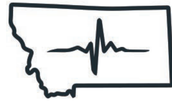

HEALTH PROFESSIONS OF MONTANA PLAN & TRUST

SELF-FUNDED HEALTH BENEFITS POLICY

PLAN &
SUMMARY PLAN DESCRIPTION

January 1, 2024

NOTICE

This policy is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self-funded multiple employer welfare arrangement.

Aggregate and Specific Excess Loss Insurance for the Plan is underwritten by an insurance company rated A or better by A.M. Best.

FOR CUSTOMER SERVICE

Call the HPMPT Claim Administrator (Medical Claims Processing):
Blue Connections, a Division of BlueCross BlueShield of Montana
P.O. Box 7982
Helena, MT 59604-7982
1-855-322-4953

Pharmacy Supervisor/Pharmacy Benefit Manager (PBM):
Prime Therapeutics
1-855-258-8471
For Prior Authorizations, fax: 1-877-243-6930

Plan Sponsor:
HPMPT Sponsor Organization, Inc.
P.O. Box 9406
Missoula, MT 59807 1-406-443-4919

FOR BENEFIT MANAGEMENT AND PRE-TREATMENT REVIEW
Call 1-855-322-4953 – **www.bcbsmt.com**

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

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INTRODUCTION

Note to Covered Persons: This Self-Funded Health Benefits Policy (this “Policy” or “Plan”) is issued through the Health Professions of Montana Plan and Trust. This Policy is intended to operate as the primary Plan Document and as the **Summary Plan Description** or “SPD” required by law. Other important SPD content is contained in the **Plan Information Appendix** at the end of this Policy. This Policy sometimes uses the terms “you” and “your” which refers to covered persons.

The term “Plan” used in this Policy refers to the program of benefits offered through the Health Professions of Montana Plan and Trust as described in the Plan Document. “Plan Document” means this Plan Document and Summary Plan Description and other documents that are specifically incorporated by reference and includes any formal interpretations or policies adopted or approved by the Plan Administrator. The Plan was originally effective May 1, 2008. The Plan was last restated effective January 1, 2024.

This document contains important information about your rights and obligations under the law and the Plan and the procedures you need to follow if you have questions about your benefits or if you disagree with a decision on your claim for benefits. This Self-Funded Health Benefits Policy provides detailed information about the benefits to which you are entitled and the steps you must take to obtain those benefits. If you have received any part of the Plan Document electronically, you are entitled to receive, free of charge, printed copies per a written request to the following address: HPMPT, P.O. Box 9406, Missoula, MT 59807.

The Plan is established and maintained to provide health benefits to Eligible Employees of Participating Employers and their Eligible Family Members. Each Participating Employer adopts the Plan for its own workforce in accordance with a separate Adoption Agreement. The Adoption Agreement provides Participating Employers with certain design choices including coverage options and eligibility requirements.

A Board of Directors represents the Participating Employers as the “Plan Sponsor,” and the Participating Employers become members of the Plan Sponsor Organization when they join the Plan. There is also a Board of Trustees that appoints or serves as the “Plan Administrator.” The Participating Employers have the right to elect members of the Boards and to control certain Plan operations in accordance with separate legal documents, including a Trust Agreement and individual Subscriber Agreements. Each Plan Sponsor Board member is affiliated with a Participating Employer and all Participating Employers and Board members share a common purpose of the extension of medical knowledge, the advancement of medical science, the improvement of the quality of health care, the improvement of the health of our citizens, the elevation of the standards of medical education, or advocacy for the prevention and cure of diseases and prolonging and adding comfort to life.

The Plan and Trust have been designed so that the Claim Administrator (Blue Connections or BCBSMT) can perform certain services and administrative functions. Other entities may be involved in the Plan and Trust.

Coverage provided under the Plan for Eligible Employees and their Eligible Family Members will be in accordance with the terms, conditions, restrictions, and limitations of this Plan.

The information contained in the Plan generally addresses certain laws such as the FMLA, COBRA, the Affordable Care Act (ACA), USERRA, and ERISA, as applicable. It is not intended to be and should not be relied upon as complete legal information or legal advice about those subjects. This is a multiple employer plan and these laws <u>will apply to different Employers differently</u>. Covered Persons and Employers should consult their own legal counsel regarding these matters.

MEDICAL BENEFIT PLAN OPTIONS – COST SHARING PROVISIONS

Single Coverage means only the Employee is covered under the Plan. Family Coverage means the Employee and any Eligible Family Member(s) are covered under the Plan.

The Single Deductible applies to Eligible Expenses Incurred during each Benefit Period. For Single Coverage, no further Deductible will apply to Eligible Expenses during that Benefit Period after the Single Coverage Deductible is met.

The Family Coverage Deductible applies to Eligible Expenses Incurred during each Benefit Period for the members of a family. If during a single Benefit Period, members of a family satisfy individual Deductible amounts that collectively equal or exceed the Deductible per family during the same Benefit Period, no further Deductible will apply to any member of that family during that Benefit Period

The Deductible applies to Eligible Expenses Incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period. **An individual Covered Person cannot contribute toward the family Deductible any more than the Individual Annual Deductible as stated in the Schedule of Medical Benefits.**

COMPREHENSIVE MEDICAL BENEFIT OPTIONS			
Plan Option	**Deductible per Covered Person / Family Per Benefit Period**	**Benefit Percentage**	**Out-of-Pocket Maximum per Covered Person / Family**
500	$500 / $1,000	80%	$2,000 / $3,500
1000	$1,000 / $2,000	80%	$3,500 / $6,500
1000	$1,000 / $2,000	70%	$5,950 / $11,900
1500	$1,500 / $3,000	80%	$5,000 / $9,500
2200	$2,200 / $4,400	80%	$6,750 / $13,000
2200	$2,200 / $4,400	70%	$8,250 / $16,500
3000	$3,000 / $6,000	80%	$6,750 / $13,000
4000	$4,000 / $8,000	80%	$6,750 / $13,000
4000	$4,000 / $8,000	70%	$8,250 / $16,500
5000	$5,000 / $10,000	80%	$6,750 / $13,000
The Family Coverage for these Comprehensive Plan Options has Embedded Deductibles. Therefore, if an individual family member meets the individual Deductible during a Benefit Period, that individual will start receiving benefits at the applicable Benefit Percentage. Also, if members of the family satisfy individual Deductible amounts that collectively equal the family Deductible, then no further Deductible will apply to any member of that family during that Benefit Period.			

HIGH DEDUCTIBLE PLAN (HDHP) HSA-COMPATIBLE BENEFIT OPTIONS			
Plan Option	**Deductible per Covered Person / Family Per Benefit Period**	**Benefit Percentage**	**Out-of-Pocket Maximum per Covered Person / Family**
3200 – 80%	$3,200 / $6,400	80%	$6,950 / $13,500
3200 – 100%	$3,200 / $6,400	100%	$3,200 / $6,400
3500 – 70%	$3,500 / $7,000	70%	$7,750 / $15,500
3500 – 80%	$3,500 / $7,000	80%	$6,950 / $13,500
3500 – 100%	$3,500 / $7,000	100%	$3,500 / $7,000
4000 – 80%	$4,000 / $8,000	80%	$6,950 / $13,500
4000 – 100%	$4,000 / $8,000	100%	$4,000 / $8,000
4500 – 70%	$4,500 / $9,000	70%	$7,750 / $15,500
4500 – 80%	$4,500 / $9,000	80%	$6,950 / $13,500
4500 – 100%	$4,500 / $9,000	100%	$4,500 / $9,000
5000 – 80%	$5,000 / $10,000	80%	$6,950 / $13,500
5000 – 100%	$5,000 / $10,000	100%	$5,000 / $10,000
5500 – 80%	$5,500 / $11,000	80%	$6,950 / $13,500
5500 – 100%	$5,500 / $11,000	100%	$5,500 / $11,000
6000 – 70%	$6,000 / $12,000	70%	$7,750 / $15,500
6000 – 80%	$6,000 / $12,000	80%	$6,950 / $13,500
6000 – 100%	$6,000 / $12,000	100%	$6,000 / $12,000
6900 – 100%	$6,900 / $13,800	100%	$6,900 / $13,800
7500 – 100%	$7,500 / $15,000	100%	$7,500 / $15,000

The Family Coverage for these HDHP Plan Options has Embedded Deductibles. Therefore, if an individual family member meets the individual Deductible during a Benefit Period, that individual will start receiving benefits at the applicable Benefit Percentage.

Also, if members of the family satisfy individual Deductible amounts that collectively equal the family Deductible, then no further Deductible will apply to any member of that family during that Benefit Period.

SCHEDULE OF MEDICAL BENEFITS – COMPREHENSIVE PLAN OPTIONS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND MAXIMUM ELIGIBLE EXPENSE (MEE)

THE BENEFIT PERIOD IS A CALENDAR YEAR

NOTICE

This Policy is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self-funded multiple employer welfare arrangement.

MEDICAL BENEFIT COST SHARING

Deductible, Benefit Percentage, and Out-of-Pocket Maximum provisions are specifically stated in the Medical Benefit Options – Cost Sharing Provisions. The Cost Sharing Provisions apply unless specifically indicated otherwise under the following benefits.

As described below, specific benefits have a co-payment rather than co-insurance. Co-payments accumulate toward Out-of-Pocket Maximums but do not accumulate towards the Deductible.

MEDICAL BENEFITS

Accidental Injury Benefit

First Dollar Benefit per Accident (before Annual Deductible) $500
Deductible Applies, Benefit Percentage Applies

Inpatient Hospital Services

Deductible Applies, Benefit Percentage Applies
Hospital Room and Board Limitation .... Average Semi-Private
Intensive Care Unit Limitation .... Maximum Eligible Expense

Physician Services – Office Visits

Deductible Waived, Co-payment Applies
Primary Care Physician…………………………………………………………………$30 Co-payment
Specialist……………………………………………………………………………….$60 Co-payment

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

Urgent Care – Facility Visit

Deductible Waived, Co-payment applies……………………………………..……$50 Co-payment

The Deductible is waived only for those charges billed for the Urgent Care facility visit evaluation and management services performed by the provider which may include: clinical

management, history examination, medical decision making, counseling, or coordination of care. The Deductible will apply to all other charges associated with the Urgent Care visit.

Diagnostic X-ray & Laboratory Services

Deductible Applies, Benefit Percentage Applies

Inpatient Mental Illness

Deductible Applies, Benefit Percentage Applies

Inpatient Substance Abuse (Alcoholism and Chemical Dependency)

Deductible Applies, Benefit Percentage Applies

Outpatient Mental Illness and Substance Abuse (Alcoholism and Chemical Dependency)

Deductible Waived, Co-payment Applies

Office Visit……………………………………………………………………………$30 Co-payment

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

Rehabilitation Therapy (Physical Therapy or Occupational Therapy)

Deductible Applies, Benefit Percentage Applies

Home Health Care

Deductible Applies, Benefit Percentage Applies

Skilled Nursing Facility

Deductible Applies, Benefit Percentage Applies

Autism Spectrum Disorders

Deductible Applies, Benefit Percentage Applies

Transplants (Major Organ/Tissue Benefit)

Deductible Applies, Benefit Percentage Applies

Includes heart, heart lung, single lung, double lung, liver, intestine, kidney, pancreas, simultaneous pancreas/kidney, bone marrow/stem cell transplants.

Services include, but are not limited to: evaluation; pre-transplant, transplant and post-transplant care (not including Outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. Charges for services incurred after such 12-month period are eligible under the Medical Benefits of this Plan.

Non-Ambulance Travel Benefit (Transplants)

Deductible Applies, Benefit Percentage Applies

Maximum Lifetime Benefit of $5,000, limited to the following:

Coach airfare (for patient and one companion, if that companion is a parent of a child who needs medical care or a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone.)

Mileage, if driving, reimbursed at IRS standard medical mileage rate

Lodging, not to exceed $50 per day (up to $50 per day may also be paid for a required companion)

Surgical Implant and/or Devices and Related Supplies

Deductible Applies, Benefit Percentage Applies
Includes Medically Necessary: Orthopedic Implants, Cardiac Implants (other than LVAD and RVAD), Cochlear Implants, and LVAD / RVAD Implants.

Benefits includes implantable device and all supplies associated with that implantable device.

Preventive Care Benefit

Deductible Waived, Benefit Percentage 100%

Colonoscopy Benefit, first one performed regardless of diagnosis for 45 years of age or older, limited to one every 10 Benefit Periods*

Deductible Waived, Benefit Percentage 100%

*Testing required earlier than 45 years or more frequently than one every 10 Benefit Periods, will be eligible only if Medically Necessary, subject to Annual Deductible and Benefit Percentage.

Chiropractic Care

Deductible Applies, Benefit Percentage Applies
Maximum Number of Treatments per Benefit Period 20
Co-payment does not apply

Acupuncture

Deductible Applies, Benefit Percentage Applies
Maximum Number of Treatments per Benefit Period 20
Maximum Benefit per Treatment $25
REFERRAL REQUIRED and co-payment does not apply

Naturopathic Care

Deductible Applies, Benefit Percentage Applies
Maximum Benefit per Benefit Period $250
Treatment includes all services provided during a calendar day, except for X-rays
REFERRAL REQUIRED and co-payment does not apply

PHARMACY BENEFIT PROGRAM

The Pharmacy Benefit Program is fully stated and described in the Pharmacy Benefit Program Appendix which is made a part of this Plan Document by this reference.

OPTIONAL BENEFIT - DENTAL PLAN

Coverage available only if Employer has elected Dental Plan coverage except that Type A (Preventive Care) is available through the Medical Plan to Dependent children less than age 18 with no Employer election or additional premium required.

DEDUCTIBLE

Deductible per Covered Person per Benefit Period $50

DENTAL EXPENSES

Type A (Preventive Care) Dental Expenses
Deductible Waived

Benefit Percentage..100%

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

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

MAXIMUM BENEFIT PER BENEFIT PERIOD PER COVERED PERSON..$1,500
(Type A, B, and C Expenses)

Dollar limits do not apply to Type A (Preventive Care) for children under age 18

ORTHODONTIC TREATMENT BENEFIT
For Dependent Children less than eighteen (18) years of age
Deductible Waived
Benefit Percentage..50%
Maximum Lifetime Benefit..$1,500

OPTIONAL BENEFIT - VISION PLAN

Coverage available only if Employer has elected Vision Plan coverage, except that Vision Examinations are available through the Medical Plan to Dependent children under age 18 with no Employer election or additional premium required.

Vision Examination (applicable for spectacle lenses or contact lenses)
Exam limited to once every Benefit Period, up to $100

Eyewear Materials payable every Benefit Period, up to..$200
Frames, Lenses, Contact Lenses, Disposable Contacts
Additional lens services, including scratch coating and tinting, are not covered

EMPLOYEE LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Underwritten by The Standard
The Employee Life and Accidental Death and Dismemberment Insurance is described in a separate certificate of coverage. Please refer to the life insurance certificate of coverage for a complete description of these benefits.

Life Insurance

Up to age 65	$10,000
At age 65 up to age 70	$6,500
At age 70 up to age 75	$5,000
At age 75 and older	$3,500

Accidental Death

Up to age 65	$10,000
At age 65 up to age 70	$6,500
At age 70 up to age 75	$5,000

At age 75 and older	$3,500

Dismemberment Benefit

One hand or one foot	50% of Accidental Death Benefit Maximum
Sight in one eye	50% of Accidental Death Benefit Maximum
Any combination of the above losses	100% of Accidental Death Benefit Maximum
Thumb and index finger of the same hand	25% of Accidental Death Benefit Maximum
Quadriplegia	100% of Accidental Death Benefit Maximum
Hemiplegia	50% of Accidental Death Benefit Maximum
Paraplegia	50% of Accidental Death Benefit Maximum

If an Employee is eligible for 1 or more of the accidental death or dismemberment benefits, the accidental death or dismemberment benefit amounts will be capped at a maximum of $10,000.00 for any one accident.

SCHEDULE OF MEDICAL BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN OPTION
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND MAXIMUM ELIGIBLE EXPENSE (MEE)

THE BENEFIT PERIOD IS A CALENDAR YEAR

NOTICE

This Policy is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self-funded multiple employer welfare arrangement.

MEDICAL BENEFIT COST SHARING

Deductible, Benefit Percentage, and Out-of-Pocket Maximum provisions are specifically stated in the Medical Benefit Options – Cost Sharing Provisions. The Cost Sharing Provisions apply unless specifically indicated otherwise under the following benefits.

MEDICAL BENEFITS

Accidental Injury Benefit
Deductible Applies, Benefit Percentage Applies

Inpatient Hospital Services
Deductible Applies, Benefit Percentage Applies
Hospital Room and Board Limitation .... Average Semi-Private
Intensive Care Unit Limitation .... Maximum Eligible Expense

Physician Services – Office Visits and Urgent Care Visits
Deductible Applies, Benefit Percentage Applies

Diagnostic X-ray and Laboratory Services
Deductible Applies, Benefit Percentage Applies

Inpatient Mental Illness
Deductible Applies, Benefit Percentage Applies

Inpatient Substance Abuse (Alcoholism and Chemical Dependency)
Deductible Applies, Benefit Percentage Applies

Outpatient Mental Illness and Substance Abuse (Alcoholism and Chemical Dependency)
Deductible Applies, Benefit Percentage Applies

Rehabilitation Therapy (Physical Therapy or Occupational Therapy)
Deductible Applies, Benefit Percentage Applies

Home Health Care

Deductible Applies, Benefit Percentage Applies

Skilled Nursing Facility

Deductible Applies, Benefit Percentage Applies

Transplants (Major Organ/Tissue Benefit)

Deductible Applies, Benefit Percentage Applies
Includes heart, heart lung, single lung, double lung, liver, intestine, kidney, pancreas, simultaneous pancreas/kidney, bone marrow/stem cell transplants.

Services include, but are not limited to evaluation; pre-transplant, transplant and post-transplant care (not including Outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. Charges for services incurred after such 12-month period are eligible under the Medical Benefits of this Plan.

Non-Ambulance Travel Benefit (Transplants)

Deductible Applies, Benefit Percentage Applies
Maximum Lifetime Benefit of $5,000, limited to the following:

Coach airfare (for patient and one companion, if that companion is a parent of a child who needs medical care or a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone.)
Mileage, if driving, reimbursed at IRS standard medical mileage rate
Lodging, not to exceed $50 per day (up to $50 per day may also be paid for a required companion)

Surgical Implant and/or Devices and Related Supplies

Deductible Applies, Benefit Percentage Applies
Includes Medically Necessary: Orthopedic Implants, Cardiac Implants (other than LVAD and RVAD), Cochlear Implants, and LVAD / RVAD Implants.

Benefits includes implantable device and all supplies associated with that implantable device.

Preventive Care Benefit

Deductible Waived, Benefit Percentage 100%

Colonoscopy Benefit, for 45 years of age or older, limited to one every 10 Benefit Periods*

Deductible Waived, ** Benefit Percentage... 100%

*Testing required earlier than 45 years or more frequently than one every 10 benefit periods, will be eligible only if Medically Necessary, subject to Annual Deductible and Benefit Percentage.

**This benefit describes colonoscopies performed in accordance with the May 18, 2021 recommendation published by the US Preventive Services Task Force. Charges related to a colonoscopy ordered by a Physician for diagnostic purposes, such as lab or tissue removal, are subject to the applicable Medical Benefits Annual Deductible and Benefit Percentage unless the charges relate to preventive care. See COVERED BENEFITS - COLONOSCOPY BENEFIT.

Chiropractic Care

Deductible Applies, Benefit Percentage Applies
Maximum Number of Treatments per Benefit Period 20

Acupuncture

Deductible Applies, Benefit Percentage Applies
Maximum Number of Treatments per Benefit Period 20
Maximum Benefit per Treatment... $25
Referral Required

Naturopathic Care

Deductible Applies, Benefit Percentage Applies
Maximum Benefit per Benefit Period ………………………………………………………………..$250
Treatment includes all services provided during a calendar day, except for X-rays
Referral Required

PHARMACY BENEFIT PROGRAM

The Pharmacy Benefit Program is fully stated and described in the Pharmacy Benefit Program Appendix which is made a part of this Plan Document by this reference.

OPTIONAL BENEFIT - DENTAL PLAN

Coverage available only if Employer has elected Dental Plan coverage, except that Type A (Preventive Care) is available through the Medical Plan to Dependent children under age 18 with no Employer election or additional premium required.

DEDUCTIBLE

Deductible per Covered Person per Benefit Period.. $50

DENTAL EXPENSES

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

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

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

MAXIMUM BENEFIT PER BENEFIT PERIOD PER COVERED PERSON....................................... $1,500
(Type A, B and C Expenses)

Dollar limits do not apply to Type A (Preventive Care) for children under age 18

ORTHODONTIC TREATMENT BENEFIT

For Dependent Children less than eighteen (18) years of age
Deductible Waived
Benefit Percentage.. 50%
Maximum Lifetime Benefit.. $1,500

OPTIONAL BENEFIT - VISION PLAN

Coverage available only if Employer has elected Vision Plan coverage, except that Vision Examinations are available through the Medical Plan to Dependent children under age 18 with no Employer election or additional premium required.

Vision Examination (applicable for spectacle lenses or contact lenses)
Exam limited to once every Benefit Period, up to $100

Eyewear Materials payable every Benefit Period, up to $200
Frames, Lenses, Contact Lenses, Disposable Contacts
Additional lens services, including scratch coating and tinting, are not covered

EMPLOYEE LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Underwritten by The Standard
The Employee Life and Accidental Death and Dismemberment Insurance is described in a separate certificate of coverage. Please refer to the life insurance certificate of coverage for a complete description of these benefits

Life Insurance	
Up to age 65	$10,000
At age 65 up to age 70	$6,500
At age 70 up to age 75	$5,000
At age 75 and older	$3,500

Accidental Death	
Up to age 65	$10,000
At age 65 up to age 70	$6,500
At age 70 up to age 75	$5,000
At age 75 and older	$3,500

Dismemberment Benefit	
One hand or one foot	50% of Accidental Death Benefit Maximum
Sight in one eye	50% of Accidental Death Benefit Maximum
Any combination of the above losses	100% of Accidental Death Benefit Maximum
Thumb and index finger of the same hand	25% of Accidental Death Benefit Maximum
Quadriplegia	100% of Accidental Death Benefit Maximum
Hemiplegia	50% of Accidental Death Benefit Maximum
Paraplegia	50% of Accidental Death Benefit Maximum

If an Employee is eligible for 1 or more of the accidental death or dismemberment benefits, the accidental death or dismemberment benefit amounts will be capped at a maximum of $10,000.00 for any one accident.

BLUECARD and INTER-PLAN PROGRAMS

Out-of-Area Services
Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or BlueShield 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.

BlueCard® Program
Under the BlueCard® Program, when a Plan Participant incurs Covered Medical Expenses (**also called "Eligible Expenses" in this Plan Document**) 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.

ELIGIBLE EXPENSES AND BENEFIT DETERMINATION

ELIGIBLE EXPENSES

Services, treatments, or supplies for Medical Benefits are Eligible Expenses if they meet all of the following requirements:

1. They are administered, ordered, or provided by a Physician (or by another Licensed Health Care Provider according to specific provisions of this Plan);

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

3. Charges do not exceed the Maximum Eligible Expense or Procedure Based Limit of the Plan, whichever is applicable; and

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

Specific Medical Benefits and other Covered Benefits in this Plan may provide other or additional requirements for Eligible Expenses.

PRE-APPROVED EXPENSES

The Plan may reimburse specific treatments, services, or supplies otherwise excluded by this Plan if the Participant obtains Pre-Approval from the Plan Administrator prior to beginning such treatment or receiving such service or supply. Pre-Approval may be given, at the sole discretion of the Plan Administrator, for medically accepted non-Experimental or Investigational treatments, services, or supplies, which, in the opinion of the Plan Administrator, are more cost effective than a covered treatment, service, or supply for the same Illness or Injury, and which benefit the Covered Person.

In order to obtain Pre-approval, the Participant must follow the procedures outlined under PROCEDURES FOR CLAIMING BENEFITS – PRE-APPROVAL PROCESS.

DEDUCTIBLE

The Deductible is as stated in the Medical Benefit Plan Options Cost Sharing Provisions.

BENEFIT PERCENTAGE

After any applicable Deductible is satisfied, Eligible Expenses Incurred by a Covered Person will be paid by the Plan according to the applicable Benefit Percentage stated in the Schedule of Medical Benefits. The Plan will pay the percentage of the Eligible Expense indicated as the Benefit Percentage.

OUT-OF-POCKET MAXIMUM

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

MAXIMUM BENEFIT

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

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

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

COVERED BENEFITS – MEDICAL BENEFITS

MEDICAL BENEFITS

The following Medical Benefits are payable as stated in the Schedule of Medical Benefits and subject to all terms and conditions of this Policy and the Plan, including but not limited to Medical Necessity and other requirements for ELIGIBLE EXPENSES. Medical Benefits include:

1. Charges made by a Hospital for:

   A. Daily Room and Board in a Semi-Private room (or private room if no Semi-Private room is available or when confinement in a private room is Medically Necessary) and general nursing services, or confinement in an Intensive Care Unit, not to exceed the applicable maximum limits shown under the Schedule of Medical Benefits.

   B. Medically Necessary Hospital Miscellaneous Expenses other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and Emergency Care or emergency room use for an Emergency Medical Condition only, Physical Therapy treatments, hemodialysis, and X-ray.

   C. Nursery neonatal units, general nursing services, including Hospital Miscellaneous Expenses for services and supplies, Physical Therapy, hemodialysis and X-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities, or premature delivery incurred by a Newborn Dependent.

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

2. Charges made by an **Ambulatory Surgical Center** when treatment has been rendered.

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

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

3. Charges made by an **Urgent Care Facility/Minor Emergency Medical Clinic** for treatment in a Medical Emergency.

   "Urgent Care Facility/Minor Emergency Medical Clinic" means a free-standing facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse (R.N.), and a Registered X-Ray Technician must

be in attendance at all times that the clinic is open. The facilities must include X-ray and laboratory equipment and a life support system. For purposes of this Plan, a clinic meeting these requirements will be considered to be an Urgent Care Facility/Minor Emergency Medical Clinic.

4. Charges for services and supplies furnished by a **Birthing Center**. "Birthing Center" means a facility staffed by Physicians and/or Certified Nurse Midwives (C.N.M.) which is licensed as a Birthing Center in the jurisdiction where it is located.

5. Routine nursery care and routine Physician care for a **Newborn Inpatient** as follows:

   A. Routine Nursery Care includes Room and Board and Hospital Miscellaneous Expenses, including circumcision, for a Newborn Dependent child.

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

6. Charges made by a **Hospice** within any one Hospice Benefit Period for:

   A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.

   B. Nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a public health nurse who is under the direct supervision of a Registered Nurse.

   C. Physical Therapy and Speech Therapy, when ordered by a Physician and rendered by a licensed therapist.

   D. Medical supplies, including drugs and biologicals and the use of medical appliances.

   E. Physician's services.

   F. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

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

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

7. The services of a **Physician** for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations. Telemedicine services are covered as Medical Benefits when such services are

Medically Necessary and the services are otherwise covered by the Plan as Medical Benefits.

8. Charges for **Pregnancy**, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy.

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

   A. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, Maximum Eligible Expense or Procedure Based Limit will be reduced for each of the lesser procedures.

   B. When an incidental procedure is performed through the same incision, the Maximum Eligible Expense or Procedure Based Limit for the initial procedure will be considered and charges will be reduced for incidental procedures.

   Notwithstanding the forgoing reductions, contracted or negotiated services will be reimbursed at the contracted or negotiated rate in accordance with the other terms of this Plan.

10. Charges for Registered Nurses (R.N.'s) or Licensed Practical Nurses (L.P.N.'s) for private duty nursing, and charges for services provided by a Licensed Practical Nurse, a Registered Nurse, a Certified Nurse Midwife (C.N.M.), or a certified Physician Assistant (P.A.) who is licensed to practice medicine in the state where the services are provided, if payment would otherwise be made under the Plan if the same services were provided by a Physician.

11. Charges for Home Infusion Therapy Services ordered by a Physician and provided by a Home Infusion Therapy Agency licensed and approved within the state in which the services are provided. A Home Infusion Therapy Agency is a health care facility that provides Home Infusion Therapy Services. Home Infusion Therapy Services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a Home Infusion Therapy Agency. Services also include education for the Covered Person, the Covered Person's caregiver, or a family member. Home Infusion Therapy Services include; pharmacy, supplies, equipment, and Skilled Nursing services when billed by a Home Infusion Therapy Agency.

    Skilled nursing services billed by a home health agency are covered under the Home Health Care Benefit.

12. Charges made by a legally qualified speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders. "Speech Therapy" means a course of treatment, ordered by a Physician, to treat speech deficiencies or impediments. The Plan will provide benefits for Speech Therapy when all of the following criteria are met:

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

    B. Improvement would not normally be expected to occur without intervention.

    C. Treatment is not rendered for stuttering.

    D. Treatment is not rendered for behavioral or learning disorders.

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

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

13. Charges for Ambulance Service under the following conditions:

    A. For Inpatient care to the nearest facility where Emergency Care or treatment can be rendered, transfer from one facility to another for care, or when Medically Necessary, from the facility to the patient's home; or

    B. For Outpatient care to the nearest facility where Emergency Care or treatment can be rendered, but only when such care is related to an Accidental Injury or Emergency Medical Condition, as defined by this Plan.

14. Charges for drugs dispensed by a Physician, Licensed Health Care Provider, Hospital or other eligible medical care facility in a clinical or Home Health care setting or billed during the course of an evaluation or management encounter.

    Conditions of coverage for Outpatient Prescription Drugs and supplies are as stated in the Pharmacy Benefit Program. Charges covered under Medical Benefits are not eligible under the Pharmacy Benefit Program.

15. Charges ordered by a Physician for X-rays, CAT scans, MRIs, microscopic tests, and laboratory tests.

16. Charges ordered by a Physician for radiation therapy or treatment and chemotherapy, including related fertility preservation services required by applicable law.

17. Charges ordered by a Physician for blood transfusions, blood processing costs, blood transport charges, blood handling charges, administration charges, and the cost of blood, plasma and blood derivatives. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Eligible Expenses.

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

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

20. Charges ordered by a Physician for the cost and administration of an anesthetic.

21. Charges by a Physician for dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics, or other Medically Necessary medical supplies, except for dental braces and corrective shoes, which are specifically excluded.

    Insulin (capped at $35 for a 30-day supply), syringes, needles, and other diabetic supplies are eligible for coverage if obtained through the Pharmacy Benefit Program of this Plan.

22. Charges for the rental of, up to the purchase price of, a wheelchair, Hospital bed, respirator or other Durable Medical Equipment, as defined by this Policy, required for therapeutic use or the purchase of this equipment if economically justified, whichever is less. If the purchase is not medically feasible, rental charges will be paid without limitation based upon purchase price.

23. Charges ordered by a Physician for Orthopaedic Appliances; artificial limbs, eyes, or larynx; or other Prosthetic Appliances.

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

"Prosthetic Appliance" means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance.

24. Charges ordered by a Physician for the replacement or repair of Durable Medical Equipment, Orthopaedic Appliances, artificial limbs, ocular prostheses, larynx, or other Prosthetic Appliances.

25. Charges for vasectomy.

26. Reasonable charges for producing medical records if incurred for the purpose of utilization review, audits, or investigating a claim for benefits if requested and approved by the Plan.

27. Charges for non-surgical treatment of toes and foot care that is directly related to or the result of treatment for diabetes.

28. Charges for treatment 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. Coverage includes charges for 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.

29. Charges for nutritional counseling for the following Covered Persons.

    A. Covered Persons diagnosed with diabetes, limited to counseling by a registered dietician, Licensed Health Care Provider, or Physician. Such charges may include, but are not limited to, how and what to eat and monitoring blood sugar.

    B. Covered Persons diagnosed with Hypercholesterolemia, limited to counseling by a registered dietician, Licensed Health Care Provider, or Physician. Such charges may include, but are not limited to, how and what to eat and monitoring cholesterol levels.

    C. Covered Persons diagnosed with inborn errors of metabolism.

30. Charges for Contraceptive Management, regardless of Medical Necessity. "Contraceptive Management" means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation, or placement of any contraceptive device. Charges for removal of contraceptive devices are covered only as a recommended preventive service under the Preventive Care benefit.

31. Charges for diabetes education for Covered Persons diagnosed with diabetes.

    A. Limited to a $250 out-patient education benefit through a Licensed Health Care Provider.

    B. Additional visits with a Licensed Health Care Provider to receive self-management education and training. Such visits are limited to 30 minutes each, and limited to 20 visits the first year of diagnosis and then limited to 12 visits in subsequent years.

Certain contraceptives are eligible for coverage through the Pharmacy Benefit Program of this Plan.

MASTECTOMY BENEFITS

Medical Benefits include charges for reconstructive breast surgery subsequent to any mastectomy. Eligible Expenses are limited to charges for the following treatment, as determined in consultation with the attending Physician and the patient:

1. All stages of reconstruction of the breast on which a mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications of a mastectomy, including lymphedemas.

Specifically excluded from this benefit are expenses for the following:

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

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

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

Medical Benefits exclude charges for a preventive/prophylactic mastectomy unless the preventive/prophylactic mastectomy is Medically Necessary.

NOTICE: If you have had or are going to have a mastectomy, the Mastectomy benefits described are consistent with the benefits required by the Women's Health and Cancer Rights Act of 1998 (WHCRA). These benefits will be provided subject to the same Deductibles and co-insurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call the HPMPT Claim Administrator (Medical Claims Processing) at 1-855-322-4953.

SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES

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

TRANSPLANTS (MAJOR ORGAN/TISSUE BENEFIT)

Charges in connection with any Medically Necessary, non-Experimental or non-Investigational organ or tissue transplant procedure are Medical Benefits payable as specifically stated in the Schedule of Medical Benefits. Coverage under this benefit includes only the following charges for the donor and recipient as applicable that are directly related to the transplant procedure:

1. Pre-transplant testing, including tissue testing, genetic testing, and blood testing;

2. Drugs and therapies associated with the transplant procedure;

3. Hospital Inpatient and Outpatient services;

4. Physician and Licensed Health Care Provider services;

5. Post-transplant treatment and testing;

6. Organ procurement from a cadaver or tissue bank and related charges for storage and transportation.

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

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

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

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

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

SKILLED NURSING FACILITY

Charges made by a Skilled Nursing Facility for services and supplies furnished by the facility during any one Convalescent Period are Medical Benefits payable as specifically stated under the Schedule of Medical Benefits and this section. Only charges in connection with convalescence from the Illness or Injury for which the Covered Person was Hospital-confined will be eligible for benefits. These charges include:

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.

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

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

HOME HEALTH CARE

Charges made by a Home Health Care Agency in accordance with a Home Health Care Plan are Medical Benefits payable as specifically stated under the Schedule of Medical Benefits and this section. Coverage under this benefit includes the following services, treatments, or supplies:

1. Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

2. Home health aides;

3. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

“Home Health Care Visit” means a single visit of any duration by an employee of a Home Health Care Agency for the purpose of providing services under the Home Health Care Plan.

“Home Health Care Agency” means a public or private organization that specializes in providing medical care and treatment in the home. Such organization must meet all of the following conditions:

1. It is licensed by the appropriate licensing authority to provide Skilled Nursing Services and other therapeutic services.

2. It has guidelines established by a professional medical group associated with the agency or organization. This professional group must include at least one Physician and one Registered Nurse (R.N.) to supervise the services provided.

3. It maintains a complete medical record on each individual.

4. It has a designated administrator.

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

Home Health Care specifically excludes the following:

1. Services and supplies not included in the approved Home Health Care Plan.

2. Services of a person who ordinarily resides in the home of the Covered Person or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

3. Services of any social worker.

4. Transportation services.

5. Housekeeping services.

6. Custodial Care.

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

REHABILITATION THERAPY (PHYSICAL THERAPY OR OCCUPATIONAL THERAPY)

Charges for Physical Therapy or Occupational Therapy are Medical Benefits payable as specifically stated in the Schedule of Medical Benefits. Coverage includes services, treatments, or supplies to the extent ordered by a Physician and rendered in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

MENTAL ILLNESS

Coverage under the Mental Illness benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment.

2. Charges for medically accepted diagnostic testing.

3. Charges for Inpatient and Partial Hospitalization at a Psychiatric Facility or Hospital for Medically Necessary treatment to the same extent services are covered for hospitalization for physical Illness or Injury by this Plan and subject to the Maximum Eligible Expense.

   One day of Inpatient hospitalization may be exchanged for two days of Partial Hospitalization (at 50% of the Inpatient Room and Board rate). Partial Hospitalization is considered Inpatient hospitalization for purposes of benefit adjudication under this Plan.

4. Charges for Medically Necessary treatment at a Psychiatric Facility or an Alcoholism and/or Substance Abuse/Chemical Dependency Treatment Facility.

SUBSTANCE ABUSE (ALCOHOLISM AND CHEMICAL DEPENDENCY)

Charges for the following Substance Abuse (Alcoholism and Chemical Dependency) services:

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

2. Charges for medically accepted diagnostic testing.

3. Charges for Inpatient and Partial Hospitalization at an Alcoholism and/or Substance Abuse/Chemical Dependency Treatment Facility or Hospital for Medically Necessary treatment to the same extent services are covered for hospitalization for physical Illness or Injury by this Plan and subject to the Maximum Eligible Expense.

AUTISM SPECTRUM DISORDERS

Medical Benefits for Autism Spectrum Disorder are covered by the Plan in the same manner as any other medical condition. Autism Spectrum Disorder Benefits may be subject to Deductibles and co-insurance or co-payment provisions of the Plan.

Treatment. Treatment for an individual diagnosed with Autism Spectrum Disorder by a Physician means *medically necessary*:

1. Applied Behavior Analysis, which can only be provided by an individual who is licensed by the behavior analyst certification board or is certified by the Montana Department of Public Health and Human Services as a family support specialist with an autism endorsement;

2. Medications prescribed by a Physician;

3. Psychiatric Care;

4. Therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state;

5. Other habilitative or rehabilitative care including but not limited to professional, counseling, guidance services, treatment programs prescribed, provided, or ordered by a Physician or a licensed psychologist who determines the care to be *medically necessary* to develop and

restore, to the maximum extent practicable, the functioning of the individual with an Autism Spectrum Disorder.

Medical Necessity. Specifically with regard to treatment of an individual with a diagnosis of Autism Spectrum Disorder, "*medically necessary*" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician or psychologist licensed in this state and that will or is reasonably expected to:

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

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

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

Treatment Plan. Coverage shall be limited to treatment that is prescribed by the treating Physician or treating psychologist in accordance with a treatment plan, which must be based on evidence-based screening criteria. The Plan may require that the Physician or treating psychologist submit the treatment plan to the Plan or the Claim Administrator, and the Plan may ask that the treatment plan be updated every six months. The treatment plan shall include all elements necessary for the Plan to pay claims appropriately. These elements include, but are not limited to:

1. diagnosis;
2. proposed treatment by types;
3. frequency and duration of treatment;
4. anticipated duration of treatment;
5. anticipated outcomes stated as goals;
6. reasons the treatment is medically necessary; and
7. signature of the treating Physician or psychologist.

CHILD HEARING LOSS

Medical benefits for the diagnosis and treatment of hearing loss for a covered child 18 years of age or younger are covered by the Plan and payable as stated in the Schedule of Medical Benefits and subject to all terms and conditions of this Policy and the Plan, subject to the following limitation:

1. Coverage shall be limited to one hearing device with required accessories or amplification device with required accessories for each ear every 3 years or as required by a licensed audiologist.

EXPERIMENTAL COVERAGE

For claims in excess of $10,000, treatment that would otherwise be considered Experimental/Investigational will be treated as not Experimental or Investigational if the proposed Experimental/Investigational treatment has been reviewed by four (4) unrelated, independent board certified Physicians actively practicing within the same specialty as the attending Physician and the four (4) reviewing Physicians have unanimously agreed that:

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

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

3. The proposed course of treatment is medically indicated and is considered the standard of care in the United States for the disease or condition being treated based upon published reports and articles in the authoritative medical and scientific literature including, but not limited to the following:

    A. The written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, treatment, device, or procedure; and

    B. The informed consent documents used by the treating facility or of another facility studying substantially the same drug, treatment, device, or procedure;

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

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

CLINICAL TRIAL COVERAGE

A Covered Person may receive coverage for routine patient costs of an Approved Clinical Trial provided that:

(a) A Physician participating in the Approved Clinical Trial concludes that the Covered Person's participation in the Approved Clinical Trial would be appropriate and accepts the Covered Person as a participant in the trial; or
(b) the Covered Person provides medical and scientific information establishing that the Covered Person's participation in the Approved Clinical Trial is appropriate because the individual meets the conditions described in the trial protocol

An "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 disease or condition and is not designed exclusively to test toxicity or disease pathophysiology. The trial must be described in one of the following subparagraphs:

(a) the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

  (i) The National Institutes of Health.
  (ii) The Centers for Disease Control and Prevention.
  (iii) The Agency for Health Care Research and Quality.
  (iv) The Centers for Medicare & Medicaid Services.
  (v) A cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
  (vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  (vii) Any of the following, if the Secretary of Health and Human Services determines that the study or investigation is comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    A. The Department of Veterans Affairs.
    B. The Department of Defense.
    C. The Department of Energy.

(b) The study or investigation is conducted under an Investigational new drug application reviewed by the Food and Drug Administration.
(c) The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

The Plan defines "routine patient costs" in accordance with MCA § 33-22-153 to include all items and services covered by the Plan 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:

(a) an Investigational item, device, or service that is part of the trial;
(b) 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;
(c) a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or
(d) an item or service paid for by the clinical review organization or sponsor of the clinical trial or any item or service customarily provided and paid for by the sponsor of a clinical trial.

The Plan does not cover routine patient costs or services received out-of-network unless such costs and services would be otherwise covered, on an out-of-network basis, if the Covered Person were not participating in the Approved Clinical Trial.

The Plan will not: deny participation by a qualified individual in an Approved Clinical Trial; deny, limit, or impose additional conditions on the coverage of routine patient costs; or discriminate against an individual on the basis of the individual's participation in an approved clinical trial. Further interpretation of the scope of an Approved Clinical Trial or routine costs shall be in accordance with governing state or federal law.

COVERED BENEFITS – PREVENTIVE CARE

Eligible Expenses Incurred under Preventive Care are not subject to Deductible and are payable as specifically stated under the Schedule of Medical Benefits.

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

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

1. Wellness care for children and adults for the following:

   A. Physical examinations by a Physician or Licensed Health Care Provider, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician or Licensed Health Care Provider and associated testing provided or ordered at the time of the examination for preventive purposes; and

   B. Immunizations according to the schedule of immunizations which is recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention.

2. Prostate Specific Antigen (PSA) test for men.

3. Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at:

   https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations

   The applicable list of recommended preventive services includes only those services for which the implementation deadline has passed, which generally means recommended preventive services will be covered beginning on the first day of the Plan year beginning one year or later after the recommendation is issued, unless the Plan states otherwise. For example, if a recommendation is issued on July 1, 2023, coverage with respect to that service will begin on January 1, 2025.

4. Office visit charges only if the primary purpose of the office visit is to obtain a recommended Preventive Care service identified above.

5. Women's Preventive Care for the following:

   A. Well-women annual visits for women 18 years of age and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits as medically appropriate.

   B. Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

   C. Human papillomavirus (HPV) DNA testing beginning at thirty (30) years of age, limited to once every three (3) years.

D. Annual counseling on sexually transmitted infections (STI's) and human immune-deficiency virus (HIV) screening for all sexually active women.

E. All Food and Drug Administration approved prescription contraceptives and female over-the-counter contraceptives when prescribed by a Physician or Licensed Health Care Provider, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Self-administered contraceptives are available only through the Pharmacy Benefit as outlined in the Pharmacy Benefit section of this Plan.

F. Breast feeding support, supplies, and counseling, including comprehensive lactation support and counseling by a trained provider during Pregnancy and/or in the postpartum period, and costs for renting or purchasing breast feeding equipment and related supplies.

G. Annual screening and counseling for interpersonal and domestic violence.

H. Screenings that are medically necessary and clinically appropriate for the examination of the breast that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

6. Qualifying Coronavirus Preventive Services. Coverage under this benefit includes an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 (COVID-19) and that is—

A. an evidence-based item or service that has in effect a rating of ''A'' or ''B'' in the current recommendations of the United States Preventive Services Task Force; or

B. an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

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

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

COVERED BENEFITS – ACCIDENTAL INJURY BENEFIT

Charges in connection with an Accidental Injury are payable as specifically stated in Schedule of Medical Benefits (Accident Benefit) the up to the maximum Accidental Injury benefit. “Accidental Injury” means an Injury sustained as a result of an external force or forces that is/are sudden, direct, and unforeseen and is/are exact as to time and place. A hernia of any kind will only be considered as an Illness.

Eligible Accident Expenses are not subject to the Deductible except under an HSA-Qualified Plan Coverage Option. Any portion of the charges exceeding the maximum Accidental Injury benefit will be considered under the Medical Benefits provisions of the Plan, subject to all Plan conditions, exclusions, and limitations.

ELIGIBLE ACCIDENT EXPENSES

Charges for the following Expenses Incurred are covered under this benefit when furnished for medical care to the Covered Person for Accidental Injuries:

1. Services and supplies (including Room and Board) furnished by a Hospital for medical care in that Hospital.

2. Physicians’ services for surgical procedures and other medical care.

3. Surgical dressings.

4. X-ray and laboratory examinations.

5. Private duty professional nursing services by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).

6. Casts, splints, trusses, braces, and crutches.

7. Ambulance service for local travel to the nearest facility capable of treating the Injury.

Services and supplies must be ordered by a Physician and furnished within a ninety-day period beginning with the date of the Accidental Injury.

COVERED BENEFITS – DENTAL PLAN

EXCEPT FOR THE "PEDIATRIC DENTAL BENEFIT," THIS BENEFIT IS COVERED ONLY IF AVAILABLE TO AND SELECTED BY THE PARTICIPATING EMPLOYER.

Pediatric Dental Benefit: Type A (Preventive Care) is available to Dependent children less than age 18 with no Employer group selection or additional premium required.

Dental Benefits are separate from Medical Benefits as set forth on the Schedule of Benefits (Dental Plan). A Covered Person (or Dependent) may receive Dental Benefits only if the Covered Person's Participating Employer is eligible for and specifically elects the Dental Plan in addition to one or more Medical Benefit Plan Options. Eligible Dental Expenses are payable as specifically stated under the Schedule of Benefits (Dental Plan) up to the maximum benefit or allowance per Benefit Period.

"Eligible Dental Expenses" means services, treatments or supplies that meet all of the following requirements:

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

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

3. Charges do not exceed the maximums set forth on the Schedule of Benefits (Dental Plan). If two or more procedures are separately suitable for the correction of a specific condition, the Maximum Eligible Expense or Procedure Based Limit will be based upon the least expensive procedure; and

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

DENTAL DEDUCTIBLE AND BENEFIT PERCENTAGE

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

Eligible Expenses Incurred by a Covered Person will be paid by the Plan according to the applicable Benefit Percentage stated in the Schedule of Benefits (Dental Plan). The Plan will pay the percentage of the Eligible Expense indicated as the Benefit Percentage.

MAXIMUM DENTAL BENEFIT PAYABLE

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

DENTAL EXPENSES INCURRED

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

DENTAL BENEFITS

TYPE A (PREVENTIVE CARE) EXPENSES

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

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

2. Topical application of sodium fluoride or stannous fluoride, but not more than two applications per benefit period; and sealants, for Covered Persons under the age of 16, with a lifetime maximum of one per tooth.

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

4. Space maintainers.

Pediatric Dental Benefit: Type A (Preventive Care) is available to Dependent children less than age 18 with no Employer election or additional premium required.

TYPE B (BASIC CARE) EXPENSES

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

1. Extractions, except for orthodontic extractions.

2. Oral surgery.

3. Fillings.

4. Nitrous Oxide when administered in connection with covered dental services.

5. General anesthesia or conscious intravenous “IV” sedation when Dentally Necessary and administered in connection with oral surgery or other Covered Dental Benefits.

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

7. Endodontic treatment, including root canal therapy.

8. Injection of antibiotic drugs.

9. Repair or re-cementing of crowns, inlays, bridgework, or dentures; or relining of dentures.

10. Prophylaxis for periodontal treatment.

TYPE C (MAJOR RESTORATIVE) EXPENSES

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

1. Gold fillings, inlays, onlays or crowns (including precision attachments for dentures).

2. Initial installation of fixed bridgework (including crowns and inlays to form abutments) to replace one or more natural teeth extracted.

3. Replacement of an existing partial denture or fixed bridgework by a new fixed bridgework, or the addition of teeth to an existing fixed bridgework. However, this item will apply only to replacements and additions that meet the “Prosthesis Replacement Rule” below.

4. Initial installation of partial or full removable dentures (including adjustments for the six (6) month period following installation) to replace one or more natural teeth extracted.

5. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or the addition of teeth to an existing partial denture. However, this item applies only to replacements and additions that meet the “Prosthesis Replacement Rule” below.

6. Charges for implantology.

7. Appliances to reduce or prevent pain or damage from bruxism (grinding of the teeth).

PROSTHESIS REPLACEMENT

Replacement of or additions to existing dentures or bridgework as described under Type B and Type C Expenses will be covered only if evidence satisfactory to the Claim Administrator is furnished that one of the following applies:

1. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.

2. The existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement.

3. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

DENTAL BENEFIT LIMITATIONS

The following examples describe limitations in Dental Benefits coverage under the Plan.

1. Restorative:

    A. Gold, baked porcelain restorations, crowns, jackets. If a tooth can be restored with a material such as amalgam and the Covered Person and dental service provider select another type of restoration, the Eligible Expense for the dental procedure actually performed will be limited to the Maximum Eligible Expense or Procedure Based Limit appropriate to the procedure using amalgam or a similar material.

B. Reconstruction. Eligible Expenses will include only the appropriate Maximum Eligible Expense or Procedure Based Limit for those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and are not covered.

2. Prosthodontics:

A. Partial Dentures. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily and the Covered Person and the dental service provider elect a more elaborate appliance, Eligible Expenses for the Covered Dental Service performed will be limited to the Maximum Eligible Expense or Procedure Based Limit appropriate to the cast chrome or acrylic denture.

B. Complete Dentures. If the Covered Person and the dental service provider decide on personalized or specialized techniques as opposed to standard procedures, the eligible expense for the dental procedure actually performed will be limited to the Maximum Eligible Expense or Procedure Based Limit appropriate to the standard procedure.

C. Replacement of existing dentures or removable or fixed bridgework. Charges for the replacement of existing dentures or removable or fixed bridgework will be considered an eligible expense only if the existing appliance is not serviceable and cannot be repaired. Otherwise, the Eligible Expense for the procedure performed will be limited to the Maximum Eligible Expense or Procedure Based Limit appropriate for those services which would be necessary to render such appliances serviceable.

DENTAL BENEFIT EXCLUSIONS

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

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

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

3. Charges for dentures, crowns, inlays, onlays, bridgework, or other appliances which are not Dentally Necessary and performed solely or primarily for Cosmetic or personal reasons, personal comfort, convenience, or beautification items, including charges for personalization or characterization of dentures. Charges for veneers, composite, plastic, silicate, or similar restorations placed on or replacing any teeth other than the ten (10) upper and lower anterior teeth are considered optional services and not Dentally Necessary. Eligible Expenses will include only the charge for a corresponding amalgam restoration.

4. Charges for facility, Ambulatory Surgery Center, and Hospital charges, if there is no satisfactory, documented, and Dentally Necessary reason, at the Plan Administrator's sole discretion, the treatment or surgery cannot be performed in the dental service provider's office.

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

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

7. Charges for any services or supplies which are for Orthodontic Treatment, including orthodontic extractions except, to the extent such charges are covered under an Orthodontic Treatment Dental Plan Option in effect for a Covered Person.

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

8. Charges for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion or for stabilizing teeth. Services include, but are not limited to, dentures, crowns, inlays, onlays, bridgework, or other appliance or service to increase vertical dimension, equilibrium, and extracoronal or other periodontal splinting.

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

10. Charges for dentures, crowns, inlays, onlays, bridgework, or other appliances which are not necessary and performed solely for Cosmetic or personal reasons.

11. Charges for oral hygiene and dietary instructions.

12. Charges for temporary dentures.

13. Charges in excess of the Maximum Eligible Expense or Procedure Based Limit.

14. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature, including but not limited to, correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia, except as specifically provided as a Covered Expense. This includes expenses incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.

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

16. Broken or missed appointments.

17. Charges for infection control (OSHA) fees or claim filing.

18. Charges for non-dental services such as training, education, instructional or educational materials, even if they are performed or provided by a dental service provider.

19. Hypnosis, prescribed drugs, pre-medications, or any euphoric drugs, with the exception of nitrous oxide.

20. Biopsies or oral pathology, except as specifically provided for under Covered Dental Services.

21. To the extent that the Covered Person could have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state, or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid.

ORTHODONTIA BENEFIT

THIS BENEFIT IS COVERED ONLY IF OPTIONAL BENEFIT – DENTAL PLAN IS AVAILABLE TO AND SELECTED BY THE PARTICIPATING EMPLOYER

Orthodontia benefits are as set forth on the Schedule of Medical Benefits (Optional Benefit - Dental Plan). A Covered Employee (or his Dependent) may receive Orthodontia benefits only if the Covered Employee's Participating Employer is eligible for and elects the Optional Benefit - Dental Plan in addition to one or more Medical Benefits Plan Options. Orthodontia benefits are subject to the Deductible, co-payment, and dollar limits stated in the Schedule of Medical Benefits (Optional Benefit - Dental Plan - ORTHODONTIC TREATMENT BENEFIT).

For Covered Dependent Children less than eighteen (18) years of age only.

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

1. Treatment for a diagnosed malocclusion.

2. Cephalometric X-ray once in any twenty-four (24) consecutive month period.

3. One set of study models per Covered Person.

4. Initial placement of braces or appliances, ongoing treatment adjustment, removal, and follow-up related to said initial placement.

5. Orthodontic extractions.

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

COVERED BENEFITS – VISION PLAN OPTION

EXCEPT FOR THE "PEDIATRIC VISION BENEFIT," THIS BENEFIT IS COVERED ONLY IF AVAILABLE TO AND SELECTED BY THE PARTICIPATING EMPLOYER

Pediatric Vision Benefit: Vision Benefits as described in the Schedule of Medical Benefits (Vision Plan) are available to Dependent children under age 18 with no Employer election or additional premium required.

Vision Plan benefits are as set forth on the Schedule of Medical Benefits (Vision Plan). A Covered Employee (or his Dependent) may receive Vision Plan benefits only if the Covered Employee's Participating Employer is eligible for and elects the Vision Plan in addition to one or more Medical Benefits Plan options.

Vision Plan benefits do not include medical eye care, diagnoses, or procedures other than routine vision exams, eyewear, and contact lenses, and are subject to the Deductible, co-payment, and dollar limits stated in the Schedule of Medical Benefits (Vision Plan).

COVERED BENEFITS – COLONOSCOPY BENEFIT

ROUTINE COLONOSCOPY BENEFIT - HDHP MEDICAL PLAN OPTIONS

Coverage under this benefit includes Physician, anesthesiologist, lab, and facility charges related to a routine colonoscopy for Covered Persons 45 years of age or older, limited to one every 10 Benefit Periods.

This benefit describes colonoscopies performed in accordance with the May 18, 2021, recommendation published by the US Preventive Services Task Force. Charges related to a colonoscopy ordered by a Physician for diagnostic purposes, such as lab or tissue removal, are subject to the applicable Medical Benefits Annual Deductible and Benefit Percentage unless the charges relate to preventive care.

COLONOSCOPY BENEFIT - COMPREHENSIVE MEDICAL PLAN OPTIONS

Coverage under this benefit includes Physician, anesthesiologist, lab, and facility charges related to a colonoscopy ordered for routine screening or diagnostic purposes for Covered Persons 45 years of age or older, limited to one every 10 Benefit Periods. This applies to the first colonoscopy performed every 10 Benefit Periods regardless of diagnosis.

Charges for testing performed earlier than 45 years of age or done more frequently than one every 10 Benefit Periods are subject to Medical Necessity and annual Deductible and benefit percentage.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following general exclusions and limitations apply to all Medical and Prescription Drug Benefits and all other Expenses Incurred under the Plan, including the optional Dental Plan and Vision Plan or any other optional benefits purchased by the Participating Employer under the Plan unless specifically provided otherwise:

1. Charges for services rendered or started, or supplies furnished prior to the effective date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions.

2. Charges which are caused by or arising out of war or act of war (whether declared or undeclared), civil unrest, armed invasion or aggression, active participation in a riot, or caused during service in the armed forces of any country.

3. Services, supplies, drugs, and devices which the Covered Person is entitled to receive or does receive from TRICARE, the Veteran's Administration (VA), or Indian Health Services but not Medicaid. This Exclusion is not intended to exclude Covered Medical Expenses from coverage if a Covered Person is a resident of a Montana State institution when Benefits are provided. Note: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Covered Person. When such a circumstance occurs, the Covered Person will receive an explanation of benefits.

4. Charges by the Covered Person for all services and supplies which are provided to treat any Illness or Injury arising out of employment when the Covered Person's Participating Employer has elected or is required by law to obtain coverage for such under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though:

   A. Coverage for the Covered Person under Workers' Compensation provides benefits for only a portion of the services Incurred;

   B. The Participating Employer has failed to obtain such coverage required by law;

   C. The Covered Person waived their rights to such coverage or benefits;

   D. The Covered Person fails to file a claim within the filing period allowed by law for such benefits; or

   E. The Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits.

   This exclusion will not apply if the Covered Person is permitted by statute not to be covered by Workers' Compensation and the Covered Person elected not to be covered by Workers' Compensation.

   This exclusion will not apply if a Covered Person's Participating Employer was not required to be covered by Workers' Compensation and did not elect to be covered by Workers' Compensation.

5. Charges for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage, as for example, when a family member provides services to a Spouse or Dependent child.

6. Charges for non-prescription vitamins or nutritional supplements, except as specifically covered under the Preventive Care Benefit.

7. Charges for services or supplies used primarily for Cosmetic, personal comfort, convenience, beautification items, television, or telephone use that are not related to treatment of a medical condition.

8. Charges for non-medical expenses such as training, education, instructions, or educational materials, even if they are performed, provided, or prescribed by a Physician.

9. Expenses Incurred by persons other than the person receiving treatment.

10. Charges in connection with services and supplies which are in excess of Maximum Eligible Expense or Procedure Based Limit.

11. Except in an Emergency, Charges for services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services. “Close Relative” means an Eligible Family Member, parent, brother, sister, child, or in-laws of the Covered Person.

12. Charges for professional services on an Outpatient basis in connection with disorders of any type or cause that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis.

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

14. Travel expenses Incurred by any person for any reason, except as specifically listed as a Covered Benefit.

15. Charges for services, treatments, or supplies that may be useful to persons in the absence of Illness or Injury such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, dehumidifiers, exercise equipment, health club memberships, etc., whether or not they have been prescribed or recommended by a Physician.

16. Charges for preparation of reports or itemized bills in connection with Eligible Expenses, unless specifically requested and approved by the Plan.

17. Charges for services or supplies that are not specifically listed as a Covered Benefit of this Plan.

18. Charges for treatments, services, or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by a Covered Employee's Participating Employer, to the extent that the expenses have been paid by another applicable portion of this Plan or any other insurance or employee benefit plan.

19. Charges for incidental supplies or over-the-counter first-aid supplies, such as, but not limited to, adhesive tape, bandages, antiseptics, analgesics, etc., except as specifically listed as a Covered Benefit.

20. Charges for the following treatments, services or supplies:

    A. Charges related to or connected with treatments, services, or supplies that are excluded under this Plan.
    B. Charges that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan.

21. Charges in connection with an Injury or Illness proximately caused by participation in or commission of a felony or illegal occupation for which a Covered Person has been convicted by a court of competent jurisdiction.

22. Charges for treatment, services, or supplies not actually rendered to or received and used by the Covered Person.

23. Any claims for services or supplies that arise from or are a result of a court order, court ordered confinement, involuntary commitment, or incarceration.

24. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature, including but not limited to correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia, except as specifically provided as a Covered Expense. This includes expenses incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.

25. Routine foot care for Covered Persons without co-morbidities, except Routine foot care is covered if a Covered Person has co-morbidities such as diabetes.

26. Orthodontia (unless covered under the Optional Benefit - Dental Plan).

27. Preventive dental care and routine dental visits for adults age 18 or older (may be covered under the optional Dental Plan).

28. Major restorative dental procedures (may be covered under the optional Dental Plan) except to the extent covered under the Accidental Injury Benefit.

29. Routine vision exams for adults age 18 or older (may be covered under the Optional Vision Plan).

30. Hearing aids, supplies, and tinnitus maskers, except as described under the Child Hearing Loss benefit.

31. Services and supplies related to: acupuncture, acupressure, homeopathy, hypnotherapy, Rolfing, holistic medicine, marriage counseling, natural medicine, religious counseling, stress management, self-help programs, except that acupuncture and naturopathic care will be covered if the Participant obtains a Physician, Physician's Assistant, or Registered Nurse Practitioner Referral, subject to treatment limitations described under the Schedule of Medical Benefits.

32. Charges in connection with treatments, services, or supplies provided for the treatment of obesity and weight reduction, including bariatric surgery or any other related bariatric procedure, except as provided under preventive services.

33. Unless Medically Necessary for purposes of receiving a Covered Benefit, and subject to reasonable medical management, services, treatment, or supplies related to or in connection with:

    A. Fertility Studies.

    B. Sterility Studies.

    C. Procedures to restore or enhance fertility.

    D. Artificial insemination.

    E. In-vitro fertilization.

F. Any other assisted reproductive technique, including fertility preservation services in excess of what is required by applicable law.

G. The reversal of a sterilization procedure.

34. Hair transplant procedures, wigs, and artificial hairpieces.

35. Services, treatment, or supplies related to custodial care.

36. Charges for treatment for marital or family counseling.

37. Services and supplies not listed on the Schedule of Benefits as a Medical Benefit or that do not meet the provisions of this Plan defining Medical Benefits.

38. Midwifery services, except those performed by a Certified Nurse Midwife (C.N.M.) who is licensed as an Advanced Practice Nurse Midwife.

39. Complications that directly result from acting against medical advice, non-compliance with specific Physician's orders, or leaving an Inpatient facility against medical advice. This Exclusion shall not be construed to discriminate against any individual based on health status, disability, or other protected class under state or federal law.

40. Equipment, including, but not limited to, motorized wheelchairs or beds, that exceeds the patient's needs for everyday living activities as defined by the Americans with Disabilities Act as amended from time to time, unless determined to be Medically Necessary by independent review and not primarily for personal convenience.

41. Specialized computer equipment, including, but not limited to, Braille keyboards and voice recognition software, unless determined to be Medically Necessary by independent review and not primarily for personal convenience.

42. Nutrition-based therapy, except as specifically covered for a particular Medical Benefit in the Medical Benefits provisions of the Plan.

43. Court-ordered examinations or treatment.

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

45. Federal Aviation Administration (FAA) and Department of Transportation (DOT) Physicals.

46. Charges for the following (known as a "Never Event") when the condition is a result of patient confinement or surgery:

    A. Removal of an object left in the body during surgery;
    B. Hospital acquired unexpected injuries such as fractures, dislocations, intracranial injuries, crushing injuries, and burns;
    C. Treatment, amputation, or removal of the wrong body part or organ.

    Providers may not seek reimbursement from a Covered Person for hospital-acquired conditions (Never Events). If the Plan has denied reimbursement to a facility under the provisions of this section and you receive bills for those charges, please contact **HPMPT Claim Administrator** at 1-855-322-4953.

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

48. Removal of contraceptive devices, unless Medically Necessary or covered under the Preventive Care Benefit.

49. Prophylactic mastectomy or prophylactic oophorectomy.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed 100% of Allowable Expenses. It applies when a Covered Person is or may also be covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan(s) pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

The benefits under this Plan shall apply only as an excess over such other sources of coverage. The Plan's benefits will be excess to, whenever possible:

(a) Any primary payer besides the Plan.
(b) Any first party insurance through medical payment coverage, personal injury protection, No-fault auto insurance coverage, uninsured or underinsured motorist coverage.
(c) Any policy of insurance from any insurance company or guarantor of a third-party.
(d) Workers' compensation or other liability insurance company.
(e) Any other source, including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Without limiting the general rules above, in the event of a motor vehicle or premises accident or an act of violence with the intent to disrupt electronic, communications, or any other business system, this Plan will be secondary to any auto "no fault" and traditional auto "fault" type contracts, homeowners, commercial general liability insurance, and any other medical benefits coverage.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan(s). The Plan may obtain information and recover overpayments from other plans to the extent necessary to properly coordinate benefits.

All benefits in the Plan are subject to this provision.

DEFINITIONS

"Allowable Expenses" means any charge not exceeding the Maximum Eligible Expense or Procedure Based Limit covered in full or part under more than one plan, at least a part of which is covered under the Plan. No more than 100% of Allowable Expenses will be paid by the Plan and all other plans together. When a plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

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

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:

    A. Hospital indemnity benefits; and

    B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims.

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

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

to this provision;

4. A licensed Health Maintenance Organization (H.M.O.);

5. Any coverage for students which is sponsored by or provided through a school or other educational institution;

6. Any coverage under a Governmental program and any coverage required or provided by any statute;

7. Automobile insurance;

8. Individual automobile insurance coverage on an automobile leased or owned by the Participating Employer or any responsible third-party tortfeasor;

9. Individual automobile insurance coverage based upon the principles of “No-Fault” coverage; or

10. Homeowner or premise liability insurance, individual or commercial.

The term “plan” will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION

When two or more benefit plans provide benefits for the same Allowable Charge, the benefit payment will follow the rules of this section.

Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

1. **Non-Dependent/Dependent**

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

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

   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

      1) The parents are married;
      2) The parents are not separated (whether or not they have ever been married); or
      3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

   B. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

   C. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s Spouse does, the Spouse’s plan is primary. This subparagraph will not apply with respect to any claim determination period, Benefit Period, or Plan Year during which benefits are paid or

provided before the entity has actual knowledge.

D. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' Spouses (if any) is:

1) The plan of the custodial parent.
2) The plan of the Spouse of the custodial parent.
3) The plan of the non-custodial parent.
4) The plan of the Spouse of the non-custodial parent.

3. **Active or Inactive Employee**

The plan that covers a person as an Employee who is neither laid-off nor retired (or as that Employee's Dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.

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

If the preceding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.

A. To determine the length of time a person has been covered under a plan, two plans will be treated as one if the Covered Person was eligible under the second within 24 hours after the first ended.

B. The start of a new plan does not include:

1) A change in the amount or scope of a plan's benefits;
2) A change in the entity that pays, provides, or administers the plan's benefits; or
3) A change from one type of plan to another (such as from a single employer plan to that of a multiple-employer plan).

C. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

5. **No Rules Apply**

If none of these preceding rules determines the primary plan, the Allowable Expenses will be determined equally between the plans.

<u>COORDINATION WITH MEDICARE</u>

Medicare Part A, Part B, and Part D will be considered a plan for the purposes of coordination of benefits. The Plan will coordinate benefits with Medicare when a Covered Person is entitled to Medicare Benefits. The Plan generally pays primary to Medicare.

A Medicare-entitled Covered Person may choose to accept or reject the Plan, except for Retirees who are or become Medicare eligible. However, if the Covered Person rejects the Plan, then the Plan will not be permitted to provide or pay for secondary benefits.

Failure to enroll in Medicare Part B or Part D when a person is initially eligible may result in the person being assessed a surcharge or a higher premium by Medicare for late enrollment in Part B or Part D.

Retirees who are or become Medicare eligible are not eligible to participate in the Plan, as described under RETIREE ELIGIBILITY in the section of this Plan titled **ELIGIBILITY AND COVERAGE PROVISIONS**.

1. **For Working Aged**

   A Covered Employee who is entitled to Medicare Part A, B, or D as a result of age may be covered under this Plan and be covered under Medicare, in which case the Plan will pay primary.

   A Spouse of a Covered Employee, entitled to Medicare Part A, B, or D as a result of age, may also be covered under this Plan and be covered under Medicare, in which case the Plan again will pay primary.

2. **For Covered Retiree's Covered Spouse**

   Medicare is primary and the Plan will be secondary for the Covered Retiree's Covered Spouse who is enrolled in Medicare Part A, B, or D if as a result of age.

   If the Covered Spouse of a Covered Retiree fails to enroll in Medicare Part B, the Plan will calculate, for each claim, the amount it would have paid if the Covered Spouse had enrolled in Medicare Part B, and the Plan does not pay for the portion of the services that Medicare would have paid. That is, benefits for the Covered Spouse who failed to enroll in Medicare Part B will be calculated by subtracting the estimated amount Medicare would have paid under Part B.

3. **For Covered Persons who are Disabled**

   The Plan is primary and Medicare will be secondary for the Covered Employee (and their Covered Spouse) who is entitled to Medicare by reason of disability, if the Covered Employee is actively employed by the Participating Employer.

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

   The Plan is primary and Medicare will be secondary for the Covered Employee (and their Covered Spouse) who is entitled to Medicare solely by reason of End Stage Renal Disease (ESRD), if the Covered Employee is actively employed by the Participating Employer.

   Except as stated below*, if Medicare entitlement for Covered Persons is due solely to End Stage Renal Disease (ESRD), the Plan will be primary only during the 30 months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the 30-month period described above:

   A. The Covered Person has no dialysis for a period of 12 consecutive months and then resumes dialysis, at which time the Plan will again become primary for a period of 30 months; or

   B. The Covered Person undergoes a kidney transplant, at which time the Plan will again become primary for a period of 30 months.

   *If a Covered Person is entitled to Medicare as a result of disability and Medicare is primary for that reason on the date the Covered Person becomes entitled to Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary and the Plan will be secondary.

COORDINATION WITH MEDICAID

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

COORDINATION WITH TRICARE

If a Covered Person is also entitled to and covered under TRICARE, the Plan will always be primary and TRICARE will always be secondary coverage. TRICARE coverage will include programs established under its authority, known as TRICARE Standard, TRICARE Extra, and TRICARE Prime.

PROCEDURES FOR CLAIMING BENEFITS

Claims must be submitted to the Plan within 12 months after the date services or treatments are received or completed. Non-electronic claims may be submitted on any approved claim form available from the provider or the Plan. The claim must be completed in full with all the requested information. A complete claim must include the following information:

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

When completed, the claim must be sent to the HPMPT Claim Administrator at P.O. Box 7982, Helena, Montana 59604-7982, FAX: 1-406-437-7875, or through any electronic claims submission system or clearinghouse to which the Claim Administrator has access.

DENTAL CLAIMS SHOULD BE MAILED TO:
Blue Cross Blue Shield of Montana
P.O. Box 6227
Helena MT 59604

PHARMACY BENEFIT CLAIMS
Claims for Pharmacy Benefits must be sent to Prime Therapeutics, referred to hereunder as the "Pharmacy Supervisor," at (phone: 1-855-258-8471). The Claim Administrator does not adjudicate claims for Pharmacy Benefits and all references to "Claim Administrator" throughout this document are replaced by "Pharmacy Supervisor" for claims related to Pharmacy Benefits. **Consult the supplementary information and procedures in PHARMACY BENEFIT PROGRAM APPENDIX to this document if your claim relates to PHARMACY BENEFITS.**

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

Upon termination of the Plan, final claims must be received within three months of the date of termination, unless otherwise established by the Plan Administrator.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL RECEIVED BY THE CLAIM ADMINISTRATOR.

The Plan will have the right, in its sole discretion and at its own expense, to require a Claimant to undergo a medical examination, when and as often as may be reasonable, and to require the Claimant to submit, or cause to be submitted, any and all medical and other relevant records it deems necessary to properly adjudicate the claim.

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims will be considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines, and administrative practices not inconsistent with the terms of the Plan. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims decisions will be made within the time periods stated below. For purposes of this section, "Claimant" means the individual requesting payment of benefits under these claims procedures or his or her Authorized Representative.

"Claim" means a submission to the Plan for payment made under the Plan in accordance with the Plan requirements.

"Claimant" does not include a Health Care Provider or other assignee, and said Health Care Provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

"Authorized Representative" means a representative, authorized by the Claimant, to act on the Claimant's behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in a form and manner approved by the Plan, and this authorization must be provided to the Plan. The Plan is not required to recognize an Authorized Representative unless the Plan receives written authorization in a form and manner approved by the Plan. However, for urgent care claims the Plan shall, even in the absence of a signed appointment of Authorized Representative form, recognize a health care professional with knowledge of the Claimant's medical condition (e.g., the treating Physician) as the Claimant's Authorized Representative unless the Claimant provides specific written direction otherwise.

INCORRECTLY FILED OR INCOMPLETE CLAIMS

Any request for Plan benefits that is not made in accordance with these claims procedures is called an **incorrectly filed** claim.

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly filed pre-service claim, the Claimant shall be notified as soon as possible but no later than five days following receipt by the Plan of the incorrectly filed claim; and (b) in the case of an incorrectly filed urgent care claim, the Claimant shall be notified as soon as possible but no later than 24 hours following receipt by the Plan of the incorrectly filed claim. The notice shall explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the Claimant.

If any information needed to process a claim is missing, as determined by the Plan, the claim shall be treated as an **incomplete claim**. If an urgent care claim is incomplete, the Plan shall notify the Claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the Claimant unless the Claimant requests written notice. The notification will describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Plan shall decide the claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information or (b) the end of the period of time provided to submit the specified information.

If a pre-service or post-service claim is incomplete, the Plan may deny the claim or may take an extension of time, as described below. If the Plan takes an extension of time, the extension notice shall include a description of the missing information and shall specify a period of no less than 45 days within which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the Claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan shall decide the claim within the

extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

TYPES OF CLAIMS

1. **Urgent Care Claims** - An Urgent Care Claim is any claim for medical care or treatment with respect to which:

   A. In the judgment of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or

   B. In the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   The Plan shall decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

2. **Pre-Service Claims** - Pre-Service Claims refer to Plan benefits that require preapproval and must be submitted to the Plan before the Claimant receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Claimant's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. For benefits not noted as being subject to required precertification or preapproval, no advance approval is necessary, and any request for advance approval will not be treated as a claim. A request with respect to Pre-Approved Expenses will be treated as a Pre-Service Claim because preapproval is required as a condition of coverage.

   The Plan shall decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

3. **Post-Service Claims** - A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Claimant's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

   Initial claims decisions on Post-Service Claims will be made within 30 days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than 30 days after receiving the claim.

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

5. **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. Rescissions are subject to a 30-day notice requirement discussed below. For purposes of deadlines for appeals and Plan determinations, a Participant's decision to dispute the Plan's Rescission is treated as an appeal of a post-service Adverse Benefit Determination.

The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through the claims process, the claim may be recharacterized. For example, a claim may initially be an Urgent Care Claim. If the urgency subsides, it may be recharacterized by the Plan as a Pre-Service Claim.

Despite the specified timeframes, nothing prevents the Claimant from voluntarily agreeing to extend the above timeframes. In addition, if the Plan is not able to decide a Pre-Service or Post-Service Claim within the above timeframes due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the Claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice shall include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected.

RESCISSION 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 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 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.

PRE-APPROVAL PROCESS

As described above under **ELIGIBLE EXPENSES AND BENEFIT DETERMINATIONS,** the Plan may reimburse specific treatments, services, or supplies otherwise excluded by this Plan if the Participant obtains Pre-Approval from the Plan Administrator prior to beginning such treatment or receiving such service or supply. Pre-Approval may be given, at the sole discretion of the Plan Administrator, for medically accepted non-Experimental or Investigational treatments, services, or supplies, which, in the opinion of the Plan Administrator, are more cost effective than a covered treatment, service, or supply for the same Illness or Injury, and which benefit the Covered Person.

In order to submit a request for Pre-Approval, the Participant must first contact the HPMPT Claim Administrator to request a Pre-Service Claim Review: 1-855-322-4953. If the Participant is advised on a Pre-Service Claim Review that the specific treatments, services, or supplies are excluded by this Plan, the Pre-Approval Denial is an Adverse Benefit Determination subject to APPEALS below.

ADVERSE BENEFIT DETERMINATION

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

1. The reason the claim was denied (Adverse Benefit Determination);

2. Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;

3. Any additional information needed to perfect the claim and why such information is needed;

4. An explanation of the Claimant's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on appeal;

5. In the case of an Urgent Care Claim, an explanation of the expedited review methods available for such claims;

Further:

6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, then the notice shall include a statement that a copy of such rule, guideline, protocol, or other criterion relied upon will be provided free of charge to the Claimant upon request; and

7. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the Claimant's medical circumstances) or a statement that such explanation will be provided free of charge upon request.

If a Claimant does not understand the reason for any Adverse Benefit Determination, he or she should contact the Claim Administrator.

APPEALS

The Claimant must exhaust internal appeals of an Adverse Benefit Determination before the Claimant may exercise his or her right to bring a civil action under Section 502(a) of ERISA. This Plan provides two levels of benefit determination review and the Claimant must exercise both levels of review before bringing a civil action. After exercising both levels of review, if the Claimant chooses to exercise his or her right to bring a civil action, then the civil action must be filed with the appropriate court within 365 days after the Plan provides written notice of the Plan's final internal Adverse Benefit Determination (after second internal appeal). Failure to file a civil action within the 365-day time period means the claim will be time barred and subject to an order of dismissal.

A Claimant has the right to submit documents, written comments, or other information in support of an appeal. A Claimant also has the right to review the claim file and is permitted to present evidence and testimony as part of the appeals process. If the Plan has considered, relied upon, or generated any new or additional evidence in deciding the claim, the Claimant will be provided with such evidence sufficiently in advance of the due date for filing the appeal to afford the Claimant an opportunity to respond to such additional evidence.

To initiate the first level of benefit review, the Claimant must submit an appeal or a request for review of the Adverse Benefit Determination to the Plan within 180 days after the Adverse Benefit Determination. The Claimant should include any additional information supporting the appeal or the information required by the Plan which was not initially provided and forward it to the Claim Administrator within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

In the case of an appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the description above of concurrent care claims), if the Claimant does not file the appeal within 30 days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate, the

Plan may reduce or terminate the approved course of treatment.

Appeals or requests for review of your EOB (Explanation of Benefits) or other Adverse Benefit Determinations must be submitted to:

HPMPT Claim Administrator
Appeals Team
P.O. Box 4309
Helena, MT 59604
Fax: 866-589-8256

For your convenience, the HPMPT Claim Administrator provides a Member Appeal Form, which may be found at: https://www.bcbsmt.com/docs/forms/claim/mt/appeal-review-form-member-mt.pdf

Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax), or electronic mail (e-mail). For questions, you may also contact the HPMPT Claim Administrator by phone at 1-855-322-4953.

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

   The first level of benefit determination review is done by the Claim Administrator. The Claim Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Claimant within 30 days following the date the Claim Administrator receives the request for reconsideration (15 days for pre-service and no more than 72 hours for urgent care).

   If, based on the Claim Administrator's review, the initial Adverse Benefit Determination remains the same and the Claimant does not agree with that benefit determination, the Claimant must initiate the second level of benefit review. The Claimant must request the second-level benefit review in writing and send the appeal directly to the HPMPT Plan Administrator at P.O. Box 9406, Missoula, MT 59807. If the Claimant sends the request for second-level benefit review to the Claim Administrator, the Claim Administrator will submit the appeal to the Plan Administrator. This request for second-level benefit review must be sent no later than 60 days after receipt of the Claim Administrator's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. **Second Level of Benefit Determination Review**

   An Appeals Committee will review the claim in question along with the additional information submitted by the Claimant. The Appeals Committee will conduct a full and fair review of the claim by the Appeals Committee who is neither the original decision maker nor the decisionmaker's subordinate. The Appeals Committee cannot give deference to the initial benefit determination. The Appeals Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental treatment, the Appeals Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination nor his or her subordinate.

   After a full and fair review of the appeal, the Plan will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than 30 days from the date the appeal is received by the Plan at each level of review (15 days for pre-service and 72 hours for urgent care).

   All claim payments are based upon the terms contained in the Plan Document on file with the Plan Administrator and the Claim Administrator. The Claimant may request, free of charge, more

detailed information, names of any medical professionals consulted, and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

In all cases, the Claimant is entitled to a full and fair review by a Plan fiduciary on appeal. The Claimant may direct questions about fiduciary oversight of the internal appeals process to the Plan Administrator.

The notification provided to the Claimant of an adverse determination on appeal will be written in a manner calculated to be understood by the Claimant (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements) and will include the following:

- the specific reason(s) for the appeal decision including any denial code and its corresponding meaning and any Plan standard used in denying the claim, including a discussion of the decision;
- a reference to the specific Plan provision(s) on which the decision is based;
- a statement advising the Claimant of the right to request diagnosis and treatment codes and their corresponding meanings;
- a statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- a description of the available external review process;
- if external review is available, a list of all documents consulted in making the appeal decision;
- a statement of the right to sue in federal court;
- a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;
- if the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided at no charge on request; and
- contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program.

INDEPENDENT EXTERNAL REVIEW

After exhaustion of all internal appeal rights stated above, a Claimant may be able to request an independent external review. Claims eligible for external review are only those that involve (a) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; or (b) Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at the time). Furthermore, a claim is not eligible for external review if:

- the Claimant is (or was) not covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Claimant was not covered under the Plan at the time the health care item or service was provided;
- the Adverse Benefit Determination is based on the fact that the Claimant was not eligible for coverage under the Plan (except where the claim relates to a Rescission of coverage);
- the Claimant has not exhausted the Plan’s internal (two-level) appeal process (unless exhaustion is not otherwise required); or
- the Claimant has not provided all the information and forms required to process an external review.

To assert this right to independent external medical review, the Claimant must request such review in writing within four months after a decision is made upon the second level benefit determination above.
Contact the Claim Administrator to make an external review request:

HPMPT Claim Administrator
Appeals Team
1-855-322-4953 P.O. Box 4309
Helena, MT 59604
Fax: 866-589-8256

If an eligible independent external review is requested, the Claim Administrator will forward the entire record on appeal, within 10 days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Claimant of its procedures to submit further information.

The IRO will issue a final decision within 45 days after receipt of all necessary information.

Expedited external review may be requested when: an Adverse Benefit Determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or a final internal Adverse Benefit Determination involves (a) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health, or ability to regain maximum function; or (b) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

The decision of the IRO will be final and binding except that either the Claimant or the Plan may request judicial review of the final decision on the claim. Any legal action brought by, or on behalf of, a Claimant for Plan benefits must be filed with the appropriate court within one year after the Plan provides written notice of the Plan's final internal Adverse Benefit Determination (after second internal appeal). Failure to file a civil action within the one-year time period has expired will be time barred and subject to an order of dismissal.

INDEPENDENT DISPUTE RESOLUTION PROCESS

This Plan will comply with the requirements of the Independent Dispute Resolution Process mandated by the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). This process is intended to provide a mechanism for the Plan to negotiate with a non-preferred provider or a provider not subject to a network discounting contract regarding the correct Qualifying Payment Amount to be applied in instances where the Participant has received specific air ambulance, Emergency Services, or non-Emergency Services to which the No Surprises Act applies. This process does not create an independent appeal or claim right for a Participant in the Plan.

ELIGIBILITY AND COVERAGE PROVISIONS

PARTICIPATING EMPLOYER ELIGIBILITY

Only Eligible Employees of a "Participating Employer" may be covered by the Plan. The requirements for being a Participating Employer are contained in separate agreements between each Participating Employer and the Plan (the "Subscriber Agreement" and the "Trust Agreement"). In general, an Employer must share a common purpose of the extension of medical knowledge, the advancement of medical science, the improvement of the quality of health care, the improvement of the health of our citizens, the elevation of the standards of medical education, or advocacy for the prevention and cure of diseases and prolonging and adding comfort to life, employ at least one Employee, and have its principal place of business in Montana. The Employer must also agree to cover at least 75% of its Eligible Employees, regularly pay required Service Fees and Trust Contributions for its participating group,andparticipate in certain other Trust operations. The terms of the Subscriber Agreements and the Trust Agreement control over the terms of the Plan in describing Participating Employer requirements.

EMPLOYEE ELIGIBILITY

Each Participating Employer identifies its Eligible Employees according to an Adoption Agreement with the Plan. The Participating Employer designates the minimum hours that Employees must work in order to be eligible (at least 80 hours per month) and may also designate a Waiting Period of up to 90 days. If you would like a copy of the Adoption Agreement, you may request a copy from your employer or the Plan Administrator.

Each Participating Employer is responsible for identifying Eligible Employees according to the selections they make in the Adoption Agreement and the other Plan Documents.

Participating Employers are solely responsible for applying Plan's eligibility rules and any of their own workplace benefit eligibility rules fairly and accurately. Participating Employers are also solely responsible for complying with all applicable employment laws, discrimination laws, and laws requiring certain employers to offer coverage to their Employees or Qualified Beneficiaries (such as under the ACA and COBRA). The Plan is entitled to rely on Participating Employers' designation of Eligible Employees and their Eligible Family Members without further inquiry.

Participating Employers are prohibited from making Employee eligibility classifications or designating waiting periods that discriminate in favor of highly-compensated employees in violation of Internal Revenue Code § 105(h) and applicable regulations.

If both Spouses (or Domestic Partners) are Employees of the same Participating Employer and both are eligible for Dependent Coverage, either Spouse, but not both, may elect Dependent Coverage. No one can be covered under the Plan as both a Covered Employee (or Covered Retiree) and a Covered Family Member of the same Participating Employer. No one can be covered under this Plan as a Dependent by more than one Covered Employee (or Covered Retiree).

EFFECTIVE DATE OF COVERAGE – WAITING PERIOD

Except for Eligible Employees who were covered under Prior Coverage (discussed below), coverage under the Plan will not start until the Employee completes the Participating Employer mandated Waiting Period of no more than 90 days, as stated in the Adoption Agreement. The "Waiting Period" is the period of active work (or Approved Leave) beginning on the Enrollment Date and ending on the Effective Date of Coverage.

"Enrollment Date" means the date an Employee becomes a Covered Employee. However, coverage under the Plan does not begin until the Effective Date of Coverage.

The "Effective Date of Coverage" means, with respect to each Eligible Employee, the first day of the

calendar month coinciding with or next following the completion of any Waiting Period, identified in the Subscriber Agreement.

For purposes of satisfying the Waiting Period, Eligible Employees who are absent from employment due to a health factor shall be considered employed during such absence. In the Subscriber Agreement, the Participating Employers may specifically designate other periods of absence due to temporary lay-off or non-health-related approved leaves as counting toward the Waiting Period provided that such designation is applied equally to all Eligible Employees.

INITIAL ENROLLMENT

Eligible Employees must enroll within 30 days immediately following the Effective Date of Coverage, or such Eligible Employee (and his or her Eligible Family Members) must wait until Annual Open Enrollment to enroll, unless a Special Enrollment provision applies.

PRIOR COVERAGE

This Prior Coverage provision applies only to a person who, at the time such person's employer became a Participating Employer in the Plan, was covered under a group health plan sponsored by such Participating Employer (or was enrolled to be covered but was subject to a waiting period) and was an Eligible Employee under this Plan.

For persons with such Prior Coverage:

1. "Enrollment Date" means the date such person first became eligible for or covered under the prior group health plan, whichever occurred first.

2. "Effective Date of Coverage" means the later of the date the person became an Eligible Employee under this Plan or the date the person completed any waiting period to which he or she was subject under the prior group health plan, provided that enrollment for such coverage is done within 30 days immediately following the Effective Date of Coverage.

3. The Plan will allow credit toward the Deductible for any portion of the Deductible that such person satisfied under the previous plan during the Benefit Period containing such person's Effective Date of Coverage.

DEPENDENT COVERAGE

Dependent Coverage means coverage for the Covered Employee or Covered Retiree and the Eligible Family Members of the Covered Employee or Covered Retiree. A Covered Employee's or the Covered Retiree's Eligible Family Members, as defined in the DEFINITIONS section of this Plan, may receive Dependent Coverage subject to the requirements of this section.

Eligible Family Members do not include a Spouse or dependent(s) of a Dependent or dependents of a Domestic Partner.

PROOF OF ELIGIBLE FAMILY MEMBERS

Each Covered Employee is responsible for identifying Eligible Family Members in accordance with the definitions and other provisions of the Plan Documents. Covered Employees must notify their Employer and the Plan of any Eligible Family Member's failure to satisfy any of the eligibility requirements, terms, or conditions of the Plan, including but not limited circumstances of death, divorce, legal separation, or ceasing to be an eligible Dependent child. Failure to accurately report the eligibility or ineligibility of any family members may result in loss of coverage, loss of COBRA rights, Rescission of coverage, and the obligation to reimburse the Plan for benefit payments.

Your Employer or the Plan Administrator reserves the right to audit, at any time, the status of your enrolled Spouse, Domestic Partner, and Dependent children to determine if they meet the eligibility criteria. During an audit, you may be required to provide proof of eligibility. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be dis-enrolled from the Plan, possibly retroactively.

At any time, the Plan may require proof that a person qualifies or continues to qualify as a Dependent, Spouse, or Domestic Partner as defined by this Plan.

Proof of marital status must be furnished to the Plan Administrator upon request, including, if requested, a copy of the Participant's or Covered Retiree's most recent federal tax return, a signed affidavit, a marriage license, and/or any other proof deemed necessary by the Plan Administrator. An eligible Spouse does not include a Spouse who is legally separated or divorced from the Covered Employee or Covered Retiree and has a court order or decree stating such from a court of competent jurisdiction.

For Domestic Partner Coverage, a signed Affidavit of Domestic Partnership, on a form approved by the Plan Administrator, must be furnished to the Plan Administrator upon enrollment and/or as may be requested from time to time.

EFFECTIVE DATE FOR DEPENDENT COVERAGE

An Eligible Family Member becomes eligible for Dependent Coverage on the first day that the Employee is eligible for Employee coverage and that the Eligible Family Member satisfies the eligibility requirements as a Spouse, Dependent, or Domestic Partner, as applicable.

Provided that a Covered Employee or Covered Retiree requests Dependent Coverage on the Plan's enrollment form, Dependent Coverage will commence on the Covered Employee's Effective Date of Coverage, provided that enrollment for Dependent Coverage is done within 30 days immediately following the Effective Date of Coverage. This subsection applies only to Eligible Family Members who are eligible on the Covered Employee's Effective Date of Coverage.

RETIREE ELIGIBILITY

A former Covered Employee whose employment with the Participating Employer terminates due solely to retirement from the Participating Employer (a "Retiree") can continue coverage under the Plan as a Covered Retiree, provided:

1. The Retiree is not eligible for Medicare;
2. The Retiree is no longer employed by any Participating Employer;
3. The Retiree is covered under this Plan on the last day of active service for the Participating Employer prior to retirement;
4. The Retiree pays a monthly contribution to the Plan as determined from time to time by the Participating Employer;
5. The Retiree has completed a minimum of two consecutive years of service with a Participating Employer immediately prior to retirement;
6. The Retiree has maintained health coverage under a Participating Employer's group health plan for a minimum of two consecutive years immediately prior to becoming a Covered Retiree under the Plan;
7. The Retiree provides the Plan with the same information required of Covered Employees;

8. The Retiree satisfies any additional criteria as determined from time to time by their Participating Employer;

9. The Participating Employer has elected to offer its Retirees continued coverage under the Plan as Covered Retirees; and

10. Each Participating Employer's number of Covered Retirees comprises no more than 25% of that Participating Employer's total number of Covered Persons.

The Eligible Family Members of a Covered Employee who are covered on the date the Covered Employee becomes eligible to enroll in Retiree Coverage may receive coverage commencing on the same date as coverage begins for the Covered Retiree.

FAMILY MEMBERS OF COVERED RETIREES WHO BECOME INELIGIBLE

If at the time the Covered Retiree becomes eligible for Medicare as a result of age, the Covered Retiree has Eligible Family Members covered under this Plan, Eligible Family Members may remain covered under this Plan until the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. The date the Eligible Family Member ceases to be eligible for coverage under this Plan; or

2. The date the Eligible Family Member becomes eligible for coverage under Medicare as a result of age.

DECLINING COVERAGE

An Eligible Employee declining coverage under this Plan is asked to state in writing the reason(s) for declining on the form provided by the Plan. **An Eligible Employee who loses existing health coverage but who did not specify that other health coverage was the reason for declining coverage under the Plan may lose their Special Enrollment Rights under the Plan.**

An Eligible Employee who declines coverage under the Plan during the Initial Enrollment Period can become covered later during Annual Open Enrollment or during a Special Enrollment Period.

ANNUAL OPEN ENROLLMENT

Eligible Employees and Eligible Family Members who do not become covered during Initial Enrollment or Special Enrollment may enroll during Annual Open Enrollment. Annual Open Enrollment occurs within the 60 days immediately preceding the first day of each Enrollment Year, or such other time as determined by the Plan Administrator and communicated to Eligible Employees.

SPECIAL ENROLLMENT PERIOD

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

"Special Enrollment Period" means a period of time allowed under this Plan, other than the eligible person's Initial Enrollment Period or Annual Open Enrollment Period, during which an eligible person can request coverage under this Plan as a result of certain events that create Special Enrollment Rights.

Effective Date of Coverage. Coverage will become effective on the first of the month following the date the Employee or Dependent becomes eligible unless a special rule applies.

Request and Application Deadlines The Employee must complete the written application for coverage following any Special Enrollment event within 60 days of the event.

Special Rules for Newborns. For a Newborn born to a Covered Employee (or Spouse), coverage will become effective on the date of the birth and coverage will continue automatically for the first 31 days. A written application for coverage must be made on the Plan's enrollment form within 60 days of birth in order for Newborn coverage to continue beyond 31 days.

Special Rules for Adoptees. For an Adoptee adopted by a Covered Employee (or Spouse), coverage will become effective on the date of the adoption or placement for adoption as designated by the official adoption decree. A written application for coverage must be made on the Plan's enrollment form within 60 days of the date of adoption or placement for adoption. The official adoption decree must also be provided.

There is no coverage for Newborn children of an Eligible Family Member other than a Spouse.

The following events trigger Special Enrollment Rights:

1. Acquisition of New Family Member:

The following individuals are eligible to enroll upon the acquisition of a new Eligible Family Member through birth, marriage, establishment of Domestic Partnership, adoption, or placement for adoption:

A. An Eligible Employee who is not enrolled;
B. An Eligible Employee who is not enrolled and his or her Spouse or Domestic Partner;
C. An Eligible Employee who is not enrolled and his or her newly acquired Dependent;
D. The Spouse or Domestic Partner of a Covered Employee or Covered Retiree;
E. An Eligible Employee who is not enrolled and the Spouse and newly acquired Dependent; and
F. The newly acquired Dependent of a Covered Employee or a Covered Retiree.

Covered Retirees have Special Enrollment Rights for new Dependents. However, an individual who did not obtain Retiree Coverage at retirement but later acquires a new Dependent will not have a Special Enrollment Right (and neither will the retiree's new Dependent).

Dependents of a Domestic Partner do not have Special Enrollment Rights.

2. Loss of Other Coverage

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

A. If the Eligible Employee loses coverage, the Eligible Employee who lost coverage and any Eligible Family Members of the Eligible Employee may enroll and become covered.

B. If an Eligible Family Member loses coverage, the Eligible Family Member who lost coverage and the Eligible Employee may enroll and become covered.

Retirees do not have Special Enrollment Rights based on loss of other coverage.

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

A. COBRA Continuation Coverage under another plan and the maximum period of COBRA Continuation Coverage under that other plan has been exhausted; or

B. Group or insurance health coverage that has been terminated as a result of termination of Employer contributions** towards that other coverage; or

C. Group or insurance health coverage (includes other coverage that is Medicare, Medicaid, or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:

1) Legal separation or divorce of the Eligible Employee;
2) Cessation of Dependent or Eligible Family Member status;
3) Death of the Eligible Employee;
4) Termination of employment of the Eligible Family Member;
5) Reduction in the number of hours of employment of the Eligible Family Member;
6) Termination of the Eligible Family Member's employer's plan; or
7) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or
8) Any loss of eligibility for individual or group coverage because the Eligible Employee or Eligible Family Member no longer resides, lives, or works in the service area of the HMO or other such plan.

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

A loss of eligibility for coverage does not occur if coverage was terminated due to a failure of the Employee or Eligible Family Member to pay premiums on a timely basis or coverage was terminated for cause.

Special Enrollment under this section is available only if coverage under another group health plan or other health insurance coverage ("Other Coverage") was the reason for declining enrollment in the Plan for the Eligible Employee or Eligible Family Member.

Individuals may enroll and become covered when coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 is terminated due to loss of eligibility, subject to the following:

A. A request for enrollment must be made either verbally or in writing 60 days after this Special Enrollment event, and enrollment for such coverage must be made within ninety days after such event.

B. If the Eligible Employee loses coverage, the Eligible Employee who lost coverage and any eligible Dependents of the Eligible Employee may enroll and become covered.

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

Individuals who are eligible for coverage under this Plan may enroll and become covered on the date they become entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement shall be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (CHIP or Medicaid). A request for enrollment either verbally or in writing must be made with 60 days after this Special Enrollment event, and enrollment for such coverage must be completed within 90 days after such event.

CHANGE IN STATUS

If an Eligible Family Member under this Plan becomes an Eligible Employee of the Participating Employer through which they are covered, they may continue their coverage as an Eligible Family Member or elect to be covered as a Covered Employee, but not both. Application for coverage must be made on the Plan's enrollment form within 60 days immediately following the date that coverage would otherwise terminate.

If a Covered Employee ceases to be an Employee of a Participating Employer, but is eligible to be covered as a Eligible Family Member of another Covered Employee of the same Participating Employer, they may elect to continue their coverage as a Eligible Family Member of such other Covered Employee. Application for coverage must be done within 60 days immediately following the date that coverage would otherwise terminate.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of the Participating Employer due to retirement, but is eligible to be a Covered Retiree, they may elect to continue their coverage as a Covered Retiree.

A "Change in Status" as described above will not be deemed to be a break or termination of coverage and will not operate to reduce or increase any coverage or accumulations toward satisfaction of the Deductible and Out-of-Pocket Maximum to which the Covered Person was entitled prior to the Change in Status.

This Plan does not allow any Change in Status or life events, other than those specifically described in this CHANGE IN STATUS section or the SPECIAL ENROLLMENT PERIOD section, that would result in a mid-year change to a Covered Employee's initial or annual enrollment elections.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

PURPOSE

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

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Covered Employee who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Covered Employee. Unless a QMCSO is more restrictive, an Alternate Recipient will have the same rights as a Dependent under the Plan and will be treated as a Covered Employee for purposes of ERISA reporting and disclosure requirements.

2. "Medical Child Support Order" means any state or court judgment, decree, or order (including approval of settlement agreement) issued by a court of competent jurisdiction or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:

    A. Provides for child support for a child of a Covered Employee under this Plan, or;

    B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and

    C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act;

3. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Covered Employee or Qualified Beneficiary is eligible under this Plan and has been determined by the Plan Administrator to meet the qualification requirements as outlined under "Procedures" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

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

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

3. Specify each period to which such order applies.

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

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

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

1. The Plan Administrator will promptly notify the Covered Employee and each Alternate Recipient of the receipt of such order and the Plan's procedures for determining whether Medical Child Support Orders are qualified orders; and

2. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Covered Employee and each Alternate Recipient of such determination.

For purposes of these notice requirements, notices will be sent to the address provided on the Medical Child Support Order. The Alternate Recipient may designate a representative for receipt of copies of notices sent to the Alternate Recipient.

ERISA REPORTING AND DISCLOSURE REQUIREMENTS

The Plan Administrator will ensure that the Alternate Recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes, such as by providing the Alternate Recipient a copy of the Summary Plan Description and any subsequent Summaries of Material Modifications generated by a Plan amendment.

NATIONAL MEDICAL SUPPORT NOTICE

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

FAMILY AND MEDICAL LEAVE ACT OF 1993

NOTICE: Compliance with employment laws, including the FMLA, is the responsibility of your Employer. Certain Employers are not subject to FMLA requirements. Covered Employees must inquire with their Employers regarding how the FMLA applies in their workplace and for information about the Employer's FMLA policies and notice requirements. This provision is simply an overview of some of the important provisions of the FMLA.

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

DEFINITIONS

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

1. Member of the Armed Forces includes, but is not limited to, members of the National Guard or Reserves who are undergoing medical treatment, recuperation, or therapy.

2. Next of Kin means the nearest blood relative to the service member.

3. Parent means the Employee's biological parent or someone who has acted as Employee's parent in place of Employee's biological parent when Employee was a son or daughter.

4. Serious health condition means an Illness, Injury, impairment, or physical or mental condition that involves:

   A. Inpatient care in a hospital, hospice, or residential medical facility; or

   B. Continuing treatment by a Health Care Provider (a Doctor of Medicine or Osteopathy who is authorized to practice medicine or surgery, as appropriate, by the state in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services).

5. Serious Injury or Illness means an Injury or Illness incurred in the line of duty that may render the Member of the Armed Forces medically unfit to perform his or her military duties.

6. Son or daughter means the Employee's biological child, adopted child, stepchild, foster child, a child placed in Employees legal custody, or a child for which Employee is acting as the parent in place of the child's natural blood related parent. The child must be:

   A. Under the age of eighteen (18); or

   B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.

7. Spouse means the Employee's legal Spouse.

EMPLOYERS SUBJECT TO FMLA

In general, FMLA applies to any Employer engaged in interstate commerce or in any industry or activity affecting interstate commerce who employs 50 or more Employees for each working day during each of 20 or more calendar workweeks in the current or preceding Calendar Year. FMLA also applies to those persons described in Section 3(d) of the Fair Labor Standards Act, 29 U.S.C. 203(d). The FMLA applies to government entities, including branches of the United States government, state governments, and political subdivisions thereof.

ELIGIBLE EMPLOYEES

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

REASONS FOR TAKING LEAVE

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

ADVANCE NOTICE AND MEDICAL CERTIFICATION

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

PROTECTION OF JOB BENEFITS

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

UNLAWFUL ACTS BY EMPLOYERS

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

ENFORCEMENT

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

TERMINATION OF COVERAGE

TERMINATION OF PARTICIPATION

Covered Employee coverage will automatically terminate immediately upon the earliest of the following dates, unless the Covered Employee is eligible for and elects COBRA Continuation Coverage:

1. On the last day of the month in which the Covered Employee's employment terminates;

2. On the last day of the month in which the Covered Employee ceases to be eligible for coverage;

3. The date the Covered Employee or Participating Employer fails to make any required contribution for coverage;

4. The date the Plan is terminated;

5. The date the Covered Employee dies;

6. On the last day of the month in which the Plan and the Participating Employer agree that the Participating Employer terminates participation in the Plan;

7. The date the Covered Employee takes a leave for service in the uniformed service, subject to continuation and reinstatement rights under USERRA; or

8. On the last day of the month in which the Plan receives the Plan’s health coverage waiver or termination form for the Covered Employee.

LEAVES OF ABSENCE

A Covered Employee whose active service ceases as a result of any leave of absence approved by the Participating Employer in accordance with the Participating Employer’s policies, may remain covered as an Employee for a **maximum** of three calendar months following the end of the month that the leave of absence is granted. Coverage during a leave of absence may not exceed three months, regardless of any Employer policies that may provide for a longer leave of absence. If the Employee does not return to active service for the group’s minimum hourly eligibility requirement at the end of three months, the Employee is no longer eligible, and coverage will be terminated. Failure to properly and timely report ineligibility will result in the Employer group being responsible for any claims and administrative expenses paid with respect to the ineligible individual. Coverage under this provision will be subject to all the provisions of the FMLA or other applicable law requiring protection of benefits during a leave of absence. During any leave of absence, Participating Employer contributions must be paid as required by law and the Subscriber Agreement.

DEPENDENT COVERAGE TERMINATION

Each Covered Employee (or Covered Retiree) is responsible for notifying his or her Employer and the Plan immediately of any Eligible Family Member's failure to satisfy any of the eligibility requirements. The Participating Employer is also independently required to notify the Plan of any eligibility changes in its workforce. See ELIGIBILITY AND COVERAGE PROVISIONS - DEPENDENT COVERAGE.

Coverage for an Eligible Family Member will automatically terminate immediately upon the earliest of the following dates, unless COBRA applies to the group and the Eligible Family Member is eligible for and elects COBRA Continuation Coverage:

1. On the last day of the month in which the Eligible Family Member ceases to be an Eligible Family Member as defined in the Plan;

2. On the last day of the month in which the Covered Employee's or Covered Retiree's coverage terminates under the Plan, except in the event that a Covered Employee or Covered Retiree exceeds their Maximum Benefit Per Benefit Period for all Causes, as stated in the Schedule of Medical Benefits, any Eligible Family Members who are covered at that time may remain covered under this Plan as long as the former Employee or Covered Retiree continues to meet the eligibility requirements of this Plan and the Eligible Family Member remains eligible for coverage under this Plan;

3. On the last day of the month in which the Covered Employee ceases to be eligible to elect Dependent Coverage for an Eligible Family Member;

4. The date the Covered Employee, Covered Retiree or the Participating Employer fails to make any required contribution for Dependent Coverage;

5. The date the Plan is terminated; or with respect to any Eligible Family Member's benefit of the Plan, the date of termination of such benefit;

6. The date the Participating Employer ceases participation in the Plan or terminates the Eligible Family Member's coverage;

7. On the last day of the month following the month in which the Covered Employee or Covered Retiree dies;

8. The date the Eligible Family Member enters the armed forces of any country as a full-time member if active duty is to exceed 31 days;

9. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Eligible Family Member whose coverage is to be terminated; or

10. On the last day of the month in which a Covered Employee or Covered Retiree and Domestic Partner terminate their Domestic Partnership. As explained in the Plan's COBRA CONTINUATION COVERAGE provisions, termination of Domestic Partnership is not a qualifying event under COBRA.

COVERED RETIREE TERMINATION

Covered Retiree coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Covered Retiree ceases to be eligible for coverage;

2. The date the Covered Retiree fails to make any required contribution for coverage;

3. The date the Plan is terminated;

4. The date the Covered Retiree dies;

5 The date the Covered Retiree becomes entitled to Medicare; or

6. The date the Covered Retiree enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one 31 days.

COBRA CONTINUATION COVERAGE

NOTICE: COBRA MAY NOT BE AVAILABLE TO COVERED PERSONS OF SMALL EMPLOYERS.

A COVERED EMPLOYEE'S OR COVERED RETIREE'S DOMESTIC PARTNER IS NOT ELIGIBLE FOR COBRA CONTINUATION COVERAGE.

In general, Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") applies to all Participating Employers, unless the Participating Employer is exempt from COBRA in the current Calendar Year because it employed less than 20 employees on at least 50% of its typical business days during the Calendar Year immediately before the current Calendar Year.

If COBRA applies to a Participating Employer, then the Covered Employees or Covered Retiree of such Participating Employer (and their covered Spouses and children) may have the right to continue Plan coverage beyond the time coverage would ordinarily have ended.

For purposes of this section on COBRA, the term "Covered Dependents" is limited to the Covered Employee's or Covered Retiree's Spouse and Dependent children according to COBRA laws. These persons who become entitled to COBRA are called "Qualified Beneficiaries." Certain Newborns, newly adopted children, and Alternate Recipients under QMCSOs may be Qualified Beneficiaries as explained further below.

The Plan Administrator and Participating Employers have agreed that Vimly Benefit Solutions act on behalf of the Plan Administrator for purposes of administering COBRA. All COBRA notices and inquiries to the "Plan Administrator" should be directed to:

COBRA Department
P.O. Box 6
Mukilteo, WA 98275-0006
206-859-2697
cobra@vimly.com

The Covered Employee and the Participating Employer are responsible for determining whether an individual is a Qualified Beneficiary entitled to COBRA coverage according to the COBRA regulations. The Plan will not be responsible for covering individuals who are designated as COBRA beneficiaries but are not legally qualified for COBRA.

QUALIFYING EVENTS

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

1. "Qualifying Events" for Covered Employees are the following events, if such event results in a loss of coverage by the Covered Employee:

   A. The Covered Employee's employment terminates for any reason other than gross misconduct.

   B. The reduction in hours of the Covered Employee's employment.

2. "Qualifying Event" for a Covered Dependent (Spouse or child) are the following events, if such event results in a loss of coverage by such Covered Dependent:

   A. Death of the Covered Employee or Covered Retiree.

B. The Covered Employee's employment terminates for any reason other than gross misconduct.

C. The reduction in hours of the Covered Employee's employment.

D. The divorce or legal separation of the Covered Employee or Covered Retiree from his or her Spouse (Qualifying Event for Spouse only).

E. A Covered Dependent child ceases to be a Dependent as defined by the Plan (Qualifying Event for child only).

F. The Covered Employee's entitlement to Medicare.

3. Qualifying Events for Covered Retirees, for purposes of this section are:

   A. Bankruptcy, if the Covered Retiree retired on or before the date of any substantial elimination of group health coverage due to bankruptcy.

4. Qualifying Events for the Dependents of Covered Retirees, for purposes of this section are:

   A. Bankruptcy, if the Dependent was a Qualified Beneficiary of a Covered Retiree on or before the day before the bankruptcy qualifying event.

NOTIFICATION RESPONSIBILITIES

The Participating Employer must notify the Plan Administrator of the following Qualifying Events within 30 days after the date the following event occurs:

1. The Covered Employee's employment terminates for any reason other than gross misconduct.
2. The reduction in hours of the Covered Employee's employment.
3. The Covered Employee or Covered Retiree becomes entitled to Medicare.

The Covered Person must notify the Plan Administrator* of the following Qualifying Events within 60 days after the date the event occurs:

1. The divorce or legal separation of the Covered Employee or Covered Retiree from his or her Spouse (Qualifying Event for Spouse only).
2. Covered Dependent child ceases to be a Dependent as defined by the Plan (Qualifying Event for child only).
3. The death of the Covered Employee or Covered Retiree.

* If the Covered Person notifies the Participating Employer, then the Participating Employer must notify the Plan Administrator within the 60-day period.

Failure by the Covered Person or the Participating Employer to provide the notice required by this subsection will result in the Plan denying COBRA eligibility and/or the Participating Employer being liable to the Plan or the former Covered Person for medical claims incurred by the Covered Person after the Qualifying Event.

ELECTION OF COVERAGE

Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than 14 days after the Plan Administrator is notified of the Qualifying Event.

A Qualified Beneficiary has 60 days from the date coverage would otherwise be lost or 60 days from the date of notification from the Plan Administrator, whichever is later, to notify the Plan Administrator that he or she elects to continue coverage under the Plan.

Any Qualified Beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA.

MONTHLY PREMIUM PAYMENTS

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

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

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

3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:

   A. If another Qualifying Event occurs during the initial 18 months of COBRA coverage, such as a death, divorce, or legal separation, the monthly fee for qualified disabled person may be up to a maximum of 102% of the applicable premium.

   B. If the second Qualifying Event occurs during the 19th through the 29th month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of 150% of the applicable premium.

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

If a Qualified Beneficiary does not make full and timely payment for COBRA coverage, then all further rights to COBRA will be lost.

SPECIAL CONSIDERATIONS IN ELECTING COBRA

Failure to elect COBRA will affect a Qualified Beneficiary's future rights under federal law. For example, individual health insurance policies that do not impose pre-existing condition exclusions need not guarantee availability if COBRA is not elected for the maximum time available.

Finally, Special Enrollment Rights under federal law are affected by COBRA. Individuals have the right to request Special Enrollment in another group health plan for which they are eligible (such as a plan

sponsored by your Spouse's employer) within 30 days after your group health coverage under the Plan ends because of a Qualifying Event. Qualified Beneficiaries have the same Special Enrollment Right at the end of COBRA coverage if COBRA is elected for the maximum time.

LENGTH OF COBRA COVERAGE

Consult the section below entitled "WHEN COBRA CONTINUATION COVERAGE ENDS" for specific information about the length of coverage. In general, COBRA lasts for up to 18 months (unless extended for Medicare entitlement, disability, or second Qualifying Event, discussed below) when the Qualifying Event is termination of employment or reduction in hours. COBRA can last for up to 36 months when the Qualifying Event is death, divorce, or legal separation of the Covered Employee or a Dependent child's losing eligibility.

MEDICARE ENTITLEMENT WITHIN 18 MONTHS PRIOR

When the Qualifying Event is the Covered Employee's termination of employment or reduction in hours and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA coverage for the Spouse and/or child(ren) who lost coverage as a result of the Qualifying Event can last until up to 36 months after the date of the Covered Employee's Medicare entitlement. This extended COBRA coverage period is available only if the Covered Employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Example: If a Covered Employee becomes entitled to Medicare eight months before the date on which he retires, COBRA coverage for his Spouse and children who lost coverage as a result of his retirement can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Before extending COBRA due to prior Medicare entitlement, the Qualified Beneficiary must submit proof of the Covered Employee's Medicare entitlement. This notice must be sent to the Plan Administrator c/o the Claim Administrator at the address provided above.

Failure to provide the required notice described above will cause all Qualified Beneficiaries to lose their rights to extend coverage due to Medicare entitlement.

DISABILITY EXTENSION OF 18-MONTH PERIOD

When the Qualifying Event is the Covered Employee's termination of employment or reduction in hours, an extension of the 18-month period may be available if a Qualified Beneficiary is disabled.

If a Qualified Beneficiary is determined by the Social Security Administration to be disabled at any time before the Qualifying Event or within 60 days after the Qualifying Event, and the Plan Administrator is properly notified in a timely fashion, then all Qualified Beneficiaries who are family members of the disabled Qualified Beneficiary can receive up to an additional 11 months of COBRA, for a total maximum of 29 months. This extension is available only to Qualified Beneficiaries who are receiving COBRA because of the Covered Employee's termination of employment or reduction in hours.

The Qualified Beneficiary who is determined disabled must provide the Plan Administrator with a copy of the Social Security Administration's disability determination letter within 60 days after the latest of: the date of the Qualifying Event, the date of the Qualified Beneficiary would lose coverage due to the Qualifying Event, or the date of the Social Security Administration's disability determination. Qualified Beneficiaries must also provide this notice before the end of the original 18-month period of COBRA. This notice must be sent to the Plan Administrator c/o Claim Administrator at the address provided above.

Failure to provide the required notice described above will cause all Qualified Beneficiaries to lose their rights to extend coverage due to disability.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD

If the first Qualifying Event is the Covered Employee's termination of employment or reduction in hours, and another Qualifying Event occurs while receiving COBRA (that would have caused a loss of coverage under the Plan) then the Qualified Beneficiaries who have elected and paid for COBRA coverage and whose COBRA coverage is still in effect at the time of the second Qualifying Event (along with certain Newborns and newly adopted children) can extend COBRA up to a maximum of 36 months. This extension is available to the Spouse and Dependent children if the (former) Employee dies or becomes divorced or legally separated, and to a Dependent child when that child stops being eligible under the Plan as a Dependent child. The extension is not available to the Spouse or Dependent child due to the Medicare entitlement of the Covered Employee unless Medicare entitlement would have caused a loss of coverage under the Plan. In all of these cases, the Plan Administrator must be notified of the second Qualifying Event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator c/o the Claim Administrator at the address provided above.

Failure to provide the required notice described above will cause all Qualified Beneficiaries to lose their rights to extend coverage due to second Qualifying Event.

WHEN COBRA CONTINUATION COVERAGE ENDS

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

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

   This exception applies to all Qualified Beneficiaries.

2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes entitled to Medicare (either Part A, B, or D);

3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made.

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

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

6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:

   A. 18 months for a Covered Employee who is a Qualified Beneficiary as a result of termination or reduction in hours of employment (subject to applicable extensions discussed above);

   B. 18 months for a Covered Dependent Spouse or child who is a Qualified Beneficiary because of a Covered Employee's termination or reduction in hours of employment (subject to applicable extensions discussed above);

C. 36 months following the date of enrollment in Medicare (as discussed further above) for those who are Qualified Beneficiaries as a result of termination or reduction in hours of employment of a Covered Employee who became entitled to Medicare within 18 months prior to the Qualifying Event.

D. On the first day of the month beginning 30 days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first 60 days of the date of the Qualifying Event and has received at least 18 months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.

E. 29 months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.

F. 36 months for all other Qualified Beneficiaries.

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

HOW COBRA APPLIES TO FMLA LEAVE

Under special rules that apply if an Employee does not return to work after FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered by the Plan during leave.

NEWBORNS AND OTHERS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with a Covered Employee during a period of COBRA coverage is considered to be a Qualified Beneficiary provided that, if the Covered Employee is a Qualified Beneficiary, the Covered Employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Annual Open Enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Covered Employee. To be enrolled in the Plan, the child must be a Dependent and satisfy the otherwise applicable Plan eligibility requirements.

In addition, a child of the Covered Employee who is receiving benefits under the Plan pursuant
to a qualified medical child support order (QMCSO) received by the Participating Employer during the Covered Employee's period of employment is entitled to the same rights to elect COBRA as a Dependent child of the Covered Employee.

NOTICE REQUIREMENTS

If a notice is late or if these Notice Requirements are not satisfied within the applicable notice period, Qualified Beneficiaries may lose the right to elect or extend COBRA, as applicable.

Any notice must be in writing and must be submitted on the Plan's required form, if any. COBRA notices to the Plan or to Plan Administrator must be mailed or hand-delivered to:

HPMPT COBRA AdministratorClaim Administrator
P.O. Box 6
Mukilteo, WA 98275-0006
206-859-2697
cobra@vimly.com

If mailed, notices must be postmarked no later than the last day of the applicable notice period. If hand-delivered, notices must be received by the HPMPT Claim Administrator at the address specified above no later than the last day of the applicable notice period. The applicable notice periods are described in the sections above regarding Qualifying Events (Election, Duration, and Extensions, as applicable).

All notices must include information sufficient to accurately identify:

1. The name of the Plan ("Health Professions of Montana Plan and Trust" or "HPMPT")
2. The name and address of the Employee who is (or was) covered under the Plan;
3. The name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage as a result of the Qualifying Event;
4. The Qualifying Event and the date it happened; and
5. The certification, signature, name, address, and telephone number of the person providing the notice.

If the Qualifying Event is a divorce or legal separation, notice must also include a copy of the decree of divorce or legal separation. If coverage is reduced or eliminated and later a divorce or legal separation occurs, and if notice to the Plan Administrator is regarding Plan coverage being reduced or eliminated in anticipation of the divorce or legal separation, notice must include evidence that coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Any notice of disability must (also) include:

1. The name and address of the disabled Qualified Beneficiary;
2. The date that the Qualified Beneficiary became disabled;
3. The names and addresses of all Qualified Beneficiaries who are still receiving COBRA coverage;
4. The date that the Social Security Administration made its determination;
5. A copy of the Social Security Administration's determination; and
6. A statement whether the Social Security Administration has subsequently determined that the disabled Qualified Beneficiary is no longer disabled.

Any notice of a second Qualifying Event must (also) include:

1. The names and addresses of all Qualified Beneficiaries who are still receiving COBRA coverage;
2. The second Qualifying Event and the date that it happened; and
3. If the second Qualifying Event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

The Covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a Qualified Beneficiary who lost coverage due to the Qualifying Event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all Qualified Beneficiaries who lost coverage due to the Qualifying Event described in the notice.

QUESTIONS

Any questions about COBRA should be directed to:

HPMPT COBRA AdministratorClaim Administrator
P.O. Box 6
Mukilteo, WA 98275-0006
206-859-2697
cobra@vimly.com

Questions can also be directed to the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

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

COVERED EMPLOYEES IN UNIFORMED SERVICE

The Plan complies with the provisions of the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA) that require continuation and reinstatement of coverage for Covered Employees in uniformed service. This Plan provision explains rights and responsibilities related to continuation and reinstatement of Plan coverage under USERRA. Covered Employees should contact their Employers for additional information about USERRA.

1. When a Covered Employee takes a leave for service in the uniformed services, the Covered Employee may elect to continue coverage under USERRA for the Covered Employee and any Covered Dependents up to 24 months from the date on which the Covered Employee's leave for uniformed service began; provided however that USERRA coverage will end earlier if one of the following events occurs:

   A. A premium payment is not made within the required time;

   B. The Covered Employee fails to apply for reemployment or return to employment within the timeframes required by USERRA and highlighted below; or

   C. The Covered Employee loses USERRA rights due to dishonorable discharge or other conduct specified in USERRA.

Return to Employment – Application. A Covered Employee's right to USERRA continuation coverage will end if the Covered Employee does not notify his or her Employer (and the Claim Administrator or Plan Administrator) of his or her intent return to work following completion of uniformed services by either reporting to work (if uniformed service was for less than 31 days) or applying for reemployment (if uniformed service was for more than 30 days).

2. A Covered Employee who elects to continue coverage under USERRA may be required to pay not more than 102% of the full premium for coverage (determined in the same manner as the applicable premium under COBRA), except that in the case of a person who performs service in the uniformed services for less than 31 days, such person may not be required to pay more than the regular Employee share of the premium for such coverage.

3. In the case of an Eligible Employee whose coverage was terminated by reason of service in the uniformed services, an exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if an exclusion or Waiting Period would not have been imposed had coverage not been terminated as a result of uniformed service. This paragraph applies to the Eligible Employee who is reemployed and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of the Eligible Employee. This provision will not apply to the coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.

4. Covered Employees may have the right to continue coverage under COBRA in addition to USERRA. If COBRA applies, then continuation coverage under COBRA and USERRA shall begin at the same time and shall run concurrently.

COVERAGE FOR A MONTANA NATIONAL GUARD MEMBER

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

"State Active Duty" means duty performed by a Member when a disaster or an emergency is declared by the proper State authority to include the time period as certified by a licensed Physician to recover from an Illness or Injury incurred while performing the state active duty.

1. "Member" means a member of the Montana Army National Guard, Montana Air National Guard, and/or Montana Home Guard.

2. In any case in which a Covered Person has coverage under this Plan and such Covered Person is absent from employment with Employer by reason of State Active Duty, the Covered Person may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election shall be the period beginning on the 31st consecutive day of State Active Duty and ending on the day immediately before the day the Covered Person returns to a position of employment with the Employer, provided the Covered Person returns to employment in a timely manner, or ending on the day immediately after the day the Covered Person fails to return to a position of employment in a timely manner.

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

   1) For State Active Duty of up to 30 days, the Member returned to employment the next regular work shift following safe travel time plus 8 hours.
   2) For State Active Duty of 30 days, but not more than one 180 days, the Member returned to employment within 14 days of termination of State Active Duty.
   3) For State Active Duty of more than 180 days, the Member returned to employment within 90 days of termination of the State Active Duty.

3. An eligible Covered Person who elects to continue Plan coverage under this Section may be required to pay:

   A. Not more than 100% of the contribution required from a similarly situated active Employee until such Covered Person becomes eligible for coverage under the State of Montana Health Benefit Plan as an employee of the Department of Military Affairs.

   B. Not more than 102% of the contribution required from a similarly situated active Employee for any period of time that the Covered Person is also eligible for coverage under the State of Montana Health Benefit Plan as an employee of the Department of Military Affairs.

4. In the case of a person whose coverage under the Plan is terminated by reason of State Active Duty, a pre-existing condition exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if such an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who is reemployed in a timely manner as defined by MMSERA and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee.

5. **In no event will this Plan cover any Illness or Injury caused by or aggravated by State Active Duty.**

FRAUD AND ABUSE

Any person who commits a fraudulent act against the Plan may be subject to criminal and civil penalties, prosecution, fine, or imprisonment as provided by law.

RESCISSIONS

Coverage under this Plan is subject to Rescission if the Covered Person commits an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact. Material facts include information about an individual's eligibility for Plan benefits and enrollment or claims information concerning a Participant's health, claims history, or current receipt of health care services (not genetic information).

The following list is illustrative, but not exhaustive, of acts that may be considered fraud, misrepresentation, or abuse against the Plan:

1. Falsifying, withholding, omitting, or concealing information to obtain coverage;

2. Misrepresenting eligibility criteria for Dependents (for example, marital status, age, full-time student status, dependent child, or the right to claim a Dependent for federal income tax purposes) to obtain or continue coverage for a person who would not otherwise meet the Dependent eligibility criteria, as defined in the Plan, and qualify for coverage;

3. Withholding, omitting, concealing, or failing to disclose any medical history or health status where required;

4. Making or using any false writing or document in connection with obtaining coverage or payment for health benefits, including falsifying or altering (a) a Certificate of Creditable Coverage to reduce or eliminate Waiting Periods or pre-existing conditions limitations under the Plan, (b) a claim, or (c) medical records;

5. Permitting a person who is not covered under the Plan to use a Plan identification card or other Plan identifying information to obtain Covered Benefits or payment under this Plan;

6. Making false or fraudulent representations in connection with delivery of or payment for health benefits or being untruthful to obtain reimbursement under this Plan;

7. Obtaining or attempting to obtain Covered Benefits under this Plan by false or fraudulent pretenses; or

8. Attempting to obtain payment for treatment, services or supplies not actually rendered to or received and used by the Covered Person.

The Plan Administrator, in its sole discretion, may take appropriate action against the Covered Person for fraud or abuse as permitted by law, including, but not limited to, terminating the Covered Person's (and the family's) coverage. Covered Persons will receive appropriate advance notice of such termination of coverage.

MISSTATEMENT OF AGE

If age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of a Covered Person's age in an enrollment form or claims filing, the Covered Person's eligibility or amount of benefits, or both, will be adjusted in accordance with the Covered Person's true age. Upon the discovery of a Covered Person's misstatement of age, benefits affected by such misstatement will be adjusted

immediately. If the Covered Person's true age is such that the person was not eligible for coverage or the amount of benefits received, the Plan is entitled to recover any such benefits according to the Rescission requirements of the Plan. Any misstatement of age will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If a Covered Employee misrepresents a Dependent's eligibility criteria (including, but not limited to marital status, age, full-time student status, dependent child relationship, or the right to claim the person as a tax dependent) to obtain coverage for a person who would not meet the Plan's definition of Dependent if the true facts were known, coverage for that person will be terminated and may be retroactively rescinded according to the Rescission requirements of the Plan..

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not an eligible Covered Person to use any identification card issued, the Plan Administrator may, in its sole discretion, terminate the coverage of the Covered Person who permits such usage.

REIMBURSEMENT TO PLAN

In accordance with the Rescission requirements of the Plan, the Plan may require reimbursement of payment for benefits for Employees' Spouses, ex-Spouses, or children or other persons who are not eligible for coverage under this Plan but for whom benefits were paid based upon:

1. Inaccurate, erroneous, or false information provided by the Employee or family member;

2. Information concealed, withheld, omitted, or not disclosed by the Employee or family member as required; or

3. Falsified or altered documents provided by the Employee or family member for the purpose of obtaining coverage.

Employee's failure to reimburse the Plan after demand is made may result in interruption or loss of benefits by the Employee and his or her family members.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits. The term "Covered Person" is used in this Recovery/Reimbursement/Subrogation section of the Policy regardless of whether such person is erroneously covered or paid by the Plan.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

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

Payment of benefits by the Plan for Employees and their 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 Covered Person authorizes the deduction of any excess payment from such benefits or other present or future compensation payments.

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

REIMBURSEMENT

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

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

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from third-parties who are legally responsible to the Covered Person for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Covered Person, 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 Covered Person's accident, Injury, condition, or Illness, which the Plan 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 Covered Person for whom benefits were paid and to take any action the Covered Person could have undertaken to recover the money paid.

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

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

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

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

2. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any third-party responsible for an accident, Injury, condition, or Illness, this Plan has a right of recovery, through Reimbursement or Subrogation or both, to the extent of its payment. The Covered Person 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.

3. The Covered Person will cooperate fully with the Plan Administrator, its agents, attorneys, and assignees regarding the recovery of any monies paid by the Plan from any party other than the Covered Person 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; providing 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.

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

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

6. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third-party or coverage, including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, 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.

RIGHT OF OFF-SET

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

CREDITABLE COVERAGE PROCEDURES

CERTIFICATE OF CREDITABLE COVERAGE

The Plan will provide Certificate of Creditable Coverage for coverage under this Plan as required by the United States Department of Labor to any Covered Person or the Covered Person's designated and authorized agent, guardian, conservator, health care plan, or health insurance as follows:

1. At the time the Covered Person ceases to be covered under this Plan;

2. At the time a Covered Person ceases to be covered by the COBRA Continuation Coverage provided by this Plan, if any; and

3. At any other time that a request is made on behalf of the Covered Person for such certification, but not later than 24 months after cessation of coverage as set out in subparagraphs 1 and 2 above, whichever is later.

HIPAA AMENDMENT

The Board of Trustees and the Sponsor Board (the "Boards" and "Plan Sponsor" as defined by HIPAA and ERISA regulations) and their workforces have access to the individually identifiable health information of Plan Participants for administration functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Boards' ability to use and disclose PHI and electronic PHI. The following HIPAA definitions of PHI and Electronic PHI apply to this Plan amendment:

> Protected Health Information (PHI). Protected Health Information (PHI) means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. Protected health information includes information of persons living or who have been deceased for less than 50 years.
>
> Electronic Protected Health Information. Electronic Protected Health Information (Electronic PHI) means Protected Health Information that is transmitted by or maintained in electronic media.

The Boards shall have access to PHI and Electronic PHI from the Plan only as permitted under this section or as otherwise required or permitted by HIPAA.

PROVISION OF PROTECTED HEALTH INFORMATION TO BOARDS

> Permitted Disclosure of Enrollment/Disenrollment Information.
>
> The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Boards information on whether the individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
>
> Permitted Uses and Disclosure of Summary Health Information.
>
> The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Boards, provided that the Boards request the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.
>
> "Summary Health Information" means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.
>
> Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes.
>
> Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph IV and obtaining written certification pursuant to paragraph VI, the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI and Electronic PHI to the Boards, provided that the Boards use or disclose such PHI and Electronic PHI only for Plan administration purposes.

"Plan administration purposes" means administration functions performed by the Boards on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Sponsor in connection with any other benefit or benefit plan of the Sponsor or any employment-related actions or decisions. Enrollment and disenrollment functions performed by the Sponsor are performed on behalf of Plan Participants and beneficiaries and are not Plan administration functions. Enrollment and disenrollment information held by the Sponsor is held in its capacity as the Sponsor Employer and is not PHI.

Notwithstanding any provisions of the Plan to the contrary, in no event shall the Boards be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES

The Boards agree that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan), Boards shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Boards with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Boards;
- report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
- make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Plan that the Boards still maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between Plan and Sponsor (i.e., the firewall), required by 45 CFR § 504(f)(2)(iii), is established.

The Boards further agree that if they create, receive, maintain, or transmit any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508, which are not subject to these restrictions) on behalf of the Plan, the Boards will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that the adequate separation between the Plan and Boards (i.e., the firewall), required by 45 CFR § 504(f)(2)(iii), is supported by reasonable and appropriate security measures;

- ensure that any agent to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and report to the Plan any security incident of which it becomes aware, as follows: Boards will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, the Boards will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

ADEQUATE SEPARATION BETWEEN PLAN AND BOARDS.

The Boards shall allow members of the Board of Trustees (the Plan Administrator), the Executive Director, and any staff of the HPMPT and the HPMPT Sponsor Organization to have access to and use of PHI only to the extent necessary to perform the plan administration functions that the Boards perform for the Plan. In the event that any one of the specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Sponsor Board for non-compliance pursuant to the workforce discipline and termination procedures. The Boards shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

CERTIFICATION OF PLAN SPONSOR.

The Sponsor has certified that Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Boards agree to the conditions of disclosure set forth in this Section.

As the operating body of the Sponsor of the Plan, the Sponsor Board certifies that the Plan documents that govern the Plan have been amended to incorporate the following provisions and the Boards shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Boards with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Boards;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Plan that the Boards still maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- ensure that the adequate separation between Plan and Sponsor (and Participating Employers) (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied;

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan; and
- report to the Plan any security incident of which it becomes aware, as follows: Plan Sponsor will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Plan Sponsor will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

ERISA STATEMENT OF RIGHTS

As a Covered Employee under the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report upon request.

4. Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, or if you request it before losing coverage or up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right receive a written explanation of the reason why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial for a full and fair review and reconsideration by the Plan Administrator, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part (an Adverse Benefit Determination), you may file suit in a state or federal court once you have exhausted your appeal rights under the Plan's claims and appeals procedures. If you believe the Plan fiduciaries have misused Plan assets, or that you have been discriminated against for asserting your rights under ERISA, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide which party will pay the court costs and legal fees. The court may order the losing party to pay these court costs and fees. You may be ordered to pay these costs and fees if you lose and the court finds your claim to be frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain further information and certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or by visiting www.dol.gov/ebsa.

GENERAL PROVISIONS

PROTECTION AGAINST CREDITORS

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

NO WAIVER OR ESTOPPEL

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

ENFORCEMENT

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

VERBAL STATEMENTS

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

PLAN IS NOT A CONTRACT OF EMPLOYMENT

The Plan constitutes the primary authority for Plan administration. The establishment, administration, and maintenance of the Plan will not be deemed to constitute a contract of employment, give any Covered Employee the right to be retained in the service of any Participating Employer, or to interfere with the right of any Participating Employer to discharge or otherwise terminate the employment of any Covered Employee.

PAYMENT OF CLAIMS TO PROVIDERS OR OTHERS

All Plan benefits are payable to a Covered Person (including a Qualified Beneficiary or Alternate Recipient as applicable). The Plan may accept claims filed by a healthcare provider and may make payments for Covered Benefits directly to a healthcare provider. A Covered Person may give written authorization for the healthcare provider to receive payment directly from the Plan. However, any authorization to receive (or the actual receipt of) direct payment from the Plan will not, by itself, constitute an assignment of health benefits or other rights under the Plan, a designation of an “Authorized Representative” for claims purposes, or a waiver of the Plan’s prohibition on assignment of benefits. The Plan has the full authority to establish the form and manner in which the Covered Person must designated an “Authorized Representative” for purposes of making claims or filing appeals with the Plan in accordance with the CLAIMS PROCEDURES

of the Plan. If the Plan makes a payment for Covered Benefits to a healthcare provider, this will fulfill the Plan's obligation to pay for such Covered Benefits. The Plan is not responsible for paying healthcare provider invoices that are balance-billed to the Plan Participant.

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

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with the coordination of benefits or other terms of this Plan have been made under any other plan or plans, the Plan will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of such provision. Amounts so paid will be deemed to be benefits paid under this Plan and, to the extent of such payment, the Plan will be fully discharged from liability under this Plan. The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

TRUST CONTRIBUTIONS

Plan assets shall be held in trust and each Participating Employer shall be subject to the terms of a separate Trust Agreement and Subscriber Agreement. Trust Contributions from the Participating Employer and Employees to the Plan will be in accordance with established rates on file with the Plan Administrator. The Plan Administrator will have the right to change the rates of any Participating Employer from time to time as needed in accordance with applicable law.

SERVICE FEE

The Participating Employer will be required to pay a Service Fee in addition to its Trust Contribution in accordance with the Subscriber Agreement. Covered Persons are not responsible for payment of any Service Fee. The Service Fee does not constitute an asset of the Plan.

COSTS AND EXPENSES OF THE PLAN

The costs and expenses incurred in the administration and maintenance of the Plan including, but not limited to, insurance premiums, legal expenses, actuarial expenses, accounting expenses, claims processing expenses, and the fees and expenses of any person or firm employed to assist in the administration of the Plan, will be paid by the Trust.

PLAN LIMITATIONS AND LIABILITY

Except for the right to receive any benefit under the Plan, no Employee or any other person will have any right, title, or interest in or to the assets of the Trust, or in or to any Trust Contributions, such contributions being made to and held under the Trust for the sole purpose of providing benefits and defraying the reasonable expenses of the Plan in accordance with the terms and provisions of the Plan and the Trust Agreement.

The Plan does not in any way guarantee the Trust from loss or depreciation or guarantee the payment of any benefit which may come due to any person covered under the Plan.

BENEFITS LIMITED TO FUND

Under no circumstances does any liability attach to the Plan Sponsor or the Plan Administrator for payment of any benefits or claims under the Plan. The Trust Fund is the only source for payment of any benefits under the Plan.

REFUNDS AND REBATES

The Plan Sponsor is the sole owner of all refunds, rebates, or other offsets to Plan costs that have not been applied to benefits or administration under the Plan. These funds are deemed received by the Plan Sponsor, not the Plan or Trust, and are not plan assets under ERISA or other applicable law.

GUARANTEED RENEWABILITY

The Plan will not deny a Participating Employer, whose Employees are Covered Employees, continued access to the same or different coverage except:

1. For nonpayment of contributions;

2. For fraud or other intentional misrepresentation of material fact by the Employer;

3. For noncompliance with material Plan provisions;

4. Because the Plan is ceasing to offer any coverage in a geographic area;

5. In the case of a Plan Option that offers benefits through a network plan, there is no longer any individual enrolled through the Employer who lives, resides, or works in the service area of the network and the Plan applies this paragraph uniformly without regard to the claims experience of Employers or any health status-related factor in relation to such individuals or their Dependents; and

6. For failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the Plan, or to employ Employees covered by such an agreement.

VENUE

The venue of any suit brought by any of the parties hereto to enforce any obligation hereunder shall be in Federal Court in Missoula, Montana.

WORKERS' COMPENSATION NOT AFFECTED

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

TITLES

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

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below. If a capitalized term used in this document is not defined in this section, then it may be defined in other Plan Documents.

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

ADOPTION AGREEMENT

"Adoption Agreement" means the separate document through which the Participating Employer adopts the Plan and makes certain plan design decisions and representations regarding its Employees.

ADVERSE BENEFIT DETERMINATION

"Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, as well as any Rescission. An Adverse Benefit Determination includes a denial, reduction, termination, or failure to provide or make payment based on a determination of an Employee's, Retiree's, or family member's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

ALCOHOLISM

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

ALCOHOLISM AND/OR SUBSTANCE ABUSE/CHEMICAL DEPENDENCY TREATMENT FACILITY

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

AMBULANCE SERVICE

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

APPLIED BEHAVIORAL ANALYSIS

"Applied Behavioral Analysis" means interactive therapies derived from evidence-based research (also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention) for the treatment of individuals diagnosed with Autism Spectrum Disorders, which treatment can only be provided by an individual who is licensed by the behavior analyst certification board or is certified by the Montana Department of Public Health and Human Services as a family support specialist with an autism endorsement, for services related to autism spectrum disorders.

AUTISM SPECTRUM DISORDERS

“Autism Spectrum Disorders” means one of the following disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;
2. Asperger’s disorder; or
3. Pervasive developmental disorder not otherwise specified.

BENEFIT PERCENTAGE

“Benefit Percentage” means that portion of Eligible Expenses payable by the Plan.

BENEFIT PERIOD

“Benefit Period” means the Calendar Year. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the Calendar Year;
2. The day the Maximum Lifetime Benefit applicable to the Covered Person becomes paid; or
3. The date the Plan terminates.

BLUECARD AND INTER-PLAN PROGRAMS

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 (**also called “Eligible Expenses” in this Plan Document**) 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. In addition, payments to non-participating healthcare providers may be adjusted as described under the definition of Maximum Eligible Expense, as discussed below.

<u>CALENDAR YEAR</u>

“Calendar Year” means the 12-month period commencing on January 1 and ending on December 31.

<u>CHIROPRACTIC CARE</u>

“Chiropractic Care” is defined by Montana Code Annotated § 37-12-102.

<u>CLAIM ADMINISTRATOR</u>

“Claim Administrator” or “HPMPT Claim Administrator” means Blue Cross and Blue Shield of Montana, a division of Health Care Service Corporation, a Mutual Legal Reserve Company (sometimes referred to by the Plan as "Blue Connections (BCBSMT)" which is the name of the internal department that administers self-funded accounts). 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.

COBRA

"COBRA" or "COBRA coverage" means continuation coverage under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CONVALESCENT PERIOD

A "Convalescent Period" commences with the date of confinement by a Covered Person in a Skilled Nursing Facility and will end the earlier of 60 days from the date of confinement or the date of discharge from the facility. A new Convalescent Period will not commence until a previous Convalescent Period has terminated.

COSMETIC

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

COVERED BENEFITS

"Covered Benefits" means the benefits identified as Eligible Expenses according to the COVERED BENEFITS sections of this Plan Document.

COVERED DEPENDENT

"Covered Dependent" means a Dependent of a Covered Employee or Covered Retiree who is enrolled for Dependent Coverage under the Plan.

COVERED DOMESTIC PARTNER

"Covered Domestic Partner" means a Domestic Partner who is enrolled for Dependent Coverage under the Plan.

COVERED EMPLOYEE

"Covered Employee" means an Eligible Employee who is enrolled for coverage under the Plan.

COVERED FAMILY MEMBER

"Covered Family Member" means a Covered Dependent, a Covered Spouse, or a Covered Domestic Partner.

COVERED PERSON

"Covered Person" means any Covered Employee, Covered Family Member, or Covered Retiree. Alternate Recipients of QMCSOs and Qualified Beneficiaries under COBRA shall also be Covered Persons to the extent provided in the Plan.

COVERED RETIREE

"Covered Retiree" means a former Covered Employee of the Participating Employer who meets the Plan's retiree eligibility requirements and is enrolled for coverage under this Plan.

CREDITABLE COVERAGE

"Creditable Coverage" means health or medical coverage under which a Covered Person was covered, prior to that Covered Person's Enrollment Date under this Plan, which prior coverage was under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Part A, Part B, or Part C of Title XVIII of the Social Security Act (Medicare).
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (program for distribution of pediatric vaccines).
5. Chapter 55 of Title 10, United States Code (TRICARE).
6. A medical care program of the Indian Health Service or a tribal organization.
7. A state health benefits risk pool.
8. The Federal Employee Health Benefits Program.
9. A public health plan, including any plan established or maintained by a State, the US Government, a foreign country, or any political subdivision of the foregoing.
10. A health benefit plan under Section 5 (e) of the Peace Corps Act.
11. The State Children's Health Insurance Program.

DEDUCTIBLE

"Deductible" means a specified dollar amount of Eligible Expenses, which will be different depending on the Plan Option selected by the Participating Employer, that must be incurred before the Plan will pay any amount for any Eligible Expense during each Benefit Period.

DENTAL HYGIENIST

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

DENTALLY NECESSARY

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

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

DENTIST

"Dentist" means a person holding one of the degree(s) of Doctor of Dental Science, Doctor of Medical Dentistry, Master of Dental Surgery, or Doctor of Medicine (oral surgeon), who is legally licensed as such

to practice dentistry in the jurisdiction where services are rendered, and the services rendered are within the scope of his or her license.

DENTURIST

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

DEPENDENT

"Dependent" means a Covered Employee's or Covered Retiree's child who:

1. Is the Covered Employee's or Covered Retiree's natural child; step-child; legally adopted child; child placed with the Covered Employee or Covered Retiree for adoption and for whom the Covered Employee or Covered Retiree has been appointed the legal guardian; and
2. Is less than 26 years of age as of the first day of the Benefit Period. This requirement is waived if the child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Covered Employee or Covered Retiree for support and maintenance. Proof of incapacity must be furnished to the Claim Administrator upon request, and additional proof may be required from time to time.

DEPENDENT COVERAGE

"Dependent Coverage" means coverage under the Plan elected by a Covered Employee or Covered Retiree for Eligible Family Members.

DOMESTIC PARTNER

"Domestic Partner" means an individual who is not legally married to a Covered Employee or Covered Retiree, but who lives with and shares a domestic life with a Covered Employee or Covered Retiree and:

1. The Covered Employee/Retiree and Domestic Partner are 18 years of age or older and each are competent to enter into a contract;
2. There exists proof of cohabitation for at least the most recent 12 consecutive months, during which the cohabited residence has served as the primary place of residence for the Covered Employee/Retiree and Domestic Partner;
3. Neither the Covered Employee/Retiree nor the Domestic Partner is married to nor the Domestic Partner of another person;
4. The Covered Employee/Retiree, as applicable, and Domestic Partner are not related to each other as determined by the laws of their state of residence;
5. The partners are responsible for each other's common welfare and have a financial interdependent relationship evidenced by one or more of the following, as determined necessary by the Plan:

    (a) Notarized copy of lease naming both Domestic Partners;
    (b) Evidence of joint savings or joint checking account that has been in effect for at least 6 months;
    (c) Title and registration of joint ownership of an automobile;
    (d) Designation of each other as primary beneficiary in wills, life insurance policies, or retirement annuities;
    (e) Evidence of joint use and liability for credit cards;
    (f) Certified copy of a life insurance policy naming Domestic Partner as the beneficiary;

(g) Evidence that Domestic Partner is a beneficiary under Employee's deferred compensation or retirement plan.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment which is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

ELIGIBLE EMPLOYEE

"Eligible Employee" means an Employee who satisfies the eligibility requirements of the Plan Documents.

ELIGIBLE EXPENSES

"Eligible Expenses" means the amount of any charge for a covered service, treatment, or supply that may be considered for payment by the Plan, including any portion of that charge that may be applied to the Deductible, co-payment, or used to satisfy the Out-of-Pocket Maximum. Eligible Expenses are equal to the actual billed charge or a contracted or negotiated rate, if applicable. Eligible Expenses are further defined and limited under the ELIGIBLE EXPENSES AND BENEFIT DETERMINATION provisions of this Plan.

ELIGIBLE FAMILY MEMBER

"Eligible Family Member" means a Dependent who has satisfied the eligibility requirements of the Plan. If a Participating Employer elects to offer coverage to Spouses and/or Domestic Partners, "Eligible Family Member" also means a Spouse or a Domestic Partner who has satisfied the eligibility requirements of the Plan.

ENROLLMENT YEAR

"Enrollment Year" means a 12-month period commencing on the date the Participating Employer either initially becomes covered or renews coverage under the Health Professions of Montana Plan and Trust.

EMERGENCY MEDICAL CONDITION

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. This definition includes mental health conditions and substance use disorders.

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

EMERGENCY CARE OR EMERGENCY SERVICES

"Emergency Care" or "Emergency Services" means, with respect to an Emergency Medical Condition, (1) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely

available to the emergency department to evaluate such Emergency Medical Condition and (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as required under section 1867 of the Social Security Act to stabilize the patient.

For these purposes, to "stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

EMPLOYEE

"Employee" means any individual employed by a Participating Employer who receives wages or earned income from such Participating Employer, including any common-law employee or self-employed partner of the Participating Employer.

"Employee" may not include any employee leased from another employer, including but not limited to those individuals defined in code section 414(n), for a term of less than one year.

ERISA

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

EXPERIMENTAL/INVESTIGATIONAL

"Experimental/Investigational" means:

1. Any drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. Any drug, device, medical treatment, or procedure for which the patient informed consent document utilized with the drug, device, treatment, or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
3. That the drug, device, medical treatment, or procedure is under study, prior to or in the absence of any clinical trial, to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with generally medically accepted means of treatment or diagnosis;
4. That based upon Reliable Evidence, the drug, device, medical treatment, or procedure is the subject of an on-going phase I or phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not considered Experimental or Investigational). However, coverage under CLINICAL TRIAL COVERAGE is not considered Experimental or Investigational.
5. Based upon Reliable Evidence, any drug, device, medical treatment, or procedure that the prevailing opinion among experts 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 generally medically accepted means of treatment or diagnosis.
   "Reliable Evidence" means only reports and articles published in authoritative medical and scientific literature; the written protocol or protocols used by a treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.
6. Any drug, device, medical treatment, or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S.

Department of Health, Center for Medicare and Medicaid Services (CMS), American Dental Association, American Medical Association).

FMLA

"FMLA" means Family and Medical Leave Act of 1993, as amended.

HIPAA

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

HOSPITAL

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

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is licensed as a Hospital under authority of the laws of the jurisdiction in which the facility is physically located;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. It provides treatment for compensation by or under the supervision of Physicians with continuous 24 hour nursing services by Registered Nurses (R.N.'s);
5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and
6. It is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

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

HSA-QUALIFIED

"HSA-Qualified" means that the Coverage Option qualifies as a high deductible health plan in accordance with Internal Revenue Code Section 223 regarding health savings accounts.

ILLNESS

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

INCURRED EXPENSES OR EXPENSES INCURRED

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

INITIAL ENROLLMENT PERIOD

"Initial Enrollment Period" means the 60-day period allowed by this Plan for enrollment when an Employee first becomes an Eligible Employee.

INJURY

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

INPATIENT

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

INTENSIVE CARE UNIT

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

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

LICENSED HEALTH CARE PROVIDER

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

LICENSED PRACTICAL NURSE

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

LICENSED PROFESSIONAL COUNSELOR

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

LICENSED SOCIAL WORKER

"Licensed Social Worker" means a person holding a master's degree (M.S.W.) in social work and who is currently licensed as a social worker in the state in which services are rendered and who provides counseling and treatment in a clinical setting for Mental Illnesses.

MAXIMUM ELIGIBLE EXPENSE

"Maximum Eligible Expense" or "MEE" means the maximum amount the Plan will pay for any covered treatment, service, or supply, subject however, to all Plan annual and lifetime maximum benefit limitations. The following criteria will apply to determination of the Maximum Eligible Expense:

1. The network criteria used by the Claim Administrator, for example: the BLUECARD and INTER-PLAN PROGRAM.

2. For services of a Licensed Physician or Licensed Health Care Provider, the criteria is:

    (a) The contracted amount as established by a preferred provider or other discounting contract;
    (b) An amount established based upon a published prevailing fee schedule for the geographic area in which the claim was incurred and adopted by the Plan and Claim Administrator if a contracted amount does not exist; or
    (c) The billed charge if less than A or B above.

3. For facility charges, the criteria are:

    (a) The contracted amount as established by a preferred provider or other discounting contract; or
    (b) The billed charge if less than the contracted rate.

4. For all Prescription Drugs not obtained through the Pharmacy Benefit Program while undergoing either Inpatient or Outpatient treatment, including injectable drugs, the criteria will be:

    (a) The contracted amount as established by a preferred provider or other discounting contract; or
    (b) The billed charge if a contracted amount does not exist.

5. For Durable Medical Equipment, the criterion is the lesser of:

    (a) The contracted amount as established by a preferred provider or other network or discounting contract; or
    (b) The billed charge.

6. For Air Ambulance, the criterion is the lesser of:

    (a) The contracted amount as established by a preferred provider or other network or discounting contract; or
    (b) The billed charge if there is no contracted amount; or
    (c) The median amount the Plan would pay to an in-network air ambulance service, which shall constitute the Qualifying Payment Amount as described below.

Annual and lifetime benefit maximums may apply to benefits that are not essential health benefits. The Plan does not place annual or lifetime benefit maximums on any essential health benefits.

The Maximum Eligible Expense for some services may be adjusted in the following circumstances:

1. Continuing Care Patients.

The Plan will continue to apply the contracted amount as established by a preferred provider for 90 days following the termination of a provider's preferred status, unless that termination is for cause, for any Covered Person who is a Continuing Care Patient. A Continuing Care Patient means a Covered Person who is "(1) undergoing a course of treatment for a serious and complex condition from the provider or facility; (2) undergoing a course of institutional or Inpatient care from the provider or facility; (3) scheduled to undergo nonelective surgery from the provider; (4) pregnant and undergoing a course of treatment for Pregnancy from the provider; or (5) determined to be terminally ill and is receiving treatment for such Illness from the provider or facility." A "serious and complex condition" means (1) in the case of an acute Illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic Illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital <u>and</u> requires specialized medical care over a

prolonged period of time. The provider must accept the amount paid by the Plan as payment in full for the services provided and must continue to adhere to all policies, procedures, and quality standards imposed by the Plan with respect to Continuing Care Patients in the same manner as if the preferred status termination had not occurred.

2. Certain Emergency Services.

The Plan will adjust the Maximum Eligible Expense for Emergency Services provided in an emergency department of a hospital or in an independent freestanding emergency department, in instances where the billing party, facility, or provider is not a preferred provider or participant in another network or discounting contract. The Maximum Eligible Expense for such services will be the median amount the Plan would pay to a preferred provider or a provider that is party to another network or discounting contract (the "Qualifying Payment Amount" or "QPA")[a]. For these purposes only, Emergency Services shall include any additional items and services furnished by the provider if those services are benefits covered under the Plan and those services are furnished after the Participant is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay in which the Emergency Services are furnished. Such additional items and services shall only be included under this definition until the treating provider determines that, taking into consideration the Participant's medical condition, the Participant is able to travel using nonmedical transportation to an available preferred provider or provider that is a participant in a network or discounting contract within a reasonable travel distance, as long as the Participant is properly notified and is able to provide voluntary and informed consent.

3. Certain Non-Emergency Services at Certain Participating Facilities.

In the case of services other than those described in item (2.) directly above, the Plan will adjust the Maximum Eligible Expense for items and services furnished to a Participant by a the billing provider that is not a preferred provider or participant in another network or discounting contract but where the facility where the services are provided is a preferred provider or participant in another network or discounting contract. The Maximum Eligible Expense for such services will be the Qualifying Payment Amount. The Maximum Eligible Expense will not be adjusted where the billing provider has satisfied specific notice and consent criteria with respect to the services received.

Any disputes with providers regarding the Qualifying Payment Amount for Air Ambulance, Certain Emergency Services, and Certain Non-Emergency Services as described in item (3.) above will be addressed through the process described under "PROCEDURES FOR CLAIMING BENEFITS - INDEPENDENT DISPUTE RESOLUTION PROCESS".

Providers that are not preferred providers and do not participate in another network or discounting contract may not balance bill or otherwise hold Plan Participants liable for amounts in excess of the Qualifying Payment Amount for services identified in items (2.), and (3.) above or Air Ambulance services.

MEDICAL POLICY

"Medical Policy" means a policy adopted by the Plan or Claim Administrator which is created and updated by Physicians and other medical providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes, and technology meet the following nationally accepted criteria:

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

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[a] In instances where the QPA cannot be determined using the median contracted rate, the Plan may apply an alternative methodology established by the Departments of Labor, Treasury, and Health and Human Services.

MEDICALLY NECESSARY

"Medically Necessary" or "Medical Necessity" means and refers to treatment, tests, services, or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

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

MEDICAID

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

MEDICARE

"Medicare" means the programs established under the Health Insurance for the Aged Act under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those age 65 or older and those with end-stage renal disease or other disabilities.

MENTAL ILLNESS

"Mental Illness" means a medically recognized psychological, physiological, nervous, or behavioral condition or disorder, affecting the brain, which can be diagnosed and treated by medically recognized and accepted methods. Conditions so recognized by the Diagnostic Statistical Manual of Mental Disorders (the most current edition) will be included in this definition.

MMSERA

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

NEWBORN

"Newborn" refers to an infant from the date of their birth until the initial Hospital discharge or until the infant is 14 days old, whichever occurs first.

OCCUPATIONAL THERAPY

"Occupational Therapy" means a program of care ordered by a Physician which is for the purpose of improving the physical, cognitive, and perceptual disabilities that influence the Covered Person's ability to

perform functional tasks related to normal life functions or occupations, and which is for the purpose of assisting the Covered Person in performing such functional tasks without assistance.

OUT-OF-POCKET MAXIMUM

"Out-of-Pocket Maximum" means the maximum dollar amount that any Covered Person or family will pay in any Benefit Period for Eligible Expenses.

OUTPATIENT

"Outpatient" means a Covered Person who is receiving medical care, treatment, services, or supplies at: a clinic, a Physician's office or a Licensed Health Care Provider's office; or at a Hospital, Psychiatric Facility, or Alcoholism and/or Substance Abuse/Chemical Dependency Treatment Facility if not a registered bed patient or Inpatient at that Hospital, Psychiatric Facility, or Alcoholism and/or Substance Abuse/Chemical Dependency Treatment Facility.

PARTIAL HOSPITALIZATION

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

PARTICIPATING EMPLOYER

"Participating Employer" means an employer member of the HPMPT Sponsor Organization that has adopted this Plan for its Eligible Employees.

PHARMACY SUPERVISOR

"Pharmacy Supervisor" means Prime Therapeutics. The Pharmacy Supervisor provides claims administration and coordination of benefits (including Medicare Part D coordination) for Pharmacy Benefits.

PHYSICAL THERAPY

"Physical Therapy" means a plan of care ordered by a Physician and provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

PHYSICIAN

"Physician" means a person holding the degree of Doctor of Medicine or Osteopathy who is legally licensed as such and acting within the scope of such license.

PHYSICIAN ASSISTANT

"Physician Assistant" means an individual who has received specialized training in physician assistance and is authorized to use the designation of "P.A." and who is licensed by the state or regulatory agency in the state in which the individual performs such physician assistant services.

PLACEMENT OR BEING PLACED FOR ADOPTION

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

PLAN

"Plan" means the program of health benefits described in this Plan Document and Summary Plan Description for the Health Professions of Montana Plan and Trust.

PLAN ADMINISTRATOR

"Plan Administrator" means the Board of Trustees, or a committee appointed by the Board of Trustees, of the Health Professions of Montana Plan and Trust.

PLAN DOCUMENT

"Plan Document" means this Plan Document and Summary Plan Description and other documents that are specifically incorporated by reference herein; and also including any formal interpretations or policies adopted or approved by the Plan Administrator.

PLAN OPTION

"Plan Option" means one or more coverage options offered under the Plan and selected by a Participating Employer.

PLAN YEAR

"Plan Year" means a 12-month period designated by the Plan for Plan business and maintaining Plan fiscal records and stop loss insurance. The Plan Year will commence January 1st and end on the last day of December of each year. The initial Plan Year was a short Plan Year which commenced on May 1, 2008 and ended on December 31, 2008.

PREGNANCY

"Pregnancy" means a physical condition commencing with conception and ending with miscarriage or birth.

PRESCRIPTION DRUG

"Prescription Drug" means a prescription drug product which

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

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

PROCEDURE BASED LIMIT

"Procedure Based Limit" is the maximum amount the Plan will pay under any circumstances for any treatment, service, or supply or combination of any treatments, services, or supplies that comprise a procedure covered by this Plan. In the event the amount of the Procedure Based Limit is less than the Plan's Maximum Eligible Expense limit or any other limit upon payment stated in the Plan, the Procedure Based Limit shall prevail and be applied. The Procedure Based Limit shall be based upon a publicly available payment schedule including Medicare allowable amounts when applicable and other similar schedules in circumstances in which Medicare allowable amounts are inapplicable or unavailable. The specific Procedure Based Limit for any treatment, service, or supply shall be based upon a mathematical formula using a multiple or percentage of the payment schedules referred to above and adopted by the Claim Administrator and the Plan.

PSYCHIATRIC CARE

"Psychiatric Care" means treatment for a Mental Illness, Alcoholism, or Substance Abuse by a licensed psychiatrist, psychologist, Licensed Social Worker, or Licensed Professional Counselor acting within the scope and limitations of their respective license, provided that such treatment is Medically Necessary as defined by the Plan and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

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

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means an individual who qualified for COBRA Continuation Coverage.

QMCSO

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

RESCISSION

"Rescission" means a cancellation or discontinuance of coverage that has retroactive effect as further defined in the RESCISSION sections of this Plan. A cancellation or discontinuation of coverage is not a Rescission if the cancellation or discontinuance of coverage has only a prospective effect or if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

REGISTERED NURSE OR REGISTERED NURSE PRACTITIONER

"Registered Nurse" or "Registered Nurse Practitioner" means an individual who has received specialized nursing training and is authorized to use the designation of "R.N." or "R.N.P." and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

ROOM AND BOARD

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

SEMI-PRIVATE

"Semi-Private" refers to the class of accommodations in a Hospital or Skilled Nursing Facility in which at least two patient beds are available per room.

SERVICE FEE

"Service Fee" means the amount identified in the Subscriber Agreement that is paid by the Participating Employer in exchange for services performed by the Sponsor Organization, Inc. The Service Fee shall be separate from the Trust Contribution and shall not be paid by Covered Persons.

SKILLED NURSING FACILITY

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

1. It is licensed to provide, on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities ("Skilled Nursing Services");
2. The Facility's services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse;
4. It maintains complete medical records on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders;
7. It is approved and licensed by Medicare.

This term also applies to Incurred Expenses in an institution known as a Skilled Nursing Facility, extended care facility, or any such other similar nomenclature.

SPOUSE

"Spouse" means the legal spouse of an Eligible Employee or a Covered Retiree, including a common law spouse under Montana law.

SUBSCRIBER AGREEMENT

"Subscriber Agreement" means the agreement between the Participating Employer ("Subscriber") and the Trust, which sets forth the rights and responsibilities of the Participating Employer and the Trust.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

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

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.

TRUST

"Trust" means the Health Professions of Montana Trust established according to a separate trust agreement.

TRUST CONTRIBUTIONS

"Trust Contributions" means contributions to the Trust made by a Participating Employer for the purpose of paying benefits to Covered Persons and defraying the reasonable administrative expenses of the Trust. The source of Trust Contributions shall be allocated between the Participating Employer and its Covered Employees in accordance with the Subscriber Agreement.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

PHARMACY BENEFIT PROGRAM APPENDIX

The Pharmacy Benefit Program is available to Covered Persons according to the Plan Coverage Option selected by the Participating Employer, and benefits are payable as specifically stated below. The Pharmacy Benefit Program is for Prescription Drugs which are self-administered. Unless otherwise specified, the Pharmacy Benefit Program is also subject to all Plan provisions, limitations, and exceptions based upon the Plan Document to which this Appendix is made a part. This Benefit does not include medications which are administered by a Licensed Health Care Provider. If a medication is administered by a Licensed Health Care Provider, the claim will process under the Covered Person's Medical Benefits.

Covered Persons enrolled in the Plan are automatically enrolled in the Pharmacy Benefit Program. There is no separate contribution cost.

PHARMACY CARD PROGRAM

Covered Persons will receive a combined medical/Prescription Drug identification card in the mail. The Prescription Drug Plan's Pharmacy Benefit Manager (PBM) provides a network of pharmacies throughout Montana and the United States. The PBM is Prime Therapeutics and is also referred to as the Pharmacy Supervisor.

DRUG LIST (FORMULARY)

The Plan will cover Prescription Drugs that are approved for inclusion on the Plan's Drug List (also known as a formulary). Changes to the Drug List can be made from time to time. Some of the factors that are evaluated include each drug's safety, effectiveness, cost, and how it compares with drugs currently on the Drug List.

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

The Drug List is available by accessing the Pharmacy Supervisor's website at www.bcbsmt.com or calling the Customer Service toll-free number on the Covered Person's identification card.
The Covered Person, or the Covered Person's prescribing Health Care Provider, can ask for a Drug List exception if the Covered Person's drug is not on the Drug List. To request this exception, the Covered Person or the Covered Person's prescriber can call the number on the back of the Covered Person's identification card to ask for a review.

If the Covered Person has a health condition that may jeopardize their life, health, or keep the Covered Person from regaining function or the Covered Person's current drug therapy uses a non-covered drug, the Covered Person's prescriber may be able to ask for an expedited review process by marking the review as an urgent request. The Pharmacy Supervisor will notify the Covered Person or the Covered Person's prescriber of the coverage decision within 24 hours after they receive the request for an expedited review. If the coverage request is denied, the Claim Administrator will let the Covered Person and the Covered Person's prescriber know why it was denied and offer the Covered Person a covered alternative drug (if applicable). If the Covered Person's exception is denied, the Covered Person may appeal the decision according to the appeals process the Covered Person will receive with the denial determination. The Covered Person should call the number on the back of the Covered Person's identification card if the Covered Person has any questions.

MEMBER PORTAL

Covered Persons have access to the Prime Therapeutics Member Portal. Go to the Prime Therapeutics website at: **www.myprime.com** and follow the registration instructions and prompts for creating an Account.

For assistance contact
Prime Therapeutics
1-855-258-8471

Important: Online information is an important component of the Plan's Pharmacy Benefit Program because it contains the most up-to-date information and members are able to navigate efficiently to specific topics. If you do not have on-line access to the Member Portal, please contact the Plan Administrator or your Employer. You are entitled to paper copies of Pharmacy Benefit information materials, including this document, free of charge upon request to the Plan Administrator.

PREVENTIVE CARE

The Plan adheres to the preventive care coverage requirements available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/, as updated from time to time. Items listed as A or B recommendations as a Preventive Service covered are not subject to co-payment or Deductible amounts.

The following over-the-counter medications are payable at 100%, Deductible and co-insurance waived, only when prescribed by a Physician or Licensed Health Care Provider as specifically covered as Recommended Preventive Services:

A. Aspirin to prevent cardiovascular disease (CVD) for men and women.
B. Oral fluoride supplementation.
C. Iron supplementation in children.
D. Supplementation with folic acid for all women capable of Pregnancy (daily supplement).

The Plan offers coverage for women's prescription contraceptives to include 100% coverage under the following guidelines. The Plan will not cover over-the-counter contraceptives (unless prescribed by a Physician or Licensed Health Care Provider and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act) or contraceptives for men. Coverage will be available through network retail or home delivery pharmacies.

The Plan will cover the following women's preventive care items:

- Oral contraceptives (birth control pills)
- Contraceptive patch
- Contraceptive ring
- Prescription diaphragm or cervical cap
- Prescription oral "morning after" pill (under age 17)

The following items are not covered by the Plan as women's preventive care:

- Over-the-counter (OTC) contraceptives, such as contraceptive sponges, spermicides, and non-prescription oral "morning after" pills, UNLESS prescribed by a Physician or Licensed Health Care Provider and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act
- Contraceptives obtained from non-network pharmacies
- Contraception methods for males
- IUDs (covered under medical benefit at 100%)
- Contraceptive implants (covered under medical benefit at 100%)

- Injectables that are not self-administered (covered under the medical benefit)

CO-PAYMENT, DEDUCTIBLE, AND MAXIMUMS

The insurance terms used in the Plan and Summary of Benefits and Coverage (SBC) are generally applied to Pharmacy Benefits in the same way they are applied to all Plan benefits. However, there are some distinctions including:

- For High Deductible Health Plan coverage, the full Plan Deductible (according to the applicable Coverage Option) must be satisfied before the Plan begins to pay Pharmacy Benefits (exception: preventive health services required under the ACA rules or permitted under the Health Savings Account safe harbor rules can be provided without a Deductible). The full Plan Out-of-Pocket Maximum applies to Pharmacy Benefits under High Deductible Health Plan coverage.
- For Comprehensive Health Plan coverage, there is no specific Deductible applicable to Pharmacy Benefits, and co-payments and co-insurance for Pharmacy Benefits do not count toward the full Plan Deductible.
- Discounts, coupons, or similar financial assistance provided by drug manufacturers or pharmacies to assist Participants in covering the cost of their Specialty Medications (including any Prescription Drug discounts and/or coupons provided to pharmacies when Participants fill a prescription) will not count towards a Participant's annual Deductible or maximum out-of-pocket requirement. Only the amount that a Participant pays separate and apart from the financial assistance will be credited as true out-of-pocket payment that will apply to the Participant's annual Deductible and maximum out-of-pocket requirement. Please see additional information under FLEX ACCESS below.

  For Example: If your Specialty Medication costs $100, and you use an $80 coupon or debit card and then pay the remaining $20 out of pocket, only the $20 will apply to your annual Deductible or maximum out-of-pocket limits.

The following definitions apply to these insurance terms (see https://www.cms.gov/cciio/resources/files/downloads/uniform-glossary-final.pdf):

- *Co-payment*: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the drug at the pharmacy. The amount can vary by the type of covered health care service.
- *Deductible:* The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.
- *Co-insurance*: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any Deductibles you owe.
- *Out-of-Pocket Limit*: The most you pay during a policy period (usually a year) before your health plan begins to pay 100% of the allowed amount.

Note below on the Schedule of Benefits that there are five benefit categories (Preventive Medications, Generics, Preferred Brand, Non-Preferred Brand, and Specialty Drugs). Also see the current per person and per family Deductible and/or out of pocket maximum you must pay in co-payments in a Benefit Period before the Plan pays 100%. The co-payment paid for Specialty Drugs purchased at a retail pharmacy may not apply to the Out-of-Pocket Maximum (see below for further information about Specialty Drugs). Items listed as A or B recommendations as a Preventive Service covered under the Affordable Care Act are not subject to co-payment or Deductible amounts.

FLEX ACCESS

The Plan participates in FlexAccess, effective February 1, 2023. Under this program, out-of-pocket costs for select drugs may be set to the max of the current design or be based on any available manufacturer-

funded assistance. Drug manufacturers may provide financial support for some, or all, of a Covered Person's out-of-pocket costs for select drugs. The Covered Person may be required to pay an amount typically $0 - $35.00 for select drugs. Any amount paid through drug manufacturer assistance program (e.g., manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) may not apply to the Covered Person's Deductible (if part of the Plan) or yearly Out-of-Pocket Maximum. The list of drugs covered under FlexAccess is subject to change. The Covered Person should call the toll-free telephone number on the back of their identification card, or FlexAccess at 1-888-302-3618, to determine whether a drug is covered under this program. If a Covered Person is taking a qualifying drug, a FlexAccess representative will contact the Covered Person to participate in the program. A Covered Person is not required to participate in this program; however, if they choose to opt-out of the program, or if they do not affirmatively enroll in any manufacturer's assistance, the Covered Person may be responsible for up to 100% of the cost of the drug. Please note there is a difference between opting out of the program and being ineligible for the program. Ineligibility may be due to a drug's exclusion from a drug manufacturer's assistance program or if a Covered Person switches to a drug that has no assistance program available or is taking a drug that is not on the FlexAccess Drug list. In the event a Covered Person is ineligible for the program, their cost for a select drug will be equal to the amount specified under this Plan.

HSA-QUALIFIED PLAN COVERAGE

For a High Deductible Health Plan Option that is HSA-Qualified, the Pharmacy Benefit Program is included in Medical Benefits and is subject to the Medical Benefits Deductible and Out-of-Pocket Maximum. Therefore, unless the medication is preventive, the Medical Benefits Deductible must be satisfied before any benefits are payable under the Pharmacy Benefit Program.

PARTICIPATING PHARMACY NETWORK

Prescription Drugs under this Benefit may be obtained using an Outpatient retail Pharmacy, an extended supply Pharmacy, or a mail-order Pharmacy approved by the Plan. To obtain a prescription from a Participating Pharmacy:

1. Go to a Prime Therapeutics Participating Pharmacy or a Participating Pharmacy that accepts the Covered Person's identification cards. To find a Prime Therapeutics Participating Pharmacy or a Participating Pharmacy nearest the Covered Person, 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 Covered Person's identification card to the pharmacist.
3. Make sure that the pharmacist has complete and correct information about the Covered Person for whom the prescription is written, including sex and date of birth.
4. When the Covered Person receives a prescription, they should sign the pharmacy log and pay their share of the cost.
5. If a Covered Person purchases Prescription Drugs from a Participating Pharmacy or mail-service Pharmacy approved by the Claim Administrator, the Covered Person must pay for the Prescription Drug Product and the pharmacy will submit the Prescription Drug claims to Pharmacy Benefit Manager.
6. The Plan makes use of a Drug List, which is a list of covered Prescription Drugs for dispensing to a Covered Person as appropriate.
7. Prescriptions filled at Hospital pharmacies are not eligible for reimbursement unless they are listed as a network pharmacy. Pharmacy Benefit Manager claim forms are available by calling the Claim Administrator at the telephone number on the inside cover of this document.

If drugs or Prescription Drug Products are purchased at a Participating Pharmacy, an extended supply Pharmacy, or a mail order Pharmacy approved by the Claim Administrator, and the Covered Person presents the Covered Person's identification card at the time of purchase, the Covered Person must pay any required Deductible, co-payment, and/or co-insurance.
If the Covered Person 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 Covered Person will be reimbursed for the Prescription Drug based on

the amount that would have been paid to the Participating Pharmacy, less the Covered Person's Deductible, co-payment, and/or co-insurance.

OUT-OF-NETWORK BENEFITS AVAILABLE TO CARD PROGRAM MEMBERS

Covered Persons may choose to purchase a prescription from a pharmacy that does not participate in the network. To be reimbursed, Covered Persons must follow these procedures:

1. Covered Persons must pay the full cost to the non-network pharmacy at the time the prescription is received.

2. Covered Persons must obtain a reimbursement form from the Pharmacy Supervisor and send the completed form and proof of drug purchase to the Pharmacy Supervisor. The Pharmacy Supervisor will process the claim for reimbursement for the amount allowed under the Plan.

   To receive assistance, contact the Pharmacy Supervisor, Prime Therapeutics, using the number listed on the first page of this Pharmacy Benefit Appendix.

3. In no case will the reimbursement exceed the cost for the same drug purchased at a network pharmacy.

MAIL SERVICE PHARMACY PROGRAM

The Covered Person may obtain maintenance prescriptions through the mail. Maintenance prescriptions are those that the Covered Person 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 this Pharmacy Benefit Program Appendix.

To obtain a mail service claim form, call the Pharmacy Supervisor at 1-866-325-5230.

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 Covered Person's current pharmacy telephone number and prescription numbers to be transferred; and
   c. The Covered Person's telephone number.

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

The Plan offers two Mail Order Pharmacy Program options:

Express Scripts
P.O. Box 66577
St. Louis, MO 63166-6577
1-833-715-0942

Ridgeway Mail-Order Pharmacy
2824 US Hwy 93 North
Victor, MT 59875
1-800-630-3214
Prescription Drug Products provided by a mail-order Pharmacy that is not approved by the Plan are not covered.

APPEAL OF PRESCRIPTION DRUGS BENEFITS DENIED IN WHOLE OR PART

The PROCEDURES FOR CLAIMING BENEFITS contained in this document, including the timelines and notification requirements detailed in that section, apply to adverse claims determinations related to Pharmacy Benefits. **As further discussed in the PROCEDURES FOR CLAIMING BENEFITS contained in the Plan document, this Plan provides 2 levels of benefit determination review and the Claimant must exercise both levels of review before bringing a civil action.** The first level appeal of an Adverse Benefit Determination related to Pharmacy Benefits must be made in writing (or orally by the attending Physician in the case of an Adverse Benefit Determination rendered on an Urgent Care Claim) and submitted to the Claim Administrator within 180 days of the notification of such Adverse Benefit Determination.

SPECIALTY MEDICATIONS

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

For the highest level of Benefits, Specialty Medications must be acquired through the Plan's contracted Specialty Care Pharmacy (BCBSMT Speciality Pharmacy Network)
www.bcbsmt.com or www.myprime.com
1-833-721-1619
Prescriber Fax: 1-888-302-1028

A list of covered Specialty Medications may be found on the Plan website at www.bcbsmt.com. Registration and other applicable forms are also located on the website.

If a Covered Person is using a specialty pharmacy medication, the Covered Person will be eligible to receive additional services when filling specialty prescriptions through the Plan's contracted specialty pharmacies. In some cases, Covered Persons will be required to purchase medications for certain diseases or conditions at a preferred specialty pharmacy that is considered a "center of excellence" for management of that particular disease and its corresponding drug distribution. These pharmacies may differ from the Plan's foundation specialty pharmacy. Information related to the Plans preferred specialty pharmacy arrangements are provided upon request.

These additional services may include:

- Support and guidance from nurses and pharmacists who are trained in these medications, their side effects, and the conditions they treat
- Expedited delivery of all specialty prescription medications
- Scheduling of refills and coordination of services with home care providers, case managers, and doctors or other health care professionals

Self-administered medications available through the specialty program may include, but are not limited to, drugs for the following conditions:

- Rheumatoid Arthritis, Crohn's, and Psoriasis

- Growth Hormones
- Multiple Sclerosis
- Hepatitis C
- Osteoporosis
- Pulmonary Arterial Hypertension
- Hematological Disorders like Hemophilia
- Neoplastic Disease or Cancer treatments

Specialty pharmacy medications are limited to a 30-day supply (and in some cases, for example drugs for cancer treatment, initial 14 day supplies will be dispensed to determine tolerability) due to restrictions on dosing, drug safety, frequent changes in therapy, and the need to minimize waste when not tolerated. 90-day supplies of Specialty Medications will require prior approval by the appropriate Pharmacy Supervisor's utilization management team.

Most medications in the specialty pharmacy program require a pre-certification to be considered for Plan coverage (See Prior Authorization below). In certain therapy categories, a drug management plan that specifies member responsibilities may be part of the pre-certification process.

Covered Person co-payments for Specialty Medications are tiered using flat dollar amounts (see the Schedule of Benefits). The Plan may provide Specialty Drug benefits from a limited group of manufacturers and some may not be offered through the Plan. Also, not all Specialty Drugs from all manufacturers are categorized as essential health benefits (as defined by the ACA) by the Plan, which means the drug may not be covered or that the co-payment or co-insurance for that drug will not count toward the Plan's or the Pharmacy Benefit's Out-of-Pocket Maximum. For questions or concerns about Specialty Drug benefits or payments, a Covered Person may contact the Pharmacy Supervisor at the numbers above or request a review by the Claim Administrator described in the PROCEDURES FOR CLAIMING BENEFITS contained in the Plan document.

PRIOR AUTHORIZATION, STEP THERAPY, DISPENSING LIMITS

Prescription Drug Products subject to Prior Authorization require prior approval from the Plan's Pharmacy Benefit Manager before they can qualify for coverage under the Plan. To determine which medications are subject to Prior Authorization, the Covered Person or provider should refer to the list of medications which applies to the Covered Person's Plan on the Pharmacy Supervisor's website at www.bcbsmt.com or call the Customer Service toll-free number identified on the Covered Person's identification card. If the Covered Person does not obtain Prior Authorization before a Prescription Drug Product is dispensed, the Covered Person 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 Covered Person should then submit a claim for the Prescription Drug on a prescription claim form to the Plan's Pharmacy Benefit Manager for reimbursement.

Prior Authorization does not guarantee payment of the Prescription Drug Product by the Plan. Even if the Prescription Drug has been approved through Prior Authorization, coverage or payment can be affected for a variety of reasons. For example, the Covered Person may have become ineligible as of the date the drug is dispensed, or the Covered Person's Benefits may have changed as of the date the drug is dispensed.

The step therapy program requires that the Covered Person has a prescription history for a prerequisite medication before the Plan will cover a targeted drug. If the Covered Person and his/her doctor decide that a prerequisite drug is not right for the Covered Person or is not as good in treating Covered Person's condition, the doctor should submit a Prior Authorization request for coverage of the second-line drug.

A dispensing limit is a limitation on the number or amount of a Prescription Drug Product covered within a certain time period and quantity of covered medication per prescription. Dispensing limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, appropriate utilization,

and to avoid misuse/abuse of the medication. A prescription written for a quantity in excess of the established limit will require a clinical review before Benefits are available.

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

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

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

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

COORDINATION OF BENEFITS

The Coordination of Benefits provisions of this Plan do not apply to the Pharmacy Benefit Program and the Plan does not coordinate benefits with regard to Prescription Drug Charges, except for coordination with Medicare Part D.

VACCINATIONS

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

Each select Participating Pharmacy that has contracted with the Pharmacy Supervisor to provide this service may have age, scheduling, or other requirements that will apply, so the Covered Person 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 Plan's Medical Benefits.

LIMITATIONS/EXCLUSIONS

Please see the Plan Section titled GENERAL PLAN EXCLUSIONS AND LIMITATIONS for exclusions that apply to this Prescription Drug Benefit. As stated above, the Pharmacy Benefit Program does not cover medications which are administered by a Licensed Health Care Provider. If a medication is

administered by a Licensed Health Care Provider, the claim will process under the Covered Person's Medical Benefits.

Charges for drugs which require a Physician's prescription are covered by this Plan under the Pharmacy Benefit, except for the following which are specifically excluded or limited:

devices and appliances*	non-legend drugs
durable medical supplies*	Rogaine, Minoxidil, or similar products
anorexiants (weight reduction)	vitamins**
Experimental or Investigational drugs	Cosmetic drugs
fertility drugs	abortifacient drugs
Retin-A	compounded drugs and bulk powders.

*Eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.
**Excluded unless prescribed by a Physician for under Preventive Care benefits.

The Plan will not cover any Prescription Drug refilled in excess of the number specified by the Participant's Physician or any refill dispensed after one year from the Physician's original order. The Plan will not cover replacement Prescription Drugs due to loss, theft, or spoilage. The Plan will not cover Prescription Drugs obtained from a pharmacy located outside the United States for consumption within the United States.

For information regarding Prior Authorization, contact the Pharmacy Benefit Manager.

MEDICARE PART D

Depending on the Plan Option, Covered Employees who are entitled to Medicare may have creditable or non-creditable Prescription Drug coverage. Medicare-eligible Covered Persons will be informed whether the Plan Option provides Creditable Coverage for purposes of Medicare Part D.

SCHEDULE OF BENEFITS

The following schedule may be updated from time to time. Please visit www.myprime.com for the most current information.

SCHEDULE OF BENEFITS

Medication Classification	Retail Rx (30-day supply)	Retail Rx (90-day supply)	Mail Order Rx (90-day supply)
ACA Preventive Drugs	$0 Co-payment	$0 Co-payment	$0 Co-payment
Generics	$15 Co-payment	$30 Co-payment	$30 Co-payment
Preferred Brand	$40 Co-payment	$80 Co-payment	$80 Co-payment
Non-Preferred Brand	$60 Co-payment	$120 Co-payment	$120 Co-payment
Specialty	$200 Co-payment*		

With the exception of certain designated Preventive Medications, Covered Persons on a High Deductible Health Plan (HDHP) Option will pay 100% of the cost of their medications until their medical plan Deductible is met. There is no prescription Deductible for Comprehensive Health Plan Options.

***The Plan applies a variable co-payment to some Specialty Drugs as described in the Pharmacy Benefit Program Appendix.**

Check www.bcbsmt.com and www.myprime.com for updates.

SUMMARY PLAN DESCRIPTION INFORMATION APPENDIX

INTRODUCTION

This Plan Information Appendix is intended to complete the Summary Plan Description content requirements for the Plan. As used in this document, “we,” “us,” and “our” refers to the Plan Administrator. “You” and “your” refers to Employees and Physicians in your workplace (and their Eligible Family Members) who are eligible to participate in, or are covered by, the Plan (also called Covered Persons or Participants).

Benefits under the Plan are provided through a Trust funded by participating employer groups. These “Participating Employers” subscribe to the Trust, become members of the Plan Sponsor, and adopt the Plan according to separate agreements. You are receiving this document because the entity for whom you work is one of the Participating Employers.

PLAN AND TRUST MANAGEMENT AND ADMINISTRATION

The HPMPT Sponsor Organization, Inc. is the “Plan Sponsor” which acts like a collective “employer” representing the sponsorship interests of the Participating Employers. The HPMPT Sponsor Organization, Inc. acts by and through its board of directors, which is called the “Sponsor Board.” The Sponsor Organization may employ a plan manager and other individuals to run the day-to-day operations and maintenance of the Plan.

The Trust’s operations are directed by a Board of Trustees. The Board of Trustees also serves as the “Plan Administrator,” which is ultimately responsible for making decisions affecting Plan administration. In addition, the Plan Administrator has delegated many administrative responsibilities to the Executive Director and other Employees of the Plan Sponsor, the Claim Administrator, and other third-parties. Sometimes a plan manager or third-party is referred to as a “plan administrator,” but the only legal “Plan Administrator” is the Board of Trustees.

PLAN SPONSOR

The HPMPT Sponsor Organization, Inc. is the “Plan Sponsor.” The HPMPT Sponsor Organization, Inc. is a Montana nonprofit mutual benefit corporation and a tax-exempt entity under Internal Revenue Code Section 501(c)(4). The Participating Employers are eligible members of the HPMPT Sponsor Organization, Inc., with the authority to elect members of the board of directors (the “Sponsor Board”) in accordance with the bylaws of the Plan Sponsor.

The Plan Sponsor maintains the name, address, and employer tax identification number submitted by each Participating Employer. You and your beneficiaries may receive from the Plan Sponsor, upon written request, information as to whether a particular Employer is a Participating Employer, and, if the Employer is a Participating Employer, the Participating Employer’s address.

The name, address and telephone number of the Plan Sponsor is:

HPMPT Sponsor Organization, Inc.
c/o HPMPT Executive Director
P.O. Box 9406
Missoula, MT 59807 Telephone: 1-406-443-4919

EMPLOYER AND PLAN IDENTIFICATION NUMBER

The employer tax identification number (EIN) assigned to the HPMPT Sponsor Organization, Inc. is 45-2078503.

The employer tax identification number (EIN) assigned to the Trust is 71-1029753.

The Plan Identification Number is 550.

PLAN TRUSTEES

The name, title, and address of the principal place of business of the Trustees of the Plan is:

> HPMPT Board of Trustees
> P.O. Box 9406
> Missoula, MT 59807 Telephone: 1-406-443-4919

PLAN ADMINISTRATOR

The name, address and telephone number of the Plan Administrator is:

> HPMPT Plan Administrator
> P.O. Box 9406
> Missoula, MT 59807 Telephone: 1-406-443-4919

PLAN ADMINISTRATOR – NAMED FIDUCIARY – POWERS AND DUTIES

The administration of the Plan is under the supervision of the Plan Administrator, acting as plan administrator and named fiduciary under ERISA § 401(b)(2).

Plan Administrator Powers. In carrying out its responsibilities under the Plan, the Plan Administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the Plan and to make all fiduciary decisions under the Plan and has all power and authority that may be necessary or helpful to accomplish such purposes. All decisions by the Plan Administrator shall be final, conclusive, and binding on all persons. The Plan Administrator's powers include, but are not limited to:

- making and enforcing such rules and regulations as in its sole and absolute and uncontrolled discretion it deems necessary or proper for the efficient administration of the Plan which are not inconsistent with the terms of the Plan or ERISA;

- interpreting the Plan and all documents governing the Plan in order to make Plan eligibility and benefit determinations in its discretion and in good faith, which interpretation is final, conclusive, and binding on all persons;

- resolving any inconsistency or ambiguity within or among the documents governing the Plan, and creating written policies or other documentation regarding such resolutions as it deems appropriate in its sole discretion;

- resolving all ambiguities under the Plan and among all documents and circumstances relating to the Plan, including making factual determinations when there is an uncertainty in the documentation or circumstances regarding an individual’s rights under the Plan;

- compensating Plan service providers from Plan assets only to the extent such compensation is reasonable and the services are necessary for Plan administration or Plan asset management and are not otherwise prohibited by ERISA;

- resolving uncertainties regarding whether funds are "plan assets" as defined by ERISA, and determining whether charges to Plan assets are appropriate and not otherwise prohibited by ERISA;

- using, employing, discharging, or consulting with one or more persons or entities with respect to advice regarding any responsibility in connection with the Plan and Trust;

- forming one or more committees or subcommittees to carry out the powers and duties of Plan Administrator;

- Making factual determinations and construing the facts in contested cases involving whether benefits should be payable under the Plan;

- having all other fiduciary powers permissible under the law;

- allocating responsibilities among fiduciaries, provided that such allocation is according to a written instrument expressly identifying the individuals responsible, and expressly describing the nature and scope of the allocated responsibilities;

- delegating other persons or entities to carry out its responsibilities, including fiduciary duties (whether or not expressly identified as such), provided that such delegation is according to a written instrument expressly identifying the delegate(s) and expressly describing the nature and scope of the delegated responsibility; and

- revoking or modifying any delegation or allocation by written instrument.

Plan Administrator Duties. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. Such duties are governed by ERISA and include, but are not limited to:

- following the terms of the Plan to the extent unambiguous and consistent with ERISA;

- giving reasonable notice of the availability and terms of the Plan to Eligible Employees from time to time;

- reviewing Participant or beneficiary appeals of Adverse Benefit Determinations;

- keeping accurate Plan records for a period of six years;

- obtaining a fidelity bond for the Plan, if applicable;

- filing such annual reports and making such other disclosures to the federal government and to the Participants at such times and in such manner as is required by ERISA and other applicable federal law;

- prudently monitoring individuals selected to perform administrative services to the Plan; and

- supervising the Plan's compliance with applicable federal and state laws.

Without limiting the ultimate discretionary authority of the Plan Administrator and Named Fiduciary, the following general rules may apply to any fiduciary of the Plan:

a. any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan or Trust and may serve in fiduciary and non-fiduciary capacities with respect to the Plan;

b. a named fiduciary (such as the Plan Administrator), or a fiduciary designated by a named fiduciary, may employ or engage one or more persons to render advice with regard to any responsibility such fiduciary has under the Plan or Trust;

c. any named fiduciary with respect to control or management of the assets of the Plan (if any) may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan;

d. fiduciaries may allocate responsibilities among themselves, provided that such allocation is according to a written instrument expressly identifying the individuals responsible and expressly describing the nature and scope of the allocated responsibilities; *provided however that trustee investment duties cannot be delegated except to an "investment manager" in accordance with ERISA;*

e. fiduciaries may, subject to their legal duty to prudently select and monitor, delegate other persons or entities to carry out their responsibilities, including fiduciary duties even if such delegated responsibilities are not identified as "fiduciary" in nature, provided that such delegation is according to a written instrument (or third-party administration agreement) expressly identifying the delegate(s) and expressly describing the nature and scope of the delegated responsibilities; *provided however that trustee investment duties cannot be delegated except to an "investment manager" in accordance with ERISA*; and

f. Plan fiduciaries may revoke or modify any such delegation or allocation by written instrument.

In the event of any delegation or allocation by or approved by the Plan Administrator in accordance with this Plan, no individual fiduciary shall be liable for any act, whether of commission or omission, taken by the person to whom the delegation or allocation is made. Except as otherwise required by ERISA's co-fiduciary rules, properly allocated or delegated responsibilities shall be exercised severally and not jointly and each fiduciary's powers, duties, obligations, and responsibilities shall be limited to those specifically allocated to such fiduciary.

The Plan Administrator shall, in all cases, retain the general duty of supervision of other administration and Plan service providers, as well as any powers and duties that the Plan Administrator, in its sole discretion, determines have not been effectively delegated to others.

<u>PLAN RECORDS AND PLAN YEAR</u>

The fiscal records for the Plan are maintained and reported based on the Plan Year, which is the 12-month period beginning each January 1 and ending each December 31. The first Plan Year was a short Plan Year, beginning on May 1, 2008 and ending on December 31, 2008.

<u>Note</u>: The Plan Year is often different from a Participating Employer's group policy renewal year (also called "Enrollment Year"). Each Employer has its own Enrollment Year because it is tied to the anniversary of the date each Employer originally joined the Trust (the "effective date"). Contact the Plan Administrator or your Employer if you are not certain of your Employer's Enrollment Year or Open Enrollment period.

<u>SOURCE AND AMOUNT OF CONTRIBUTIONS</u>

Monthly Trust Contributions ("premiums") to the Trust are made by a Participating Employer and may be funded partly by contributions or salary reductions from a Participating Employer's covered Participants. Participating Employers determine what portion of the benefits must be paid by the Participating Employer and what portion must be paid by its covered Participants. However, your employer cannot require you to pay more than 50% of the premium for any of the Medical Benefits Plan Options. The Trust

may adjust this percentage in the future. Any amounts paid by a Participating Employer will be paid out of such Participating Employer's general assets.

Monthly Trust Contributions ("premiums") do not include the "service fee" paid by your Participating Employer to the Plan Sponsor for sponsorship services, including settlor expenses and certain marketing and promotion expenses. The service fee is directed to an account segregated from the Trust account. Although the service fee is included in monthly invoices, the service fee is separately identified as a separate item on billing statements.

Your Participating Employer has agreed that it will not require or permit you to pay, directly or indirectly, any part of this service fee. The service fee is separated from each group's premium on their annual rating quote, so that each group can properly calculate Participant contributions to only the premium. If you have any concerns about this, please contact your Employer or the Plan Sponsor.

PAYMENT OF BENEFITS

Even though we sometimes use the term "policy" or "premium" because they are commonly understood, your benefits are not paid through insurance policies. All benefits provided under the Plan are self-funded because all Participating Employers make monthly contributions (like "premiums") to the Trust Fund. Then the Trust funds are used to pay benefits to Covered Persons. If benefit claims exceed certain specific or aggregate levels, then the Plan's "stop-loss" insurance policy will reimburse the Trust so that it can pay the claims, but the stop-loss insurer does not pay any benefits directly.

The primary function of the Trust Fund is to receive and hold Employer and Employee contributions and to pay claims and Plan expenses. Because the Plan is not funded with insurance, generally only the Trust and your Participating Employer are responsible for payment of your benefits. Participating Employers other than your Employer are generally not responsible for payment of your benefits under the Plan.

TYPE OF PLAN ADMINISTRATION – THIRD-PARTY

As discussed above, the Plan Administrator delegates claims handling and other administration to a third-party, often identified as the Claim Administrator. The Plan is administered by contract with the "Claim Administrator." Blue Connections' administrative services may include: enrollment, claims administration, COBRA Continuation Coverage administration, Health Insurance Portability and Accountability Act ("HIPAA") administration, administration of Qualified Medical Child Support Orders ("QMCSOs"), coordination of benefits (including Medicare coordination), Subrogation, cost containment, financial, banking, and billing.

The address and telephone number of the Claim Administrator:

HPMPT Claim Administrator
P.O. Box 7982
Helena, MT 59604- 7982
1-855-322-4953

NAME AND ADDRESS OF AGENT FOR LEGAL PROCESS

Service of legal process may be made upon a Plan Trustee or the Plan Administrator or the designated agent for legal process. The name and address of the designated agent for service of legal process for the Plan is:

HPMPT
c/o Larsen Law, PLLC, Attn: Dave Larsen
412 S. King Ave, Suite 105
Middleton, ID, 83644
1-208-810-4333

PLAN DOCUMENTS

The Plan Document means this Plan Document and Summary Plan Description and other documents that are specifically incorporated by reference herein; and also including any formal interpretations or policies adopted or approved by the Plan Administrator. Upon written request to the Plan Administrator, copies of any or all of the Plan Documents will be furnished to you or your beneficiary at no charge or a nominal charge. You may inspect the Plan Documents by contacting the Plan Administrator to arrange a meeting at the Plan's administrative office in Helena, Montana.

AMENDMENT AND TERMINATION OF PLAN

The Sponsor Board, on behalf of the Participating Employers, has established the Plan with the bona fide intention and expectation that it will continue indefinitely, but it reserves the right to amend or terminate the Plan (including any or all of the Plan Options and any part of the Plan Documents such as the Participating Employer adoption agreement), in whole or in part, at any time, without liability. This includes, without limitation, the right to increase or decrease the Participating Employers' contribution rates or service fees or the Participants' contribution requirements at any time, and to modify all or any part of the coverage with respect to any or all of the Participants covered.

Participating Employers are encouraged to make recommendations to the Sponsor Board for Plan design improvements. However, Participating Employers cannot unilaterally amend the Plan (or the Adoption Agreement after it is submitted to the Trust). Any attempted amendment, modification, or termination must be made or approved by the Plan Sponsor. The name, address, and telephone number of the Plan Sponsor is:

HPMPT Sponsor Organization, Inc.
P.O. Box 9406
Missoula, MT 59807 Telephone: 1-406-443-4919

Any termination of the Plan or Trust will be in accordance with the provisions of the Plan, the Trust Agreement, and the Plan Sponsor's bylaws then in effect and the agreements under which the Participating Employers adopted the Plan and subscribed to the Trust. Upon termination or discontinuance of the Plan or Trust (including any or all of the Medical Benefit Plan Options), you will not have any further rights, other than for the payment of benefits for covered losses or expenses incurred before the date of termination. The amount and form of any final benefit you or your beneficiary receive will depend on the Plan Documents then in effect and the Plan Administrator's decisions.

CHILDREN'S HEALTH INSURANCE PROGRAM NOTICE

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44

U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Notice of Privacy Practices
for
Health Professions of Montana Plan and Trust

You are receiving this notice because you are or may become covered, through your Employer, by a group health plan (referred to herein as the "Health Plan" or "we" or "us") sponsored by the Health Professions of Montana Plan and Trust Sponsor Organization ("HPMPT") and available to you through your Employer.

This notice describes how medical information about you may be used and disclosed by the HPMPT and how you can get access to this information. **Please review it carefully.**

If you have questions about whether a particular program is subject to this notice, contact the HPMPT HIPAA Privacy Officer using the contact information below:

HPMPT HIPAA Privacy Officer
P.O. Box 9406
Missoula, MT 59807
(406)-443-4919

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication about your health and claims records
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information when we are taking the following actions:

- Answering coverage questions from your family and friends
- Providing disaster relief
- Marketing our services and selling your information

Our Uses and Disclosures
We may use and share your information in order to:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan, including making decisions about paying claims
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and we must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these situations, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these situations, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to HPMPT or your Employer for plan administration.

Example: Your Employer contracts with us to provide a health plan, and we provide your Employer with certain statistics to explain the premiums we charge.

Example: You appeal a denied claim and we provide HPMPT with information about the claim and the denial in accordance with the Health Plan's procedures for appeals.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director if you die.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.