Bozeman School District #7

YOUR GROUP HEALTH, VISION AND DENTAL PLAN

HSA $5,000

Plan Document

Effective September 1, 2016

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Blue Cross and Blue Shield of Montana, a division of Health Care Service Corporation is not affiliated with, and does not pay claims for the Bozeman School District #7 Dental and Vision Plans.
FOR CUSTOMER SERVICE AND PREAUTHORIZATION
Call 1-855-258-3489

www.bcbsmt.com
- BCBSMT Provider Directory
- Wellness
- Other Online Services and Information

BLUECARD NATIONWIDE/WORLD WIDE COVERAGE PROGRAM
1-800-810-BLUE (2583) – http://provider.bcbs.com

FOR APPEALS
Urgent Care Appeals Only: 1-800-447-7828
Other Appeals: Send via fax to 1-406-437-7875 or mail to BCBSMT at address below

FOR PRESCRIPTION DRUG BENEFITS

Pharmacy Benefit Manager (PBM)
- Prime Therapeutics 1-800-423-1973
- For preauthorizations, fax: 1-877-243-6930

PBM Website
www.myprime.com

Claim Forms 1-866-325-5230
Pharmacy Locator 1-866-325-5230

Specialty Care Pharmacy (Prime Therapeutics Specialty Pharmacy LLC)
1-877-627-MEDS (6337)
- www.primetherapeutics.com/specialty
- Prescriber Fax 1-877-828-3939

Mail Order Services
- PrimeMail 1-866-325-5230
  PO Box 27836
  Albuquerque, NM 87125-7836
- Ridgeway Mail-Order Pharmacy 1-800-630-3214
  2824 US Hwy 93 North
  Victor, MT 59875

Blue Cross and Blue Shield of Montana
560 North Park Avenue
PO Box 4309
Helena, MT 59604-4309

FOR CLAIMS
Blue Cross and Blue Shield of Montana
PO Box 7982
Helena, MT 59604-7982
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HEALTH BENEFIT PLAN FOR EMPLOYEES OF BOZEMAN SCHOOL DISTRICT # 7

PLAN OPERATION

Plan Name
Bozeman School District # 7 Employee Health Benefit Plan

Type of Plan
Bozeman School District # 7 maintains the Employee Health Benefit Plan for the exclusive benefit of and to provide health benefits to its eligible employees, retired employees, their legal spouses, and eligible dependents. The Plan provides hospital, medical and surgical coverage for eligible Participants.

Type of Participants Covered by the Plan
Employees, retirees, their legal spouses, and their eligible dependent children may participate based upon the eligibility requirements set forth in the Plan.

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

Plan Sponsor's Identification Number
81-6000413

Plan Number
501

Plan Effective Date
September 1, 2016

Plan Benefit Year
September 1 through August 31

Plan Year
September 1 through August 31

Plan Administrator
Steve Johnson
Deputy Superintendent Operations
404 West Main St
PO Box 520
Bozeman, MT 59771

Named Fiduciary(ies)
Steve Johnson
Deputy Superintendent Operations
404 West Main St
PO Box 520
Bozeman, MT 59771
Type of Administration

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

Claim Administrator

Blue Cross and Blue Shield of Montana
560 North Park Avenue
P.O. Box 4309
Helena, MT 59604
1-800-447-7828

Claim Administrator’s Disclosures

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

Certain Responsibilities of the Employer and the Claim Administrator

Employer responsibility

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

Claim Administrator responsibility

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

Relationship of Parties

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

In relation to the Plan

The Employer hereby acknowledges (i) that an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee welfare benefit plan document of the Employer, the Employer agrees that no allocation or delegation of any fiduciary or non–fiduciary responsibilities under the Plan or any other employee welfare benefit plan of the Employer is effective with respect to or accepted by the Claim Administrator.

In relation to the Plan Administrator/Named Fiduciary(ies)

The Claim Administrator is not the plan administrator of the Employer’s separate employee welfare benefit plan as defined under ERISA. It is understood and agreed that (i) the Employer has a named Plan Administrator and a Named Fiduciary within the meaning of § 414(g) of the Internal Revenue Code of 1986, as amended; (ii) said Plan Administrator serves within the meaning of § 3(16)(A) of ERISA; and (iii) the Claim Administrator is not a fiduciary of the Employer, the Plan Administrator or of the Plan.

In relation to the Claim Administrator’s responsibilities

The Claim Administrator’s responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of the Employer’s plan. As such, the Claim Administrator is intended to be a service provider but not a fiduciary with respect to the Employer’s ERISA employee welfare benefit plan. The Employer represents that its ERISA employee welfare benefit plan contains the plan procedure described above regarding the designation of responsibilities under a plan and, accordingly, the Claim Administrator may, pursuant to Sections 402(c)(2) and 405(c)(1)(B) of ERISA, render advice with respect to claims and administer claims on behalf of the plan administrator of the Employer’s ERISA welfare benefit plan. The Claim Administrator has no other authority or responsibility with respect to Employer’s ERISA employee welfare benefit plan.

Funding Mechanism

Benefits under this Plan are funded from employee, retired employees and employer contributions up to the benefit limits defined in the Plan Document. Payments are made from this fund to pay benefits.

Source of Contribution

Contributions for employees and covered family members are paid in part by the Plan Sponsor out of its general assets and in part by employees.

Agent for Service of Legal Process

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

Amendment, Termination, or Modification of the Plan

The Plan Administrator reserves the right to amend, modify or terminate the Plan in whole or in part at any time. Expenses incurred prior to the effective date of any amendment are based on the provisions in effect at the time the expenses were incurred.
INTRODUCTION

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

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

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

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

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

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

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

Preauthorization. Explains the methods used to curb unnecessary and excessive charges.

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

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

Exclusions and Limitations. Shows what charges are not covered.


Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

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

Definitions. Defines those Plan terms that have a specific meaning.
Certain terms in this Plan Document are defined in the Definitions section. Defined terms are capitalized.

## SCHEDULE OF BENEFITS

### Employee Health Benefit Plan

<table>
<thead>
<tr>
<th>Group Name:</th>
<th>Bozeman School District #7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Number:</td>
<td>X66680</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>September 1, 2016</td>
</tr>
<tr>
<td>Benefit Period:</td>
<td>September 1 to August 31</td>
</tr>
</tbody>
</table>

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

### Deductible:

<table>
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<tr>
<th></th>
<th>Individual:</th>
<th>Family:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible:</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

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

Deductible does not apply to the following Benefits:

- Generic Preventive Prescription Drugs
- Preventive Health Care
- Well-Child Care

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

<table>
<thead>
<tr>
<th>Coinsurance:</th>
<th>In-Network:</th>
<th>None</th>
</tr>
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<tbody>
<tr>
<td>Out-of-Network:</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of Pocket Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of Pocket Amount:</th>
<th>$5,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

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

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

- Charges in excess of the Allowable Fee
- Transplants not provided at a Center of Excellence

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

### Term of Plan Document: Monthly
### BENEFIT INFORMATION

Deductible applies to all services unless noted otherwise.

<table>
<thead>
<tr>
<th>BENEFIT INFORMATION</th>
<th>IN-NETWORK COINSURANCE/ COPAYMENT</th>
<th>OUT-OF-NETWORK COINSURANCE/ COPAYMENT</th>
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<tr>
<td><strong>Accident Benefit</strong></td>
<td>Professional Provider Services</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Facility Services</td>
<td>None</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Autism Spectrum Disorders</strong></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Services, except [medications/prescription drugs and] Applied Behavior Analysis (ABA) services that are described in the Benefit section entitled Autism Spectrum Disorders are covered under medical Benefits. Medications/prescription drugs are covered under the Prescription Drug Pharmacy Integrated Benefit. ABA services are only covered for Participants under 19 years of age</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Chemical Dependency Treatment</strong></td>
<td>Outpatient</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Maximum Number of Visits Covered per Benefit Period – 45</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Counseling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum Number of Visits Covered per Benefit Period – 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Maximum per Benefit Period – 30 Days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Detoxification – 3 Days</td>
<td></td>
</tr>
<tr>
<td>The Plan will pay up to 30 days of Inpatient Care per Participant per Benefit Period for professional services, Hospital services, or services of a Freestanding Inpatient Facility. The Participant may exchange one day of inpatient hospitalization for two days of Partial Hospitalization. This means two days of Partial Hospitalization will count as one day for the purpose of accumulating the overall 30 day maximum inpatient Chemical Dependency Benefit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colonoscopies</strong></td>
<td>Routine*</td>
<td>None, No Deductible</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>*Colonoscopies with a Routine diagnosis are paid under the Preventive Health Care Benefit for Participants age 50 and older.</td>
<td></td>
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<tr>
<td><strong>Convalescent Home Services</strong></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Maximum Per Benefit Period – 90 Days</td>
<td></td>
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<tr>
<td><strong>Diabetic Education Benefit</strong></td>
<td></td>
<td>None</td>
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<tr>
<td><strong>Diagnostic Services</strong></td>
<td>Professional Provider Services</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Facility Services</td>
<td>None</td>
</tr>
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<td><strong>Durable Medical Equipment</strong></td>
<td>Rental (up to Purchase Price), Purchase and Repair and Replacement of Durable Medical Equipment</td>
<td>None</td>
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<td><strong>Emergency Room Care</strong></td>
<td>Professional Provider Services</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Facility Services</td>
<td>None</td>
</tr>
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<td><strong>Foot Orthotics</strong></td>
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### SCHEDULE OF BENEFITS, continued

#### BENEFIT INFORMATION
Deductible applies to all services unless noted otherwise.

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK COINSURANCE/ COPAYMENT</th>
<th>OUT-OF-NETWORK COINSURANCE/ COPAYMENT</th>
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<tbody>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Maximum Per Benefit Period – 100 Visits</td>
<td>None</td>
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<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Inpatient Day Maximum – 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Maximum per Day – $200*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Lifetime Maximum – $7,500*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bereavement Counseling Maximum per Benefit Period – 500*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite Care Maximum per Benefit Period – $2,500*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*All Hospice services are included in the $7,500 lifetime maximum.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Facility Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Mammograms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine</td>
<td>None, No Deductible</td>
<td>None, No Deductible</td>
</tr>
<tr>
<td>Medical</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Facility Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Medical Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Illness (Including Severe Mental Illness)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Treatment per Benefit Period – 35 Visits</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient Treatment per Benefit Period – 30 Days</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>The Plan will pay up to 30 days of Inpatient Care per Participant per Benefit Period for professional services, Hospital services, or services of a Freestanding Inpatient Facility. The Participant may exchange one day of inpatient hospitalization for two days of Partial Hospitalization. This means two days of Partial Hospitalization will count as one day for the purpose of accumulating the overall 30-day maximum inpatient Mental Illness Benefit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Inpatient Treatment Maximum Benefit - 60 Days</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Newborn Initial Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Facility Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Office Visit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit and any Covered Services provided during the office visit.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Orthopedic Devices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Facility Services – Inpatient and Outpatient</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>BENEFIT INFORMATION</td>
<td>IN-NETWORK COINSURANCE/ COPAYMENT</td>
<td>OUT-OF-NETWORK COINSURANCE/ COPAYMENT</td>
</tr>
<tr>
<td>---------------------</td>
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</tr>
<tr>
<td><strong>Physician Medical Services</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Prescription Drug Pharmacy Integrated Benefit</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Refer to the last page of this Schedule of Benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Health Care</strong></td>
<td>None, No Deductible</td>
<td>None, No Deductible</td>
</tr>
<tr>
<td><strong>Prostheses Benefit</strong></td>
<td>Rental (up to Purchase Price), Purchase and Repair and Replacement of Prosthetics</td>
<td>None</td>
</tr>
<tr>
<td><strong>Rehabilitation Therapy</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Facility Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Sigmoidoscopies</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Facility Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Sigmoidoscopies with a Routine diagnosis are paid under the Preventive Health Care Benefit for Participants age 50 and older.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgery Center Services - Outpatient</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Facility Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Therapies – Outpatient</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Professional Provider Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Facility Services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Maximum Benefit per Benefit Period for Physical Therapy on the spinal column – 10 Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Benefits at a Center of Excellence</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Travel Expenses</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Maximum per Transplant – $2,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lodging and Meals</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Maximum per Day – $100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits for travel, lodging and meals if the Participant lives more than 50 miles from the approved facility and the expenses are incurred within 4 days of the procedure to discharge to home date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits at any Facility other than a Center of Excellence* – $5,000 Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Travel, lodging and meal expenses are not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*This Deductible is separate from the medical Deductible and does not apply to the Out of Pocket Amount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Travel, Meals and Lodging Benefit</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Maximum Benefit Per Day – $40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Number of Days Per Benefit Period – 60</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>BENEFIT INFORMATION</td>
<td>IN-NETWORK COINSURANCE/ COPAYMENT</td>
<td>OUT-OF-NETWORK COINSURANCE/ COPAYMENT</td>
</tr>
<tr>
<td>-------------------------------------</td>
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<td>--------------------------------------</td>
</tr>
<tr>
<td>Well-Child Care Services</td>
<td>None, No Deductible</td>
<td>None, No Deductible</td>
</tr>
</tbody>
</table>
### Prescription Drug Information

<table>
<thead>
<tr>
<th></th>
<th>Maximum</th>
<th>Deductible</th>
<th>Copayment/Coinsurance</th>
</tr>
</thead>
</table>

**Prescription Drug Pharmacy Integrated Benefit**

(The Prescription Drug Pharmacy Integrated Benefit utilizes a Drug List.) Deductible does not apply to certain contraceptive products. Refer to the Preventive Health Care Benefit. Deductible also does not apply to smoking cessation products and over-the-counter aids/medications, for two 90-day treatment regimens.

#### Retail Pharmacy Prescriptions
- **34-day supply**: Applies, None

#### Mail Service Maintenance Prescriptions
- **90-day supply**: Applies, None

#### Extended Supply Network
- **Retail Pharmacy**
  - **90-day supply**: Applies, None

#### Preventive Medications
- **Retail Pharmacy**
  - **34-day supply**
    - Generic: Does Not Apply
    - Brand-Name (Formulary): Does Not Apply
    - Brand-Name (Non-Formulary): Does Not Apply
  - **90-day supply**
    - Generic: Does Not Apply
    - Brand-Name (Formulary): Does Not Apply
    - Brand-Name (Non-Formulary): Does Not Apply

#### Mail Order Pharmacy
- **90-day supply**
  - Generic: Does Not Apply
  - Brand-Name (Formulary): Does Not Apply
  - Brand-Name (Non-Formulary): Does Not Apply

#### Extended Supply Network
- **90-day supply**
  - Generic: Does Not Apply
  - Brand-Name (Formulary): Does Not Apply
  - Brand-Name (Non-Formulary): Does Not Apply
ELIGIBILITY AND COVERAGE

Eligibility for Participation

The following Participants are eligible for participation in the Plan:

1. Active Employees who are eligible for coverage per the terms of:
   a. A collective bargaining agreement; or
   b. The District Policies manual.

2. Medicare eligible retirees, and Medicare eligible spouses of Employees and retirees, that reside outside of the state of Montana, who are eligible for coverage per the terms of:
   a. A collective bargaining agreement; or
   b. The District Policies manual.

3. Non-Medicare eligible retirees and non-Medicare eligible spouses and dependents who are eligible per the terms of:
   a. A collective bargaining agreement; or
   b. The District Policies manual.

4. Classified Employees regularly scheduled to work 20 or more hours per week.

5. Employees in a class eligible for coverage.

Both Husband and Wife as Employees

1. Any person covered under the Plan as an Employee cannot be covered under the Plan as a dependent.

2. Children will be covered as a dependent of the mother or father, but not both.

Declining Coverage

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

Enrollment

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

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

   Charges for covered Routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.
For coverage of sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child must be enrolled as a dependent under this Plan within 31 days of the child’s birth in order for non-routine coverage to take effect from the birth.

3. Timely (Initial or Late) Enrollment.
   a. Timely Initial Enrollment. The enrollment will be “timely” if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.
   b. Late Enrollment. An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late Enrollees and their dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during Open Enrollment.

   If an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment, or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

   The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on September 1.

4. Open Enrollment.

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

5. Plan Identification Card.

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


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

7. Special Enrollment When Other Coverage is Lost.
   a. Eligible Individuals. A special enrollment period may be available if an eligible Employee, when initially eligible, declined enrollment for himself/herself and/or the spouse and/or dependents because of coverage under other health insurance. When that coverage ends, the following persons can enroll:
      1. Eligible Employee
      2. Dependents of the covered Employee, including the spouse
      3. Eligible Employee and dependents, including the spouse
   b. Conditions for Special Enrollment. When the Employee declined enrollment for the Employee and/or eligible Family Members, and the Employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment, the Employee and/or eligible Family Members will be eligible to enroll if either of the following occurs:
      1. The Employee or Family Member had COBRA continuation coverage and the COBRA continuation coverage has expired; or
      2. The Employee or Family Member had other coverage that was not under a COBRA continuation provision and the other coverage has been terminated because either of the following occurs:
         a. A loss of eligibility for the coverage. Loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of
The Employee or Family Member loses eligibility under either the Children’s Health Insurance Program or the Medicaid Program, or the Employee or Family Member becomes eligible for financial assistance for group health coverage, under either the Children’s Health Insurance Program or the Medicaid Program.

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

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

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

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

8. **Special Enrollment for Marriage, Birth, Adoption, or Placement for Adoption.**

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

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

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

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

1. In the case of marriage, the date of marriage if the completed request for enrollment (application) is received by the Plan within 31 days after the date of marriage. If the application is received after 31 days of the date of marriage, the enrollee will be considered a Late Enrollee.

2. In the case of the dependent’s birth, the date of such birth. Within 31 days from the date of birth, the Plan must be notified and any premiums/fees must be paid or the child will not have coverage.

   In addition, coverage for the newborn child will be provided only if the Beneficiary Member remains covered on the health plan. Coverage for a Dependent’s newborn child will be provided only if the Beneficiary Member adopts the newborn child, or is the legal guardian of the newborn child.

3. In the case of the dependent’s adoption or placement for adoption, the date of such an event. In the event the placement for adoption is disrupted prior to the legal adoption and the child is removed from placement, coverage shall cease upon the date the placement is disrupted.

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

**PROVIDERS OF CARE FOR PARTICIPANTS**

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

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

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

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

The Participant may obtain a list of Participating Providers from Blue Cross and Blue Shield of Montana free of charge by contacting the Plan at the number listed on the inside cover of this Plan Document.

**PPO Providers**

Blue Cross and Blue Shield of Montana has a PPO Network of Hospitals and surgery centers in Montana that is utilized under this Benefit Plan. Outside of the state of Montana, there are also Blue Cross and/or Blue Shield PPO Hospitals and surgery centers nationwide.

**Out of State Services**

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

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

*Some Blue Cross and/or Blue Shield Plans require services to be provided by a PPO professional provider for the Participant to receive the In-Network level of Benefit. Contact the Plan for additional information on out of state services.

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

**Out of PPO Network Referrals**

There may be circumstances under which the most appropriate treatment for the Participant’s condition is not available through the PPO Network. When this occurs, it is recommended the Participant’s attending Physician contact the Claim Administrator for an out-of-PPO Network referral. If the Claim Administrator approves the referral, those services will process with the In-Network Coinsurance. If the referral is not approved and the Participant chooses to obtain services from a non-PPO Network provider, the Participant will be responsible for any difference between the Blue Cross and Blue Shield of Montana Allowable Fee and the provider’s billed charges.

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

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

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

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

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

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

Claim Payment Assignment

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

Claim Dispute

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

OUT-OF-AREA SERVICES – THE BLUECARD PROGRAM

Out-of-Area Services

Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever a Plan Participant obtains healthcare services outside of the Blue Cross and Blue Shield of Montana service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

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

1. BlueCard® Program

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

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

- The billed covered charges for the Plan Participant’s covered services; or
- The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Montana.

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

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

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

2. Non-Participating Healthcare Providers Outside of the Blue Cross and Blue Shield of Montana Service Area

a. Plan Participant Liability Calculation

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

b. Exceptions

In certain situations, Blue Cross and Blue Shield of Montana may use other payment bases, such as billed covered charges, the payment Blue Cross and Blue Shield of Montana would make if the healthcare services had been obtained within the Blue Cross and Blue Shield of Montana service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Blue Cross and Blue Shield of Montana will pay for services rendered by non-participating healthcare providers. In these situations, the Plan Participant may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

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**PREAUTHORIZATION**

The Claim Administrator has designated certain covered services which require Preauthorization in order for the Participant to receive the maximum Benefits possible under this Plan Document.

The Participant is responsible for satisfying the requirements for Preauthorization. This means that the Participant must request Preauthorization or assure that the Participant’s Physician, provider of services, the Participant’s
authorized representative, or a Family Member complies with the requirements below. If the Participant utilizes a Network Provider for covered services, that provider may request Preauthorization for the services. However, it is the Participant’s responsibility to assure that the services are preauthorized before receiving care.

To request Preauthorization, the Participant or his/her Physician must call the Preauthorization number shown on the Participant’s Identification Card before receiving treatment. The Claim Administrator will assist in coordination of the Participant’s care so that his/her treatment is received in the most appropriate setting for his/her condition and that the Participant receives the highest level of Benefits under this Plan Document.

Preauthorization does not guarantee that the care and services a Participant receives are eligible for Benefits under The Plan Document. In addition, a nonparticipating provider or non-PPO provider can bill the Participant for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus Deductible, Coinsurance and/or Copayment even if the service is an Emergency Service or if the service has been Preauthorized.

Preauthorization Process for Inpatient Services
For an Inpatient facility stay, the Participant must request Preauthorization from the Claim Administrator before the Participant’s scheduled admission. The Claim Administrator will consult with the Participant’s Physician, Hospital, or other facility to determine if Inpatient level of care is required for the Participant’s illness or injury. The Claim Administrator may decide that the treatment the Participant needs could be provided just as effectively in a different setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician’s office).

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

If the Participant does not request Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant will be responsible for the full cost of the services.

Preauthorization Process for Mental Illness, Severe Mental Illness and Chemical Dependency Services
All Inpatient and partial hospitalization services related to treatment of Mental Illness, Severe Mental Illness and Chemical Dependency must be Preauthorized by the Claim Administrator.

Preauthorization is not required for therapy visits to a Physician or other professional Provider licensed to perform covered services under this Plan Document. However, all services are subject to the provisions in the section entitled Concurrent Review.

If the Claim Administrator determines that the Participant’s treatment does not require Inpatient or partial hospital level of care, the Participant and the Participant’s Provider will be notified of that decision. If the Participant proceeds with an Inpatient stay or partial hospital level of care, without the Claim Administrator's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant does not request Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant will be responsible for the full cost of the services.

Preauthorization Process for Other Outpatient Services
In addition to the Preauthorization requirements outlined above, the Claim Administrator also requires Preauthorization for certain Outpatient services, including Home Health Care, Hospice Services and Home Infusion Therapy. For additional information on Preauthorization, the Participant or the Provider may call the Customer Service number on the Participant’s identification card.

It is NOT necessary to preauthorize standard x-ray and lab services or Routine office visits.
If the Claim Administrator does not approve the Outpatient Service, the Participant and the Participant’s Provider will be notified of that decision. If the Participant proceeds with the services without the Claim Administrator’s approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant does not request Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

The Benefits section of this Plan Document details the services which are subject to Preauthorization.

Preauthorization Request Involving Non-Urgent Care

Except in the case of a Preauthorization Request Involving Urgent Care (see below), the Claim Administrator will provide a written response to the Participant’s Preauthorization request no later than 15 days following the date we receive the Participant’s request. This period may be extended one time for up to 15 additional days, if we determine that additional time is necessary due to matters beyond our control.

If the Claim Administrator determines that additional time is necessary, the Claim Administrator will notify the Participant in writing, prior to the expiration of the original 15-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to make the determination.

If an extension of time is necessary due to the need for additional information, the Claim Administrator will notify the Participant of the specific information needed, and the Participant will have 45 days from receipt of the notice to provide the additional information.

The Claim Administrator will provide a written response to the Participant’s request for Preauthorization within 15 days following receipt of the additional information. The procedure for appealing an adverse Preauthorization determination is set forth in the section entitled Complaints and Grievances.

Preauthorization Request Involving Urgent Care

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

In case of a Preauthorization Request Involving Urgent Care, the Claim Administrator will respond to the Participant no later than 72 hours after receipt of the request, unless the Participant fails to provide sufficient information, in which case, the Participant will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. A Benefit determination will be made as soon as possible (taking into account medical exigencies) but no later than 72 hours after the initial request, or within 48 hours after the missing information is received (if the initial request is incomplete).

NOTE: The Claim Administrator’s response to the Participant’s Preauthorization Request Involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Preauthorization Request Involving Emergency Care

If the Participant is admitted to the Hospital for Emergency Care and there is not time to obtain Preauthorization, the Participant’s Provider must notify the Claim Administrator within two working days following the Participant’s emergency admission.

Preauthorization Required For Certain Prescription Drug Products and Other Medications

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

1. Prescription Drugs – Covered Under the Prescription Drug Pharmacy Integrated Benefit Benefit

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

2. Other Medications – Covered Under Medical Benefits

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

For any medication that is subject to Preauthorization, the Participant or provider should fax the request for Preauthorization to the Blue Cross and Blue Shield of Montana Medical Review Preauthorization Department at 1-866-589-8256. The Participant or provider may also submit a written request for Preauthorization. Preauthorization forms are located on the Claim Administrator’s website at www.bcbsmt.com, and may be printed directly from the website. The Claim Administrator will notify the Participant and provider of the Preauthorization determination.

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

To determine which medications are subject to Preauthorization, the Participant or provider should refer to the list of medications which applies to the Participant’s Claim Administrator on the Claim Administrator’s website at www.bcbsmt.com or call the Customer Service toll-free number identified on the Participant’s identification card or the Claim Administrator’s website at www.bcbsmt.com.

General Provisions Applicable to All Required Preauthorizations

1. No Guarantee of Payment

Preauthorization does not guarantee payment of Benefits by the Claim Administrator. Even if the Benefit has been Preauthorized, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date of service or the Participant’s Benefits may have changed as of the date the service.

2. Request for Additional Information

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

3. Failure to Obtain Preauthorization

If the Participant does not obtain Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted to determine whether or not the services, supplies, or treatment were Medically Necessary, performed in the appropriate setting, and otherwise meet the terms and conditions of the Claim Administrator. The Participant may be responsible for charges for any Benefits which were not performed in the appropriate setting, were not Medically Necessary, were Experimental, Investigational or Unproven, or did not otherwise meet the terms and conditions of the Plan Document, including any applicable Medical Policy or Pharmacy Policy.

Any treatment the Participant receives which is not a covered service under this Plan Document, or is not determined to be Medically Necessary, or is not performed in the appropriate setting will be excluded from the Participant’s Benefits. This applies even if Preauthorization approval was requested or received.

Concurrent Review

Whenever it is determined by the Claim Administrator, that Inpatient care or an ongoing course of treatment may no longer meet medical necessity criteria or is considered Experimental/Investigational/Unproven (EIU), the Participant,
Participant’s Provider or the Participant’s authorized representative may submit a request to the Claim Administrator for continued services. If the Participant, the Participant’s Provider or the Participant’s authorized representative requests to extend care beyond the approved time limit and it is a Request Involving Urgent Care, the Claim Administrator will make a determination on the request/appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

**Care Coordination**

The goal of care coordination is to help the Participant receive the most appropriate care that is also cost effective. If the Participant has an ongoing medical condition or a catastrophic illness, the Participant or their designee should contact the Claim Administrator. If appropriate, a care coordinator will be assigned to work with the Participant and the Participant’s providers to design a treatment plan. Care coordination is a voluntary program. Care coordination involves Participant education, referral coordination, utilization review, and individual case planning and/or alternative care.

Care coordination shall be determined on a case-by-case basis, and the Plan’s determination to provide the benefits in one instance shall not obligate the Claim Administrator to provide the same or similar alternative benefits for the same or any other Plan Participant, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A care coordinator collaborates with the Participant, the family and the attending Physician in order to develop a plan of care to meet the Participant’s health service needs. Coverage may be provided for noncovered benefits if the result is improved care at a lesser cost. The plan of care may include some of the following:

1. Personal support and education for the Participant;
2. Contacting the family to offer assistance for coordination of medical care needs;
3. Monitoring response to treatment;
4. Monitoring Hospital or Skilled Nursing Facility;
5. Determining alternative care options; and
6. Assisting in obtaining any necessary equipment and services.

**BENEFITS**

The Plan will pay for the following Covered Medical Expenses when Medically Necessary and provided by a Covered Provider. Payment is based on the Allowable Fee and is subject to Deductibles and other provisions, as applicable.

Benefits outlined in this section are subject to any specific exclusions identified for that specific Benefit and to the exclusions and limitations outlined in the Exclusions and Limitations section.

**Accident**

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

**Advanced Practice Registered Nurses and Physician Assistants - Certified**

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

**Ambulance**

Licensed ambulance transport required for a Medically Necessary condition to the nearest appropriate site.
Anesthesia Services

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

The Plan will not pay for:

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

Approved Clinical Trials

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

Autism Spectrum Disorders

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

Covered services include:

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

Note: Applied Behavior Analysis (ABA), also known as Lovaas Therapy, is only available for Participants under age 19.

The Schedule of Benefits describes payment limitations for these services.

Birthing Centers

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

Blood Transfusions

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

Chemical Dependency

Outpatient Services

Care and treatment for Chemical Dependency when the Participant is not an Inpatient Participant and care is provided by:

1. a Hospital;
2. a Mental Health Treatment Center;
3. a Chemical Dependency Treatment Center;
4. a Physician or prescribed by a Physician;
5. a psychologist;
6. a licensed social worker;
7. a licensed professional counselor;
8. an addiction counselor licensed by the state; or
9. a licensed psychiatrist.

Outpatient services are subject to the following conditions:

1. the services must be provided to diagnose and treat recognized Chemical Dependency;
2. the treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Chemical Dependency; and
3. no Benefits will be provided for hypnotherapy or for services given by a staff member of a school or halfway house.

Inpatient Care Services

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

1. a Hospital;
2. a Freestanding Inpatient Facility; or
3. a Physician.

The Plan will not pay for services of a residential treatment center for the treatment of Chemical Dependency.

Preauthorization is required for Inpatient Care services. Please refer to the section entitled Preauthorization.

Partial Hospitalization

Care and treatment of Chemical Dependency, while the Partial Hospitalization services are provided by a:

1. a Hospital;
2. a Freestanding Inpatient Facility; or
3. a Physician.

Preauthorization is required for Partial Hospitalization services. Please refer to the section entitled Preauthorization.

The Schedule of Benefits describes payment limitations for these services.

Chemotherapy

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

Colonoscopies (Medical and Routine)

Services provided for colonoscopies, including professional and facility charges.

Colonoscopies with a Routine diagnosis are paid under the Preventive Health Care Benefit for Participants age 50 or older.

Contraceptives

Services and supplies related to contraception, including but not limited to, oral contraceptives, contraceptive devices and injections, subject to the terms and limitations of the Plan Document. Oral contraceptives are paid as described in the Prescription Drug Pharmacy Integrated Benefit section and certain contraceptive products are covered under the Preventive Health Care section.

Deductible and Coinsurance do not apply to contraceptives covered under the Preventive Health Care Benefit, whether provided during an office visit or through the Prescription Drug Pharmacy Integrated Benefit. For additional information, access www.bcbsmt.com and click on the Participants tab and select Pharmacy.
Convalescent Home Services

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

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

The Plan considers extended care confinements separated by less than 7 days as one period of confinement. The Plan will not pay for custodial care.

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

Dental Services

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

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

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

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

Diabetes Treatment (Office Visit)

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

Diabetic Education

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

Diagnostic Services

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

1. X-rays and Other Radiology. Some examples of other radiology include:
   - Computerized tomography scan (CT Scan)
   - MRIs
   - Nuclear medicine
   - Ultrasound
2. Laboratory Tests. Some examples of laboratory tests include:
   - Urinalysis
   - Blood tests
   - Throat cultures

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

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

**Durable Medical Equipment**

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

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

Replacement Equipment.

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

The Plan will not pay for the following items:

1. exercise equipment;
2. car lifts or stair lifts;
3. biofeedback equipment;
4. self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition;
5. air conditioners and air purifiers;
6. whirlpool baths, hot tubs, or saunas;
7. waterbeds;
8. other equipment which is not always used for healing or curing;
9. Deluxe equipment. The Plan has the right to decide when deluxe equipment is required. However, upon such decision, payment for computerized and deluxe equipment will be based on the Allowable Fee for standard equipment;
10. computer-assisted communication devices;
11. durable medical equipment required primarily for use in athletic activities;
12. replacement of lost or stolen durable medical equipment;
13. repair to rental equipment; and
14. duplicate equipment purchased primarily for Participant convenience when the need for duplicate equipment is not medical in nature.

**Emergency Room Care**

1. Emergency room care for an accidental Injury.
2. Emergency room care for sudden and serious Illness.

**Home Health Care**

The following services, when prescribed and supervised by the Participant’s attending Physician provided in the Participant’s home by a licensed Home Health Agency and which are part of the Participant’s treatment plan:
1. Nursing services.
2. Home Health Aide services.
3. Hospice services.
5. Occupational Therapy.
7. Medical social worker services.
8. Medical supplies and equipment suitable for use in the home.
9. Medically Necessary personal hygiene, grooming and dietary assistance.

The Plan will not pay for:

1. Maintenance or custodial care visits.
2. Domestic or housekeeping services.
3. "Meals-on-Wheels" or similar food arrangements.
4. Visits, services, medical equipment, or supplies not approved or included as part of the Participant’s treatment plan.
5. Services for mental or nervous conditions.
6. Services provided in a nursing home or skilled nursing facility.

Preauthorization is required for home health care. Please refer to the section entitled Preauthorization.

*The Schedule of Benefits describes payment limitations for these services.*

**Home Infusion Therapy Services**

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

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

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

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

Preauthorization is required for home infusion therapy services. Please refer to the section entitled Preauthorization.

**Hospice Care**

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

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

Preauthorization is required for hospice care. Please refer to the section entitled Preauthorization.
The Schedule of Benefits describes payment limitations for these services.

**Hospital Services - Facility and Professional**

**Inpatient Care Services Billed by a Facility Provider**

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

2. **Miscellaneous Hospital Services**
   a. Laboratory procedures.
   b. Operating room, delivery room, recovery room.
   c. Anesthetic supplies.
   d. Surgical supplies.
   e. Oxygen and use of equipment for its administration.
   f. X-ray.
   g. Intravenous injections and setups for intravenous solutions.
   h. Special diets when Medically Necessary.
   i. Respiratory therapy, chemotherapy, radiation therapy, dialysis therapy.
   j. Physical Therapy, Speech Therapy and Occupational Therapy.
   k. Drugs and medicines which:
      1. Are approved for use in humans by the U.S. Food and Drug Administration; and
      2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
      3. Require a Physician’s written prescription.

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

Preauthorization is required for Inpatient Care. Please refer to the section entitled Preauthorization.

**Inpatient Care services are subject to the following conditions:**

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

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

3. Preauthorization is required for Inpatient Care. Please refer to the section entitled Preauthorization.

**Inpatient Care Medical Services Provided and Billed by a Professional Provider**

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

Medical services do not include surgical or maternity services. Inpatient Care medical services are covered only if the Participant is eligible for Benefits under the Hospital Services, Inpatient Care Services section for the Hospital admission.
Medical care visits are limited to one visit per day per Covered Provider unless a Participant’s condition requires a Physician's constant attendance and treatment for a prolonged period of time.

Observation Beds/Rooms
Payment will be made for observation beds when Medically Necessary.

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

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

Mammograms (Routine and Medical)
Mammography examinations.
The minimum mammography examination recommendations are:

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

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

Newborns and Mothers Health Protection Act. Under federal law, Benefits may not be restricted for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. In any case, under federal law, plans or insurers may not require that a provider obtain Preauthorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

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

Please refer also to the Newborn Initial Care section.

Medical Supplies
The following supplies for use outside of a Hospital:

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

Medical supplies are covered only when:

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

**Mental Illness**

Benefits described in this section do not include Benefits for Severe Mental Illness. Please refer to the Severe Mental Illness section for those Benefits.

**Outpatient Services**

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

1. Hospital;
2. Physician or prescribed by a Physician;
3. Mental Health Treatment Center;
4. Chemical Dependency Treatment Center;
5. Psychologist;
6. Licensed social worker;
7. Licensed professional counselor;
8. Licensed addiction counselor; or

Outpatient Benefits are subject to the following conditions:

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

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

**Inpatient Care Services**

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

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

**The Plan will not pay for services of a residential treatment center for the treatment of Mental Illness.**

Preauthorization is required for Inpatient Care services. Please refer to the section entitled Preauthorization.

**Partial Hospitalization**

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

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

Preauthorization is required for Partial Hospitalization services. Please refer to the section entitled Preauthorization.
The Schedule of Benefits describes payment limitations for these services.

Naturopathy

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

Newborn Initial Care

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

Office Visits

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

Orthopedic Devices/Orthotic Devices

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

Physician Medical Services

Medical services by a Covered Provider for:

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

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

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

Postmastectomy Care and Reconstructive Breast Surgery

Postmastectomy Care

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

Reconstructive Breast Surgery

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

   Coverage described in 1(a) through 1(d) will be provided in a manner determined in consultation with the attending Physician and the patient.

2. Breast prostheses as the result of a mastectomy.

The Women’s Health and Cancer Rights Act is federal law that requires the services listed above to be covered under this health Plan.
For specific Benefits related to postmastectomy care, refer to that specific Benefit, e.g., surgical services and Hospital services.

**Prescription Drug Pharmacy Integrated Benefit**

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

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

1. Are approved for use in humans by the U.S. Food and Drug Administration; and  
2. Require a Physician’s written prescription; and  
3. Are dispensed under federal or state law pursuant to a prescription order or refill.

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

The Participant, or the Participant’s prescribing health care provider, can ask for a Drug List exception of the Participant’s drug is not on the Drug List (also known as a formulary). To request this exception, the Participant of the Participant’s prescriber, can call the number on the back of the Participant’s ID card to ask for a review. If the Participant has a health condition that may jeopardize his/her life, health or keep the Participant from regaining functions or the Participant’s current drug therapy uses a non-covered drug, the Participant of the Participant’s prescriber maybe able to ask for an expedited review process. BCBSMT will, the Participant or the Participant’s prescriber, know the coverage decision within 24 hours after they receive the request for an expedited review. If the coverage request is denied, BCBSMT will let the Participant and Participant’s prescriber know why it was denied and offer the Participant a covered alternative drug (if applicable). If the Participant’s exception is denied, the Participant may appeal the decision according to the appeals process the Participant will receive with the denial determination. The Participant should call the number on the back of the ID card if the Participant has any questions.

**Drug Lists**

Covered drugs are selected by the Claim Administrator based upon the recommendations of a committee, which is made up of current and previously practicing physicians and pharmacists from across the country, some of which are employed by or affiliated with Blue Cross and Blue Shield of Montana. The committee considers drugs regulated by the FDA for inclusion on the Drug List. Some of the factors committee members evaluate include each drug’s safety, effectiveness, cost, and how it compares with drugs currently on the Drug List. The committee considers drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to the Drug List can be made from time to time.

The Claim Administrator may offer multiple Drug Lists. By accessing www.bcbsmt.com or www.myprime.com or calling the Customer Service toll-free number on the Participant’s identification card, the Participant or provider can determine the Drug List that applies to the Participant’s Plan and whether a particular drug is on the Drug List.

**Covered Prescription Drug Products**

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

1. Legend drugs - drugs requiring written prescriptions and dispensed by a licensed pharmacist for treatment of an Illness or Injury.  
2. One prescription oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug administration.  
3. Insulin on prescription.  
4. Disposable insulin needles/syringes.  
5. Test strips.  
7. Oral contraceptives, contraceptive devices or injections prescribed by a Physician.
8. Smoking cessation products and over-the-counter smoking cessation aids/medications with a written prescription, as required by the Affordable Care Act. Tobacco counseling is available under the Preventive Health Care Benefit.
9. Compounded medications.
10. Folic acid, iron supplements, vitamins and injectable vitamins are covered as a prescription.
11. Prescription prenatal vitamins.
12. Proton pump inhibitors.

The Schedule of Benefits lists the payment limitations for these Prescription Drug Products.

Non-Covered Prescription Drug Products

The Plan will not pay for:
1. Nonlegend drugs other than insulin.
2. Anabolic Steroids.
3. Any drug used for the purpose of weight loss.
4. Fluoride supplements, except as required by the Affordable Care Act for children under age 6.
5. Over-the-counter drugs that do not require a prescription, except non-sedating antihistamines.
6. Prescription Drug Products for cosmetic purposes, including the treatment of alopecia (hair loss) (e.g., Minoxidil, Rogaine, Retin A, Differin, Anita, Renova).
7. Prescription drugs for which there is an exact over-the-counter equivalent.
8. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those otherwise covered under this section.
9. Drugs used for erectile dysfunction, regardless of medical necessity.
10. Insulin pumps and glucose meters. Insulin pumps and glucose meters are covered under the Durable Medical Equipment Benefit.
11. Drugs or items labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Participant is charged for the item.
12. Biological sera, blood, or blood plasma.
13. Prescription Drug Products which are to be taken by or administered to the Participant, in whole or in part, while the Participant is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility’s charge.
14. Any Prescription Drug Product refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician’s original order.
15. Replacement prescription drugs or Prescription Drug Products due to loss, theft or spoilage.
16. Prescription products obtained from a pharmacy located outside the United States for consumption within the United States.
17. Prescription Drug Products provided by a mail-order pharmacy that is not approved by the Plan.
18. Infertility medications.
19. Repackaged medications.
20. Drugs determined by The Claim Administrator to have inferior efficacy or significant safety issues.
21. Some drugs are manufactured under multiple brand names and have many therapeutic equivalents. Generic medications may also have several therapeutic equivalents. In such cases, The Claim Administrator may limit Benefits to specific therapeutic equivalents. If the Participant does not accept the therapeutic equivalents that are covered under the Prescription Drug program, the drug purchased will not be covered under any Benefit level.

Vaccinations Obtained Through Select Participating Pharmacies

Vaccinations are available through select Participating Pharmacies that have Plan Documented with Blue Cross and Blue Shield of Montana. To obtain a current list of Participating Pharmacies and a list of covered vaccines, The Participant can call the Customer Service toll-free number identified on the Participant’s identification card or access www.bcbsmt.com and click on “Participant Services”. Then click on the “Prescription Drug Plan Information” and
select “Pharmacy Program”. The Participant should present his/her Identification Card to the pharmacist at the time services are received. The pharmacist will inform the Participant of any applicable Copayment and/or Coinsurance.

Each select Participating Pharmacy that has Plan Documented with Blue Cross and Blue Shield of Montana to provide this service may have age, scheduling, or other requirements that will apply, so the Participant should contact the Participating Pharmacy in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit but are covered under the medical benefits of the health plan.

Controlled Substances Limitation
If the Plan determines that a Participant may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any Benefits for additional drugs may be subject to a review for Medical Necessity, appropriateness and other restrictions.

Purchase and Payment of Prescription Drug Products
Prescription Drug Products may be obtained using an Outpatient pharmacy, a Prime Extended Supply Pharmacy or a mail-order pharmacy approved by the Plan. To use a mail-order pharmacy, the Participant must send an order form and the prescription to the address listed on the mail-order service form and pay the required Deductible and Coinsurance. The address of each mail order pharmacy approved by the Plan is listed on the inside cover of this Plan Document.

If drugs or Prescription Drug Products are purchased at a Participating Pharmacy, a Prime Extended Supply Pharmacy or a mail order pharmacy approved by the Plan, and the Participant presents the Participant’s ID card at the time of purchase, the Participant must pay for the Prescription Drug Product and the Participating Pharmacy will submit a claim for the Prescription Drug Product to the Plan’s Pharmacy Benefit Manager. The cost of the covered drug or Prescription Drug Product will then accumulate to the Participant’s Deductible and Out-of-Pocket Amount. Once the Deductible is met, the Participant will only be required to pay the appropriate Coinsurance if the amount can be determined by the pharmacy at the time of purchase.

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

If drugs, Prescription Drug Products or vaccinations are purchased at a nonparticipating Outpatient pharmacy, the Participant must pay for the prescription or vaccination at the time of dispensing and then file a prescription drug claim form with the Claim Administrator’s Pharmacy Benefit Manager for reimbursement. The Participant will be reimbursed at 50% of the amount that would have been paid to a Participating Pharmacy, less the Participant’s Deductible and Copayment/Coinsurance.

Prescription Drug Products Subject to Preauthorization, Step Therapy or Quantity Limits

1. Prescription Drug Products subject to Preauthorization require prior approval from the Plan’s Pharmacy Benefit Manager before they can qualify for coverage under the Plan. If the Participant does not obtain Preauthorization before a Prescription Drug Product is dispensed, the Participant may pay for the prescription and then pursue authorization of the drug from the Plan’s Pharmacy Benefit Manager. If the authorization is approved by the Plan’s Pharmacy Benefit Manager, the Participant should then submit a claim for the prescription drug on a prescription claim form to the Plan’s Pharmacy Benefit Manager for reimbursement.

2. Preauthorization does not guarantee payment of the Prescription Drug Product by the Plan. Even if the prescription drug has been preauthorized, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date the drug is dispensed or the Participant’s Benefits may have changed as of the date the drug is dispensed.

3. A step therapy program is designed to help the Participant use the lowest cost product(s) within a drug class. Drugs subject to step therapy are widely considered equivalent to other products within the class by both physicians and pharmacists. In order to obtain a medication within a step therapy program, the Participant must fail a first line drug. In general, first line products are usually generic medications. In some cases, a pharmacy policy will allow the step therapy to be waived. The pharmacy policies are located on the Plan website at www.bcbsmt.com.

4. A quantity limit is a limitation on the number or amount of a Prescription Drug Product covered within a certain time period. Quantity limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, to control for billing errors by pharmacies, to encourage dose consolidation, appropriate utilization,
and to avoid misuse/abuse of the medication. A prescription written for a quantity in excess of the established limit will require a Preauthorization before Benefits are available.

Certain Prescription Drug Products, such as those used to treat rheumatoid arthritis, growth hormone deficiency, hepatitis C, or more serious forms of anemia, hypertension, and epilepsy, are subject to Preauthorization, step therapy, or quantity limits. The Prescription Drug Products included in the prescription drug program are subject to change, and medications for other conditions may be added to the program.

If the Participant’s provider is prescribing a Prescription Drug Product subject to Preauthorization, step therapy, or quantity limits, the provider should fax the request for Preauthorization to the Claim Administrator’s Pharmacy Benefit Administrator at the fax number listed on the inside cover of this Plan Document. The Participant and provider will be notified of the Claim Administrator’s Pharmacy Benefit Administrator’s determination.

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

To find out more about Preauthorization/step therapy/quantity limits or to determine which Prescription Drug Products are subject to Preauthorization, step therapy or quantity limits, the Participant or provider should refer to the Drug List which applies to the Participant’s Plan at www.bcbsmt.com or www.myprime.com or call the Customer Service toll-free number identified on the Participant’s identification card.

Specialty Medications

1. Specialty Medications are generally prescribed for individuals with complex or ongoing medical conditions such as multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These high cost medications also have one or more of the following characteristics:
   a. Injected or infused, but some may be taken by mouth
   b. Unique storage or shipment requirements
   c. Additional education and support required from a health care professional
   d. Usually not stocked at retail pharmacies

2. Some Specialty Medications must be acquired through the Plan’s contracted Specialty Pharmacy listed on the inside cover of this Plan Document. A list of those medications may be found on the Plan website at www.bcbsmt.com. Registration and other applicable forms are also located on the website.

Preventive Health Care

Covered preventive services include, but are not limited to:

1. Services that have an “A” or “B” rating in the United States Preventive Services Task Force’s current recommendations; and

2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention; and

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

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

   a. Lactation Services

      Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. In addition, the Claim Plan will reimburse the Participant the actual cost for the purchase of a manual or electric breast pump. The Participant may purchase a maximum of two electric breast pumps
per year or rent Hospital-grade pumps. For additional information, access www.bcbsmt.com, then click on Member Services. Under Member Services, click on “Advantages of Membership” and select “New Mothers.”

b. Contraceptives

Food and Drug Administration approved contraceptive methods, including certain contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity. For additional information, access www.bcbsmt.com and click on the Participants tab and select Pharmacy; and


Examples of Preventive Health Care services include, but are not limited to, physical examinations, colonoscopies, immunizations and vaccinations.

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

Prostheses

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

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

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

Replacement Prosthesis.

1. Replacement of a prosthesis will not be subject to any reduced replacement Coinsurance that may be applicable if the replacement is five (5) years of longer after the original purchase.

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

The Plan will not pay for the following items:

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

Radiation Therapy

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

Rehabilitation – Facility and Professional

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

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

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

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

Rehabilitation Facility Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations
   a. Room and Board, which includes but is not limited to dietary and general, medical and rehabilitation nursing services.

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

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

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

Preauthorization is required for Rehabilitation Facility Inpatient Care. Please refer to the section entitled Preauthorization.

Rehabilitation Facility Inpatient Care is subject to the following conditions:

1. The Participant will be responsible to the Rehabilitation Facility for payment of the Facility’s charges if the Participant remains as an Inpatient Participant when Rehabilitation Facility Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed “reserved” for a Participant.

2. The term “Rehabilitation Facility” does not include:
   a. A Hospital when a Participant is admitted to a general medical, surgical or specialty floor or unit (other than a rehabilitation unit) for acute Hospital care, even though rehabilitation services are or may be provided as a part of acute care.
   b. A nursing home;
   c. A rest home;
   d. Hospice;
e. A skilled nursing facility;

f. A Convalescent Home;

g. A place for care and treatment of Chemical Dependency;

h. A place for treatment of Mental Illness;

i. A long-term, chronic-care institution or facility providing the type of care listed above.

**Rehabilitation Facility Inpatient Care Services Billed by a Professional Provider**

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

**Outpatient Rehabilitation**

Rehabilitation Therapy provided on an outpatient basis by a Facility or Professional Provider.

**Severe Mental Illness**

Benefits include but are not limited to:

1. Inpatient Care services, Outpatient services, rehabilitation services and medication for the treatment of Severe Mental Illness;

2. Services provided by a licensed Physician, licensed Advanced Practice Registered Nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed Physician; and

3. Services provided by a licensed Advanced Practice Registered Nurse with prescriptive authority and specializing in mental health.

Refer to the Mental Illness Benefit on the Schedule of Benefits. The Schedule of Benefits lists the payment limitations for these services.

**Sigmoidoscopies (Medical and Routine)**

Services provided for sigmoidoscopies, including professional and facility charges.

Sigmoidoscopies with a Routine diagnosis are paid under the Preventive Health Care Benefit for Participants age 50 or older.

**Surgical Services**

**Surgical Services Billed by a Professional Provider**

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

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

Services of a surgical facility or a freestanding surgery center licensed, or certified for Medicare, by the state in which it is located and have an effective peer review program to assure quality and appropriate patient care. The surgical procedure performed in a surgical facility or a freestanding surgery center is recognized as a procedure which can be safely and effectively performed in an Outpatient setting.

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

**Surgical Services Billed by a Hospital (Inpatient and Outpatient)**
Services of a Hospital for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery.

**Telemedicine**

Benefits for services provided by Telemedicine when such services are Medically Necessary Covered Medical Expenses provided by a Covered Provider.

**Therapies - Outpatient**

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

**Transplants**

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

For certain transplants, Blue Cross and Blue Shield of Montana contracts with a number of Centers of Excellence that provide transplant services. Blue Cross and Blue Shield of Montana highly recommends use of the Centers of Excellence because of the quality of the outcomes at these facilities. Participants being considered for a transplant procedure are encouraged to contact Blue Cross and Blue Shield of Montana Customer Service to discuss the possible benefits of utilizing the Centers of Excellence.

Transplant services include:

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

Payment by the Plan is subject to the following conditions:

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

The Plan will not pay for:

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

Transplant Travel includes:

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

**The Schedule of Benefits describes payment limitations for these services.**
Travel, Meals and Lodging

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

The Schedule of Benefits describes payment limitations for these services.

Well-Child Care

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

Benefits shall include coverage for:

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

EXCLUSIONS AND LIMITATIONS

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

1. All services, supplies, drugs and devices which are provided to treat any Illness or Injury arising out of employment when the Participant’s Employer has elected or is required by law to obtain coverage for Illness or Injury under state or federal Workers’ Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This Exclusion applies to all services and supplies provided to treat such Illness or Injury even though:
   a. Coverage under the government legislation provides benefits for only a portion of the services incurred.
   b. The Employer has failed to obtain such coverage required by law.
   c. The Participant waives his or her rights to such coverage or benefits.
   d. The Participant fails to file a claim within the filing period allowed by law for such benefits.
   e. The Participant fails to comply with any other provision of the law to obtain such coverage or benefits.
   f. The Participant was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

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

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

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

   Note: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Participant. When such a circumstance occurs, the Participant will receive an explanation of benefits.
3. Services, supplies, and medications provided to treat any Injury to the extent the Participant receives, or would be entitled to receive where liability is reasonably clear, benefits under an automobile insurance policy. Such benefits received by the Participant shall be used first to satisfy any remaining Coinsurance, Copayment and Deductible related to the Injury for which claims are submitted to the Plan. The Injury related claims must be submitted to the Plan to apply any applicable credit to Coinsurance, Copayment and/or Deductible.

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

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

6. Any loss for which a contributing cause was the commission of a felony, or an attempt to commit a felony. This exclusion does not apply if the loss is related to being a victim of domestic violence.

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

8. Professional or courtesy discounts.

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

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

11. Orthodontics.

12. All dental services, including but not limited to ridge augmentation and vestibuloplasty, whether performed by Physicians, dentists, oral surgeons and/or any other provider, except for services provided as the result of a Dental Accident, or as specifically included in the section entitled Dental Services.

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

14. Hearing aids, except that Medically Necessary cochlear implants may be covered per Medical Policy.

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

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

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

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

   a. Experimental/Investigational/Unproven Services.
   b. Not accepted standard medical practice. The Plan may consult with physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice.
   c. Not a Covered Medical Expense.
   d. Not Medically Necessary.
   e. Not covered under applicable Medical Policy.

19. Any services, supplies, drugs and devices considered to be Experimental/Investigational/Unproven Services and which are provided during a Phase I or II clinical trial, or the experimental or research arm of a Phase III clinical trial. This includes services, supplies, drugs and devices under study to determine the maximum tolerated
dosage(s), toxicity, safety, efficacy or efficacy as compared with standard treatment, or for the diagnosis of the condition in question.

20. Private duty nursing.

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

22. Reversal of an elective sterilization.

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

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

25. Chiropractic services and supplies.

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

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

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

29. Services or supplies related to sexual reassignment and reversal of such procedures.

30. Services, supplies, drugs and devices relating to any of the following treatments or related procedures:
   a. Acupuncture.
   b. Acupressure.
   c. Homeopathy.
   d. Hypnotherapy.
   e. Rolfing.
   f. Holistic medicine.
   g. Religious counseling.
   h. Self-help programs.

31. Services provided by a massage therapist.

32. Sanitarium care, custodial care, rest cures, or convalescent care to help the Participant with daily living tasks. No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, or extended care facility for the types of care outlined in this exclusion. Examples include but are not limited to, help in:
   a. Walking.
   b. Getting in and out of bed.
   c. Bathing.
   d. Dressing.
   e. Feeding.
   f. Using the toilet.
   g. Preparing special diets.
   h. Supervision of medication which is usually self-administered and does not require the continuous attention of medical personnel.

33. Residential treatment centers for Chemical Dependency and Mental Illness.

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

35. Over-the-counter food supplements, formulas, and/or Medical Foods, regardless of how administered except when used for Inborn Errors of Metabolism.

36. Services, supplies, drugs and devices for the surgical treatment of any degree of obesity, whether provided for weight control or any medical condition.
37. Services, supplies, drugs and devices for weight reduction or weight control. This Exclusion does not include intensive behavioral dietary counseling when services are provided by a Physician, Physician Assistant or Nurse Practitioner.

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

39. Services, supplies, drugs and devices for the treatment of Illness, Injury and/or complications resulting from services that are not Covered Medical Expenses.

40. Tutoring services.

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

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

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

44. Court ordered treatment for mental disorders and substance abuse unless determined to be Medically Necessary.

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

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

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

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

CLAIMS INFORMATION

How to Obtain Benefits for Covered Medical Expenses
When a Participant obtains services from a covered health care provider, the Participant must present the Participant’s identification card to the provider of care. Billing and payments for Physician, Hospital, and other other providers usually will be handled directly by the provider’s office. Normally, there are no claim forms for the Participant to file. A Participating Professional or Facility Provider will always file claims directly with the Claim Administrator.

How to File a Claim
If it is necessary for the Participant to file a claim, the Participant should obtain an itemized bill from the provider which includes all information about the services so the Claim Administrator can determine whether or not they are Covered Medical Expenses. The itemized bill must contain the following information:

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

Send this itemized bill to:

Blue Cross and Blue Shield of Montana
P.O. Box 7982
Helena, MT 59604-7982

In certain instances, the Claim Administrator may require that additional documents or information be submitted, including, but not limited to, accident reports and medical records. This information must be submitted within the time frame requested when the additional documentation is requested, before payment can be made for the services.

Claims must be submitted no later than 12 months from the date of service.

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

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

**Prescription Drug Claims - Filling Prescriptions at a Retail Pharmacy**

Outpatient prescription drugs are available through the Prime Therapeutics Prescription Drug Pharmacy Integrated Benefit.

1. Go to a Prime Therapeutics Participating Pharmacy or an Extended Supply Pharmacy that accepts Participant ID cards. To find out if a pharmacy takes part in the program, ask the pharmacist. To find a Prime Therapeutics Participating Pharmacy or an Extended Supply Pharmacy nearest the Participant, check the list on the website www.bcbsmt.com or call the pharmacy locator at the telephone number on the inside cover of this document.

2. Present the prescription and the Participant’s ID card to the pharmacist.

3. Make sure that the pharmacist has complete and correct information about the Participant for whom the prescription is written, including sex and date of birth.

4. When the Participant receives a prescription, he or she should sign the pharmacy log and pay his or her share of the cost.

5. If a Participant purchases prescription drugs from a participating outpatient pharmacy, an extended supply pharmacy or mail-service pharmacy approved by the Plan, the Participant must pay for the Prescription Drug Product and the pharmacy will submit the prescription drug claims to Prime Therapeutics.

6. For prescriptions filled at a pharmacy that is not part of the network, the Participant will need to pay the pharmacist the entire cost of the prescription at the time the prescription is filled and dispensed and submit a paper claim to Prime Therapeutics for reimbursement. If a Participant does not present his or her ID card at a Participating Pharmacy, a paper claim must be submitted by the Participant to Prime Therapeutics for reimbursement. The Participant will be reimbursed at the contracted rate minus Coinsurance and Deductible, if applicable, in both situations. The Participant will not receive the preferred pricing.

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

**Mail-Service Pharmacy - A Special Cost Saving Opportunity**

A convenient way to get maintenance prescriptions is through the mail. Maintenance prescriptions are those that the Participant expects to continue using for an extended period of time and for which a prescription can be written for up to a 90-day supply. Coverage for costly prescriptions should be verified prior to ordering. Specific Benefits are outlined in the Prescription Drug Pharmacy Integrated Benefit section in this document.
Ordering prescriptions through the mail service pharmacy is very easy. To obtain a mail service claim form, call the Claim Administrator at the telephone number on the inside cover of this document.

To order a prescription:

1. Complete all sections and sign the Mail-Service order form.

2. Enclose the following:
   a. the original prescription written for a 90-day supply;
   b. the Participant’s current pharmacy telephone number, prescription numbers to be transferred; and
   c. the Participant’s telephone number.

3. Mail the form to the mail service pharmacy at the address listed on the form.

**COORDINATION OF BENEFITS WITH OTHER INSURANCE**

The Coordination of Benefits (COB) provision applies when a Participant has health care coverage under more than one plan. “Plan” is defined below.

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

**Definitions**

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

**Plan**

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

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

The term plan does not include:

1. hospital indemnity coverage or other fixed indemnity coverage;
2. accident only coverage;
3. specified disease or specified accident coverage;
4. limited benefit health coverage, if determined by the commissioner to be "excepted benefits" as defined in 33-22-140, MCA;
5. school accident type coverage;
6. benefits for non-medical components of long-term care policies;
7. Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

**This Plan**
In a COB provision, “this plan” means that part of the Plan Document providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Plan Document providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules
The rules that determine whether this plan is a primary plan, or secondary plan, when the person has health care coverage under more than one plan.

1. When this plan is primary, it determines payment for Covered Medical Expenses first before those of any other plan without considering any other plan's benefits.

2. When this plan is secondary, it determines its benefits after those of another plan and may reduce payment for Covered Medical Expenses so that payment by all plans does not exceed 100% of the total allowable expense.

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

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

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

2. If a Participant is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

3. If a Participant is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

4. If a Participant is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan’s payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the primary plan because a Participant has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

Order of Benefit Determination Rules
When a Participant is covered by two or more plans, the rules for determining the order of benefit payments are as follows:
1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan; and

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

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

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

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

Non-Dependent or Dependent.

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

Dependent Child Covered Under More Than One Plan.

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

1. Dependent Child - Parents are married or are living together
   a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
   b. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

2. Dependent Child - Parents are divorced or separated or not living together
   a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
   b. If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of (a) above shall determine the order of benefits;
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (a) above shall determine the order of benefits; or
   d. If there is no court decree allocating responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
      • The plan covering the custodial parent;
      • The plan covering the spouse of the custodial parent;
      • The plan covering the non-custodial parent; and then;
      • The plan covering the spouse of the non-custodial parent.

3. Dependent Child Covered Under More than One Plan of Individuals Who Are Not the Parents of the Child
   The provisions of (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.
4. Active Employee or Retired or Laid-off Employee

The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, (or is a dependent of such employee) is the primary plan. The plan covering that same person as a retired or laid-off employee (and the dependent of such employee) is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the section Non-Dependent or Dependent can determine the order of benefits.

5. COBRA or State Continuation Coverage

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

6. Longer or Shorter Length of Coverage

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Blue Cross and Blue Shield of Montana may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the Participant claiming benefits. Blue Cross and Blue Shield of Montana need not inform, or get the consent of, any person to do this. Each Participant claiming benefits under this plan must give Blue Cross and Blue Shield of Montana any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Blue Cross and Blue Shield of Montana may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Blue Cross and Blue Shield of Montana will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.
Right of Recovery

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

Coordination With Medicare

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

1. For Working Aged

Medicare pays secondary to the Plan for Benefits for Participants and their spouses who are Participants, covered by employers with 20 or more Employees, who qualify for age-based Medicare as a result of attaining age 65 and older and who are covered by virtue of the Participant’s current employment status.

Medicare will be the primary for a Participant that refuses coverage under this Plan Document.

Medicare will pay primary to the Plan for the working aged Participants covered by employers with fewer than 20 Employees, including a multi-employer association if the Participant is covered by an employer within the multi-employer association with fewer than 20 Employees.

2. For Disabled Participants under Age 65

Medicare pays secondary to the Plan for Benefits for Participants under age 65, covered by employers with 100 or more employees, who qualify for disability-based Medicare and are covered by virtue of a Participant’s current employment status.

Medicare pays primary to the Plan for disabled Participants under age 65 covered by employers with fewer than 100 employees.

3. For End-Stage Renal Disease

Medicare pays secondary to the Plan for Benefits for Participants who qualify for Medicare as a result of end-stage renal disease ("ESRD"), regardless of employer size, and are entitled to Benefits payable under this Plan Document, for the first 30 months that a particular Participant qualifies for Medicare as a result of ESRD. After the 30 month period, Medicare will pay primary to the Plan.

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

a. If the Plan is required to pay before Medicare under 1 or 2 above for a Participant before the Participant qualifies for Medicare based on ESRD, the Plan will continue to pay primary to Medicare after the Participant becomes covered under Medicare based on ESRD but only for the 30 month period above, after which Medicare will pay primary to the Plan.

b. If the Plan is required to pay primary to Medicare based on ESRD and the Participant that qualifies for Medicare based on ESRD above later becomes entitled to age-based or disability-based Medicare during the 30 month period, Medicare will pay second to the Plan for the duration of the 30 month period, after which Medicare will pay primary to the Plan. If the Participant qualifies for age-based or disability-based Medicare after the 30 month period, Medicare will pay primary to the Plan.

c. Medicare continues to be primary to the Plan after an aged or disabled Participant becomes eligible for Medicare based on ESRD if:

1. The Participant is already entitled to Medicare on the basis of age or disability when the Participant becomes eligible for Medicare based on ESRD; and

2. The Group has fewer than 20 employees in the case of age-based Medicare or fewer than 100 employees in the case of disability-based Medicare.
4. For Retired Persons

Medicare is primary to the Plan for Participants age 65 if the Participant is a qualified individual age 65 and over and retired.

Medicare is primary to the Plan for Participant’s spouse who is also a Participant and who is a qualified individual if both the Participant and the Participant spouse are age 65 and over and retired.

5. Current Employment Status

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

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

TERMINATION OF COVERAGE

Coverage under the Plan will terminate under the following circumstances:

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

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

2. Termination for Nonpayment of Premium

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

3. Termination of Coverage of Children and Spouse.

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

Termination of Benefits on Termination of Coverage

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

Certificate of Creditable Coverage

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

COBRA

Certain employers maintaining group health coverage plans (whether insured or self-insured) must provide COBRA continuation coverage for qualified beneficiaries when group health coverage is lost. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). To lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before a qualifying event. A loss of coverage need not occur immediately after a qualifying event so long as the loss of coverage occurs before the end of the maximum COBRA coverage period. A qualified beneficiary is entitled to the coverage made available to similarly situated employees.

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

1. Small Employer Exception

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

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

2. Qualified Beneficiaries

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

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

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

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

3. Qualifying Events

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

a. Employee

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

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

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

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

c. Dependent Children

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

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

d. Retirees

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

4. Period of Coverage

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

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

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

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

c. Bankruptcy

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

1. Covered retiree: The maximum duration of the COBRA coverage is the lifetime of the retired covered employee.
2. Covered spouse, surviving spouse, or Dependent child of covered retiree: The maximum duration of the COBRA coverage ends the earlier of:
a. the date of death (of the spouse, surviving spouse or Dependent child); or
b. 36 months after the death of the covered retiree.

5. Providing Notice of Qualifying Events

a. Responsibilities of Qualified Beneficiaries

1. General Notice Requirements

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

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

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

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

The following information should be included:

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

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

2. Second Qualifying Event

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

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

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

d. The second qualifying event is one that would have caused loss of coverage in the absence of the first qualifying event.

If COBRA coverage was previously extended from 18 months to 29 months due to a Medicare disability determination, the maximum COBRA coverage period under a second qualifying event will be 36 months.
If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and Dependent children will end 36 months from the date the employee became entitled to Medicare as a result of turning 65 (but the covered employee’s maximum coverage period will be 18 months).

3. Disability Extension

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

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

a. The qualifying event must be a termination or reduction of hours of a covered employee’s employment; and

b. The qualified beneficiary must have been determined under Title II or XVI of the Social Security Act (SSA) to be disabled at any time during the first 60 days of the COBRA continuation coverage.

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

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

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

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

b. Responsibilities of Plan Administrator

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

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

c. Responsibilities of the COBRA Administrator

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

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

6. Election of COBRA Coverage - Notice Requirements

After a qualified beneficiary or COBRA administrator has provided notice of a qualifying event, the qualified beneficiary will receive a COBRA Election form.
Each qualified beneficiary has an independent right to elect COBRA coverage. The qualified beneficiary or a representative of the qualified beneficiary must return the COBRA Election form to the administrator within 60 days from the date on the COBRA Election form. **Important Information:** If the COBRA Election form is not returned within the 60-day timeframe, COBRA coverage will not be provided to any qualified beneficiaries.

7. Trade Adjustment Assistance Eligible Employees

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

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

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

8. Payment of Premium

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

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

9. Termination of Continued Coverage

a. Coverage terminates the last day of the maximum required period under COBRA;

b. Any of the following events will result in termination of coverage prior to expiration of the 18-Month, 29-Month, or 36-Month period:

1. The first day on which timely payment is not made with respect to the qualified beneficiary;

2. The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

3. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes covered under any other group health plan; or

4. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

10. Questions Concerning COBRA Coverage

For any questions concerning COBRA coverage, contact Blue Cross and Blue Shield of Montana (BCBSMT) at 1-800-447-7828.

11. Provide Notice of Address Changes

In order to protect all COBRA rights, Participants must notify the administrator and Blue Cross and Blue Shield of Montana of any changes to the Participant’s or Family Member’s addresses. A Participant should also keep a copy of any notices for personal records.
COMPLAINTS AND GRIEVANCES

Complaints and Grievances

The Claim Administrator has established a complaint and grievance process. A complaint involves a communication from the Participant expressing dissatisfaction about the Claim Administrator’s services or lack of action or disagreement with the Claim Administrator’s response. A grievance will typically involve a complaint about a provider or a provider’s office, and may include complaints about a provider’s lack of availability or quality of care or services received from a provider’s staff.

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

APPEALS

Claims Procedures

Types of Claims

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

1. Pre-Service Claims

   A pre-service claim is any claim for a Benefit that, under the terms of this Plan Document, requires authorization or approval from the Claim Administrator or the Claim Administrator’s subcontracted administrator prior to receiving the Benefit. For example, certain Prescription Drug Products require prior authorization under the terms of this Plan Document and are considered pre-service claims.

2. Urgent Care Claims

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

3. Post-Service Claims

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

4. Rescission Claims

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

5. Concurrent Care Claim

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

**Initial Claim Determination by Type of Claim**

1. **Pre-Service Claim Determination and Notice**
   a. Notice of Determination
      
      Upon receipt of a pre-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial determination, but no later than 15 days after receiving the claim.
   
   b. Notice of Extension
      1. For reasons beyond the control of the Claim Administrator
         
         The Claim Administrator may extend the 15-day time period for an additional 15 days for reasons beyond the Claim Administrator’s control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which the Claim Administrator expects to render a decision.
      2. For receipt of information from the Participant to decide the claim
         
         If the extension is necessary due to the Participant’s failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the Participant will be given 45 days from receipt of the notice within which to provide the specified information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

2. **Urgent Care Claim Determination and Notice**
   a. Designation of Claim
      
      Upon receipt of a pre-service claim, the Claim Administrator will make a determination if the claim involves urgent care. If a physician with knowledge of the Participant’s medical condition determines the claim involves urgent care, the Claim Administrator will treat the claim as an urgent care claim.
   
   b. Notice of Determination
      
      If the claim is treated as an urgent care claim, the Claim Administrator will provide the Participant with notice of the determination, either verbally or in writing, as soon as possible consistent with the medical exigencies but no later than 72 hours from the Claim Administrator’s receipt of the claim. If verbal notice is provided, the Plan will provide a written notice within 3 days after the date the Claim Administrator notified the Participant.
   
   c. Notice of Incomplete or Improperly Submitted Claim
      
      If an urgent care claim is incomplete or was not properly submitted, the Claim Administrator will notify the Participant about the incomplete or improper submission no later than 24 hours from the Claim Administrator’s receipt of the claim. The Participant will have at least 48 hours to provide the necessary information. The Claim Administrator will notify the Participant of the initial claim determination no later than 48 hours after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

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

1. For reasons beyond the control of the Claim Administrator

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

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

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

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

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

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

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

3. If the Participant’s claim did not involve urgent care, the time periods for deciding pre-service claims and post-service claims, as applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

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

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

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

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

b. A statement that the Participant will have the right to appeal any final decision of the Plan to rescind coverage after the thirty (30) day period;

c. A reference to the Plan provision(s) on which the rescission is based;

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

Notice of an Adverse Benefit Determination

An “adverse benefit determination” is defined as a rescission or a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Benefit. If the Claim Administrator’s determination constitutes an adverse benefit determination, the notice to the Participant will include:
1. The reason(s) for the adverse benefit determination. If the adverse benefit determination is a rescission, the notice will include the basis for the fraud and/or intentional misrepresentation of a material fact;

2. A reference to the applicable Plan Document provision(s), including identification of any standard relied upon in the Plan to deny the claim (such as a medical necessity standard), on which the adverse benefit determination is based;

3. A description of the Claim Administrator’s internal appeal and external review procedures (and for urgent care claims only, a description of the expedited review process applicable to such claims), contact information for a consumer appeal assistance program, and if applicable, a statement of the Participant’s right to file a civil action under Section 502(a) of ERISA;

4. If applicable, a description of any additional information necessary to complete the claim and why the information is necessary;

5. If applicable, a statement that any internal Medical Policy or guideline or other medical information relied upon in making the adverse benefit determination, and an explanation for the same, will be provided, upon request and free of charge;

6. If applicable, a statement that an explanation for any adverse benefit determination that is based on an experimental treatment or similar exclusion or limitation or a medical necessity standard will be provided, upon request and free of charge;

7. If applicable, a statement that diagnosis and treatment codes will be provided, and their corresponding meanings, upon request and free of charge; and

8. A statement that reasonable access to and copies of all documents and records and other information relevant to the adverse benefit determination will be provided, upon request and free of charge.

How to File an Internal Appeal of an Adverse Benefit Determination

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

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

2. Access to Plan Documents

   The Participant may at any time during the filing period, receive reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination upon request and free of charge. Documents may be viewed at the Claim Administrator’s office, at 560 North Park Avenue, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding holidays. The Participant may also request that Blue Cross and Blue Shield of Montana mail copies of all documentation to the Participant.

3. Submission of Information and Documents

   The Participant may present written evidence and testimony, including any new or additional records, documents or other information that are relevant to the claim for consideration by the Plan during the appeal process.

4. Consideration of Comments

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

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

5. **Scope of Review**

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

6. **Consultation with Medical Professionals**

If the claim is, in whole or in part, based on medical judgment, the Claim Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not have been involved in the initial adverse benefit determination (nor have been a subordinate of any person previously consulted). The Participant may request information regarding the identity of any health care professional whose advice was obtained during the review of the Participant’s claim.

**Time Period for Notifying Participant of Final Internal Adverse Benefit Determination**

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

<table>
<thead>
<tr>
<th>Type of Claim on Appeal</th>
<th>Time Period for Notification of Final Internal Adverse Benefit Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Claim</td>
<td>No later than 72 hours from the date the Claim Administrator received the Participant’s appeal, taking into account the medical exigency.</td>
</tr>
<tr>
<td>Pre-Service Claim</td>
<td>No later than 30 days from the date the Claim Administrator received the Participant’s appeal.</td>
</tr>
<tr>
<td>Post-Service Claim</td>
<td>No later than 60 days from the date the Claim Administrator received the Participant’s appeal.</td>
</tr>
</tbody>
</table>
| Concurrent Care Claim     | • If the Participant’s claim involved urgent care, no later than 72 hours from the date the Plan received the Participant’s appeal, taking into account the medical exigency.  
                          • If the Participant’s claim did not involve urgent care, the time period for deciding a pre-service (non-urgent care) claim and a post-service claim, as applicable, will govern. |
| Rescission Claim          | No later than 60 days from the date the Claim Administrator received the Participant’s appeal. |

**Content of Notice of Final Internal Adverse Benefit Determination**

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

1. The specific reason(s) for the final internal adverse benefit determination, including a discussion of the decision. If the final internal adverse benefit determination upholds a rescission, the notice will include the basis for the fraud or intentional misrepresentation of a material fact;

2. A reference to the applicable Plan Document provision(s), including identification of any standard relied upon in the Plan to deny the claim (such as a medical necessity standard), on which the final internal adverse benefit determination is based;

3. If applicable, a statement describing the Participant’s right to request an external review and the time limits for requesting an external review;
4. If applicable, a statement that any internal Medical Policy or guideline or medical information relied on in making the final internal adverse benefit determination will be provided, upon request and free of charge;

5. If applicable, an explanation of the scientific or clinical judgment for any final internal adverse benefit determination that is based on a medical necessity or an experimental treatment or similar exclusion or limitation as applied to the Participant’s medical circumstances;

6. If applicable, a statement that diagnosis and treatment codes will be provided, with their corresponding meanings, upon request and free of charge;

7. Contact information for a consumer appeal assistance program and a statement of the Participant’s right to file a civil action under Section 502(a) of ERISA; and

8. A statement that reasonable access to and copies of all documents and records and other information relevant to the final internal adverse benefit determination will be provided, upon request and free of charge.

External Review Procedures

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

1. Rescissions of coverage; and

2. Medical judgment, including those adverse benefit determinations that are based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or adverse benefit determinations that certain treatments are experimental or investigational.

External review is not available for:

1. Adverse benefit determinations that are based on contractual or legal interpretations without any use of medical judgment; and

2. Adverse benefit determinations that are based on a failure to meet requirements for eligibility under a group health plan.

Standard External Review Procedures

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

1. Request for a Standard External Review

   The Participant must submit a written request to the Claim Administrator for a standard external review within 4 months from the date the Participant receives an adverse benefit determination or a final internal adverse benefit determination.

2. Preliminary Review

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

   a. The Participant is or was covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Participant was covered under the Plan when the health care item or service was provided;

   b. The adverse benefit determination or final internal adverse benefit determination relates to the Participant’s failure to meet the Plan’s eligibility requirements;

   c. The Participant has exhausted (or is not required to exhaust) the Plan’s internal appeals process;

   d. The Participant has provided all the information and forms required to process the external review.

   Within 1 day after completing its review, the Claim Administrator will notify the Participant in writing if the request is eligible for external review. If further information or materials are necessary to complete the review, the written notice will describe the information or materials and the Participant will be given the remainder of the 4 month period or 48 hours after receipt of the written notice, whichever is later, to provide the necessary information or
materials. If the request is not eligible for external review, the Plan will outline the reasons for ineligibility in the notice and provide the Participant with contact information for the U.S. Employee Benefits Security Administration (toll free number 866.444.EBSA (3272).

3. **Assignment of an IRO**

Following a preliminary review determination that the Participant’s request is eligible for external review, the Plan will assign the Participant’s request to an Independent Review Organization (IRO) to perform the external review. To ensure independence of the external review and to minimize potential bias, the Plan will contract with at least three IROs who are accredited by URAC or a similar nationally recognized accrediting organization and will rotate assignments among the three IROs (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO shall not be eligible for any financial incentives based upon the likelihood that the IRO will support the denial of claims.

4. **Notice of Acceptance for External Review**

The IRO will timely provide the Participant with written notice of the request’s eligibility and acceptance for external review. The IRO will inform the Participant that the Participant may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO will consider such additional information in its external review.

5. **Plan Submission of Documents to the IRO**

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

6. **Reconsideration by Plan**

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

7. **Standard of Review**

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

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

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

a. A general description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;

b. The date the IRO received the assignment to conduct the external review and the date of the IRO’s decision;

c. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

d. A discussion of the principal reason(s) for the IRO’s decision, including the rationale for its decision and any evidence-based standards relied on in making the decision;

e. A statement that the IRO’s determination is binding, unless other remedies are available to the Claim Administrator or the Participant under state or federal law;

f. A statement that judicial review may be available to the Participant and the Plan; and

g. Contact information for a consumer appeal assistance program.

9. Compliance with IRO Decision

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

Expedited External Review Procedures

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

1. Request for Expedited External Review

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

a. If the Participant received an adverse benefit determination that denied the Participant’s claim and: (1) the Participant filed a request for an internal urgent care appeal; and (2) the delay in completing the internal appeal process would seriously jeopardize the life or health of the Participant or the Participant’s ability to regain maximum function; or

b. Upon receipt of a final internal adverse benefit determination which involves: (1) a medical condition of the Participant for which a delay in completing the standard external review would seriously jeopardize the Participant’s life or health or the Participant’s ability to regain maximum function; or (2) an admission, availability of care, a continued stay, or a health care item or service for which the Participant received emergency services, but has not been discharged from a facility.

2. Preliminary Review

Immediately upon receiving the Participant’s request for expedited external review, the Claim Administrator will determine whether the request is eligible for external review, considering the same preliminary review requirements set forth in the Preliminary Review paragraph, Standard External Review Procedures section. After the preliminary review is complete, the Claim Administrator will immediately notify the Participant in writing if the request is eligible for external review or requires further information or materials to complete the request. The Participant will have until the end of the 4-month period to file a request for external review or 48 hours (whichever is later) to complete the request.

3. Assignment of an IRO

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

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

5. Notice of Final External Review Decision

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

a. A description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;

b. The date the IRO received the assignment to conduct the external review and the date of the IRO’s decision;

c. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

d. A discussion of the principal reason(s) for the IRO’s decision, including the rationale for its decision and any evidence-based standards relied on in making the decision;

e. A statement that the IRO’s determination is binding, unless other remedies are available to the Plan or the Participant under state or federal law;

f. A statement that judicial review may be available to the Participant or the Claim Administrator; and

g. Contact information for the appropriate consumer appeal assistance program.

6. Compliance with IRO Decision

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

7. Deemed Exhaustion of Internal Appeal Process

a. The Participant will be deemed to have exhausted the internal appeal process and may request external review or pursue any available remedies under state law or if applicable, a civil action under 502(a) of ERISA, if the Plan fails to comply with its claims and appeals procedures, except that claims and appeals procedures will not be deemed exhausted based on violations that are:

1. De minimis;
2. Non-prejudicial to the Participant;
3. Attributable to good cause or matters beyond the Claim Administrator’s control;
4. In the context of an ongoing, good faith exchange of information between the Participant and the Plan; and
5. Not reflective of a pattern or practice of violations by the Claim Administrator.

b. Upon request of the Participant, the Claim Administrator will provide an explanation of a violation within 10 days. The explanation will include a description of the basis for the Plan’s assertion that the violation does not result in the deemed exhaustion of the Claim Administrator’s internal claims and appeals procedures.

c. If the Participant seeks external or judicial review based on deemed exhaustion of the Claim Administrator’s internal claims and appeals procedures, and the external reviewer or court rejects the Participant’s request, the Claim Administrator will notify the Participant within a reasonable period of time, not to exceed 10 days, of the Participant’s right to resubmit the Participant’s internal appeal. The timeframe for appealing the adverse benefit determination begins to run when the Participant receives the notice of the right to resubmit the Participant’s internal appeal.
QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

1. The Family and Medical Leave Act of 1993 (FMLA) requires Employers, who employ at least 50 workers within a 75 mile radius of the workplace, to provide eligible Employees with up to 12 weeks of leave during any 12-month period for any of the following reasons:
   a. To care for a newborn child;
   b. Because a child has been placed with the Employee for adoption or foster care;
   c. To care for the Employee’s spouse, child, or parent, who has a serious health condition;
   d. The Employee’s own serious health condition makes the Employee unable to perform his or her job.

2. Eligible Employees are those who have been employed by the Employer for at least 12 months and who have worked at least 1,250 hours for that Employer during the previous 12-month period.

3. The health Benefits of an Employee and dependents, if any, will be maintained during FMLA leave on the same terms and conditions as if the Employee had not taken leave.

4. The health Benefits of an Employee and dependents, if any, may lapse at the Employer's discretion during FMLA leave if the Employee does not pay his or her share of the premiums in a timely manner or the Employee does not elect health Benefits during the FMLA leave. Upon return from leave, the Employee and dependents, if any, will be reenrolled in the health Benefit plan as if the coverage had not lapsed.

5. The Employee's reenrollment in the health plan will be effective upon the date on which the Employee returns to work.

6. An Employee who takes FMLA leave and fails to pay any required premium contribution or fails to return from leave will be entitled to COBRA coverage for the maximum COBRA coverage period beginning when the FMLA coverage terminated.

PRIVACY OF PROTECTED HEALTH INFORMATION

Protected Health Information about a Plan Participant will not be disclosed to the Plan Sponsor by the Health Plan or any Business Associate servicing the Health Plan, unless the Plan Sponsor certifies that the Plan Documents have been amended to include this section and the Plan Sponsor agrees to abide by this section. Any disclosure to and use by the Plan Sponsor will comply with all provisions of this section.

Definitions

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

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

2. Federal Regulations.
   Those regulations entitled Standards for Privacy of Individually Identifiable Health Information, 45 CFR §160 and §164.
A self-insured employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act (ERISA) that provides coverage for medical care.

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

5. Plan Participant.
A person covered under the Group Health Plan.

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

7. Protected Health Information (PHI).
Individually identifiable health information transmitted, including electronic transmission, or maintained in any form or medium.

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

1. To permit the Plan Sponsor to carry out Plan administration functions that are in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2. Disclosures to the Plan Sponsor of a Plan Participant’s PHI will be explained in the Notice of Privacy Practices issued to Plan Participants by the Health Plan.

3. No Plan Participant’s PHI will be disclosed to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other Benefit or Employee Benefit plan of the Plan Sponsor. Claims are classified by type of claim and the timeline in which a decision must be decided and a notice provided depends on the type of claim involved. The initial benefit claim determination notice will be included in the Participant’s explanation of benefits (EOB) or in a letter from the Plan, whether adverse or not. There are five types of claims:

Restrictions on Plan Sponsor’s Use and Disclosure of PHI
The Plan Sponsor will:

1. Not use or further disclose PHI except as permitted or required by the Plan Documents, as amended by this section, or required by law.

2. Ensure that any agent, including subcontractors, to whom it provides PHI agrees to the restrictions and provisions of the Plan Documents, including this section.

3. Not use or disclose PHI for the purpose of employment-related actions or decisions or in connection with any other Benefit or Employee Benefit plan of the Plan Sponsor.

4. Promptly report to the Health Plan any use or disclosure of PHI that does not comply with the provisions of this section upon learning of such noncompliance.

5. Make PHI, located in a Plan Participant’s designated record set, available to the Plan Participant who is the subject of the information, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for their information.

6. Make PHI, located in a Plan Participant’s designated record set, available for amendment, and amend PHI, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for amendment.

7. Provide an accounting of disclosure to Plan Participants in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for an accounting of disclosures.
8. Make its internal practices, books, and records, relating to its use and disclosure of PHI, available to the Health Plan and the United States Department of Health and Human Services to determine compliance with Federal Regulations.

9. If feasible, and subject to 9b below:
   a. Return or destroy all PHI, and retain no copies, when the PHI is no longer needed for the Plan administration functions for which the disclosure was made. This includes:
      1. PHI, in whatever form or medium (including any electronic medium under the Plan Sponsor’s custody or control), received from the Health Plan or a Business Associate; and
      2. Any data or compilations derived from and allowing identification of any Plan Participant who is the subject of the PHI.
   b. If it is not feasible to return or destroy all PHI, the Plan Sponsor will limit the use or disclosure of any PHI that it cannot return or destroy to those purposes that make it unfeasible to return or destroy the PHI.

Adequate Separation Between the Plan Sponsor and the Plan

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

Steve Johnson, Deputy Superintendent Operations
Lacy Clark, Benefits Specialist

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

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

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

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

GENERAL PROVISIONS

Plan Administrator Powers and Duties

The Plan Administrator shall have total and exclusive responsibility to control, operate, manage, and administer the Plan in accordance with its terms. The Plan Administrator shall have all the authority that may be necessary or helpful to enable it to discharge its responsibilities with respect to the Plan. Without limiting the generality of the preceding sentence, the Plan Administrator shall have the exclusive right: to interpret the Plan; to determine eligibility for coverage under the Plan; to determine eligibility for Benefits under the Plan; to construe any ambiguous provisions of the Plan; to correct any default; to supply any omission; to reconcile any inconsistency; and to decide any and all questions arising in administration, interpretation, and application of the Plan.
The Plan Administrator shall have full discretionary authority in all matters related to the discharge of its responsibilities and the exercise of authority under the Plan, including, without limitation, the construction of the terms of the Plan, and the determination of eligibility for coverage and Benefits. The decisions of the Plan Administrator, as Plan Administrator, shall be conclusive, binding and final upon all persons having or claiming to have any right or interest in or under the Plan and no such decision shall be modified under judicial review unless such decision is proven to be arbitrary or capricious.

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

**Entire Plan; Changes**

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

**Modification of Plan**

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

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

**Notice of Change**

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

**Clerical Errors**

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

**Notice of Annual Meeting**

The Policyholder is hereby notified that it is a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative or by proxy at all meetings of Members of said Company. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

For purposes of the aforementioned paragraph the term "Member" means the group, trust, association or other entity to which this Plan Document has been issued. It does not include Family Members covered under the Plan Document. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Plan Document to "premium(s) (dues)" shall mean "charge(s)."
Notices Under Plan

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

Rescission of Plan Document

This Plan Document is subject to rescission if the Participant commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, concerning a Participant’s health, claims history, or current receipt of health care services.

Payment of Claims and Assignment of Benefits

Claim Payment Assignment

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

Claim Dispute

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

Plan Coverage Assignment

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

Validity of Plan

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

Participants Rights

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

Alternate Care

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

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

Pilot Programs

The Plan reserves the right to develop and enter into pilot programs to test the success of providing Benefits for care not normally covered under this Plan. The existence of a pilot program does not guarantee that all Participants are eligible for the pilot program Benefits or that such Benefits will be permanent.

Research Fees

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

Cooperation of Participant

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

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

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

Statements are Representations

In the absence of fraud, all statements by applicants or the Participant shall be deemed to be representations and not warranties.

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

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

Any Participant who, with intent to defraud of knowing that he or she is facilitating a fraud against the Employer, submits an application or files a claim containing a false, incomplete, or misleading statement is guilty of fraud. The Employer reserves the right to take appropriate action in any instance where fraud is at issue.
Participant/Provider Relationship

Choosing a Provider

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

Claim Administrator’s Role

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

Intent of Terminology

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

Provider’s Role

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

Recovery, Reimbursement, and Subrogation

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

1. Right to Recover Benefits Paid in Error

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

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

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

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

2. Reimbursement

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

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

3. Subrogation

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

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

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

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

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

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

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

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

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

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

5. Right of Offset

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

DEFINITIONS

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

ACCIDENT

An unexpected traumatic incident or unusual strain which is:

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

Some examples include:

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

ADVANCED PRACTICE REGISTERED NURSE

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

ALLOWABLE FEE

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

1. Medicare RBRVS based is a system established by Medicare to pay physicians for a “work unit.” The RBRVS value is determined by multiplying a “relative value” of the service by a “converter” to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers’ billed charge; or
2. Diagnosis-related group (DRGs) methodology is a system used to classify hospital cases into one of approximately 500 to 900 groups that are expected to have similar hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of hospital resources for the given DRG regardless of the actual hospital resources used. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating providers under the DRG system can be considerably less than the nonparticipating providers’ billed charge; or

3. Billed Charge is the amount billed by the provider; or

4. Case Rate methodology is an all inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Case Rate system can be considerably less than the nonparticipating providers’ billed charge; or

5. Per Diem methodology is an all inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Per Diem system can be considerably less than the nonparticipating providers’ billed charge; or

6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating providers under the Flat fee per category of service system can be considerably less than the nonparticipating providers’ billed charge; or

7. Flat fee per unit of service fixed payment amount for a unit of service, For instance, a unit of service could be the amount of “work units” customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Flat fee per unit system can be considerably less than the nonparticipating providers’ billed charge; or

8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or

9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or

10. The amount negotiated with the Pharmacy Benefit Manager or manufacturer or the actual price for prescription or drugs; or

11. The American Society of Anesthesiologists’ Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a “work unit.” The payment value is determined by multiplying a “relative value” of the service by a “converter” to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the system can be considerably less than the nonparticipating providers’ billed charge.

12. For nonparticipating providers in Montana, the Allowable Fee is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for nonparticipating providers will represent an average contract rate for Participating Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. Blue Cross and Blue Shield of Montana will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by nonparticipating providers which may also alter the Allowable Fee for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Plan within 90 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.
In the event the nonparticipating Allowable Fee does not equate to the nonparticipating provider’s billed charges, the Participant will be responsible for the difference, along with any applicable Copayment, Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the Plan’s nonparticipating Allowable Fee for a particular service, Participants may call the customer service number shown on the back of their Identification Card.

**APPLIED BEHAVIOR ANALYSIS (ABA) - (ALSO KNOWN AS LOVAAS THERAPY)**
Medically Necessary interactive therapies or treatment derived from evidence-based research. The goal of ABA is to improve socially significant behaviors to a meaningful degree, including:

1. increase desired behaviors or social interaction skills;
2. teach new functional life, communication, or social, skills;
3. maintain desired behaviors, such as teaching self control and self-monitoring procedures;
4. appropriate transfer of behavior from one situation or response to another;
5. restrict or narrow conditions under which interfering behaviors occur;
6. reduce interfering behaviors such as self injury.

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

Services must be provided by an appropriately certified provider.

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

1. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
2. Exempt from an investigational new drug application; or
3. Approved or funded by:
   - The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
   - A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
   - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes for Health for center support groups; or
   - The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and provide unbiased scientific review by individuals who have no interest in the outcome of the review.

**BENEFIT**
The payment for services of a Covered Provider to a Participant for Covered Medical Expenses under this Plan.

**BENEFIT PERIOD**
For the Plan, the Benefit Period is the period set forth in the Schedule of Benefits.

For the Participant the Benefit Period is the same as that described for the Plan except that if the Participant’s Effective Date is after the Effective Date of the Plan, the Participant’s Benefit Period begins with his or her Effective Date and ends on the same date the Plan Benefit Period ends. Thus, the Participant’s Benefit Period may be less than 12 months.

**BEST EVIDENCE**
Means evidence based on

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

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

BRAND-NAME
A drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

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

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

CHEMICAL DEPENDENCY
The uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner or other appropriate medical practitioner.

CHEMICAL DEPENDENCY TREATMENT CENTER
A facility which provides treatment for Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician or an addiction counselor licensed by the state. The facility must also be licensed or approved as a Chemical Dependency Treatment Center by the Department of Public Health and Human Services or must be licensed or approved by the state where the facility is located.

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

CLINICAL PEER
A physician or other health care provider who:

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

CODE
The Internal Revenue Code of 1986, as amended.

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

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

CONCURRENT CARE
Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or
Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Participant's condition requires the skills of separate Physicians.
CONSULTATION SERVICES
Services of a consulting Physician requested by the attending Physician. These services include discussion with the attending Physician and a written report by the consultant based on an examination of the Participant.

CONVALESCENT HOME
An institution, or distinct part thereof, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is a/an:

1. skilled nursing facility;
2. extended care facility;
3. extended care unit; or
4. transitional care unit.

A Convalescent Home is primarily engaged in providing continuous nursing care by or under the direction and supervision of a registered nurse for sick or injured persons during the convalescent stage of their illness or injuries and is not, other than incidentally, a rest home or home for Custodial Care, or for the aged.

NOTE: In no event, shall this term include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and treatment of Mental Illness or Chemical Dependency.

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

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

1. Covered under the Plan;
2. In accordance with Medical Policy; and
3. Provided to the Participant by and/or ordered by a covered provider for the diagnosis or treatment of an active Illness or Injury or in providing maternity care.

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

COVERED PROVIDER
A provider that has satisfied the necessary qualifications to practice within the state of Montana or another state and that has been recognized by the Claim Administrator as a provider of services for Benefits described in the Plan Document. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine whether a provider is covered, the Claim Administrator looks to the nature of the services rendered and the extent of licensure.

CREDITABLE COVERAGE
Coverage that the Participant had for medical benefits under any of the following plans, programs and coverages:

1. a group health plan
2. health insurance coverage
3. Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1935c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4 (Medicare)
4. Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s (Medicaid)
5. Title 10, chapter 55, United States Code (TRICARE)
6. a medical care program of the Indian Health Service or of a tribal organization
7. the Montana Comprehensive Health Association provided for in 33-22-1503 (MCHA)
8. a health plan offered under Title 5, chapter 89, of the United States Code (Federal Employee Health Benefits Program)
9. a public health plan
10. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e)
11. a high risk pool in any state

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

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

DEDUCTIBLE
The dollar amount each Participant must pay for Covered Medical Expenses incurred during the Benefit Period before the Plan will make payment for any Covered Medical Expense to which the Deductible applies.

Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. Thus, Coinsurance, Copayment, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Participant's responsibility.

If two or more Participants covered under the same Family Membership satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Participant of the Family Membership.

If a Participant is in the Hospital on the last day of the Participant’s Benefit Period and continuously confined through the first day of the next Benefit Period, only one Deductible will be applied to that Hospital stay (facility charges only). If the Participant satisfied the Participant’s Deductible prior to that Hospital stay, no Deductible will be applied to that stay.

DRUG LIST
A list that identifies those Prescription Drug Products that are covered by the Plan for dispensing to Participants when appropriate. This list is reviewed quarterly and subject to modification. Details can be found on the pharmacy page at www.bcbsmt.com or by visiting www.myprime.com.

EFFECTIVE DATE
For a Participant, the Effective Date is the date the Participant has met the requirements of the Plan and is shown on the records of the Plan to be eligible for Benefits. For the Plan, the Effective Date is the date shown on the Schedule of Benefits. However, certain provisions shall be effective as of the dates specified within those provisions. The Effective Date of any amendment to the Plan is the Effective Date set forth on such amendment.

EMPLOYEE
Any person (other than a nonresident alien who receives no U.S. income from the Employer) who is employed by the Employer. Notwithstanding the foregoing, the term "Employee" shall also include any officer, or former officer of the Employer for whom the Employer is contractually bound by written agreement to provide health Benefits. Employee shall not include any person who is classified by the Employer as an independent contractor or as a leased Employee.

EMPLOYER
Bozeman School District #7

ERISA
The Employee Retirement Income Security Act of 1974, as amended and all regulations applicable thereto.

EVIDENCE-BASED STANDARD
The conscientious, explicit, and judicious use of the current Best Evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

EXCLUSION
A provision which states that The Plan has no obligation to make payment for specific services.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN
A drug, device, biological product or medical treatment or procedure is Experimental, Investigational and/or Unproven if the Plan determines that:
• The drug, device, biological product or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product or medical treatment or procedure is furnished; or
• The drug, device, biological product or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials, or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
• The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

EXPERT OPINION
A belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

FAMILY MEMBER
A Participant who has been enrolled by an enrolled Employee and who is one of the following:

1. His or her legal Spouse.
2. His or her unmarried or married biological child, adopted child, or child placed for adoption and who is under the age of 26 years.
3. Children for who the Employee becomes legally responsible by reason of placement for adoption, as defined in Montana law.
4. An unmarried or married child of the Employee and/or spouse who is 26 years of age or older may qualify as a Family Member if the child:
   a. Has been covered under the Plan before age 26; and
   b. Cannot support himself/herself because of intellectual disability or physical handicap; and
   c. Is legally dependent on the enrolled Employee for support.

Proof of those qualifications must be supplied to the Plan within 31 days of the child’s 26th birthday. Although there is no limiting age for handicapped children, the Plan reserves the right to require periodic certification from the enrolled Employee of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child’s 26th birthday.

Notwithstanding any other restrictions or criteria in this definition of Family Member of the section entitled Eligibility and Coverage, as provided in ERISA 609(a), the Plan shall provide coverage to any “alternate recipient” with respect to a “qualified medical child support order.”

FAMILY MEMBERSHIP
The family unit including the enrolled Employee and all Family Members who have been accepted as Participants of the Plan.

FREESTANDING INPATIENT FACILITY
For treatment of Chemical Dependency, it means a facility which provides treatment for Chemical Dependency in a community-based residential setting for persons requiring 24-hour supervision and which is a Chemical Dependency Treatment Center and is approved as a Freestanding Inpatient Facility by the alcohol authority of the state.

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

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

HOME HEALTH AGENCY
An agency licensed by the state which provides home health care to the Participant in the Participant’s home.
HOME HEALTH AIDE
A nonprofessional worker who has been trained for home care of the sick and is employed by a Home Health Agency.

HOME HEALTH SERVICE
The services provided by a Home Health Agency that must be:

1. Prescribed and supervised by the Participant’s attending Physician;
2. Provided through a licensed Home Health Agency; and
3. Provided to the Participant in the Participant’s home.

HOME INFUSION THERAPY AGENCY
A health care provider that provides home infusion therapy services.

HOSPITAL
A facility providing, by or under the supervision of licensed Physicians, services for medical diagnoses, treatment, rehabilitation, and care of injured, disabled, or sick individuals. A Hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week and provides 24-hour nursing care by licensed registered nurses.

ILLNESS
An alteration in the body or any of its organs or parts which interrupts or disturbs the performance of a vital function, thereby causing or threatening pain or weakness.

IN-NETWORK
Providers who are:

1. Participating Blue Cross and Blue Shield of Montana Professional Providers;
2. Participating Blue Cross and Blue Shield of Montana Facility Providers, except for Hospitals and surgery centers;
3. PPO Hospitals and surgery centers; or
4. Blue Cross and/or Blue Shield PPO providers outside of Montana.

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

INJURY
Physical damage to an individual’s body, caused directly and independent of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

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

1. Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent homes;
5. Freestanding inpatient facilities.

INPATIENT PARTICIPANT
A Participant who has been admitted to a facility as a registered bed patient for Inpatient Care.

LATE ENROLLEE
An eligible Employee or dependent, other than a special enrollee under the special enrollment provisions who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 31 days. However, an eligible Employee or dependent is not considered a Late Enrollee if a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered Employee’s health benefit plan and request for enrollment is made within 31 days after issuance of the court order. If an individual is
employed by an employer that offers multiple health benefit plans, and the individual elects a different plan during an open enrollment period, that individual is not a Late Enrollee.

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

MEDICAL FOODS
Nutritional substances in any form that are:

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

MEDICAL OR SCIENTIFIC EVIDENCE
Evidence found in the following sources:

1. peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's library of medicine for indexing in Index Medicus and Excerpta Medica, published by the Reed Elsevier group;
3. medical journals recognized by the Secretary of Health and Human Services under 42 U.S.C. 1395x(t)(2)(B) of the federal Social Security Act;
4. the following standard reference compendia:
   a. the American Hospital Formulary Service Drug Information;
   b. Drug Facts and Comparisons;
   c. the American Dental Association Guide to Dental Therapeutics; and
   d. the United States Pharmacopeia;
5. findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
   a. the federal Agency for Healthcare Research and Quality;
   b. the national Institutes of Health;
   c. the National Cancer Institute;
   d. the National Academy of Sciences;
   e. the Centers for Medicare and Medicaid Services;
   f. the Food and Drug Administration; and
   g. any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6. any other medical or scientific evidence that is comparable to the sources listed in subsection 4 or 5.

MEDICAL POLICY
The Claim Administrator’s policy which is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

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

Medical Policy is reviewed and modified periodically as is necessary.

MEDICALLY NECESSARY (MEDICAL NECESSITY)
Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:
1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
3. not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

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

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

**MEDICALLY NECESSARY (FOR AUTISM, ASPERGER’S DISORDER AND PERVERSIVE DEVELOPMENTAL DISORDER)**

Any care, treatment, intervention, service, or item that is prescribed, provided or ordered by a physician or psychologist and that will or is reasonably expected to:

1. Prevent the onset of an illness, condition, injury, or disability;
2. Reduce or improve the physical, mental, or developmental effects of an illness, condition, or injury, or disability; or
3. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

**MENTAL HEALTH TREATMENT CENTER**

A treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by an interdisciplinary team, including a licensed physician, psychiatric social worker and psychologist. The facility must be:

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

**MENTAL ILLNESS**

A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

1. present distress or a painful symptom;
2. a disability or impairment in one or more areas of functioning; or
3. a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

Mental Illness does not include:

1. developmental disorders;
2. speech disorders;
3. psychoactive substance use disorders;
4. eating disorders (except for bulimia and anorexia nervosa);
5. impulse control disorders (except for intermittent explosive disorder and trichotillomania); and
6. Severe Mental Illness.
MULTIDISCIPLINARY TEAM
A group of health service providers who are either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. For the purposes of Rehabilitation Therapy, members of the Multidisciplinary Team may include, but are not limited to, a licensed psychologist, licensed speech therapist, registered physical therapist, or licensed occupational therapist.

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

OUT-OF-NETWORK
Providers who are:
1. Non-participating professional providers;
2. Non-participating facility providers;
3. Non-PPO Network Hospitals and surgery centers; or
4. Blue Cross and Blue Shield of Montana Participating Hospitals and surgery centers that are not in the PPO Network.

OUT OF POCKET AMOUNT
For the Participant:
The total amount of Deductible a Participant must pay for Covered Medical Expenses and any Coinsurance/Copayment for Prescription Drugs incurred during the Benefit Period. Once the Participant has satisfied the Out of Pocket Amount, the Participant will not be required to pay the Participant’s Deductible for Covered Medical Expenses or any Coinsurance/Copayment for Prescription Drugs for the remainder of that Benefit Period. The Out of Pocket Amount for the Participant is listed in the Schedule of Benefits.

In some instances, the Deductible for certain Benefits does not apply to the Out of Pocket Amount and the Participant will be required to pay the Deductible for those Benefits, even though the Participant has satisfied the Out of Pocket Amount. Please refer to the Schedule of Benefits for application of Deductible.

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

Non-covered services, transplants not provided at a Center of Excellence and amounts over the allowed amount billed by a non-participating provider do not accumulate to the Out of Pocket Amount and are the Participant’s responsibility.

For the Family:
The total amounts of Deductible for Covered Medical Expenses and any Coinsurance/Copayment for Prescription Drugs a Family Membership must pay for services incurred during that Benefit Period. Once the Deductible paid by the Participant during the Benefit Period for two or more Family Participants covered under the same Family Membership total the Out of Pocket Amount for the family, the Participants covered under the same Family Membership will not be required to pay the Deductible for Covered Medical Expenses the remainder of that Benefit Period. The Out of Pocket Amount for the family is listed on the Schedule of Benefits.

In some instances, the Deductible for certain Benefits does not apply to the Out of Pocket Amount and the Participant will be required to pay the Deductible for those Benefits, even though the Participant has satisfied the Out of Pocket Amount. Please refer to the Schedule of Benefits for application of Deductible.

Non-covered services, transplants not provided at a Center of Excellence and amounts over the allowed amount billed by a non-participating provider do not accumulate to the Out of Pocket Amount and are the Participant’s responsibility.

OUTPATIENT
Services or supplies provided to the Participant by a Covered Provider while the Participant is not an Inpatient Participant.
PARTIAL HOSPITALIZATION
A time-limited ambulatory (Outpatient) program offering active treatment which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

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

PARTICIPANT
An eligible Employee or Eligible Family Member who has applied for participation in accordance with the section entitled Eligibility and Coverage, has been accepted as a Participant of the Plan, and maintains participation in the Plan.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA FACILITY PROVIDER
A facility which has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana and may include, but are not limited to, Hospitals, home health agencies, Convalescent Homes, skilled nursing facilities, Freestanding Inpatient Facilities and freestanding surgical facilities. Please read the section entitled Providers of Care for Participants.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA PROFESSIONAL PROVIDER
A provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana and may include, but are not limited to, Physicians, physician assistants, nurse specialists, dentists, podiatrists, speech therapists, physical therapists and occupational therapists. Please read the section entitled Providers of Care for Participants.

PARTICIPATING PHARMACY
A pharmacy that has entered into an agreement with the Pharmacy Benefit Manager to provide Prescription Drug Products to Participants and has agreed to accept specified reimbursement rates.

PARTICIPATING PROVIDER
A provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana.

PHARMACY BENEFIT MANAGER
The company with whom the Claim Administrator has entered into an agreement for the processing of prescription drug claims.

PHYSICAL THERAPY
The treatment of a disease or injury by physical means (e.g., hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices) to relieve pain, restore maximum function and prevent disability following disease, injury, or a loss of a bodily part.

PHYSICIAN
A person licensed to practice medicine in the state where the service is provided.

PLAN
Plan means the health benefit plan for Employees of the company, the Plan Document, or any other relevant documents pertinent to the operation and maintenance of the Plan.

PLAN ADMINISTRATOR
Plan Administrator means the company and/or its designee who is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purpose of the Employee Retirement Income Security Act of 1974, as amended, and any applicable state legislation of a similar nature, the company will be deemed to be the Plan Administrator of the Plan unless by action of the board of directors, the company designates an individual or committee to act as Plan Administrator of the Plan.

PLAN BENEFIT YEAR
The period specified as the Benefit Period in the Schedule of Benefits.

PLAN DOCUMENT
This document which sets forth and governs the rights and duties of the Plan Sponsor, Plan Administrator, Claim
Administrator, and Participants under the Plan and modified by any policies, interpretations, rules, practices, and procedures made by the Sponsor.

POLICYHOLDER
The (1) employing entity corporation, partnership, sole proprietor or other employer, or (2) association, or (3) trust which has executed the Group Application for the Plan Document. An ERISA Health Benefit Program may not be a Policyholder hereunder, but a sponsor of or trust implementing an ERISA Health Benefit Program may be a Policyholder hereunder.

PPO-A PREFERRED PROVIDER ORGANIZATION
A provider or group of providers which have contracted with the Plan to provide services to Participants covered under PPO Benefit Contracts.

PPO NETWORK
A provider or group of providers which have a PPO contract with Blue Cross Blue Shield of Montana. The Participant may obtain a list of PPO providers from Blue Cross Blue Shield of Montana upon request. Payment to a non-PPO Network provider is subject to the non-PPO Network provider reduction shown in the Schedule of Benefits and the Special Provisions section of this document.

PREAUTHORIZATION
A process to inform the Participant whether or not a proposed service, medication, supply, or on-going treatment is Medically Necessary and is a Covered Medical Expense of this Plan.

PRESCRIPTION DRUG PRODUCT
A medication, product or device approved by the Food and Drug Administration and dispensed under federal or state law only pursuant to a prescription order or refill.

PROFESSIONAL CALL
An interview between the Participant and the professional provider in attendance. The professional provider must examine the Participant and provide or prescribe medical treatment and/or advice. "Professional Call" does not include telephone calls or any other communication where the Participant is not examined by the professional provider, except as included in the Benefit section entitled Telemedicine.

PROOF OF LOSS
The documentation accepted by the Claim Administrator upon which payment of Benefits is made.

QUALIFIED INDIVIDUAL (For an Approved Clinical Trial)
An individual with group health coverage or group or individual health insurance coverage who is eligible to participate in an Approved Clinical Trial according to the trial protocol for the treatment of cancer or other Life-Threatening Condition because:

1. The referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate; or

2. The individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

RANDOMIZED CLINICAL TRIAL
A controlled, prospective study of patients who have been assigned at random to an experimental group or a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention. The term includes a study of the groups for variables and anticipated outcomes over time.

RECONSTRUCTIVE BREAST SURGERY
Surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

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

REHABILITATION FACILITY
A facility, or a designated unit of a facility, licensed, certified or accredited to provide Rehabilitation Therapy including:
1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or a facility associated or co-located with a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital;
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Participant, regardless of the category of facility licensure.

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

1. provided by a Rehabilitation Facility in an Inpatient Care or outpatient setting;
2. provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;
3. designed to restore the patient’s maximum function and independence; and
4. Medically Necessary to improve or restore bodily function and the Participant must continue to show measurable progress.

RESIDENTIAL TREATMENT CENTER
A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders. Requirements: Blue Cross and Blue Shield of Montana requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by Blue Cross and Blue Shield of Montana as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

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

ROUTINE PATIENT COSTS
All items and services covered by a group health plan or a plan of individual or group health insurance coverage when the items or services are typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. The term does not include:

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

SEVERE MENTAL ILLNESS
The following disorders as defined by the American psychiatric association:

1. schizophrenia;
2. schizoaffective disorder;
3. bipolar disorder;
4. major depression;
5. panic disorder;
6. obsessive-compulsive disorder; and
7. autism.
Coverage for a child with autism who is 18 years of age or younger is provided under the Autism Spectrum Disorders Benefit if the child is diagnosed with:

1. Autistic Disorder;
2. Asperger’s Disorder; or
3. Pervasive Developmental Disorder not otherwise specified.

SPECIALTY MEDICATIONS
High cost, hard to manage injectables, select orals, and/or infused therapies that are administered by the patient or Physician for the treatment of chronic Illness.

SPECIALTY PHARMACY
A pharmacy which has entered into an agreement with the Claim Administrator to provide Specialty Pharmaceuticals to Participants and which has agreed to accept specified reimbursement rates.

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

SPOUSE
The opposite sex or the same sex person to whom the Employee is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

TELEMEDICINE
Telemedicine means the use of interactive audio, video, or other telecommunications technology that is:

1. Used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and
2. Delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq.

The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology. The term does not include the use of audio-only telephone, e-mail, or facsimile transmissions.

IN WITNESS WHEREOF, the Employer has caused this Plan to be duly executed, effective as of the Plan’s Effective Date.

Bozeman School District #7

By: 

Its: 

Date: 
Notice That Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under this group health plan coverage no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to reenroll in the plan. Individuals have 30 days beginning with the start of the plan year to request enrollment.

Enrollment will be effective retroactively to the first day of the plan year beginning on or after September 23, 2010.

Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage for children ended before attainment of age 26 are eligible to enroll in this group health coverage, regardless of student status, financial dependency or marital status. Individuals may request enrollment for such children for 30 days beginning with the start of the plan year.

Enrollment will be effective retroactively to the first day of the plan year beginning on or after September 23, 2010.

For additional information regarding these notices, contact:

Blue Cross and Blue Shield of Montana
560 North Park Ave.
Helena, MT 59604-4309
1-800-447-7828
BOZEMAN SCHOOL DISTRICT # 7

VISION REIMBURSEMENT PLAN

Plan Year
The plan year is September 1st through August 31st.

Eligibility
If you, and/or dependents, are enrolled in the medical care benefit program you are automatically enrolled in the vision plan. Your coverage under this plan will include eligible employees, retirees, spouses and dependent children. Definition of these groups will be the same as in the medical care benefit program.

Once you are in the plan, it is necessary that you notify the School District Benefits Clerk promptly when you have a change in your dependents. Notification should be made to the Benefits Clerk by completing a new enrollment form when your marital status changes, when you have a new dependent or when your dependents are no longer eligible for coverage.

Benefits
This plan will pay 75% of covered vision procedure expenses with a maximum of $250 of annual benefits per covered individual. If the vision process is covered by a medical plan it is not covered by the vision plan: examples are surgery, prescription, accidents, and hospitalization.

Covered Vision Expenses
All vision correction procedures are covered vision expenses if provided by or under the direction of an optometrist or ophthalmologist licensed to practice by the state in which he or she practices. Also covered are glasses and contacts.

Direct Reimbursement Procedure

1. Each claim needs to have an itemized bill and proof of payment (a copy of a cancelled check, a paid receipt or a charge card receipt). Include the name of the employee and the patient on each bill and receipt.

2. If the claim has been partially paid by another insurance plan, attach a copy of the Explanation of Benefits and your proof of payment.

3. Benefits are paid as a direct reimbursement to the employee. The claims will be processed weekly, if possible, and the reimbursement will take a minimum of two weeks. The reimbursement will be sent to the mailing address on record in the District Benefits office.

4. Submit claims to:
   Vision Claims, Bozeman Schools
   P.O. Box 520
   Bozeman, MT 59771
   or
   Vision Claims, Bozeman Schools
   Payroll Office
   Willson Building

5. Vision expenses are to be submitted within one year of service.

Type of Plan
The Vision Plan is a self-insured reimbursement plan. Premium contributions go directly into a Bozeman School District fund which is used to pay the cost of the benefits and administration for Plan members.

The Vision Plan is a “direct reimbursement” plan, which means that no outside insurance company is involved. The employer will reimburse vision charges as outlined below directly to the eligible employee. Note this is a reimbursement plan only, liability for vision work remains with the employee.
Coordination of Benefits Between the Plan and Other Plans

The Plan has been designed to help meet the cost of vision treatment. Since it is not intended that greater benefits be paid to you than your actual vision expenses, the amount of benefits payable under the Plan will take into account any coverage a family member has under other "plans." This Plan may pay deductibles and co-insurance not paid by other plans or programs, if they are within plan benefit amounts.

If a person is covered under this Plan and one or more other plans, as defined below, the benefits payable with respect to him/her under this Plan will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, will not exceed 100% of the allowable expenses.

"Plan" means any plan under which medical or vision benefits or services are provided by group insurance, self-insurance, school, other educational institution, governmental programs or coverage required or provided by any statute, or any similar plan or program.

If your spouse or dependents are covered by another vision plan, vision expenses must first be submitted to their plan. Any expenses which are not covered by their plan, and you have paid, may be submitted for reimbursement according to the plan reimbursement schedule.

Plan Termination

The District may terminate the plan upon 30 days notice. Upon termination the right of participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the plan will be communicated to the participants.

Individual Termination of Coverage

If an eligible employee is terminated or resigns, any vision expense (s) incurred before his/her termination or resignation will be reimbursed as outlined in this Plan.

Unless he/she contributes premium for continued participation as required by COBRA, the coverage of any employee covered under the Plan shall terminate on the earliest of the following dates:

1. The date of termination of the plan; or;
2. The date his/her membership ceases in an eligible class; or the date all or certain benefits are terminated;
3. The date he/she becomes a full-time member of the Armed Forces of any country; or
4. The date he/she fails to make a required contribution, if any.

Plan is Not a Contract

The Plan shall not be deemed to constitute a contract between the Employer and any employees or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time, provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Employer with the Bargaining representatives of any employees.

Plan Design Approved by Plan Participants

April 1998

Rewritten September 1, 2003

Revised September 1, 2005
BOZEMAN SCHOOL DISTRICT # 7

DENTAL REIMBURSEMENT PLAN

Plan Year
The plan year is September 1st through August 31st.

Eligibility
Same as defined under the medical care benefit program. Eligibility under this plan will include eligible employees, retirees, spouses and dependent children. Definitions of these groups will be the same as in the medical care benefit program.

Once you are in the plan, it is necessary that you notify the School District Benefits Clerk promptly when you have a change in your dependents. Notifications should be made to the Benefits Clerk by completing a new enrollment form when your marital status changes, when you have a new dependent or when your dependents are no longer eligible for coverage.

Enrollment
Each year the participant will receive an enrollment form. Complete the dental enrollment information and return during the enrollment period, July and August, to the Benefits Clerk in the Willson Building.

Benefits
This plan will pay 100% of the first $200 of covered dental and orthodontic procedure expenses and 50% of additional covered expenses to a maximum of $800 per covered family member per plan year. If the dental process is covered by a medical plan, it is not covered by the dental plan. Examples are surgery, prescription, accidents, and hospitalization.

Covered Dental Expenses
All dental procedures are covered dental expenses if provided by or under the direction of a dentist licensed to practice by the state in which he or she practices.

Direct Reimbursement Procedure

1. Each claim needs to have an itemized bill and proof of payment (a copy of a cancelled check, a paid receipt or a charge card receipt). Include the name of the employee and the patient on each bill and receipt. It is not necessary to pay the entire bill to submit a claim – you may submit a claim for partial payments of the bill as you pay them.

2. If the claim has been partially paid by another insurance plan, attach a copy of the Explanation of Benefits and your proof of payment to the dentist.

3. Benefits are paid as a direct reimbursement to the employee. The claims will be processed weekly, if possible, and the reimbursement will take a minimum of two weeks. The reimbursement will be sent to the mailing address on record in the District Benefits office.

4. Submit claims to:
   Dental Claims, Bozeman Schools or Payroll Office
   P.O. Box 520 or Payroll Office
   Bozeman, MT 59771 or Willson Building

5. Dental expenses are to be submitted within one year of service.
**Type of Plan**

The Dental Plan is a self-insured reimbursement plan. Premium contributions go directly into a Bozeman School District fund which is used to pay the cost of the benefits and administration for Plan members.

The Dental Plan is a “direct reimbursement” plan, which means that no outside insurance company is involved. The employer will reimburse dental/orthodontic charges as outlined below directly to the eligible employee. Note this is a reimbursement plan only, liability for dental/orthodontic work remains with the employee.

**Coordination of Benefits Between the Plan and Other Plans**

The Plan has been designed to help meet the cost of dental treatment. Since it is not intended that greater benefits be paid to you than your actual dental expenses, the amount of benefits payable under the Plan will take into account any coverage a family member has under other “plans.” This Plan may pay deductibles and co-insurance not paid by other plans or programs, if they are within plan benefit amounts.

If a person is covered under this Plan and one or more other plans, as defined below, the benefits payable with respect to him/her under this Plan will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, will not exceed 100% of the allowable expenses.

“Plan” means any plan under which medical or dental benefits or services are provided by group insurance, self-insurance, school, other educational institution, governmental programs or coverage required or provided by any statute, or any similar plan or program.

If your spouse or dependents are covered by another dental plan, dental expenses must first be submitted to their plan. Any expenses which are not covered by their plan, and you have paid, may be submitted for reimbursement according to the plan reimbursement schedule.

**Plan Termination**

The District may terminate the plan upon 30 days notice. Upon termination the right of participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the plan will be communicated to the participants.

**Individual Termination of Coverage**

If an eligible employee is terminated or resigns, any dental or orthodontic expense(s) incurred before his/her termination or resignation will be reimbursed as outlined in this Plan.

Unless he/she contributes premium for continued participation as required by COBRA, the coverage of any employee covered under the Plan shall terminate on the earliest of the following dates:

1. The date of termination of the plan; or;
2. The date his/her membership ceases in an eligible class; or the date all or certain benefits are terminated;
3. The date he/she becomes a full-time member of the Armed Forces of any country; or
4. The date he/she fails to make a required contribution, if any.

**Plan is Not a Contract**

The Plan shall not be deemed to constitute a contract between the Employer and any employees or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time, provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Employer with the Bargaining representatives of any employees.
Approved by the Joint Insurance Committee
December 9, 1993

Amended by Plan Participants
April 1998

Rewritten September 1, 2003

Revised September 1, 2005