SECOND CORRECTED AMENDMENT #2
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION
FOR THE
HEALTH BENEFIT PLAN FOR EMPLOYEES OF
HELENA SCHOOL DISTRICT #1 - GROUP 3000684

Effective October 1, 2021, the Health Benefit Plan for Employees of Helena School District #1 is amended as follows:

"**PROVIDER BENEFIT**" section is added immediately following "**INTRODUCTION**" section as follows:

PROVIDER BENEFIT

TIER 1 PROVIDER

Services provided by Tier 1 providers are payable as stated in the Schedule of Medical Benefits.

Tier 1 providers include St. Peter's Hospital Facility, St. Peter's Hospital Professional Providers and St. Peter's Hospital Urgent Care Facility.

TIER 2 PROVIDER

Services provided by Tier 2 providers are payable as stated in the Schedule of Medical Benefits.

Tier 2 providers include all other covered providers that agree to provide services.

Please visit Allegiance's website at www.askallegiance.com/HSD1 to access links for directories of available providers.

The "**MEDICAL BENEFIT PLAN OPTIONS COST SHARING PROVISIONS**" section is deleted in its entirety.

The "**SCHEDULE OF MEDICAL BENEFITS**" is renamed and replaced as follows:

SCHEDULE OF MEDICAL BENEFITS - PREMIUM PLAN
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND MAXIMUM ELIGIBLE EXPENSE (MEE) OR UP TO THE PROCEDURE BASED LIMIT

BENEFIT PERIOD IS A TWELVE MONTH PERIOD
(OCTOBER 1 THROUGH SEPTEMBER 30 OF EACH SUCCEEDING YEAR)

COST SHARING PROVISIONS PER BENEFIT PERIOD	**TIER 1**	**TIER 2**
DEDUCTIBLE (Embedded) Per Covered Person Per Family	 $0 $0	 $500 $1,000
Deductible applies to all benefits unless specifically indicated as waived.		
BENEFIT PERCENTAGE Before Out-of-Pocket Maximum After Out-of-Pocket Maximum	 100% 100%	 80% 100%
Benefit Percentage applies after applicable Deductible is satisfied and applies to all benefits unless specifically stated otherwise.		
COPAYMENT Deductible is waived if Copayment applies. Copayment applies to all charges billed by the same provider on the same day including, but not limited to: evaluation and management, diagnostic lab, X-ray, office surgery, diagnostic miscellaneous testing and allergy injections. Copayments do not apply towards the Deductible, but do apply towards the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.		
OUT-OF-POCKET MAXIMUM (Embedded) Per Covered Person Per Family	 $2,000 $3,000	
Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. Pharmacy Copayments do apply toward the applicable Pharmacy Benefit Deductible and Out-of-Pocket Maximum. Out-of-Pocket Maximums cross accumulate between the Network and Non-Network Out-of-Pocket Maximums.		
MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES	None	
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	None	

COST SHARING PROVISIONS PER BENEFIT PERIOD	TIER 1	TIER 2
PRE-CERTIFICATION/PRE-TREATMENT REVIEW Pre-certification or Pre-treatment Review by the Plan is strongly recommended for certain services. If Pre-certification or Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted. Except for Genetic Therapy (Cellular Therapy and Gene Therapy), pre-certification is strongly recommended for Inpatient Hospital admissions or to notify the Plan of an emergency admission. Pre-certification is required for Genetic Therapy (Cellular Therapy and Gene Therapy) within 24 hours before scheduled Inpatient Hospital admission or as soon as is reasonable possible for non-scheduled admissions, including Emergency admissions. **Failure to obtain Pre-Certification Genetic Therapy will result in a denial of benefits.** **See Hospital Admission Certification and Pre-Treatment Review for further details.**		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
ACCIDENTAL INJURY BENEFIT		
	100%	100%, Deductible Waived
Does not include charges for Chiropractic Care, Physical, Occupational and Speech Therapy.		
ACUPUNCTURE TREATMENT		
	No Benefit	No Benefit
ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)		
	100%	80% after Deductible
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY		
Inpatient Facility Services	80%	80%, Deductible Waived
Inpatient Professional Provider Services	100%	100%, Deductible Waived
Outpatient Facility Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
Office Visit Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
ALLERGY TREATMENT		
Office Visit	100% after $10 Primary Care Physician or $40 Specialty Care Physician Copayment	80% after Deductible
Diagnostic Testing	100%	80% after Deductible
Injection and Serum	100%	80% after Deductible
Copayment is waived when an office visit charge is not assessed.		
AMBULANCE SERVICE		
Air Ambulance	80% after Tier 2 Deductible	
Ground Ambulance	80% after Tier 2 Deductible	
AMBULATORY SURGICAL CENTER		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
AUTISM SPECTRUM DISORDER (ASD) AND/OR DOWN SYNDROME BENEFIT		
	Not Available	100% after $10 Copayment, Deductible Waived
Includes certain treatments associated with Autism Spectrum Disorder (ASD) and/or Down Syndrome for Dependent children eighteen (18) years of age or younger.		
BARIATRIC SURGERY		
	Not Available	80% after Deductible
Benefit limits: limited to one (1) procedure, up to $22,500 Maximum Lifetime Benefit. Includes complications. **Benefit is limited to Employees covered under this Plan as either a Participant or a covered Dependent. Covered Dependents who are <u>not</u> Employees are not eligible for this benefit.**		
BIRTHING CENTER		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
CARDIAC REHABILITATION THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
CHEMOTHERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
CHIROPRACTIC CARE		
	Not Available	80% after Deductible
Benefit Limits: 35 Treatments Maximum Benefit per Benefit Period $25 Maximum Benefit per Treatment $100 Maximum Benefit for Diagnostic X-rays per Benefit Period Treatment includes all services provided during a calendar day, except for X-rays. **Benefit limits are for services received from all Providers.**		
COLONOSCOPY		
Routine Colonoscopy	100%	100%, Deductible Waived
Diagnostic Colonoscopy Facility Services	100% after $10 Copayment	80% after Deductible
Diagnostic Colonoscopy Professional Provider Services	100% after $10 Copayment	80% after Deductible
Benefit Limits: Diagnostic Colonoscopy limited to $1,900 Maximum Benefit per procedure. **Benefit limits are for services received from all Providers.**		
CONTRACEPTIVES (Including Contraceptive Management)		
Administered during Office Visit	100%	100%, Deductible Waived
See Pharmacy Benefit for details if obtained from a Pharmacy.		
DIABETIC EDUCATION		
	100%	80% after Deductible
Benefit Limits: $250 Maximum Benefit per Benefit Period. Benefit includes Outpatient self-management training and education for the treatment of diabetes. Such training and education must be provided by a Provider with expertise in diabetes. **Benefit limits are for services received from all Providers.**		
DIAGNOSTIC TESTS - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
DIALYSIS TREATMENTS - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
EATING DISORDER BENEFIT		
	100%	80% after Deductible
Benefit Limits: $2,000 Maximum Benefit per Benefit Period $6,000 Maximum Lifetime Benefit per Covered Person Benefit limits do not apply to psychological/psychiatric services. **Benefit limits are for services received from all Providers.**		
EMERGENCY ROOM SERVICES		
Facility Services for Emergency	100% after $250 Copayment, Deductible Waived	
Professional Provider Services for Emergency	Tier 2 Deductible, then 100% after $10 Copayment	
Facility Services for non-emergency	No Benefit	No Benefit
Professional Provider Services for non-emergency	100% after $10 Copayment	80% after Deductible
Copayment is waived if admitted as Inpatient immediately following the emergency room. If admitted as Inpatient from the Emergency Room, Inpatient Hospital benefits will apply.		
GENETIC THERAPY DRUGS		
	100%	75% after Deductible
HEARING AIDS / BAHA (Includes exam and fitting)		
Preventive Hearing Exam	100%	100%, Deductible Waived
Diagnostic Hearing Services	100%	80% after Deductible
Hearing Aid	100%	80% after Deductible
Bone Anchored Hearing Aid (BAHA)	100%	80% after Deductible
Benefit Limits: Hearing Aids limited to one (1) per ear per 3 Benefit Periods up to $2,500. (Includes exam and fitting. Bone Anchored Hearing Aid (BAHA) limited to one (1) per ear up to $10,000 Maximum Lifetime Benefit. **Benefit limits are for services received from all Providers.** See Medical Benefits for further details.		
HOME HEALTH CARE		
	100%	50%, Deductible Waived
Benefit Limits: 2 visits per day, up to $50 per visit Maximum Benefit per Benefit Period. **Benefit limits are for services received from all Providers.**		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
HOSPICE CARE		
Inpatient Facility Services	80%	80% after Deductible
Inpatient Professional Provider Services	100%	80% after Deductible
Outpatient Facility Services	100% after $10 Copayment	80% after Deductible
Outpatient Professional Provider Services	100% after $10 Copayment	80% after Deductible
HOSPITAL SERVICES		
Inpatient Facility Services	80%	80% after Deductible
Inpatient Professional Provider Services	100%	80% after Deductible
Outpatient Facility Services	100% after $10 Copayment	80% after Deductible
Outpatient Professional Provider Services	100% after $10 Copayment	80% after Deductible
INFERTILITY		
Diagnostic testing to determine infertility	100%	80% after Deductible
Infertility Treatment	No Benefit	No Benefit
INFUSION SERVICES - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
MAMMOGRAMS		
Routine Mammograms	100%	100%, Deductible Waived
Diagnostic Mammograms Facility Services	100% after $10 Copayment	80% after Deductible
Diagnostic Mammograms Professional Provider Services	100% after $10 Copayment	80% after Deductible
MEDICAL EQUIPMENT/SUPPLIES		
Durable Medical Equipment	100%	80%, Deductible Waived
Prosthetic Appliances	100%	80%, Deductible Waived
Orthopedic Devices	100%	80%, Deductible Waived
Other Medical Supplies	100%	80% after Deductible
Repair or Replacement	100%	50% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
MENTAL ILLNESS		
Inpatient Facility Services	80%	80%, Deductible Waived
Inpatient Professional Provider Services	100%	100%, Deductible Waived
Outpatient Facility Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
Office Visit Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
NATUROPATHY/HOMEOPATHIC		
	No Benefit	No Benefit
NON-AMBULANCE TRAVEL BENEFIT		
	80% after Tier 2 Deductible	
Benefit Limits: $5,000 Maximum Lifetime Benefit, limited to: Coach airfare. If driving, IRS standard mileage rate reimbursement. Meals limited to $50 per day per person. Lodging not to exceed $125 per day. For the patient and one companion, limited to travel to a contracted Center of Excellence if treatment at a contracted Center of Excellence is more cost effective than the same treatment if received from other providers.		
OCCUPATIONAL THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
OFFICE VISIT		
Primary Care Physician	100% after $10 Copayment	80% after Deductible
Specialty Care Physician	100% after $40 Copayment	80% after Deductible
ORGAN AND TISSUE TRANSPLANT SERVICES		
Inpatient Facility Services	80% after Deductible	80% after Deductible
Inpatient Professional Provider Services	100%	80% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
PHYSICAL THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
PREGNANCY/MATERNITY SERVICES		
Office Visit (if not part of a global fee)	100% after $10 Copayment	80% after Deductible
Inpatient Facility Services	80%	80% after Deductible
Inpatient Professional Provider Services	100%	80% after Deductible
Outpatient Facility Services	100% after $10 Copayment	80% after Deductible
Outpatient Professional Provider Services	100% after $10 Copayment	80% after Deductible
See Preventive Care Benefit for well-women prenatal visits.		
PREMIER JOINT REPLACEMENT PROVIDER BENEFIT		
	100%, Deductible Waived	
Benefit Limits: Maximum Benefit per joint replacement procedure: Knee Replacement . . . . . $33,358.54 Hip Replacement . . . . . $33,358.54 Maximums apply to all services charged by the facility, physician/surgeon, assisting surgeon, surgical assistant and anesthesiology associated with the knee or hip joint replacement procedure during Inpatient stay. Procedures must be performed at a Premier Joint Replacement Provider. "Premier Joint Replacement Provider" means a provider contracted with the Plan Supervisor to accept a single specified fee for all services related to knee or hip joint replacement from the date of the Hospital admission to the date of discharge. **Pre-treatment Review by the Plan is strongly recommended for all joint replacement procedures. If a provider is utilized other than a Premier Joint Replacement Provider, cost sharing and balance billing for excessive charges may result.**		
PRESCRIPTION DRUGS		
	See Pharmacy Benefit for Details	
PREVENTIVE CARE		
	100%	100%, Deductible Waived
If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
RADIATION THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
RESIDENTIAL TREATMENT FACILITY, PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT SERVICES		
Inpatient Facility Services	Not Available	80%, Deductible Waived
Inpatient Professional Provider Services	Not Available	100%, Deductible Waived
Outpatient Facility Services	Not Available	100% after $10 Copayment, Deductible Waived
Outpatient Professional Provider Services	Not Available	100% after $10 Copayment, Deductible Waived
RESPIRATORY THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
ROUTINE FOOT CARE		
Facility Services	80%	80% after Deductible
Professional Provider Services	100%	80% after Deductible
Benefit Limits: $2,000 Maximum Benefit per Benefit Period. **Benefit limits are for services received from all Providers**		
ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE		
Facility Services	80%	80% after Deductible
Professional Provider Services	100%	80% after Deductible
Non-Routine Newborn Care applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section. See Preventive Care Benefit for Well-Child Care.		
SKILLED NURSING FACILITY		
Facility Services	80%	80% after Deductible
Professional Provider Services	100%	80% after Deductible
SPEECH THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
STERILIZATION PROCEDURES		
Female Sterilization Procedures	100%	100%, Deductible Waived
Vasectomy Inpatient Facility Services	80%	80% after Deductible
Vasectomy Inpatient Professional Provider Services	100%	80% after Deductible
Vasectomy Outpatient Facility Services	100% after $10 Copayment	80% after Deductible
Vasectomy Outpatient Professional Provider Services	100% after $10 Copayment	80% after Deductible
SURGERY - OUTPATIENT		
Facility Services	100% after $10 Copayment	80% after Deductible
Professional Provider Services	100% after $10 Copayment	80% after Deductible
SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES		
Facility Services	80%	80% after Deductible
Professional Provider Services	100%	80% after Deductible
TELEMEDICINE		
	100%, Deductible Waived	
TMJ/JAW DISORDERS		
	No Benefit	No Benefit
URGENT CARE FACILITY		
	100% after $25 Copayment	80% after Deductible
VOLUNTARY SECOND AND THIRD SURGICAL OPINION BENEFIT		
	100%	100%, Deductible Waived
Benefit Limits: $100 Maximum Benefit per Eligible Surgical Opinion.		
WALK-IN RETAIL HEALTH CLINIC		
Riverwood Health Montana Medical Clinic	100% after $25 Copayment	
Walk-In Retail Health Clinic limited to Riverwood Health Montana Medical Clinic.		

The "**SCHEDULE OF MEDICAL BENEFITS - STANDARD PLAN**" is added immediately following the "**SCHEDULE OF MEDICAL BENEFITS - PREMIUM PLAN**", as renamed and amended above, as follows:

SCHEDULE OF MEDICAL BENEFITS - STANDARD PLAN
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND MAXIMUM ELIGIBLE EXPENSE (MEE) OR UP TO THE PROCEDURE BASED LIMIT

BENEFIT PERIOD IS A TWELVE MONTH PERIOD
(OCTOBER 1 THROUGH SEPTEMBER 30 OF EACH SUCCEEDING YEAR)

COST SHARING PROVISIONS PER BENEFIT PERIOD	**TIER 1**	**TIER 2**
DEDUCTIBLE (Embedded) Per Covered Person Per Family	 $0 $0	 $1,000 $2,000
Deductible applies to all benefits unless specifically indicated as waived.		
BENEFIT PERCENTAGE Before Out-of-Pocket Maximum After Out-of-Pocket Maximum	 100% 100%	 70% 100%
Benefit Percentage applies after applicable Deductible is satisfied and applies to all benefits unless specifically stated otherwise.		
COPAYMENT Deductible is waived if Copayment applies. Copayment applies to all charges billed by the same provider on the same day including, but not limited to: evaluation and management, diagnostic lab, X-ray, office surgery, diagnostic miscellaneous testing and allergy injections. Copayments do not apply towards the Deductible, but do apply towards the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.		
OUT-OF-POCKET MAXIMUM (Embedded) Per Covered Person Per Family	 $5,000 $10,000	
Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. Pharmacy Copayments do apply toward the applicable Pharmacy Benefit Deductible and Out-of-Pocket Maximum. Out-of-Pocket Maximums cross accumulate between the Network and Non-Network Out-of-Pocket Maximums.		
MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES	None	
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	None	

COST SHARING PROVISIONS PER BENEFIT PERIOD	TIER 1	TIER 2
PRE-CERTIFICATION/PRE-TREATMENT REVIEW Pre-certification or Pre-treatment Review by the Plan is strongly recommended for certain services. If Pre-certification or Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted. Except for Genetic Therapy (Cellular Therapy and Gene Therapy), pre-certification is strongly recommended for Inpatient Hospital admissions or to notify the Plan of an emergency admission. Pre-certification is required for Genetic Therapy (Cellular Therapy and Gene Therapy) within 24 hours before scheduled Inpatient Hospital admission or as soon as is reasonable possible for non-scheduled admissions, including Emergency admissions. **Failure to obtain Pre-Certification Genetic Therapy will result in a denial of benefits.** **See Hospital Admission Certification and Pre-Treatment Review for further details.**		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
ACCIDENTAL INJURY BENEFIT		
	100%	100%, Deductible Waived
Does not include charges for Chiropractic Care, Physical, Occupational and Speech Therapy.		
ACUPUNCTURE TREATMENT		
	No Benefit	No Benefit
ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)		
	100%	70% after Deductible
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY		
Inpatient Facility Services	70%	70%, Deductible Waived
Inpatient Professional Provider Services	100%	100%, Deductible Waived
Outpatient Facility Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
Office Visit Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
ALLERGY TREATMENT		
Office Visit	100% after $10 Primary Care Physician or $40 Specialty Care Physician Copayment	70% after Deductible
Diagnostic Testing	100%	70% after Deductible
Injection and Serum	100%	70% after Deductible
Copayment is waived when an office visit charge is not assessed.		
AMBULANCE SERVICE		
Air Ambulance	70% after Tier 2 Deductible	
Ground Ambulance	70% after Tier 2 Deductible	
AMBULATORY SURGICAL CENTER		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
AUTISM SPECTRUM DISORDER (ASD) AND/OR DOWN SYNDROME BENEFIT		
	Not Available	100% after $10 Copayment, Deductible Waived
Includes certain treatments associated with Autism Spectrum Disorder (ASD) and/or Down Syndrome for Dependent children eighteen (18) years of age or younger.		
BARIATRIC SURGERY		
	Not Available	70% after Deductible
Benefit limits: limited to one (1) procedure, up to $22,500 Maximum Lifetime Benefit. Includes complications. **Benefit is limited to Employees covered under this Plan as either a Participant or a covered Dependent. Covered Dependents who are <u>not</u> Employees are not eligible for this benefit.**		
BIRTHING CENTER		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
CARDIAC REHABILITATION THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
CHEMOTHERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
CHIROPRACTIC CARE		
	Not Available	70% after Deductible
Benefit Limits: 35 Treatments Maximum Benefit per Benefit Period $25 Maximum Benefit per Treatment $100 Maximum Benefit for Diagnostic X-rays per Benefit Period Treatment includes all services provided during a calendar day, except for X-rays. **Benefit limits are for services received from all Providers.**		
COLONOSCOPY		
Routine Colonoscopy	100%	100%, Deductible Waived
Diagnostic Colonoscopy Facility Services	100% after $10 Copayment	70% after Deductible
Diagnostic Colonoscopy Professional Provider Services	100% after $10 Copayment	70% after Deductible
Benefit Limits: Diagnostic Colonoscopy limited to $1,900 Maximum Benefit per procedure. **Benefit limits are for services received from all Providers.**		
CONTRACEPTIVES (Including Contraceptive Management)		
Administered during Office Visit	100%	100%, Deductible Waived
See Pharmacy Benefit for details if obtained from a Pharmacy.		
DIABETIC EDUCATION		
	100%	70% after Deductible
Benefit Limits: $250 Maximum Benefit per Benefit Period. Benefit includes Outpatient self-management training and education for the treatment of diabetes. Such training and education must be provided by a Provider with expertise in diabetes. **Benefit limits are for services received from all Providers.**		
DIAGNOSTIC TESTS - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
DIALYSIS TREATMENTS - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
EATING DISORDER BENEFIT		
	100%	70% after Deductible
Benefit Limits: $2,000 Maximum Benefit per Benefit Period $6,000 Maximum Lifetime Benefit per Covered Person Benefit limits do not apply to psychological/psychiatric services. **Benefit limits are for services received from all Providers.**		
EMERGENCY ROOM SERVICES		
Facility Services for Emergency	100% after $250 Copayment, Deductible Waived	
Professional Provider Services for Emergency	Tier 2 Deductible, then 100% after $10 Copayment	
Facility Services for non-emergency	No Benefit	No Benefit
Professional Provider Services for non-emergency	100% after $10 Copayment	70% after Deductible
Copayment is waived if admitted as Inpatient immediately following the emergency room. If admitted as Inpatient from the Emergency Room, Inpatient Hospital benefits will apply.		
GENETIC THERAPY DRUGS		
	100%	75% after Deductible
HEARING AIDS / BAHA (Includes exam and fitting)		
Preventive Hearing Exam	100%	100%, Deductible Waived
Diagnostic Hearing Services	100%	70% after Deductible
Hearing Aid	100%	70% after Deductible
Bone Anchored Hearing Aid (BAHA)	100%	70% after Deductible
Benefit Limits: Hearing Aids limited to one (1) per ear per 3 Benefit Periods up to $2,500. (Includes exam and fitting. Bone Anchored Hearing Aid (BAHA) limited to one (1) per ear up to $10,000 Maximum Lifetime Benefit. **Benefit limits are for services received from all Providers.** See Medical Benefits for further details.		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
HOME HEALTH CARE		
	100%	50%, Deductible Waived
Benefit Limits: 2 visits per day, up to $50 per visit Maximum Benefit per Benefit Period. **Benefit limits are for services received from all Providers.**		
HOSPICE CARE		
Inpatient Facility Services	70%	70% after Deductible
Inpatient Professional Provider Services	100%	70% after Deductible
Outpatient Facility Services	100% after $10 Copayment	70% after Deductible
Outpatient Professional Provider Services	100% after $10 Copayment	70% after Deductible
HOSPITAL SERVICES		
Inpatient Facility Services	70%	70% after Deductible
Inpatient Professional Provider Services	100%	70% after Deductible
Outpatient Facility Services	100% after $10 Copayment	70% after Deductible
Outpatient Professional Provider Services	100% after $10 Copayment	70% after Deductible
INFERTILITY		
Diagnostic testing to determine infertility	100%	70% after Deductible
Infertility Treatment	No Benefit	No Benefit
INFUSION SERVICES - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
MAMMOGRAMS		
Routine Mammograms	100%	100%, Deductible Waived
Diagnostic Mammograms Facility Services	100% after $10 Copayment	70% after Deductible
Diagnostic Mammograms Professional Provider Services	100% after $10 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
MEDICAL EQUIPMENT/SUPPLIES		
Durable Medical Equipment	100%	70%, Deductible Waived
Prosthetic Appliances	100%	70%, Deductible Waived
Orthopedic Devices	100%	70%, Deductible Waived
Other Medical Supplies	100%	70% after Deductible
Repair or Replacement	100%	50% after Deductible
MENTAL ILLNESS		
Inpatient Facility Services	70%	70%, Deductible Waived
Inpatient Professional Provider Services	100%	100%, Deductible Waived
Outpatient Facility Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
Office Visit Services	100% after $10 Copayment	100% after $10 Copayment, Deductible Waived
NATUROPATHY/HOMEOPATHIC		
	No Benefit	No Benefit
NON-AMBULANCE TRAVEL BENEFIT		
	70% after Tier 2 Deductible	
Benefit Limits: $5,000 Maximum Lifetime Benefit, limited to: Coach airfare. If driving, IRS standard mileage rate reimbursement. Meals limited to $50 per day per person. Lodging not to exceed $125 per day. For the patient and one companion, limited to travel to a contracted Center of Excellence if treatment at a contracted Center of Excellence is more cost effective than the same treatment if received from other providers.		
OCCUPATIONAL THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
OFFICE VISIT		
Primary Care Physician	100% after $10 Copayment	70% after Deductible
Specialty Care Physician	100% after $40 Copayment	70% after Deductible
ORGAN AND TISSUE TRANSPLANT SERVICES		
Inpatient Facility Services	70%	70% after Deductible
Inpatient Professional Provider Services	100%	70% after Deductible
PHYSICAL THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
PREGNANCY/MATERNITY SERVICES		
Office Visit (if not part of a global fee)	100% after $10 Copayment	70% after Deductible
Inpatient Facility Services	70%	70% after Deductible
Inpatient Professional Provider Services	100%	70% after Deductible
Outpatient Facility Services	100% after $10 Copayment	70% after Deductible
Outpatient Professional Provider Services	100% after $10 Copayment	70% after Deductible
See Preventive Care Benefit for well-women prenatal visits.		
PREMIER JOINT REPLACEMENT PROVIDER BENEFIT		
	100%, Deductible Waived	

Benefit Limits: Maximum Benefit per joint replacement procedure:

Knee Replacement $33,358.54
Hip Replacement $33,358.54

Maximums apply to all services charged by the facility, physician/surgeon, assisting surgeon, surgical assistant and anesthesiology associated with the knee or hip joint replacement procedure during Inpatient stay.

Procedures must be performed at a Premier Joint Replacement Provider. “Premier Joint Replacement Provider” means a provider contracted with the Plan Supervisor to accept a single specified fee for all services related to knee or hip joint replacement from the date of the Hospital admission to the date of discharge.

Pre-treatment Review by the Plan is strongly recommended for all joint replacement procedures. If a provider is utilized other than a Premier Joint Replacement Provider, cost sharing and balance billing for excessive charges may result.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
PRESCRIPTION DRUGS		
	See Pharmacy Benefit for Details	
PREVENTIVE CARE		
	100%	100%, Deductible Waived
If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.		
RADIATION THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
RESIDENTIAL TREATMENT FACILITY, PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT SERVICES		
Inpatient Facility Services	Not Available	70%, Deductible Waived
Inpatient Professional Provider Services	Not Available	100%, Deductible Waived
Outpatient Facility Services	Not Available	100% after $10 Copayment, Deductible Waived
Outpatient Professional Provider Services	Not Available	100% after $10 Copayment, Deductible Waived
RESPIRATORY THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
ROUTINE FOOT CARE		
Facility Services	70%	70% after Deductible
Professional Provider Services	100%	70% after Deductible
Benefit Limits: $2,000 Maximum Benefit per Benefit Period. **Benefit limits are for services received from all Providers.**		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE		
Facility Services	70%	70% after Deductible
Professional Provider Services	100%	70% after Deductible
Non-Routine Newborn Care applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section. See Preventive Care Benefit for Well-Child Care.		
SKILLED NURSING FACILITY		
Facility Services	70%	70% after Deductible
Professional Provider Services	100%	70% after Deductible
SPEECH THERAPY - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
STERILIZATION PROCEDURES		
Female Sterilization Procedures	100%	100%, Deductible Waived
Vasectomy Inpatient Facility Services	70%	70% after Deductible
Vasectomy Inpatient Professional Provider Services	100%	70% after Deductible
Vasectomy Outpatient Facility Services	100% after $10 Copayment	70% after Deductible
Vasectomy Outpatient Professional Provider Services	100% after $10 Copayment	70% after Deductible
SURGERY - OUTPATIENT		
Facility Services	100% after $10 Copayment	70% after Deductible
Professional Provider Services	100% after $10 Copayment	70% after Deductible
SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES		
Facility Services	70%	70% after Deductible
Professional Provider Services	100%	70% after Deductible
TELEMEDICINE		
	100%, Deductible Waived	
TMJ/JAW DISORDERS		
	No Benefit	No Benefit
URGENT CARE FACILITY		
	100% after $25 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
VOLUNTARY SECOND AND THIRD SURGICAL OPINION BENEFIT		
	100%	100%, Deductible Waived
Benefit Limits: $100 Maximum Benefit per Eligible Surgical Opinion.		
WALK-IN RETAIL HEALTH CLINIC		
Riverwood Health Montana Medical Clinic	100% after $25 Copayment	
Walk-In Retail Health Clinic limited to Riverwood Health Montana Medical Clinic.		

Within "**MEDICAL BENEFITS**", item 1 is replaced as follows:

1. Charges made by a Hospital for:

   A. Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit.

   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 room use for an Emergency 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.

   D. Therapy which has been prescribed by a speech pathologist or Physician and includes a written treatment plan with estimated length of time for therapy. Treatment rendered for stuttering or for behavioral or learning disorders is excluded.

Within **"MEDICAL BENEFIT EXCLUSIONS",** items 9 and 26 and 27 are replaced as follows:

9. Charges in connection with eye refractions, the purchase or fitting of eyeglasses or contact lenses. **This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.**

26. Charges for hearing aids, supplies and tinnitus maskers, except as specifically covered.

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

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

HELENA SCHOOL DISTRICT #1

BY: _____

TITLE: _____