Domestic Partners ends. Coverage will not be terminated as stated until the pre-existing exclusionary period of the other coverage is no longer applicable.

2. On the date, after the date of election for Continuation Coverage for Domestic Partners, that the Domestic Partner or enrolled child of domestic partner becomes enrolled in Medicare (either Part A, Part B or Part D);

3. On the first date that timely payment of any premium required under the Plan with respect to Continuation Coverage for Domestic Partners is not made to the Plan Administrator.

4. On the date the Employer ceases to provide any group health plan coverage to any Employee.

5. On the date of receipt of written notice that the Domestic Partner wishes to terminate Continuation Coverage for Domestic Partners.

6. On the date that the maximum coverage period for Continuation Coverage for Domestic Partners and their children ends, as follows:
   
   A. Eighteen (18) months following the date coverage is lost due to termination or reduction in hours of the Participant’s employment.

   B. Thirty-six (36) months following the date coverage is lost as a result of death of the Participant, termination of the domestic partnership, a child of the domestic partner ceasing to be eligible.
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 is absent from employment 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 CHAMPVA 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 Participant has coverage under this Plan, and such Participant is absent from employment with Employer by reason of State Active Duty, 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 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 Participant returns to a position of employment with the Employer, provided the Participant returns to employment in a timely manner, or ending on the day immediately after the day the Participant 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 Participant 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 Participant 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 Participant 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 CHAMPVA related to eligibility for those coverages.
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.

MACoHCT, 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, will 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 will 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, 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 will terminate 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 will 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 any person who was not otherwise eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate or false information, or information omitted by the Participant must be reimbursed to the Plan by the Participant. The Participant’s failure to reimburse the Plan after demand is made, may result in an interruption in or loss of benefits to the Participant and Dependents, 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.

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, the Covered Person agrees to hold the money received in trust 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 will be paid as a result of said accident, Injury, condition or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Covered Person is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages.

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. 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.
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.

In the event that a Covered Person decides not to pursue a claim against any third party or insurer, the Covered Person will not 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. Under the terms of this Plan, the Plan Supervisor is not required to pay any claim where there is evidence of liability of a third party unless the Covered Person signs the Plan’s Third-Party Reimbursement Agreement and follows the requirements of this section. However, the Plan, in its discretion, may instruct the Plan Supervisor not to withhold payment of benefits while the liability of a party other than the Covered Person is being legally determined. If a repayment agreement is requested to be signed, the Plan’s right of recovery through Reimbursement and/or Subrogation remains in effect regardless of whether the repayment agreement is actually signed.

2. 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.

3. The Covered Person 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 monies; 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.

4. 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.

5. 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.

6. 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. Monies paid by the Plan will be repaid in full, in first priority, except as limited by 2-18-901 and 902, MCA, as amended.
RIGHT OF OFF-SET

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

PURPOSE

The purpose of the Master Plan Document/Summary Plan Description 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 and their covered Dependents.

PLAN YEAR

The Plan Year will be the period of time for each Member Group or Sub-Entity as defined in the Schedule of Medical Benefits and as subsequently amended from time to time.

PLAN SPONSOR

The Plan Sponsor is the Montana Association of Counties.

PLAN SUPERVISOR

The Plan Supervisor is Allegiance Benefit Plan Management, Inc.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is Montana Association of Counties Health Care Trust (MACoHCT) which has the authority to control and manage the operation and administration of the Plan. MACoHCT may delegate responsibilities for the operation and administration of the Plan. MACoHCT will have 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 Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

PLAN INTERPRETATION

MACoHCT has full discretionary authority to interpret and apply all Plan provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. MACoHCT may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Final authority to interpret and apply the provisions of the Plan rests exclusively with MACoHCT. Decisions of MACoHCT made in good faith will be final and binding.

CONTRIBUTIONS TO THE PLAN

The amount of contributions to the Plan are to be made on the following basis:

MACoHCT, in consultation with retained actuaries, will from time to time evaluate the costs of the Plan and determine the amount to be contributed by each Member Group or Sub-Entity.

Each Member Group or Sub-Entity provides contributions for coverage under this Plan for at least a portion of the cost of coverage. The Participant may be required to provide contributions for either Participant or Dependent coverage. The determination of the contribution to be provided by the Member Group or Sub-Entity and the Participant will be made by the Member Group or Sub-Entity in accordance with the terms and conditions of the Plan. No portion of contributions for COBRA Continuation Coverage will be paid by the Plan. Specific information regarding the actual amount of any contribution for coverage under this Plan may be obtained from the applicable Member Group or Sub-Entity. The amount of any contribution for coverage, except the amounts for COBRA Continuation Coverage, may be increased, decreased or modified at any time by the Plan.
Plan Administration

If the Trust is terminated, the Plan and the Participants will have no obligation to contribute to the Plan after the date of termination.

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Master Plan Document/Summary Plan Description contains all the terms of the Plan and may be amended at any time as authorized and adopted by the MACoHCT Board of Trustees. Written notification of any amendments, modifications, revocations or terminations will be given to 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

MACoHCT may be terminated at any time at the recommendation of the Trustees by an instrument or instruments in writing and delivered to all trustees serving at the time at least sixty (60) days before the proposed dates of termination.

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTIONS

Each Participant covered under this Plan will be issued a Plan Document/Summary Plan Description (SPD) 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 will have 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 will also have the right to have an autopsy performed in case of death to the extent permitted by law.

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. No payments will be made to any provider of services unless the Covered Person is liable for such expenses.

The Plan will not recognize assignments of payment of benefits from non-Participating Providers. The Plan, at the discretion of the Plan Administrator, will pay the Procedure Based Maximum Expense (PBME) (Referenced Based Pricing) amount to the Covered Person or to the Covered Person and the provider jointly who incurred the claim (or the Participant, Qualified Beneficiary or Alternate Recipient if the Covered Person is a minor), and will notify 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 the payment of any benefit. Any payment made under this subsection will constitute a complete discharge of the Plan’s obligation to the extent of such payment and the Plan will not be required to oversee the application of the money so paid.

LEGAL PROCEEDINGS

No action at law or equity will 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 will 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.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan will be waived, and there will be 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 will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

VERBAL STATEMENTS

Verbal statements or representations of MACoHCT, 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 MACoHCT, its agents and Employees, or Covered Persons will 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 will 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 will have free choice of any licensed Physician, Licensed Health Care Provider or surgeon and the patient-provider relationship will be 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 will be amended to conform; all other parts of the Plan will 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 will affect the right thereafter to enforce such provision, nor will 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 will 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 will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability under this Plan.

The benefits that are payable will 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 will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If MACoHCT finds that such an attempt has been made with respect to any payment due or which will become due to any Participant, MACoHCT, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, MACoHCT will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as MACoHCT may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Plan Document/Summary Plan Description constitutes the primary authority for Plan administration. The establishment, administration and maintenance of this Plan will not be deemed to constitute a contract of employment, give any Participant of each Member Group or Sub-Entity the right to be retained in the service of the Member Group or Sub-Entity, or to interfere with the right of the Member Group or Sub-Entity to discharge or otherwise terminate the employment of any Participant.
GENERAL DEFINITIONS

Certain words and phrases in this Plan Document/Summary Plan Description are defined below and references of such words or phrases will be capitalized when used throughout the Plan Document/Summary Plan Description. The failure of a word or phrase to appear capitalized does not waive the special meaning given to that word or phrase, unless the context requires otherwise. 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/Summary Plan Description 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.

ACCIDENTAL INJURY

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

ACTIVE SERVICE

“Active Service” means that an Employee is in service with the Member Group or Sub-Entity on a day for which the Employee is compensated at his regular rate of pay for the members regularly scheduled work or by the use of statutory vacation leave, statutory sick leave, statutory holiday pay or compensatory time for hours previously worked. Workers’ Compensation and Disability payments are not considered compensated time for the purpose of Active Service.

ADVERSE BENEFIT DETERMINATION

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

ALCOHOLISM

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

ALCOHOLISM AND/OR CHEMICAL DEPENDENCY TREATMENT FACILITY

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

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

AMBULATORY SURGICAL CENTER

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

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

BENEFIT PERCENTAGE

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

BENEFIT PERIOD

“Benefit Period” refers to a time for each Member Group or Sub-Entity as defined in the Schedule of Medical Benefits and as amended from time to time. Such Benefit Period will terminate on the earliest of the following dates:

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

BIRTHING CENTER

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

CALENDAR YEAR

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

CERTIFIED NURSE MIDWIFE

“Certified Nurse Midwife” (CNM) means an individual who has received advanced nursing training and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

CHEMICAL DEPENDENCY

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

“CIGNA LifeSOURCE Facility” means any Network facility (or Supplemental Network or Optum Network if applicable) that provides transplant or other complex medical services as applicable and for which the Plan Administrator is able to obtain a discount for services.

COBRA

“COBRA” means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

“COBRA Continuation Coverage” means the coverage provided under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 and its amendments.

CONVALESCENT NURSING FACILITY

See “Skilled Nursing Facility.”

COSMETIC

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

COVERED PERSON

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

CUSTODIAL CARE

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

DEDUCTIBLE

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

DENTAL HYGIENIST

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

DENTALLY NECESSARY

“Dentally Necessary” 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.

**DENTURIST**

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

**DEPENDENT**

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

**DEPENDENT COVERAGE**

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

**DURABLE MEDICAL EQUIPMENT**

“Durable Medical Equipment” means equipment which is:

1. Able to withstand repeated use, e.g., could normally be rented, and used by successive patients; and

2. Primarily and customarily used to serve a medical purpose; and

3. Not generally useful to a person in the absence of Illness or Injury.

**ELIGIBLE EXPENSES**

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

“Emergency” means acute symptoms that a prudent layperson with average knowledge of health and medicine would expect that the absence of medical attention would place the individual's health in serious jeopardy, or seriously impair body functions, organs or parts.

EMPLOYEE

“Employee” means a person employed by a Member Group or Sub-Entity, recognized by a Member Group or Sub-Entity as a common-law Employee and who is on the Member Group’s or Sub-Entity’s W-2 payroll.

EMPLOYER

“Employer” means the County or any affiliated agencies, special districts or boards that have adopted this Plan for its Employees.

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


EXPERIMENTAL/INVESTIGATIONAL

“Experimental/Investigational” means:

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

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

3. That the drug, device or medical treatment or procedure is under study, prior to or in the absence of any clinical trial, to determine its maximum tolerated dose, its toxicity, or its safety; or

4. That based upon Reliable Evidence, the drug, device, medical treatment or procedure is the subject of an on-going Phase I or Phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not considered Experimental or Investigational.) For chemotherapy regimens, a Phase II clinical trial is not considered Experimental or Investigational when both of these criteria are met:

   A. The regimen or protocol has been the subject of 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 listed by the National Comprehensive Cancer Network is supported by level of evidence Category 2B or higher; or
5. Based upon Reliable Evidence, any drug, device, medical treatment or procedure that the prevailing opinion among experts is that further studies or clinical trial are necessary to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or

6. Any drug, device, medical treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, Centers for Medicare and Medicaid Services (CMS), American Dental Association, American Medical Association).

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

FAMILY

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

FMLA

“FMLA” means Family and Medical Leave Act.

GENDER IDENTITY DISORDER/ GENDER DYSPHORIA

DSM-V diagnosis in children:

1. A definite difference between experienced/expressed gender and the one assigned at birth of at least six (6) months duration. At least six (6) of the following must be present:

   A. Persistent and strong desire to be of the other sex or insistence that they belong to the other sex.
   B. In male children, a strong preference for cross-dressing and in female children, a strong preference for wearing typical masculine clothing and dislike or refusal to wear typical feminine clothing.
   C. Fantasizing about playing opposite gender roles in make-belief play or activities.
   D. Preference for toys, games or activities typical of the opposite sex.
   E. Rejection of toys, games and activities conforming to one’s own sex. In male children, avoidance of rough-and-tumble play, and in female children, rejection of typically feminine toys, games and activities.
   F. Preference for playmates of the other sex.
   G. Dislike for sexual anatomy. Male children may hate their penis and testes, and female children may dislike urinating sitting.
   H. Desire to acquire the primary and/or secondary sex characteristics of the opposite sex.

2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The subtypes may be ones with or without defects or defects in sexual development.
DSM-V diagnosis in adolescents and adults:

1. A definite mismatch between the assigned gender and experienced/expressed gender for at least six (6) months duration as characterized by at least two (2) or more of the following features:

   A. Mismatch between experienced or expressed gender and gender manifested by primary and/or secondary sex characteristics at puberty.
   
   B. Persistent desire to rid oneself of the primary or secondary sexual characteristics of the biological sex at puberty.
   
   C. Strong desire to possess the primary and/or secondary sex characteristics of the other gender.
   
   D. Desire to belong to the other gender.
   
   E. Desire to be treated as the other gender.
   
   F. Strong feeling or conviction that he or she is reacting or feeling in accordance with the identified gender.

2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

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

HIPAA

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

HOME HEALTH CARE AGENCY

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

HOME HEALTH CARE PLAN

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

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) or Licensed Vocational Nurse (LVN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.
HOSPICE BENEFIT PERIOD

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

HOSPITAL

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

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an emergent or Inpatient basis at the patient's expense; and

2. It is licensed as a Hospital or a critical access hospital under the laws of the jurisdiction in which the facility is located; and

3. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an Illness or an Injury or provides for the facilities through arrangement or agreement with another hospital; and

4. It provides treatment by or under the supervision of a Physician or osteopathic Physician with nursing services by Registered Nurses as required under the laws of the jurisdiction in which the facility is licensed; and

5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and

6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

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

ILLNESS

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

INCURRED EXPENSES OR EXPENSES INCURRED

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

INITIAL ENROLLMENT PERIOD

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

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

INPATIENT

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

INTENSIVE CARE UNIT

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

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

LICENSED HEALTH CARE PROVIDER

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

LICENSED PRACTICAL NURSE

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

LICENSED PROFESSIONAL COUNSELOR

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

LICENSED SOCIAL WORKER

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

LICENSED VOCATIONAL NURSE

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

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

MEDICAID

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

MEDICALLY NECESSARY OR MEDICAL NECESSITY

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

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

MEDICAL POLICY

“Medical Policy” means a policy adopted by the Plan which is created and updated by Physicians and other medical providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

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

MEMBER GROUP

“Member Group” means a Member Entity or Affiliate Entity as defined by the MACoHCT Agreement and Declaration of Trust Amended and Restated that have adopted this Plan for its Employees.

MENTAL ILLNESS

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

MMSERA

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

NAMED FIDUCIARY

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

NEWBORN

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

NON-PARTICIPATING PROVIDER

A “Non-Participating Provider” means a provider who is not a Participating Provider.

OCURRENTINAL THERAPY

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

ORTHODONTIC TREATMENT

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

ORTHODONTIST

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

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

OUT-OF-POCKET MAXIMUM

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

OUTPATIENT

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

PARTIAL HOSPITALIZATION

“Partial Hospitalization” means care in a day care or night care facility for a minimum of twenty (20) hours per week, during which therapeutic clinical treatment is provided.

PARTICIPANT

“Participant” means an Employee, County Elected Official or County Appointed Official of a Member Group or Sub-Entity who is eligible and enrolled for coverage under this Plan.

PARTICIPATING PROVIDER

“Participating Provider” means a provider that agrees to provide services as part of an agreement.

PHYSICAL THERAPY

“Physical Therapy” means a plan of care provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

PHYSICIAN

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

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 Montana Association of Counties Health Care Trust for Member Groups or Sub-Entities, the Plan Document/Summary Plan Description and any other relevant documents pertinent to its operation and maintenance.
PLAN ADMINISTRATOR

“Plan Administrator” means Montana Association of Counties Health Care Trust (MACoHCT) which is responsible for the day-to-day functions and management of the Plan. MACoHCT may employ persons or firms to process claims and perform other Plan-connected services.

PLAN SPONSOR

“Plan Sponsor” is the Montana Association of Counties.

PLAN SUPERVISOR

“Plan Supervisor” is Allegiance Benefit Plan Management, Inc.

PLAN YEAR

“Plan Year” means the period of time for each Member Group or Sub-Entity as defined in the Schedule of Medical Benefits and as subsequently amended from time to time.

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.

PROCEDURE BASED MAXIMUM EXPENSE or PBME (REFERENCED BASED PRICING)

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

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

The PBME (Referenced Based Pricing) for Emergency Services will apply to both Participating Providers and non-Participating Providers, but only during the time that the medical Emergency exists and will cease to apply when the Covered Person’s condition is stable and no longer emergent. When the PBME (Referenced Based Pricing) for Emergency Services ceases to apply, the PBME (Referenced Based Pricing) for the applicable additional services, if any, will apply.
For non-contracted providers for emergency services, air ambulance and non-contracted providers providing services in a contracted facility, the PBME is equal to and used as the Qualified Payment Amount for No Surprises Billing Act purposes.

**PROSTHETIC APPLIANCE**

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

**PSYCHIATRIC CARE**

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

**PSYCHIATRIC FACILITY**

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

**PSYCHOLOGIST**

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

**QMCSO**

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

**QUALIFIED BENEFICIARY**

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

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

**REGISTERED NURSE**

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

**REHABILITATION THERAPY**

“Rehabilitation Therapy” is specialized treatment monitored/provided by a Multi-disciplinary Team providing multi-modality treatment in either an inpatient or outpatient basis for an Injury or physical deficit, with the purpose of restoring or bringing body function to a condition of function as near as possible to what it was before the Illness or loss of body part or body function. Rehabilitative services include, but are not limited to, physical therapy, occupational therapy, speech therapy and cardiac rehabilitation.
General Definitions

Care provided must be under the direction of a qualified Physician and have a formal written treatment plan with a specific goal.

“Multi-disciplinary Team” in this context is a group of health service providers who must be either licensed, certified or otherwise approved to practice their respective professions in the state where the services are provided.

RESIDENTIAL TREATMENT FACILITY

“Residential Treatment Facility” means an institution which:

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

RETIREE

“Retiree” means a former covered Employee of a Member Group or Sub-Entity who meets the Plan’s Retiree eligibility requirements and is enrolled for coverage under this Plan.

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.

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 can request coverage under this Plan as a result of certain events that create special enrollment rights.

SPEECH THERAPY

“Speech Therapy” means a course of treatment to treat speech deficiencies or impediments.
SUB-ENTITY

“Sub-Entity” means an Employer which can obtain health coverage for its Employees under a group health plan sponsored by a Member Entity as authorized by 2-18-705, MCA. A Sub-Entity does not include a medical facility, nursing home, long-term care facility, economic development corporation or other employers as defined by 2-18-705, MCA, whose Employees are W-2 Employees of a county under the county’s employer identification number.

TELEMEDICINE

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

URGENT CARE FACILITY

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

USERRA

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

For groups composed of public employees and officers, an Employee who was an eligible covered Employee under this Plan on the day immediately before the date of retirement and who meets the retirement eligibility established by law or Employer, may continue to remain a member of the Health Benefits Plan.

SPOUSE AND DEPENDENT CHILDREN COVERAGE

The spouse of a retired covered Employee who was an eligible covered spouse under this Plan on the day immediately before the date of retirement may continue to remain a member of the Health Benefits Plan.

The surviving spouse of a retired covered Employee shall be provided the opportunity to remain a member of the group as long as the spouse is eligible for retirement benefits accrued by the deceased covered Employee.

The surviving children of a deceased covered Employee may remain members of the group as long as they are eligible for retirement benefits accrued by the deceased covered Employee.

Persons meeting these requirements who wish to remain members of the group must furnish satisfactory evidence of their qualifications to the Plan Supervisor within thirty (30) days after such eligibility commences and make arrangements for payment of premium through the Member Group or Sub-Entity.
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 as applicable.

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 stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Call the Montana Association of Counties Health Care Trust claims number at (888) 883-3233 for more information.

An additional copy of the WHCRA notice is provided below to be shared with covered Dependent(s)

This Plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Call the Montana Association of Counties Health Care Trust claims number at (888) 883-3233 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 Participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Documents/Summary Plan Descriptions 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/Summary Plan Descriptions 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/Summary Plan Description 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/Summary Plan Descriptions 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.
## PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION

FOR THE

MONTANA ASSOCIATION OF COUNTIES HEALTH CARE TRUST

APPENDIX A

MEMBER GROUPS PLAN YEAR/BENEFIT PERIOD/OPEN ENROLLMENT PERIOD

<table>
<thead>
<tr>
<th>GROUP #</th>
<th>COUNTY</th>
<th>PLAN YEAR</th>
<th>BENEFIT PERIOD</th>
<th>OPEN ENROLLMENT PERIOD</th>
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