PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

for the

HEALTH BENEFIT PLAN
FOR EMPLOYEES OF
HELENA SCHOOL DISTRICT # 1

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

The Plan has been established for the benefit of
eligible Employees and their Dependents of:

HELENA SCHOOL DISTRICT #1

Claims Processed By:

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
2806 South Garfield Street
Missoula, MT 59801

Missoula Area Phone Number: (406) 721-2222
Toll-Free Number: (855) 999-8878

COVER/SIGNATURE PAGE

Effective October 1, 2025, Helena School District #1 restates its self-funded Health Care Plan for the benefit of eligible Employees and their eligible Dependents entitled, HEALTH BENEFIT PLAN FOR EMPLOYEES OF HELENA SCHOOL DISTRICT #1 (the Plan).

The purpose of this Plan is to provide reimbursement for Expenses Incurred for covered services, treatment or supplies as a result of Medically Necessary treatment for Illness or Injury of the District's eligible Employees and their eligible Dependents. The District, in conjunction with any required contributions by its Employees, agrees to make payments to the Plan's Trust in order for payments to be made for covered services, treatments or supplies as provided by this Plan.

The District has caused this instrument to be executed as of the day first mentioned above.

HELENA SCHOOL DISTRICT #1

BY: ____________________________________

TITLE: ____________________________________

TABLE OF CONTENTS

INTRODUCTION

Effective October 1, 2025, Helena School District #1, hereinafter referred to as the District, restates its benefits, rights and privileges which will pertain to participating Employees, referred to as Participants, and the eligible Dependents of such Participants, as defined, and which benefits are provided through a fund established by the District and referred to as the Plan. This booklet describes the Plan in effect as of October 1, 2025.

Coverage provided under this Plan for Employees and their Dependents will be in accordance with the Eligibility, Effective Date, Qualified Medical Child Support Order, Termination, Family and Medical Leave Act and other applicable provisions as stated in this Plan.

Helena School District #1 (the Plan Sponsor and the Plan Administrator) has retained the services of an independent Plan Supervisor, experienced in claims processing, to handle health claims. The Plan Supervisor for the Plan is:

Allegiance Benefit Plan Management, Inc. (Allegiance)
2806 South Garfield Street
Missoula, Montana 59801

Please read this booklet carefully before incurring any medical expenses. For specific questions regarding coverage or benefits, please refer to the Plan Document/Summary Plan Description. As a result of current health care reform laws that may require plan changes during the year, this Plan Document/Summary Plan Description will not be provided in paper format until all changes are made. This Plan Document/Summary Plan Description will be posted and available in electronic format on the Helena School District's intranet website for viewing and it can be downloaded. In addition, a paper copy of this Document may be requested at no cost from the Helena School District Personnel Benefits Office, or call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions concerning the Plan.

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

The information contained in this Plan Document/Summary Plan Description is only a general statement regarding FMLA, COBRA, USERRA, and QMCSO. It is not intended to be and should not be relied upon as complete legal information about those subjects. Covered Persons and Employers should consult their own legal counsel regarding these matters.

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

Prior Authorization or Pre-certification is required for certain services. If Prior Authorization or Pre-certification is not obtained, benefits will not be paid when the claim is submitted. See Hospital Admission Certification and Pre-treatment Review for further details.

To obtain Pre-certification, Pre-treatment Review or Prior-Authorization, call the utilization management company at (800) 342-6510.

PARTICIPATING PROVIDER BENEFIT

This Plan provides benefits through a group of Participating Providers. A "Participating Provider" means a provider that agrees to provide services as part of an agreement. Using Participating Providers offers cost-saving advantages because a Covered Person pays only a percentage of the scheduled fee for services provided.

A "Non-Participating Provider" means a provider who is not a Participating Provider. A Covered Person who uses a Non-Participating Provider will pay more and may result in balance billing.

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

TIER 1 PROVIDER

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

Tier 1 Participating 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 Participating Providers (Participating Providers) are payable as stated in the Schedule of Medical Benefits.

Tier 2 Participating 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.

NON-PARTICIPATING PROVIDER BENEFIT EXCEPTION

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

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

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

3. Charges for Emergency use of an Air Ambulance.

TRANSITION OF CARE

Certain Eligible Expenses that would have been considered at the Network benefit level by the prior claims administrator but which are not considered at the Network benefit level by the current Plan Supervisor may be paid at the applicable Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous Network but who is not a member of the Plan's current Network in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the Network medical plan benefit level may continue for ninety (90) days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

1. Cancer if under active treatment with chemotherapy and/or radiation therapy.
2. Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
3. If the Covered Person is Inpatient in a Hospital on the effective date.
4. Post acute Injury or surgery within the past three (3) months.
5. Pregnancy in the second or third trimester and up to eight (8) weeks postpartum.
6. Behavioral health - any previous treatment.
7. Receiving care for end-stage renal disease or dialysis.
8. Terminally ill, with anticipated life expectancy of six months or less.

To be eligible for this benefit, call the customer service number listed on the Participant's identification card.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

CONTINUITY OF CARE

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

1. Pregnancy in the second or third trimester or postpartum care;
2. Continuation of treatment for a chronic or acute medical condition;
3. Active care at an Inpatient facility;
4. A disabling, degenerative, congenital or life threatening Illness;
5. Ongoing treatment of a terminal illness or serious medical condition; or
6. A Mental Illness or Alcohol and/or Chemical Dependency condition.

To be eligible for this benefit, call the customer service number listed on the Participant's identification card.

SCHEDULE OF MEDICAL BENEFITS - OPTION 1
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)

<table>
<tr><th>COST SHARING PROVISIONS</th><th>TIER 1</th><th>TIER 2</th></tr>
<tr><td>DEDUCTIBLE (Embedded)
Per Covered Person per Benefit Period
Per Family per Benefit Period</td><td>
$0
$0</td><td>
$1,500
$3,000</td></tr>
<tr><td colspan="3">Deductible applies to all benefits unless specifically indicated as waived.</td></tr>
<tr><td>BENEFIT PERCENTAGE
Before Out-of-Pocket Maximum
After Out-of-Pocket Maximum</td><td>
100%
100%</td><td>
70%
100%</td></tr>
<tr><td colspan="3">Benefit Percentage applies after applicable Deductible is satisfied and applies to all benefits unless specifically stated otherwise.</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td>OUT-OF-POCKET MAXIMUM (Embedded)
Per Covered Person per Benefit Period
Per Family per Benefit Period</td><td colspan="2">
$4,000
$8,000</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td>MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES</td><td colspan="2">None</td></tr>
<tr><td>MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES</td><td colspan="2">None</td></tr>
</table>

COST SHARING PROVISIONS	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: 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 not 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	100% after $25 Copayment, Deductible Waived, up to $50 Maximum Benefit per Treatment
Benefit Limits: ♦ 25 Treatments Maximum Benefit per Benefit Period ♦ $100 Maximum Benefit for Diagnostic X-rays per Benefit Period Treatment includes all services provided during a calendar day, except for X-rays.		
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 $3,500 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%	70% after Deductible
Professional Provider Services	100%	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 are for services received from all providers.** Benefit limits do not apply to psychological/psychiatric services.		
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%	70% 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% after Deductible
Prosthetic Appliances	100%	70% after Deductible
Orthopedic Devices	100%	70% after Deductible
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		
	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 Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable) if treatment at a Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable) is more cost effective than the same treatment if received from other providers.

TYPE OF SERVICE / LIMITATIONS	TIER 1	TIER 2
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	
Applies only to non-complicated scheduled knee and hip replacement procedures. This is bundled service offered by some hospitals in Montana. The fees for this service are generally less than from other providers for the same services. Please contact Allegiance for further information about specific hospitals and prices.		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2
PREVENTIVE CARE		
	100%	100%, Deductible Waived

Covered Services:
- ♦ Well-Child Care
- ♦ Physical examinations
- ♦ Pelvic examination and pap smear
- ♦ Laboratory and testing
- ♦ Hearing and vision screening
- ♦ Breast cancer screening (e.g., Mammograms, Magnetic Resonance Imaging (MRIs), Ultrasounds and similar breast cancer screening services)
- ♦ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE)
- ♦ Cardiovascular screening blood tests
- ♦ Colorectal cancer screening tests
- ♦ Vaccinations and Immunizations recommended by Physician
- ♦ BRCA1 and BRCA2 when medically indicated
- ♦ Nutritional counseling
- ♦ Well Women Preventive Care subject to Plan limitations on sterilization procedures

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

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

TYPE OF SERVICE / LIMITATIONS	TIER 1	TIER 2
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

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2
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.**		
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	70%	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

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2
TELEMEDICINE		
	100%, Deductible Waived	
TMJ/JAW DISORDERS		
	No Benefit	No Benefit
URGENT CARE SERVICES		
	100% after $25 Copayment	70% 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		
	100% after $25 Copayment	No Benefit

SCHEDULE OF MEDICAL BENEFITS - OPTION 2
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	PARTICIPATING PROVIDERS
DEDUCTIBLE (Embedded) Per Covered Person per Benefit Period Per Family per Benefit Period	 $3,000 $6,000
Deductible applies to all benefits unless specifically indicated as waived.	
BENEFIT PERCENTAGE Before Out-of-Pocket Maximum After Out-of-Pocket Maximum	 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 Benefit Period Per Family per Benefit Period	 $7,000 $14,000
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.	
MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES	None
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	None

COST SHARING PROVISIONS	PARTICIPATING PROVIDERS

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 for 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 PARTICIPATING PROVIDERS
ACCIDENTAL INJURY BENEFIT	
	100%, Deductible Waived
Does not include charges for Chiropractic Care, Physical, Occupational and Speech Therapy.	
ACUPUNCTURE TREATMENT	
	No Benefit
ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET Imaging, etc.)	
	70% after Deductible
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY	
Inpatient Facility Services	70%, Deductible Waived
Inpatient Professional Provider Services	100%, Deductible Waived
Outpatient Facility Services	100% after $10 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after $10 Copayment, Deductible Waived
Office Visit Services	100% after $10 Copayment, Deductible Waived
ALLERGY TREATMENT	
Office Visit	70% after Deductible
Diagnostic Testing	70% after Deductible
Injection and Serum	70% after Deductible
AMBULANCE SERVICE	
Air Ambulance	70% after Deductible
Ground Ambulance	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT PARTICIPATING PROVIDERS
AMBULATORY SURGICAL CENTER	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
AUTISM SPECTRUM DISORDER (ASD) AND/OR DOWN SYNDROME BENEFIT	
	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	
	70% after Deductible
Benefit limits: 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 not Employees are not eligible for this benefit.**	
BIRTHING CENTER	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
CARDIAC REHABILITATION THERAPY - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
CHEMOTHERAPY - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
CHIROPRACTIC CARE	
	100% after $25 Copayment, Deductible Waived, up to $50 Maximum Benefit per Treatment
Benefit Limits: ♦ 25 Treatments Maximum Benefit per Benefit Period ♦ $100 Maximum Benefit for Diagnostic X-rays per Benefit Period Treatment includes all services provided during a calendar day, except for X-rays.	
COLONOSCOPY	
Routine Colonoscopy	100%, Deductible Waived
Diagnostic Colonoscopy Facility Services	70% after Deductible
Diagnostic Colonoscopy Professional Provider Services	70% after Deductible
Benefit Limits: Diagnostic Colonoscopy limited to $3,500 Maximum Benefit per procedure.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT PARTICIPATING PROVIDERS
CONTRACEPTIVES (Including Contraceptive Management)	
Administered during Office Visit	100%, Deductible Waived
See Pharmacy Benefit for details if obtained from a Pharmacy.	
DIABETIC EDUCATION	
	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.	
DIAGNOSTIC TESTS - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
DIALYSIS TREATMENTS - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
EATING DISORDER BENEFIT	
	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.	
EMERGENCY ROOM SERVICES	
Facility Services for Emergency	70% after Deductible
Professional Provider Services for Emergency	70% after Deductible
Facility Services for non-emergency	No Benefit
Professional Provider Services for non-emergency	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	
	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT PARTICIPATING PROVIDERS
HEARING AIDS / BAHA (Includes exam and fitting)	
Preventive Hearing Exam	100%, Deductible Waived
Diagnostic Hearing Services	70% after Deductible
Hearing Aid	70% after Deductible
Bone Anchored Hearing Aid (BAHA)	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. See Medical Benefits for further details.	
HOME HEALTH CARE	
	50%, Deductible Waived
Benefit Limits: 2 visits per day, up to $50 per visit Maximum Benefit per Benefit Period.	
HOSPICE CARE	
Inpatient Facility Services	70% after Deductible
Inpatient Professional Provider Services	70% after Deductible
Outpatient Facility Services	70% after Deductible
Outpatient Professional Provider Services	70% after Deductible
HOSPITAL SERVICES	
Inpatient Facility Services	70% after Deductible
Inpatient Professional Provider Services	70% after Deductible
Outpatient Facility Services	70% after Deductible
Outpatient Professional Provider Services	70% after Deductible
INFERTILITY	
Diagnostic testing to determine infertility	70% after Deductible
Infertility Treatment	No Benefit
INFUSION SERVICES - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
MAMMOGRAMS	
Routine Mammograms	100%, Deductible Waived
Diagnostic Mammograms Facility Services	70% after Deductible
Diagnostic Mammograms Professional Provider Services	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT PARTICIPATING PROVIDERS
MEDICAL EQUIPMENT/SUPPLIES	
Durable Medical Equipment	70% after Deductible
Prosthetic Appliances	70% after Deductible
Orthopedic Devices	70% after Deductible
Other Medical Supplies	70% after Deductible
Repair or Replacement	50% after Deductible
MENTAL ILLNESS	
Inpatient Facility Services	70%, Deductible Waived
Inpatient Professional Provider Services	100%, Deductible Waived
Outpatient Facility Services	100% after $10 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after $10 Copayment, Deductible Waived
Office Visit Services	100% after $10 Copayment, Deductible Waived
NATUROPATHY/HOMEOPATHIC	
	No Benefit
NON-AMBULANCE TRAVEL BENEFIT	
	70% after 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 Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable) if treatment at a Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable) is more cost effective than the same treatment if received from other providers.	
OCCUPATIONAL THERAPY - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
OFFICE VISIT	
Primary Care Physician	70% after Deductible
Specialty Care Physician	70% after Deductible
ORGAN AND TISSUE TRANSPLANT SERVICES	
Inpatient Facility Services	70% after Deductible
Inpatient Professional Provider Services	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT PARTICIPATING PROVIDERS
PHYSICAL THERAPY - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
PREGNANCY/MATERNITY SERVICES	
Office Visit (if not part of a global fee)	70% after Deductible
Inpatient Facility Services	70% after Deductible
Inpatient Professional Provider Services	70% after Deductible
Outpatient Facility Services	70% after Deductible
Outpatient Professional Provider Services	70% after Deductible
See Preventive Care Benefit for well-women prenatal visits.	
PREMIER JOINT REPLACEMENT PROVIDER BENEFIT	
	100%, Deductible Waived
Applies only to non-complicated scheduled knee and hip replacement procedures. This is bundled service offered by some hospitals in Montana. The fees for this service are generally less than from other providers for the same services. Please contact Allegiance for further information about specific hospitals and prices.	
PREVENTIVE CARE	
	100%, Deductible Waived
Covered Services: ♦ Well-Child Care ♦ Physical examinations ♦ Pelvic examination and pap smear ♦ Laboratory and testing ♦ Hearing and vision screening ♦ Breast cancer screening (e.g., Mammograms, Magnetic Resonance Imaging (MRIs), Ultrasounds and similar breast cancer screening services) ♦ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ♦ Cardiovascular screening blood tests ♦ Colorectal cancer screening tests ♦ Vaccinations and Immunizations recommended by Physician ♦ BRCA1 and BRCA2 when medically indicated ♦ Nutritional counseling ♦ Well Women Preventive Care subject to Plan limitations on sterilization procedures Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT PARTICIPATING PROVIDERS
RADIATION THERAPY - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
RESIDENTIAL TREATMENT FACILITY, PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT SERVICES	
Inpatient Facility Services	70%, Deductible Waived
Inpatient Professional Provider Services	100%, Deductible Waived
Outpatient Facility Services	100% after $10 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after $10 Copayment, Deductible Waived
RESPIRATORY THERAPY - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
ROUTINE FOOT CARE	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
Benefit Limits: $2,000 Maximum Benefit per Benefit Period.	
ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE	
Facility Services	70% after Deductible
Professional Provider Services	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% after Deductible
Professional Provider Services	70% after Deductible
SPEECH THERAPY - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT PARTICIPATING PROVIDERS
STERILIZATION PROCEDURES	
Female Sterilization Procedures	100%, Deductible Waived
Vasectomy Inpatient Facility Services	70% after Deductible
Vasectomy Inpatient Professional Provider Services	70% after Deductible
Vasectomy Outpatient Facility Services	70% after Deductible
Vasectomy Outpatient Professional Provider Services	70% after Deductible
SURGERY - OUTPATIENT	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES	
Facility Services	70% after Deductible
Professional Provider Services	70% after Deductible
TELEMEDICINE	
	100%, Deductible Waived
TMJ/JAW DISORDERS	
	No Benefit
URGENT CARE SERVICES	
	100% after $25 Copayment, Deductible Waived
VOLUNTARY SECOND AND THIRD SURGICAL OPINION BENEFIT	
	100%, Deductible Waived
Benefit Limits: $100 Maximum Benefit per Eligible Surgical Opinion.	
WALK-IN RETAIL HEALTH CLINIC	
	100% after $25 Copayment, Deductible Waived

PHARMACY BENEFIT

Retirees or Dependents of Retirees who are sixty-five (65) years of age or older are not eligible for Pharmacy Benefits.

Prescription drug charges are payable only through the Plan's Pharmacy Benefit Manager (PBM) program (Rightway), which program is sponsored in conjunction with and is an integral part of this Plan. The PBM will provide separate information for details regarding Network pharmacies, Preferred Brand prescriptions and Specialty Drugs upon enrollment for coverage under this Plan.

Generic Preferred - Member Choice (DAW2): If the Physician does not prescribe Dispense as Written (DAW), and there is a generic alternative for the prescription drug, and the Covered Person chooses a brand name instead, the Covered Person must pay the difference in cost (penalty) between the generic and brand name medication plus the applicable brand Copayment amount. Penalty amount does not apply toward any Deductible or Out-of-Pocket Maximum and the penalty amount will continue to apply after the Out-of-Pocket Maximum has been met.

<u>COST SHARING PROVISIONS - OPTION 1 AND OPTION 2</u>

Pharmacy Deductible per Benefit Period

Per Covered Person. $100

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

Pharmacy Out-of-Pocket Maximum per Benefit Period

Per Covered Person. $700

Per Family $1,300

Pharmacy Out-of-Pocket Maximum includes the Pharmacy Deductible and any applicable Pharmacy Copayments. After satisfaction of the Pharmacy Out-of-Pocket Maximum, Copayments will no longer apply for the remainder of the Benefit Period. Pharmacy Copayments do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum.

Copayment per Prescription after Pharmacy Deductible				
Drug Type	**Retail PBM Network 34-day supply**	**Member Submit 34-day supply**	**Mail Order or Retail up to 90-day supply**	**Specialty Drug 90-day supply**
Generic	$12	$12	$24 up to 90-day supply	$24 up to 90-day supply
Preferred Brand	$40 + 40%	$40 + 40%	$104 up to 90-day supply	$104 up to 90-day supply
Non-Preferred Brand	$50 + 50%	$50 + 50%	$120 up to 90-day supply	$120 up to 90-day supply

Copayment per Prescription after Pharmacy Deductible
The following are payable at 100% and are not subject to any Deductible or Copayment: 1. Prescribed generic contraceptives or brand if generic is unavailable; 2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and 3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. 4. COVID-19 home tests up to 8 tests per month (2 kits).

COVERAGE

Coverage for prescription drugs will include only those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. Self-administered contraceptives, implantable contraceptives, and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider. Contraceptive Management, injectable contraceptives, contraceptive devices, diaphragms and cervical caps are covered under the Preventive Care Benefits of this Plan.

2. Diabetic supplies including: insulin and insulin pump supplies, syringes, needles, swabs, blood test strips, blood glucose calibration solutions, urine tests, lancets and lancet devices and OTC hyperglycemic products. Insulin pumps are covered under Medical Benefits, subject to all provisions and limitations of this Plan.

3. Blood monitors and kits. Blood monitors and kits are also eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

4. Smoking deterrents prescribed by a Physician or Licensed Health Care Provider and only if covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

5. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

6. Self-injectable medications including: Emergency allergic kits, glucagon kits, injectable migraine agents, androgens/anabolic steroids and leuprolide acetate 1 mg.

7. Hemophilia factors.

8. Supplements to treat specific medical conditions Rx and OTC (e.g., Nutren Renal).

9. Allergy extracts (oral only).

10. COVID-19 home tests up to 8 tests per month (2 kits).

11. Growth hormones. Prior Authorization required.

12. Compound medications. Prior Authorization required.

13. Syringes used to administer medication other than insulin.

SERVICE OPTIONS

PBM Network Prescriptions: Available only through a retail pharmacy that is part of the PBM Network. The pharmacy will bill the Plan directly for that part of the prescription cost that exceeds the Copayment (Copayment amount must be paid to pharmacy at time of purchase). The prescription identification card is required for this option.

Member Submit Prescriptions: Available only if the prescription identification card is not used at a PBM pharmacy. Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the PBM, along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription. Prescriptions obtained from a non-participating pharmacy are not allowed.

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. The pharmacy will bill the Plan directly for prescription costs that exceed the Copayment.

Specialty Drugs: Generic or non-generic drugs classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty Drugs must be obtained from a preferred specialty pharmacy. Only the first two prescriptions can be obtained at a network retail pharmacy. All subsequent refills must be obtained through a preferred specialty pharmacy. A list of Specialty Drugs and preferred specialty pharmacies may be obtained from the PBM or Plan Supervisor.

COPAY MAXIMIZATION AND ALTERNATIVE FUNDING (SPECIALTY DRUG) PROGRAM

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis.

Up to a 30-day supply of Specialty Drugs will be covered at a time. Specialty Drugs are only available through the approved Rightway specialty pharmacy network. The pharmacy network is subject to change. Not all Specialty Drugs are covered by the pharmacy benefit; some specialty drugs may be covered under the medical benefit.

Specialty Preferred Generic, Preferred Brand and Non-Preferred Brand Drugs are drugs on the Rightway Specialty Drug list that are covered under the pharmacy benefit at the designated tier. Specialty Drugs are required to be filled at a Rightway Specialty Network pharmacy.

Excluded Specialty Brand Drugs are Specialty Products listed on the Helena School District Specialty Program Drug list that are excluded from coverage under the pharmacy benefit. Enrollment in the Helena School District Specialty Program will allow Rightway to identify potential alternative funding programs for these select Specialty Drugs. If the Covered Person does not enroll in the Helena School District Specialty Program, the Covered Person will pay 100% of drug costs for the Helena School District Specialty Program drugs.

Discounts, coupons, or other similar financial assistance from alternative funding sources will not count towards any annual Deductible or Out-of-Pocket Maximum requirement. Only the amount the Covered Person pays will be credited as a true out-of-pocket payment that will apply towards the annual Deductible and Out-of-Pocket Maximum requirement.

The Specialty Program is not available in Georgia, Kentucky, Louisiana, North Carolina, Oklahoma, or Virginia. This list of excluded states is subject to change.

DRUG OPTIONS

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

Preferred Brand: Non-generic drugs and supplies listed as Preferred Brand by the PBM Program as stated in a written list provided to Covered Persons and updated from time to time.

Non-Preferred Brand: Copyrighted or patented brand name drugs (Non-Generic) which are not recognized or listed as Preferred Brand drugs or supplies by the PBM Program. On limited occasions a Generic may be included when specific regulatory or market places circumstances exist.

COPAYMENT

"Copayment" means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of service. Copayments are specifically stated in this section. Copayments are not payable by the Plan and do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments do apply towards the Pharmacy Out-of-Pocket Maximum and after satisfaction of the Pharmacy Out-of-Pocket Maximum, Copayments will no longer apply for the remainder of the Benefit Period.

PRIMARY COVERAGE UNDER ANOTHER PLAN

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

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

2. The prescription drug receipt and explanation of benefits from primary carrier showing the total charges and amounts paid for eligible prescription drugs, along with a reimbursement form must be submitted to Allegiance Benefit Plan Management, Inc, or through the PBM if primary coverage is Medicare Part D. This Plan will reimburse the Participant for the remainder of Eligible Expenses subject to the Copayments stated in this section. In order to receive reimbursement, the drug receipt must be submitted to the Pharmacy Benefit Manager.

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

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

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

SUPPLY LIMITS

Supply is limited to 34 days for PBM Network and Member Submit Prescriptions, or 90-day supply for Mail Order and Specialty Prescriptions.

Prescription drug refills are not allowed until 80% of the retail or 75% of the mail order prescribed day supply is used.

The amount of certain medications are limited to promote safe, clinically appropriate drug usage. Any additional prescribed supply exceeding any clinically appropriate limits will be reviewed for Medical Necessity. A current list of applicable quantity limits can be obtained by contacting the PBM at the number listed on the Participant's identification card.

PRIOR AUTHORIZATION

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

EXCLUSIONS

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

1. Cosmetic only indications including, but not limited to: photo-aged skin products (Renova), hair growth or hair removal agents (Propecia, Vaniqa) and injectable Cosmetics (Botox Cosmetic).
2. Dermatology: agents used in the treatment of acne and/or for Cosmetic purposes or depigmentation products used for skin conditions requiring a bleaching agent.
3. Legend homeopathic drugs.
4. Fertility agents; oral, vaginal and injectable.
5. Erectile dysfunction/impotency treatment.
6. Weight management.
7. Serums, toxoids and vaccines, except as specifically covered under the Affordable Care Act.
8. Legend vitamins and legend fluoride products, except as specifically covered under the Affordable Care Act.
9. Over-the-counter equivalents and non-legend medications (OTC), except as specifically covered under the Affordable Care Act.
10. Durable Medical Equipment.*
11. Experimental or Investigational drugs.
12. Abortifacient drugs.
13. Compounded pharmaceuticals containing bulk chemicals.
14. Addyi-HSDD.
15. Medical Foods.
16. Inhaler assisting devices. *
17. Rhogam.
18. Anabolic steroids.
19. Biologics, Allergy serums/Living Organism Products.
20. Blood and blood plasma.
21. Compound kits.
22. Diagnostic agents.

23. Implants. Products that are implanted within the body and cannot be self-administered.

24. Injectable medications that cannot be self-administered or those that require monitoring from a provider. *

25. Prescriptions obtained from a non-participating pharmacy.

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

NON-FORMULARY EXCLUSION

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

PHARMACY APPEALS

Information regarding appealing pharmacy benefit claims is found in the Procedures for Claiming Benefits section of this document.

MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

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

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider; and
2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary; and
3. Charges do not exceed the Eligible Expense of the Plan; and
4. They are not excluded under any provision or section of this Plan.

Treatments, services or supplies excluded by this Plan may be reimbursable if such charges are approved by the Plan Administrator prior to beginning such treatment. Prior approval is limited to medically accepted non-experimental or investigational treatments, services or supplies, which, in the opinion of the Plan Administrator, are more cost effective than a covered treatment, service or supply for the same Illness or Injury, and which benefit the Covered Person.

DEDUCTIBLE (Embedded)

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

If the Covered Person is in the Hospital on the last day of the Benefit Period and continuously confined beyond the first day of the next Benefit Period, only one Deductible amount will be applied to the Hospital charges for that hospital stay. If the Deductible has been satisfied prior to this hospital admission, no Deductible amount will be applied to the Hospital charges for that stay.

BENEFIT PERCENTAGE

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

OUT-OF-POCKET MAXIMUM (Embedded)

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, is stated in the Schedule of Medical Benefits and includes amounts applied toward the Deductible, amounts in excess of the Benefit Percentage paid by the Plan and all Copayments for Medical Benefits (Office Visit Benefit and St. Peter’s Hospital Urgent Care Facility). 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 receive credit toward the Family Out-of-Pocket Maximum for more than the Individual Out-of-Pocket Maximum as stated in the Schedule of Medical Benefits.

MAXIMUM BENEFIT

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

COMMON ACCIDENT PROVISION

If a Family incurs expenses from the same accident, only one Deductible will be applied to that Family in the Benefit Period in which the accident occurred.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

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

CHANGES IN COVERAGE CLASSIFICATION

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

MEDICAL BENEFITS

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

Prior Authorization or Pre-certification is required for certain services. If Prior Authorization or Pre-certification is not obtained, benefits will not be paid when the claim is submitted.

See Hospital Admission Certification and Pre-treatment Review for further details.

The following Medical Benefits are payable as stated in the Schedule of Medical Benefits and subject to the applicable Cost Sharing Provisions and all terms and conditions of this Plan. Medical Benefits include:

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.

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

3. Charges made by an Urgent Care Facility when treatment has been rendered.

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

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

   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.

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

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

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.

   B. Nursing care by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), a public health nurse who is under the direct supervision of a Registered Nurse.

   C. Physical Therapy and Speech Therapy, when 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.

7. The services of a legally qualified Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care and surgical opinion consultations.

   Charges are eligible for drugs intended for use in a Physicians' office or settings other than home use that are billed during the course of an evaluation or management encounter. However, any oral or injectable drug that can be administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit, unless there is a documented medical reason for administration of the drug in an office or other Outpatient setting.

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, 100% of the Eligible Expense will be considered for the Major Procedure; and 50% of the Eligible Expense will be considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services will be reimbursed at the contracted or negotiated rate.

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

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

10. Charges for Registered Nurses (RN), Licensed Practical Nurses (LPN) or Licensed Vocational Nurses (LVN) for private duty nursing.

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

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

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

13. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs regardless of Medical Necessity and FDA approved over-the-counter female contraceptives prescribed by a Physician or Licensed Health Care Provider.

    However, any oral or injectable drug that can be administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit, unless there is a documented medical reason for administration of the drug in an office or other Outpatient setting.

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

14. Charges for x-rays, CAT scans, MRIs, microscopic tests and laboratory tests.

15. Charges for radiation therapy or treatment and chemotherapy. However, any oral or injectable drug that can be administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit, unless there is a documented medical reason for administration of the drug in an office or other Outpatient setting.

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

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

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

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

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

    Blood monitors and kits are eligible for coverage under the Medical Benefits and Pharmacy Benefits, subject to all provisions and limitations of this Plan. Insulin pumps are covered under Medical Benefits, subject to all provisions and limitations of this Plan. Diabetic supplies are only eligible for coverage as specifically stated under the Pharmacy Benefit of this Plan.

21. Charges for vitamins and nutritional supplements specifically prescribed for treatment of Phenylketonuria (PKU).

22. Charges for adhesive tape, bandages, antiseptics or other over-the-counter first aid supplies only upon prior approval of the Plan. Approval will be based on guidelines of cost effectiveness and Medically Necessary treatment of an Illness or Injury as determined by the Plan Administrator.

23. Charges for the Durable Medical Equipment, Orthopedic Appliances or Prosthetic Appliances as follows:

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

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

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

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

    A. 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.

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

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

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

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

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

26. Charges for Contraceptive Management, regardless of Medical Necessity.

27. Charges for the following Mental Illness services:

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

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

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

    D. Medically Necessary treatment at a Psychiatric Facility.

28. Charges for the following Alcohol and/or Chemical Dependency services:

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

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

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

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

29. Charges for vasectomy. Charges for sterilization procedures for females are covered under the Preventive Care Benefit.

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

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

    Routine Patient Costs do not include any investigational item, device, or service that is part of the Approved Clinical Trial; an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or an item or service customarily provided and paid for by the sponsor of an Approved Clinical Trial.

    "Approved Clinical Trial" means a Phase I clinical trial that is conducted in relation to the prevention, detection, or treatment of an acutely life-threatening disease state and is not designed exclusively to test toxicity or disease pathophysiology. The Approved Clinical Trial must be:

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

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

C. Approved or funded by:

1) The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the entities described above;
2) A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
3) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
4) The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:
    a) Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    b) Provide unbiased scientific review by individuals who have no interest in the outcome of the review.

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

31. Charges for services for Complex Care Coordination and Transitional Care Management, based on specific CPT Codes for those services as approved by Medicare, and not subject to the Medical Necessity requirements of the Plan.

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

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

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

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

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

33. Charges for the initial purchase of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary surgical procedure to the eye, cataract surgery or for aphakic patients, soft lenses or sclera shells intended for use as corneal bandages.

BARIATRIC SURGERY BENEFIT

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

Limited to Employees covered under this Plan as either a Participant or Covered Dependent. Covered Dependents who are not Employees are not eligible for this benefit.

Coverage includes charges for bariatric surgery for the treatment of Morbid Obesity/Clinically Severe Obesity based on Medical Policy.

COLONOSCOPY BENEFIT

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

DENTAL SERVICES - ACCIDENTAL INJURY

Coverage includes charges for dental treatment required because of Accidental Injury to natural teeth. Such expenses must be Incurred within six (6) months of the date of accident except in the event that it is medically impossible for service to be completed within that time frame because of the age of the Covered Person or because of the healing process of the Injury. Coverage will not in any event include charges for treatment for the repair or replacement of a denture.

This Plan will be primary for any charges covered under this Plan that may also be covered under a Dental Plan sponsored by the Employer.

GENDER IDENTITY DISORDER/GENDER DYSPHORIA SERVICES

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

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

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

Certain services are excluded from coverage under the Medical Benefits Exclusion section of the Plan. It is important to review those exclusions. Pre-treatment Review is strongly recommended for treatment of Gender Identity/Gender Dysphoria. Failure to obtain Pre-treatment Review may result in significant out-of-pocket expenses not covered by the Plan.

GENETIC THERAPY (CELLULAR THERAPY AND GENE THERAPY)

Coverage includes charges for Genetic Therapy (Cellular Therapy and Gene Therapy) received on an Inpatient or Outpatient basis at a Hospital, Ambulatory Surgery Center or Physician's office.

Prior Authorization is required as soon as the possibility of a Genetic Therapy arises. **Failure to obtain Prior Authorization for Genetic Therapy will result in a denial of benefits.**

Pre-Certification is required within 24 hours before scheduled Inpatient Hospital admissions or as soon as is reasonable possible for non-scheduled admissions, including Emergency admissions. **Failure to obtain Pre-Certification for Genetic Therapy will result in a denial of benefits.**

HEARING AID / BAHA

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

Coverage includes charges in connection with the fitting and purchase of hearing aid or Bone Anchored Hearing Aid (BAHA) implantable device including; hearing examination, hearing aid or BAHA implantable device, and related services and supplies, subject to all terms and conditions of this Plan. Services must be rendered by a licensed audiologist. Charges for batteries are excluded.

HOME HEALTH CARE BENEFIT

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

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

1. Part-time or intermittent nursing care by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN) or public health nurse who is under the direct supervision of a Registered Nurse;

2. Home health aides;

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

Home Health Care specifically excludes the following:

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

2. Services of a person who ordinarily resides in the home of the Covered Person, 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.

NUTRITIONAL COUNSELING

Charges for treatment rendered by a registered dietician, or other Licensed Healthcare Provider, for individuals with medical conditions or Mental Illness that require a special diet or counseling. Such conditions include but may not be limited to, diabetes mellitus, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, hyperlipidemias and Mental Illness (e.g., anorexia, bulimia nervosa).

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Charges are payable as specifically stated in the Schedule of Medical Benefits for Physical, Occupational and Speech Therapy. Care provided must be under the direction of a qualified Physician and have a formal treatment plan with a specific goal.

Coverage for Physical Therapy is based upon Medical Necessity and charges will be denied if determined not to be Medically Necessary or when treatment is no longer Medically Necessary.

Coverage includes Physical Therapy or Occupational Therapy in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

Coverage includes 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.

PREVENTIVE CARE

Charges are payable as specifically stated in the Schedule of Medical Benefits. Coverage under this benefit includes the following routine services, subject to the following limitations:

1. Routine Newborn Inpatient Nursery/Physician Care including the following services:

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

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

2. Routine Wellness care for children and adults for the following:

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

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

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

4. Routine hearing exams for all ages.

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

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

7. Women's Preventive Care for the following:

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

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

   C. Human papillomavirus (HPV) DNA testing.

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

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

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

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

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.

The District offers other preventive benefits from time to time through the District sponsored Wellness Program. Charges, if applicable, for these benefits are not covered by the Plan, and should not be submitted to the Plan Supervisor for payment. Please consult the Wellness Program for more specific information.

PROPHYLACTIC MASTECTOMY

Coverage includes charges for a prophylactic mastectomy if the preventive/prophylactic mastectomy is medically indicated and acceptable only upon prior approval by the Plan Administrator based upon an independent medical review.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

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

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

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

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

Specifically excluded from this benefit are expenses for the following:

1. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;
2. Breast augmentation procedures unrelated to producing a symmetrical appearance;
3. Implants for the non-affected breast unrelated to producing a symmetrical appearance;
4. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

RESIDENTIAL TREATMENT FACILITY

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

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

ROUTINE FOOT CARE BENEFIT

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

Charges for routine foot care services are payable as specifically stated in the Schedule of Medical Benefits. Coverage includes charges for the following procedures to the extent they do not exceed the applicable limits shown in Schedule of Medical Benefits:

1. An open cutting operation for weak, strained, flat, unstable or unbalanced feet;
2. The removal of nail roots; and
3. Treatment or corns, calluses or toenails if the Covered Person has metabolic or peripheral vascular disease.

Routine Foot Care specifically excludes charges for orthotics.

SPINAL SURGERY BENEFIT

Benefits for all spinal surgeries shall be covered based upon the then current best practices guidelines published by the American Academy of Neurological Surgeons as applicable to the specific surgical procedure including, but not limited to, any and all requirements or guidelines for prior conservative treatment before surgery is performed. None of the requirements can be waived except by written request of the treating surgeon and the unanimous concurrence of two (2) board certified independent review neurological surgeons that a requirement or guideline is not medically appropriate for the specific patient, diagnosis and medical history.

SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES

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

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.

EXPERIMENTAL COVERAGE

Treatment that would otherwise be considered Experimental/Investigational will be covered if the proposed Experimental/Investigational treatment has been reviewed by four (4) unrelated, independent board certified Physicians actively practicing within the same speciality 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; and

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

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

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

VOLUNTARY SECOND OR THIRD SURGICAL OPINION BENEFIT

Expenses Incurred under this benefit are not subject to any Deductible. Charges are payable at 100% of the Eligible Expense, up to the maximum benefit stated in the Schedule of Medical Benefits. The claim must indicate that charges are for a Second or Third Surgical Opinion. Claims that do not indicate Second or Third Surgical Opinion will be considered under the Medical Benefits Section of the Plan, subject to all Plan conditions, exclusions and limitations.

Charges are covered as follows:

1. Eligible Expense of a legally qualified Physician for a second opinion consultation if non-emergency, elective surgery is recommended by the Covered Person's attending Physician. The Physician rendering the second opinion regarding the Medical Necessity of such surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

2. Eligible Expense of a legally qualified Physician for a third consultation, if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such opinion, and must not be affiliated in any way with the consulting Physician, or with the Physician who will be performing the actual surgery.

ACCIDENTAL INJURY BENEFIT

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

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

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

1. Services and supplies (including Room and Board) furnished by a Hospital for medical care in that Hospital.
2. Doctors' 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 (RN), a Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN).
6. Casts, splints, trusses, braces and crutches.
7. Ambulance service for local travel to the nearest facility capable of treating the Injury.

Charges for Chiropractic Care services, and Physical Therapy, Occupational Therapy and Speech Therapy are specifically excluded under this benefit.

HOSPITAL ADMISSION CERTIFICATION

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 reasonably possible for non-scheduled admissions, including Emergency admissions. **Failure to obtain Pre-Certification Genetic Therapy will result in a denial of benefits.**

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

1. Provide information regarding coverage before receiving treatment, services, or supplies;

2. Provide information about benefits regarding proposed procedures or alternate treatment plans;

3. Assist in determining out-of-pocket expenses and identify possible ways to reduce them;

4. Help avoid reductions in benefits which may occur if the services are not Medically Necessary or the setting is not appropriate; and

5. If appropriate, assign a case manager to work with the Covered Person and the Covered Person's providers to design a treatment plan.

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

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

PRE-ADMISSION CERTIFICATION REVIEW

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

To pre-certify, call the utilization management company at (800) 342-6510 for pre-admission certification review.

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

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

CONTINUED STAY CERTIFICATION

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

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

EMERGENCY NOTIFICATION/CERTIFICATION

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

To notify the Plan of an emergency admission, call the utilization management company at (800) 342-6510 for emergency admission certification.

MATERNITY NOTIFICATION

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

PROVIDER SELF-AUDIT PROGRAM

Covered Persons may receive a refund if they discover an overcharge on their medical bill that:

1. Was not detected by the provider of services; and

2. Was not detected by the Plan; and

3. Was part of the charges for services which are covered under this Plan.

The Covered Person should request a copy of his/her itemized bill for services, and review it for services not received, such as tests, x-rays, etc. that were not performed. If an overcharge is discovered by the Covered Person, he/she should ask the provider to correct the overcharge and send the Covered Person a revised itemized bill. The Covered Person should clearly mark both itemized bills "Provider Self-Audit Program" and send them to:

Allegiance Benefit Plan Management, Inc.
Attention: Claims Department
Provider Self-Audit Program
2806 South Garfield Street
Missoula, Montana 59801

The Plan may refund 50% of the total amount of the overcharge, up to a maximum $1,000 refund based on an overcharge of $2,000. The minimum overcharge eligible to qualify under the Provider Self-Audit Program is a $50 overcharge with a minimum refund of $25.

PRE-TREATMENT REVIEW

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

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

1. Surgeries:

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

2. Organ or Tissue Transplants.

3. Infertility. (Not covered.)

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

5. Outpatient dialysis.

6. Infusion services.

7. Obesity treatment. (Limitations apply.)

8. Bariatric Surgery benefits. (Limitations apply.)

9. Cancer treatments.

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

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

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

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

14. Surgical treatment of TMJ. (Not covered.)

15. Home Health Care services. (Limitations apply.)

16. Residential Treatment Facility.

17. Gender Identity Disorder/Gender Dysphoria Services.

18. Growth hormone therapy. Pre-treatment Review requires a letter from the attending Physician documenting the need for such therapy in advance of dates of service.

19. Genetic Therapy (Cellular Therapy and Gene Therapy). Prior Authorization required. **Failure to obtain Prior Authorization will result in a denial of benefits.**

To obtain Pre-treatment Review from the Plan, submit the following to the Plan Supervisor via facsimile (fax) at (855) 999-3896:

1. A complete description of the procedure(s) or treatment(s) for which review is requested;
2. A complete diagnosis and all medical records regarding the condition that supports the requested procedure(s) or treatment(s) including, but not limited to, informed consent form(s), all lab and/or x-rays, or diagnostic studies;
3. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding CPT or HCPCS codes;
4. The attending Physician's prescription, if applicable;
5. A Physician's referral letter, if applicable;
6. A letter of Medical Necessity;
7. A written treatment plan; and
8. Any other information deemed necessary to evaluate the request for Pre-treatment Review.

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

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

MEDICAL BENEFIT EXCLUSIONS

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

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

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

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

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

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

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

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

8. Charges for special duty nursing services are excluded:

   A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or

   B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.

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

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

11. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, or any other assisted reproductive technique.

12. Charges for marital counseling or family counseling (e.g., problems in relationship with spouse or partner, not including diagnosed Medical Illness or Alcoholism and/or Chemical Dependency conditions), recreational counseling, wilderness programs and spa treatments.

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

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

15. Charges for orthotics, acupuncture, naturopathy, holistic medical procedures or rolfing.

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

17. Charges for any services, care or treatment for sexual dysfunction including medications, surgery, medical, counseling or Psychiatric Care or treatment.

18. Charges for any surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism.

19. Charges related to Custodial Care.

20. Charges for artificial organ implant procedures.

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

22. Charges for complications that directly result from acting against medical advice, non-compliance with specific Physician’s orders or leaving an Inpatient facility against medical advice.

23. Charges for equipment including, but not limited to, motorized wheelchairs or beds, that exceeds the patient’s needs for every day living activities as defined by the Americans with Disabilities Act as amended from time to time, unless Medically Necessary by independent review and not primarily for personal convenience.

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

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

26. 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.

27. Charges for nutrition-based therapy for alcoholism or drug addiction.

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

29. Charges for immunizations, medications and other preventive treatments that are recommended because of increased risk due to type of employer or travel including, but not limited to, immunizations, medications and/or other preventive treatments for malaria and yellow fever.

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

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

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

33. Charges for FAA and DOT Physicals.

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

    A. Removal of an object left in the body during surgery;

    B. Catheter-associated urinary tract infection;

    C. Pressure ulcers;

    D. Vascular catheter-associated infection;

    E. Infection inside the chest after coronary artery bypass graft surgery;

    F. Hospital acquired injuries such as fractures, dislocations, intracranial injuries, crushing injuries and burns;

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

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

36. Charges for treatment of Gender Identity Disorder/Gender Dysphoria when the services are for reversal of a prior gender reassignment surgery or reversal of a prior surgery to revise secondary sex characteristics.

37. Charges for Autism Spectrum Disorder, as defined, related services provided in a public school setting and paid for by the public school are specifically excluded.

38. Charges for COVID-19 home tests. Coverage is provided as outlined under the Pharmacy Benefit.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following general exclusions and limitations apply to all Expenses Incurred under this Plan:

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

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

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

4. Charges by the Covered Person for all services and supplies resulting from any Illness or Injury which occurs in the course of employment for wage or profit, or in the course of any volunteer work when the organization, for whom the Covered Person is volunteering, has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including employees' compensation or liability laws of the United States (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though:

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

   B. The Covered Person's employer/volunteer organization has failed to obtain such coverage required by law;

   C. The Covered Person waived his/her rights to such coverage or benefits;

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

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

   F. The Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective.

   G. The Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

   This exclusion will not apply to household and domestic employment, employment not in the usual course of the trade, business, profession or occupation of the Covered Person or Employee, or employment of a Dependent member of an Employee's family for whom an exemption may be claimed by the Employee under the Internal Revenue Code, or in cases in which it is legally impossible to obtain Workers' Compensation coverage for a specific Illness or Injury.

5. Charges for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

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

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

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

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

10. 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.

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

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

13. Travel Expenses Incurred by any person for any reason, except as specifically listed as a covered under the Non-Ambulance Travel Benefit. Benefit limits apply as stated in the Schedule of Medical Benefits.

14. Charges for services, treatments or supplies that may be useful to persons in the absence of Illness or Injury such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, dehumidifiers, exercise equipment, health club memberships, concierge provider subscription fees (monthly or annually), app store purchases, or any other membership or subscription fees, whether or not they have been prescribed or recommended by a Physician.

15. Charges in connection with any operation or treatment for temporomandibular joint dysfunction (TMJ) 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. This includes Expenses Incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.

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

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

18. Charges for any services or supplies to the extent that benefits are otherwise provided under this Plan, or under any other plan of group benefits that the Participant's employer contributes to or sponsors.

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

20. Charges for dental braces

21. Charges for corrective shoes.

22. 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. Subject to applicable state or federal law, 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.

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

24. Charges for any services, treatments or supplies incurred while physically present in the State of New York.

COORDINATION OF BENEFITS

The Coordination of Benefits provision prevents the payment of benefits which exceed the Allowable Expense. It applies when the Participant or Dependent who is covered by this Plan is or may also be covered by any other plan(s). This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan(s), will not exceed 100% of Allowable Expense. Only the amount paid by this Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization is hereby given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document/Summary Plan Description are subject to this provision.

DEFINITIONS

"Allowable Expense" as used herein means:

1. If the claim as applied to the primary plan is subject to a contracted or negotiated rate, Allowable Expense will be equal to that contracted or negotiated amount.

2. If the claim as applied to the primary plan is not subject to a contracted or negotiated rate, but the claim as applied to the secondary plan is subject to a contracted or negotiated rate, the Allowable Expense will be equal to that contracted or negotiated amount of the secondary plan.

3. If the claim as applied to the primary plan and the secondary plan is not subject to a contracted or negotiated rate, then the Allowable Expense will be equal to the secondary plan's chosen limits for non-contracted providers.

"Plan" as used herein means any plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

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

    A. Hospital indemnity benefits; and

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

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

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

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

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

6. Any coverage under a governmental program, and any coverage required or provided by any statute.

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

ORDER OF BENEFIT DETERMINATION

1. **Non-Dependent/Dependent:**

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

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

   Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      2) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

   B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
      2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph A of this paragraph shall determine the order of benefit;
      3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph A of this paragraph shall determine the order of benefit;
      4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         a) The plan covering the custodial parent;
         b) The plan covering the custodial parent's spouse;
         c) The plan covering the non-custodial parent; and then
         d) The plan covering the non-custodial parent's spouse.

   C. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a or b of this paragraph as if those individuals were parents of the child.

D. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph 5 applies.

E. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in subparagraph A to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-Off Employee**

A. The plan that covers a person as an active employee that is an employee who is neither laid-off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

B. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.

4. **COBRA or State Continuation Coverage:**

A. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering the same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

B. If the other plan dos not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.

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

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

B. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

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

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

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

6. If none of the preceding rules determines the order of benefits, the Allowable Expense shall be shared equally between the plans.

COORDINATION WITH MEDICARE

Medicare Part A, Part B and Part D will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits. This means that the Plan will only pay the amount that Medicare would not have covered, even if the Covered Person does not elect to be covered under Medicare. Also, failure to enroll in Medicare Part B or Part D when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment in Part B or Part D.

1. **For Working Aged**

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

   A covered Dependent, eligible for Medicare Part A, Part B or Part D as a result of age, of a covered Employee may also be covered under this Plan and be covered under Medicare, in which case the Plan again will pay primary. A covered Dependent, eligible for Medicare Part A, Part B or Part D as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

2. **For Retired Persons**

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

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

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

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

   The Plan is primary and Medicare will be secondary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability, if the Employee is actively employed by the Employer.

   The Plan is secondary and Medicare will be primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

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

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

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

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

*If a Covered Person is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary and 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/CHAMPVA

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

If the Covered Person is eligible for Medicare and entitled to veterans benefits through the Department of Veterans Affairs (VA), the Plan will always be primary and the VA will always be secondary for non-service connected medical claims. For these claims, the Plan will make payment to the VA as though the Plan was making payment secondary to Medicare.

PROCEDURES FOR CLAIMING BENEFITS

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

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

When completed, the claim must be sent to the Plan Supervisor, Allegiance Benefit Plan Management, Inc., at PO Box 21074, Eagan, Minnesota 55121, (406) 721-2222 or (855) 999-8878 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

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

Upon termination of the Plan, final claims must be received within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL RECEIVED BY THE PLAN SUPERVISOR.

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

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims will be considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines and administrative practices not inconsistent with the terms of the Plan. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims decisions will be made within the time periods stated below. For purposes of this section, "Covered Person" will include the claimant and the claimant's Authorized Representative; "Covered Person" does not include a health care provider or other assignee, and said health care provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

"Authorized Representative" means a representative authorized by the claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization.

INFORMATION REGARDING URGENT CARE CLAIMS IS PROVIDED UNDER THE DISCLOSURE REQUIREMENTS OF APPLICABLE LAW; THE PLAN DOES NOT MAKE TREATMENT DECISIONS. ANY DECISION TO RECEIVE TREATMENT MUST BE MADE BETWEEN THE PATIENT AND HIS OR HER HEALTHCARE PROVIDER; HOWEVER, THE PLAN WILL ONLY PAY BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THIS PLAN.

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

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

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

   There are no Urgent Care requirements under this Plan and therefore, there are no rights to appeal a pre-service Urgent Care Claim denial.

2. **Pre-Service Claims** - Pre-Service Claims must be submitted to the Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Covered Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are procedures stated in the Plan Document/Summary Plan Description which the Plan recommends be utilized before a Covered Person obtains medical care.

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

   In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) calendar days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) calendar 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 limits is not an Adverse Benefit Determination.) The Plan will notify the Covered Person sufficiently in advance to allow an appeal for uninterrupted continuing care before the benefit is reduced or terminated. Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time must be decided within twenty-four (24) hours of the Plan's receipt of the request. The appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially-prescribed period.

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

APPEALING AN UN-REIMBURSED PHARMACY CLAIM

Send Pharmacy appeals to: Rightway Appeals; Attn: Prior Authorization Appeals; PO Box 996; Portland, Maine 04104.

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

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

1. The reason the claim was denied;

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

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

4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan Supervisor at the address or telephone number shown on the claim denial.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person can also request an external review at any time. Before bringing a civil action, the Covered Person must exercise his or her right through the review levels.

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to Allegiance Benefit Plan Management; Appeals; PO Box 21222; Eagan, Minnesota 55121. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

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

   The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within fifteen (15) calendar days following the date the Plan Supervisor receives the request for reconsideration.

   If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Plan Supervisor, not later than sixty (60) calendar days after receipt of the Plan Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

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

   A delegate of the Board of Trustees of Helena School District #1 will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the delegate of the Board of Trustees of Helena School District #1 who is neither the original decisionmaker nor the decisionmaker's subordinate. The delegate of the Board of Trustees of Helena School District #1 cannot give deference to the initial benefit determination. The delegate of the Board of Trustees of Helena School District #1 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 delegate of the Board of Trustees of Helena School District #1 will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.
   After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) calendar days.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review. The Covered Person may request an external review at any time. If the external review is requested before the Plan appeal processes, then the Covered Person is waiving those processes preceding the external review.

INDEPENDENT EXTERNAL REVIEW FOR A PRE-SERVICE CLAIM

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) calendar days after a decision is made upon the second level benefit determination above.

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

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

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

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

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

1. The reason the claim was denied;
2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan Supervisor at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to Allegiance Benefit Plan Management; Appeals; PO Box 21222; Eagan, Minnesota 55121. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

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

   The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within thirty (30) calendar days following the date the Plan Supervisor receives the request for reconsideration.

   If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Plan Supervisor, not later than sixty (60) calendar days after receipt of the Plan Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

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

   The Helena School District #1 Health Benefit Committee will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by Helena School District #1 Health Benefit Committee who is neither the original decisionmaker nor the decisionmaker's subordinate. Helena School District #1 Health Benefit Committee cannot give deference to the initial benefit determination. Helena School District #1 Health Benefit 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, Helena School District #1 Health Benefit Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

   After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within a reasonable time, but no later than thirty (30) calendar days from the date the appeal is received by the Plan at each level of review.

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

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review. The Covered Person may request an external review at any time. If the external review is requested before the Plan appeal processes, then the Covered Person is waiving those processes preceding the external review.

INDEPENDENT EXTERNAL REVIEW FOR A POST-SERVICE CLAIM

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) calendar days after a decision is made upon the second level benefit determination above.

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

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

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

ELIGIBILITY PROVISIONS

EMPLOYEE ELIGIBILITY

An eligible Employee under this Plan includes only a person who is employed by the District on a continuing and regular basis.

1. Class I - Is classified as a regular and contract Employee and is employed by the District on a continuing and regular basis; or

2. Class II - Is employed by the District as a Variable Hour Employee, including temporary, part-time, substitute teachers and seasonal Employees, and completes a Measurement Period of twelve (12) consecutive months.

   "Measurement Period" is the period of time adopted by the Plan for Variable Hour Employees during which such Employees' work hours and applicable leave are measured to determine whether such Employees are eligible for coverage.

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

WAITING PERIOD

An Employee's Waiting Period will be subject to the Employee's employment classification, and submission of a fully completed enrollment form for the Employee.

With respect to an eligible Employee, coverage under the Plan will not start until the Employee completes a Waiting Period. The Plan's Waiting Period is the period of time between the date of receipt by the District of full payment of the first month's premium for coverage and the following:

1. Class I - The last day of the month following fifty-nine (59) days from the date of the receipt by the District of full payment of the first month's premium.

2. Class II - For Variable Hour Employees, the last day of the month from the end of the Measurement Period defined in Employee Eligibility subsection above. If elected, coverage under this section shall continue for a period of not more than twelve (12) months provided the Participant remains employed by the Employer regardless of the number of hours worked during that time period. This period of time is the Coverage Period.

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant or Retiree has been assigned by the Employer, and who is either:

1. The Participant's or Retiree's legal spouse according to the marriage laws of the state where the marriage was first solemnized or established. Proof of common law marriage must be furnished to the Plan Administrator upon request at the beginning of each Benefit Period, including a copy of the Participant's or Retiree's most recent Federal tax return and signed Affidavit.

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

2. The Participant's or Retiree's domestic partner, provided **all** of the following "Required Eligibility Conditions" are met:

   A. The Participant and domestic partner are both eighteen (18) years of age or older and each has the capacity to enter into a contract: and

   B. Are not legally married to, nor the domestic partner of, or a Dependent of any other person; and

   C. Are not related by blood or marriage; and

   D. Do not have a parental relationship with the other; and

   E. Have entered into the domestic partner relationship voluntarily, willingly and without reservation; and

   F. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:

      1) Living together as a couple; and
      2) Mutual support of each other; and
      3) Mutual responsibility for each other's welfare; and
      4) Joint responsibility for the necessities of life.

   G. Have been living together as a couple for at least twelve (12) months prior to the date of the Affidavit; and

   H. Intend to continue the domestic partner relationship indefinitely, with the understanding that the relationship is terminable at the will of either partner; and

   I. The domestic partnership is verified by at least three (3) of the following:

      1) Evidence of joint purchase and ownership of a home;
      2) Notarized copy of residential lease naming both domestic partners;
      3) Evidence of joint savings or joint checking account that has been in effect for at least six (6) months;
      4) Title and registration of joint ownership of an automobile;
      5) Evidence of joint use and liability for active credit cards;
      6) Evidence that domestic partner is a beneficiary under Employee's deferred compensation or retirement plan;
      7) Evidence of mutually granted powers of attorney or mutually granted healthcare powers of attorney;
      8) Employee's last will and testament evidencing that domestic partner is a major recipient of estate proceeds;
      9) Other documentary evidence which depicts significant joint financial interdependency between the Employee and domestic partner, - please describe (this documentation is subject to approval by the Helena School District #1 (life insurance beneficiary does not qualify)).

3. The Participant's or Retiree's Dependent child who meets all of the following "Required Eligibility Conditions":

   A. Is a natural child; step-child; legally adopted child; a child who has been Placed for Adoption with the Participant or domestic partner and for whom as part of such placement the Participant or domestic partner has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

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

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

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

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

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

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

RETIREE ELIGIBILITY

A Retiree is considered eligible for coverage under this Plan only if the Retiree was covered under this Plan as a Participant on his or her last day of Active Service for the Employer prior to retirement, and subject to the terms of 2-18-704 MCA.

Retirees who are sixty-five (65) years of age or older are not eligible for Pharmacy Benefits.

RETIREE DEPENDENT ELIGIBILITY

A Retiree's Dependents and surviving Dependents upon the death of the Retiree are also eligible if the Retiree was eligible for coverage and covered under this Plan, subject to the terms of 2-18-704, MCA., but only if such Dependents were covered under this Plan on the date of the Retirees retirement from the Employer (District) or upon the Retiree's death, whichever is applicable.

Dependents of Retirees who are sixty-five (65) years of age or older are not eligible for Pharmacy Benefits.

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan will commence at 12:01 A.M. in the time zone in which the Covered Person permanently resides, on the date such coverage becomes effective.

PARTICIPANT COVERAGE

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

An eligible Employee who declines Participant coverage under the Plan during the Initial Enrollment Period will be able to become covered later as a Late Enrollee, subject to the restrictions upon Late Enrollees, or during Open Enrollment Period and Special Enrollment Period.

A Variable Hour Employee will remain covered for a period of time not to exceed twelve (12) months from the effective date of coverage (the Coverage Period) regardless of the number of hours worked and applicable leave, as long as the individual remains employed by the District. At the end of the Coverage Period, if the individual remains employed as a Variable Hour Employee during the Coverage Period, the individual will remain covered for a period of time not to exceed an additional twelve (12) months.

“Coverage Period” is the maximum period of time Variable Hour Employees can be covered under the Plan as active Employees after completion of a Measurement Period as defined in the Eligibility Provisions under the Employee Eligibility subsection.

If an eligible Employee chooses not to enroll or fails to enroll for coverage under the Plan during the Initial Enrollment Period, coverage for the Employee and Dependents will be deemed waived.

If a Participant chooses not to re-enroll or fails to re-enroll during any Open Enrollment Period, coverage for the Participant and any Dependents covered at the time will remain the same as that elected prior to the Open Enrollment Period.

DEPENDENT COVERAGE

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

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

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

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will be during the month of August of each year, during which an Employee and the Employee's eligible Dependents, who are not covered under this Plan, may request Participant or Dependent coverage. Coverage must be requested on the Plan's enrollment platform.

Coverage requested during the Open Enrollment Period will begin on the first day of school for the fall semester of the year the Open Enrollment occurs.

LATE ENROLLMENT

Any eligible person who makes application for Participant or Dependent coverage under the Plan other than during the Initial Enrollment Period, Open Enrollment Period or Special Enrollment Period will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective on the first day of the month immediately following the date such application on the Plan's enrollment platform is received by the Plan Administrator.

Dependents of Retirees are not eligible for Late Enrollment.

SPECIAL ENROLLMENT PERIOD

In addition to other enrollment times allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below. An eligible person who makes a special enrollment request during any such applicable Special Enrollment Period will not be considered a Late Enrollee.

Domestic partners, or the Dependent(s) of a domestic partner, are not eligible for Special Enrollment Rights.

Dependents of Retirees are not eligible for Special Enrollment.

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

Coverage will become effective on the date of the event if the Employee makes a special enrollment request, verbally or in writing, within sixty (60) days of any special enrollment event and application for such coverage is made on the Plan's enrollment platform within ninety (90) days of the event.

1. An eligible Employee who is not enrolled and eligible Dependents, including step children, who are acquired under the following specific events may enroll and become covered:

   A. Marriage to the Employee; or

   B. Birth of the Employee's child; or

   C. Adoption of a child by the Employee, provided the child is under the age of 19; or

   D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

2. A Participant may enroll eligible Dependents, including step children, who are acquired under the following specific events:

   A. Marriage to the Participant; or

   B. Birth of the Participant's child; or

C. Adoption of a child by the Participant, provided the child is under the age of 19; or

D. Placement for Adoption with the Participant, provided such Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

3. The spouse of a Participant (Covered Employee), may enroll and will become covered on the date of the following specific events:

A. Marriage to the Participant; or

B. Birth of the Participant's child; or

C. Adoption of a child by the Participant, provided the child is under the age of 19; or

D. Placement for Adoption with the Participant, provided such Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

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

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

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

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

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

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

C. Group or insurance health coverage (includes other coverage that is Medicare) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:

1) Legal separation or divorce of the eligible Employee;
2) Cessation of Dependent status;
3) Death of the eligible Employee;
4) Termination of employment of the eligible Dependent;
5) Reduction in the number of hours of employment of the eligible Dependent;
6) Termination of the eligible Dependent's employer's plan; 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 Dependent 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 Dependent to pay premiums on a timely basis or coverage was terminated for cause.

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

For any Special Enrollment event, the Participant may also elect to change Plan Options to any Plan Option offered by the Plan. The Plan Option for the Dependent must be the same as the Participant.

CHANGE IN STATUS

If a Covered Dependent under this Plan becomes an eligible Employee of the District, he/she may continue his/her coverage as a Dependent if he/she is less than .90 FTE or is ineligible for cafeteria benefit dollars or elect to be covered as a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of the District, but is eligible to be covered as a Dependent under another Employee/Participant, he/she may elect to continue his/her coverage as a Dependent of such Employee/Participant.

Application for coverage due to a Change in Status must be made on the Plan's enrollment platform, within sixty (60) days immediately following the date the Employee becomes or ceases to be an eligible Employee. A Change in Status will not be deemed to be a break or termination of coverage and will not operate to reduce or increase any 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.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

The Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSO), and to enforce these procedures as legally required.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. “Alternate Recipient” means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.

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

   A. Provides for child support for a child of a Participant under this Plan; 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. “Plan” means this self-funded Employee Health Benefit Plan, including all supplements and amendments in effect.

4. “Qualified Medical Child Support Order” means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Plan Administrator to meet the qualification requirements as outlined under Procedures for Notifications and Determinations of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

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

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

3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

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

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

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

NATIONAL MEDICAL SUPPORT NOTICE

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

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

DEFINITIONS

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

1. "Member of the Armed Forces" includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation or therapy.

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

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

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

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

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

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

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

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

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

7. "Spouse" means a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides, including common law marriage and same-sex marriage.

EMPLOYERS SUBJECT TO FMLA

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

ELIGIBLE EMPLOYEES

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

REASONS FOR TAKING LEAVE

FMLA leave must be granted (1) to care for the Employee's newborn child; (2) to care for a child Placed for Adoption with the Employee 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 thirty (30) days advance notice when the requested leave is “foreseeable.” If the leave is not foreseeable, the Employee must notify the Employer as soon as is practicable, generally within one to two working days. An Employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee’s serious health condition, the Employer may require second or third opinions, at the Employer’s expense, and a certification of fitness to return to work prior to allowing the Employee to return to work.

PROTECTION OF JOB BENEFITS

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

UNLAWFUL ACTS BY EMPLOYERS

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

ENFORCEMENT

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

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

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

1. On the last day of the month in which the Participant's employment terminates; or
2. On the last day of the month in which the Participant ceases to be eligible for coverage; or
3. The date the Participant fails to make any required contribution for coverage; or
4. The date the Plan is terminated; or
5. The date the District terminates the Participant's coverage; or
6. The date the Participant dies; or
7. The date the Participant enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days; or
8. On the last day of the month in which the Plan receives the Plan’s Health Coverage Waiver Form for the Participant.
9. For Variable Hour Employees on the last day of the Coverage Period, unless at the expiration of the Coverage Period, the Participant is otherwise eligible as the result of a subsequent Measurement Period or as a result of being reclassified as a Class I Employee.

A Participant whose Active Service ceases because of Illness or Injury or as a result of any other approved leave of absence may remain covered as an Employee in Active Service for a period of twelve (12) weeks, or such other length of time that is consistent with and stated in the District's current Employee Personnel Policy Manual, Collective Bargaining Agreement, any formal leave policy adopted by the District, or pursuant to the Family and Medical Leave Act. Coverage under this provision will be subject to all the provisions of FMLA if the leave is classified as FMLA leave.

A Participant whose Active Service ceases due to temporary layoff will be considered employed by the District for the purposes of his/her coverage under this Plan, and such coverage may continue until the end of the month in which the layoff began.

If a Participant's coverage is to be continued during disability, approved leave of absence or temporary layoff, the amount of his or her coverage will be the same as the Plan benefits in force for an active Employee, subject to the Plan’s right to amend coverage and benefits.

RETIREE TERMINATION

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 Retiree ceases to be eligible for coverage; or
2. The date the Retiree fails to make any required contribution for coverage; or
3. The date the Plan is terminated; or

4. The date the District terminates the Retiree's coverage; or

5. The date the Retiree dies; or

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

REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of termination of employment and who again becomes eligible for coverage under the Plan within a thirteen (13) week period immediately following the date of such termination of employment will become eligible for reinstatement of coverage on the date of renewed eligibility. Coverage will be reinstated for the Employee and eligible Dependents on the date of renewed eligibility, provided that application for such coverage is made on the Plan's enrollment platform within sixty (60) days after the date of renewed eligibility.

Reinstatement of Coverage is subject to the following:

1. Credit will be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.

2. All prior accumulations toward annual or Maximum Lifetime Benefit will apply.

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

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

DEPENDENT TERMINATION

Each Covered Person, whether Participant or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of Dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage After Termination. Domestic partners, or the Dependent(s) of a domestic partner, are not eligible for COBRA Continuation Coverage.

Coverage for a Dependent will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Dependent ceases to be an eligible Dependent as defined by the Plan; or

2. On the last day of the month in which the Participant's coverage terminates under the Plan; or

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

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

5. The date the Plan is terminated; or

6. The date the District terminates the Dependent's coverage; or

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

8. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Dependent whose coverage is to be terminated.

9. On the last day of the month during which written verification of Dependent status was not received by the Plan, if such verification was requested by the Plan by a date certain during that month.

10. On the last day of the month the Participant or domestic partner terminate their domestic partnership as evidenced by a signed Dissolution of Domestic Partnership.

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

CONTINUATION COVERAGE AFTER TERMINATION

Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Employees and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more employees.

A Participant's domestic partner or the Dependent(s) of a domestic partner are not eligible for COBRA Continuation Coverage.

The Plan Administrator is Helena School District #1, 1325 Poplar Street, Helena, MT 59601; (406) 324-2008. COBRA Continuation Coverage for the Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097, Missoula, MT 59806, (406) 721-2222; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com.

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

1. Qualifying Events for Participants, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:

   A. The termination (other than by reason of gross misconduct) of the Participant's employment.

   B. The reduction in hours of the Participant's employment.

2. Qualifying Events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:

   A. Death of the Participant or Retiree.

   B. Termination of the Participant's employment.

   C. Reduction in hours of the Participant's employment.

   D. The divorce or legal separation of the Participant or Retiree from his or her spouse.

   E. A covered Dependent child ceases to be a Dependent as defined by the Plan.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Employer of a Qualifying Event within sixty (60) days after the date of the event occurs:

1. Death of the Participant or Retiree.

2. The divorce or legal separation of the Participant or Retiree from his or her spouse.

3. A covered Dependent child ceases to be a Dependent as defined by the Plan.

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

1. Termination (other than by reason of gross misconduct) of the Participant's employment.

2. Reduction in hours of the Participant's employment.

ELECTION OF COVERAGE

When the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than fourteen (14) days after the Plan Administrator is notified of the Qualifying Event.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notification from the Plan Administrator, whichever is later, to notify the Plan Administrator that he or she elects to continue coverage under the Plan. Failure to elect continuation within that period will cause coverage to end.

MONTHLY PREMIUM PAYMENTS

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

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

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

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

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

   B. If the second Qualifying Event occurs during the nineteenth (19^{th}) through the twenty-ninth (29^{th}) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, facsimile (406) 523-3131; email COBRAinquire@askallegiance.com.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and Dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and Dependent children if the former Employee dies or becomes divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097, Missoula, MT 59806; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

The Dependents of a former Employee are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of the former Employee's enrollment in Part A, Part B or Part D of Medicare, whichever occurs earlier.

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

1. Eighteen (18) months after the Qualifying Event of termination of employment or reduction in hours of employment; or

2. Thirty-six (36) months after the former Employee's enrollment in Medicare.

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

WHEN COBRA CONTINUATION COVERAGE ENDS

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

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance.

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

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

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

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

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

   A. Eighteen (18) months for a former Employee who is a Qualified Beneficiary as a result of termination (or reduction of hours) of employment;

   B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen month period entitling that Dependent to an additional eighteen (18) months;

   C. For the Dependent who is a Qualified Beneficiary as a result of termination (or reduction of hours) of employment of the former Employee if that former Employee enrolled in Medicare before termination (or reduction of hours) of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.

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

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

   F. Thirty-six (36) months for all other Qualified Beneficiaries.

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

<u>OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE</u>

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

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

1. The month after employment ends; or

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

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

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

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

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to Allegiance COBRA Services, Inc. or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Marketplace visit www.HealthCare.gov.

INFORM THE PLAN OF ADDRESS CHANGES

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

COVERAGE FOR A MILITARY RESERVIST

To the extent required by the Uniform Services Employment and Reemployment Rights Act (USERRA), the following provisions will apply:

1. If a Participant is absent from employment with Employer by reason of service in the uniformed services, or by reason for service as a reservist in the Federal Emergency Management Agency (FEMA) who is deployed for disaster response, the Participant may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:

    A. The twenty-four (24) month period beginning on the date on which the Participant's absence begins; or

    B. The period beginning on the date on which the Participant's absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment, as required by USERRA.

2. A Participant who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.

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

4. The requirements of this section shall not supersede any anti discrimination in coverage requirement promulgated by TRICARE/CHAMPVA related to eligibility for those coverages.

COVERAGE FOR A MONTANA NATIONAL GUARD MEMBER

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

"State Active Duty" means duty performed by a Montana National Guard member when a disaster is declared by the proper State authority and shall include the time period as certified by a licensed physician to recover from an Illness or Injury incurred while performing the state active duty.

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

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

   A. For State Active Duty of thirty (30) days but not more than one hundred eighty (180) days, the next regularly scheduled day of Active Service following fourteen (14) days after the termination of State Active Duty.

   B. For State Active Duty of more than one hundred eighty (180) days, the next regularly scheduled day of Active Service following ninety (90) days after the termination of State Active Duty.

2. An eligible Participant who elects to continue Plan coverage under this Section may be required to pay:

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

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

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

4. In no event will this Plan cover any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State Active Duty.

5. The requirements of this section shall not supersede any anti discrimination in coverage requirement promulgated by TRICARE/CHAMPVA related to eligibility for those coverages.

FRAUD AND ABUSE

THIS PLAN IS SUBJECT TO FEDERAL LAW WHICH PERMITS CRIMINAL PENALTIES FOR FRAUDULENT ACTS COMMITTED AGAINST THE PLAN. STATE LAW MAY ALSO APPLY.

Anyone who knowingly defrauds or tries to defraud the Plan, or obtains Plan funds through false statements or fraudulent schemes, may be subject to criminal prosecution and penalties. The following may be considered fraudulent:

1. Falsifying eligibility criteria for a Dependent, such as marital status or age, to get or continue coverage for that Dependent when not otherwise eligible for coverage;

2. Falsifying or withholding medical history or information required to calculate benefits;

3. Falsifying or altering documents to get coverage or benefits;

4. Permitting a person not otherwise eligible for coverage to use a Plan ID card to get Plan benefits; or

5. Submitting a fraudulent claim or making untruthful statements to the Plan to get reimbursement from the Plan for services that may or may not have been provided to a Covered Person;

The Plan Administrator, in its sole discretion, may take additional action against the Participant or Covered Person including, but not limited to, terminating the Participant or Covered Person's coverage under the Plan.

MISSTATEMENT OF AGE

If the Covered Person's age was misstated on an enrollment form or claim, the Covered Person's eligibility or amount of benefits, or both, will be adjusted to reflect the Covered Person's true age. If the Covered Person was not eligible for coverage under the Plan or for the amount of benefits received, the Plan has a right to recover any benefits paid by the Plan. A misstatement of age will not continue coverage that was otherwise properly terminated or terminate coverage that is otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If a Participant misrepresents a Dependent's marital status, age, Dependent child relationship or other eligibility criteria to get coverage for that Dependent, when he or she would not otherwise be eligible, coverage for that Dependent will terminate as though never effective.

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not otherwise eligible as a Covered Person to use an ID card, the Plan Sponsor may, at the Plan Sponsor's sole discretion, terminate the Covered Person's coverage.

REIMBURSEMENT TO PLAN

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan but for whom benefits were paid based upon fraud as defined in this section must be reimbursed to the Plan by the Participant. Failure to reimburse the Plan upon request may result in an interruption or a loss of benefits by the Participant and Dependents.

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefitted from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits, or from the benefits for any covered Family member even if the erroneous payment was not made on that Family member's behalf.

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate or false information, or information omitted by the Participant must be reimbursed to the Plan by the Participant. The Participant's failure to reimburse the Plan after demand is made, may result in an interruption in or loss of benefits to the Participant and Dependents, and could be reported to the appropriate governmental authorities for investigation of criminal fraud.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine.

The provisions of this section apply to any Physician or Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Physician or Licensed Health Care Provider fails to refund a payment of benefits, the Plan may refuse to recognize future assignments of benefits to that provider.

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. 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.

<u>SUBROGATION</u>

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 authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Covered Person's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

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

2. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any 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 assigns, 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 ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers including, but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.

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

6. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, except as limited by 2-18-901 and 902, MCA, as amended.

7. The Plan will abide by and follow current Montana law and public policy regarding "Make Whole" restrictions on any recovery under this section, provided however, the Covered Person shall provide documentation to the plan upon request to substantiate that the Covered person has not been made whole. An undocumented allegation of the same by the Covered person or the Covered Person's attorney shall not be sufficient.

RIGHT OF OFF-SET

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

PLAN ADMINISTRATION

PURPOSE

The purpose of the Plan Document/Summary Plan Description is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of the claim. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees and their covered Dependents.

EFFECTIVE DATE

The effective date of the Plan is October 1, 1994; restated October 1, 2025.

PLAN YEAR

The Plan Year will commence October 1 of each year and end on September 30 of each succeeding year.

PLAN SPONSOR

The Plan Sponsor is Helena School District #1.

PLAN SUPERVISOR

The Supervisor of the Plan is Allegiance Benefit Plan Management, Inc.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is the Board of Trustees of Helena School District #1, a political subdivision of the State of Montana, who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

PLAN INTERPRETATION

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

CONTRIBUTIONS TO THE PLAN

The District will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the District, if any, and the amount to be contributed, if any, by each Participant.

If the District terminates the Plan, the District and Participants will have no obligation to contribute to the Plan after the date of termination.

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Plan Document/Summary Plan Description contains all the terms of the Plan and may be amended at any time by the Plan Administrator. Any changes will be binding on each Participant and on any other Covered Persons referred to in this Plan Document/Summary Plan Description.

The authority to amend the Plan is delegated by the Plan Administrator. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the Chairperson of the Board of Trustees, Superintendent of Schools or other person designated in writing by the Board of Trustees.

Written notification of any amendments, modifications, revocations or terminations will be given to Plan Participants at least sixty (60) days prior to the effective date, except for amendments effective on the first day of a new Plan Year, for which thirty (30) days advance notice is required.

TERMINATION OF PLAN

The District reserves the right at any time to terminate the Plan by a written notice. All previous contributions by the District will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

Each Participant covered under this Plan will be issued a Plan Document/Summary Plan Description (SPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits and the limitations and exclusions of the Plan.

GENERAL PROVISIONS

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during pendency of the claim hereunder. The Plan will also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law. Such examination will be at the Plan's expense.

PAYMENT OF CLAIMS

All Plan benefits are payable to a Participant, Qualified Beneficiary or Alternate Recipient, whichever is applicable. All or a portion of any benefits payable by the Plan may, at the Covered Person's option and unless the Covered Person requests otherwise in writing not later than the time of filing the claim, be paid directly to the health care provider rendering the service, if proper written assignment is provided to the Plan. No payments will be made to any provider of services unless the Covered Person is liable for such expenses.

If any benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate. The Plan, in its sole option, may require that an estate, guardianship or conservatorship be established by a court of competent jurisdiction prior to the payment of any benefit. Any payment made under this subsection will constitute a complete discharge of the Plan's obligation to the extent of such payment and the Plan will not be required to oversee the application of the money so paid.

LEGAL PROCEEDINGS

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

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan will be waived, and there will be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

VERBAL STATEMENTS

Verbal statements or representations of the Plan Administrator, its agents and Employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and Employees, or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF PHYSICIAN

The Covered Person will have free choice of any legally qualified Physician, Licensed Health Care Provider or surgeon and the Physician-patient relationship will be maintained.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the applicable law. Only that provision which is contrary to applicable law will be amended to conform; all other parts of the Plan will remain in full force and effect.

MISCELLANEOUS

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which will become due to any Participant, the Plan Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

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

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document/Summary Plan Description are defined below. If the defined term is not used in this document, the term does not apply to this Plan.

Masculine pronouns used in this Plan Document/Summary Plan Description will include either the masculine or feminine gender unless the context indicates otherwise.

Any words used herein in the singular or plural will include the alternative as applicable.

ACCIDENTAL INJURY

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

ACTIVE SERVICE

"Active Service" means that an Employee is in service with the District on a day which is one of the District's regularly scheduled work days and that the Employee is performing all of the regular duties of his/her employment with the District on a regular basis, either at one of the District's business establishments or at some location to which the District's business requires him/her to travel.

ADVERSE BENEFIT DETERMINATION

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

ALCOHOLISM

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

ALCOHOLISM AND/OR CHEMICAL DEPENDENCY TREATMENT FACILITY

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

AMBULANCE SERVICE

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

AMBULATORY SURGICAL CENTER

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

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

AUTISM SPECTRUM DISORDER

"Autism Spectrum Disorder" means neurological disorders, usually appearing in the first three (3) years of life, that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

BENEFIT PERCENTAGE

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

BENEFIT PERIOD

"Benefit Period" refers to a time period of one year, which is either a Calendar Year or other annual period, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or

2. The date the Plan terminates.

BIRTHING CENTER

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

CALENDAR YEAR

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

CHEMICAL DEPENDENCY

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

CIGNA LIFESOURCE FACILITY

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

CLOSE RELATIVE

"Close Relative" means the spouse, parent, brother, sister, child, in-laws, domestic partner or domestic partner's child of the Covered Person.

COBRA

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

COBRA CONTINUATION COVERAGE

"COBRA Continuation Coverage" means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of "COBRA".

CONTRACEPTIVE MANAGEMENT

"Contraceptive Management" means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation, placement or removal of any contraceptive device.

CONVALESCENT NURSING FACILITY

See "Skilled Nursing Facility".

COSMETIC

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

COVERED PERSON

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

CUSTODIAL CARE

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

DEDUCTIBLE

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

DENTIST

"Dentist" means a person holding one of the following degrees–Doctor of Dental Science, Doctor of Medical Dentistry, Master of Dental Surgery or Doctor of Medicine (oral surgeon) -- who is legally licensed as such to practice dentistry in the jurisdiction where services are rendered, and the services rendered are within the scope of his or her license.

A "Dentist" will not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

DEPENDENT

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

DEPENDENT COVERAGE

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

DISTRICT

"District" means Helena School District #1 or any affiliated board, agency or political subdivision that has adopted this Plan for its Employees.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment which is:

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

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

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

ELIGIBLE EXPENSES

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

EMERGENCY

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

EMPLOYEE

"Employee" means a person employed by the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer's W-2 payroll.

Employee does not include any employee leased from another employer including, but not limited to, those individuals defined in Internal Revenue Code Section 414(n), or an individual classified by the Employer as a contract worker or independent contractor if such persons are not on the Employer's W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc.

EMPLOYER

"Employer" means Helena School District #1 or any affiliated board, agency or political subdivision that has adopted this Plan for its Employees.

ENROLLMENT DATE

"Enrollment Date" means the date a person becomes eligible for coverage under this Plan or the eligible person's effective date of coverage under this Plan, whichever occurs first. For Late Enrollees, Enrollment Date will always be the effective date of coverage under this Plan.

EXPERIMENTAL/INVESTIGATIONAL

"Experimental/Investigational" means:

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

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

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

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

   A. The regimen or protocol has been the subject of a completed and published Phase II clinical trial which demonstrates benefits equal to or greater than existing accepted treatment protocols; and

   B. The regimen or protocol listed by the National Comprehensive Cancer Network is supported by level of evidence Category 2B or higher; or

5. Based upon Reliable Evidence, any drug, device, medical treatment or procedure that the prevailing opinion among experts is that further studies or clinical trial are necessary to determine it maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or

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

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

FAMILY

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

FMLA

"FMLA" means Family and Medical Leave Act.

GENDER IDENTITY DISORDER/GENDER DYSPHORIA

DSM-V diagnosis in children:

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

   A. Persistent and strong desire to be of the other sex or insistence that they belong to the other sex.

   B. In male children, a strong preference for cross-dressing and in female children, a strong preference for wearing typical masculine clothing and dislike or refusal to wear typical feminine clothing.

   C. Fantasizing about playing opposite gender roles in make-belief play or activities.

   D. Preference for toys, games or activities typical of the opposite sex.

   E. Rejection of toys, games and activities conforming to one's own sex. In male children, avoidance of rough-and-tumble play, and in female children, rejection of typically feminine toys, games and activities.

   F. Preference for playmates of the other sex.

   G. Dislike for sexual anatomy. Male children may hate their penis and testes, and female children may dislike urinating sitting.

   H. Desire to acquire the primary and/or secondary sex characteristics of the opposite sex.

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

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

DSM-V diagnosis in adolescents and adults:

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

   A. Mismatch between experienced or expressed gender and gender manifested by primary and/or secondary sex characteristics at puberty.

B. Persistent desire to rid oneself of the primary or secondary sexual characteristics of the biological sex at puberty.

C. Strong desire to possess the primary and/or secondary sex characteristics of the other gender.

D. Desire to belong to the other gender.

E. Desire to be treated as the other gender.

F. Strong feeling or conviction that he or she is reacting or feeling in accordance with the identified gender.

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

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

GENETIC THERAPY

"Genetic Therapy" or "Gene Therapy" means therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

HIPAA

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

HOME HEALTH CARE AGENCY

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

HOME HEALTH CARE PLAN

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

HOSPICE

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

HOSPICE BENEFIT PERIOD

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

HOSPITAL

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

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

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

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

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

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

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

HOSPITAL MISCELLANEOUS EXPENSES

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

ILLNESS

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

INCURRED EXPENSES OR EXPENSES INCURRED

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

INITIAL ENROLLMENT PERIOD

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

INJURY

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

INPATIENT

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

INTENSIVE CARE UNIT

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

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

LATE ENROLLMENT OR LATE ENROLLEE

"Late Enrollment" or "Late Enrollee" means an eligible person who makes application for Participant or Dependent Coverage under this Plan other than during the Initial Enrollment Period, Open Enrollment Period or Special Enrollment Period.

LICENSED HEALTH CARE PROVIDER

"Licensed Health Care Provider" means any provider of health care services who is licensed or certified by any applicable governmental regulatory authority to the extent that services are within the scope of the license or certification and are not specifically excluded by this Plan.

LICENSED PRACTICAL NURSE

"Licensed Practical Nurse" (LPN) means an individual who has received specialized nursing training and practical nursing experience, and is licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LICENSED SOCIAL WORKER

"Licensed Social Worker" means a person holding a Master's Degree in social work and who is currently licensed as a social worker in the state in which services are rendered, and who provides counseling and treatment in a clinical setting for Mental Illnesses.

LICENSED VOCATIONAL NURSE

"Licensed Vocational Nurse" (LVN) means an individual who has received specialized nursing training and practical nursing experience, and is licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

MMSERA

“MMSERA” means the Montana Military Service Employment Rights Act (MMSERA), as amended.

MAXIMUM ELIGIBLE EXPENSE

“Maximum Eligible Expense” (MEE) means the maximum amount considered for payment by this Plan 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. For services of a Network Physician or Licensed Health Care Provider at a Network facility:

   A. A contracted amount as established by a preferred provider or other discounting contract.

2. For services of a Non-Network Physician or Licensed Health Care Provider at a Non-Network facility:

   A. The lesser of billed charges or 150% of the allowable charge established by Medicare for the same service or similar service; or billed charge; or

   B. 20% off providers billed charge.

3. For services of a Non-Network Physician or Licensed Health Care Provider at a Network facility and who was not disclosed as such to the Covered Person when services were rendered:

   A. A maximum amount equal to the median network allowable charge for the same service in the same geographic area; or

   B. An amount established by federally appointed mediator if more than A above.

4. For facility charges, except emergency use of a Non-Network emergency room:

   A. A contracted amount as established by a preferred provider or other discounting contract;

   B. The lesser of billed charges or 250% of Medicare based on the facility or the nearest facility in the geographical area; or

   C. A schedule maintained by the Plan Supervisor and based upon the average billed charge, reduced by 20%.

5. For all prescription drugs not obtained through the Plan’s Pharmacy Drug Program while undergoing either Inpatient or Outpatient treatment, including injectable drugs:

   A. A contracted amount as established by a preferred provider or other discounting contract;

   B. 125% of the current Medicare allowable fee, if a contracted amount does not exist; or

   C. The billed charge if less than A or B above.

6. For Durable Medical Equipment:

   A. A contracted amount as established by a preferred provider or other discounting contract;

   B. The allowable charge established by application of the Medicare DME Fee Schedule; or

   C. The billed charge if less than A or B above.

7. For Air Ambulance:

   A. A contracted amount as established by a preferred provider or other discounting contract; or

   B. A maximum amount equal to the median network allowable charge for the same services; or

   C. An amount established by a federally appointed mediator if more than B above.

8. For Ground Ambulance:

   A. A contracted amount as established by a preferred provider or other discounting contract; or

   B. 250% of the allowable charge established by application of the Medicare Ambulance Fee Schedule; or

   C. 80% of billed charges if no contract rate or Medicare allowable; or

   D. The billed charge if less than A, B or C.

9. For Emergency charges of a Non-Network emergency room:

   A. A maximum amount equal to the median network allowable charge for the same services in the same geographic area; or

   B. An amount established by a federally appointed mediator if more than A above.

10. For surgical implants (devices and related supplies):

    A. A contracted amount as established by a preferred provider or other discounting contract;

    B. 50% of billed charges; or

    C. 150% of invoice if less than B above.

11. For Dialysis Centers:

    A. A contracted amount established by a preferred provider or any other discounting contract;

    B. An amount equal to 200% of the Medicare Allowable fee for the same treatment if an out-of-network provider is used and no discounting contract can be established; or

    C. The billed charge if less than A or B above.

<u>MAXIMUM LIFETIME BENEFIT</u>

"Maximum Lifetime Benefit" means the maximum benefit payable while a person is covered under this Plan. The Maximum Lifetime Benefit will not be construed as providing lifetime coverage, or benefits for a person's Illness or Injury after coverage terminates under this Plan.

<u>MEDICAID</u>

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

MEDICALLY NECESSARY OR MEDICAL NECESSITY

Except for Autism and Down syndrome, “Medically Necessary” or “Medical Necessity” means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose an Illness or Injury; and

2. Are ordered by a Physician or Licensed Health Care Provider and consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and

3. Are not primarily for the convenience of the Covered Person, Physician or other Licensed Health Care Provider; and

4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person and are in accordance with the Plan’s Medical Policy; and

5. Are not of an Experimental/Investigational or solely educational nature; and

6. Are not provided primarily for medical or other research; and

7. Do not involve excessive, unnecessary or repeated tests; and

8. Are commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and

9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration (FDA) or Center for Medicare/Medicaid Services (CMMS), pursuant to that entity’s program oversight authority based upon the medical treatment circumstances.

For Autism, “Medically Necessary” or “Medical Necessity” means any care, treatment, intervention, service or item that is prescribed, provided or ordered by a Physician or Psychologist and will or is reasonable expected to:

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

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

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

For Down syndrome, “Medically Necessary” or “Medical Necessity” means any care, treatment, intervention, service, or item that is prescribed, provided or order by a Physician licensed in the state of Montana, and that will or is reasonably expected to:

1. Reduce or improve the physical, mental or developmental effects of Down syndrome; or

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

MEDICAL POLICY

"Medical Policy" means a policy adopted by the Plan which is created and updated by Physicians and other medical providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;

2. Scientific studies showing conclusive evidence of improved net health outcome; and

3. In accordance with any established standards of good medical practice.

MEDICARE

"Medicare" means the programs established under the "Health Insurance for the Aged Act," Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those who are eligible for Medicare Part A, Part B or Part D as a result of age, those with end-stage renal disease, or with disabilities.

MENTAL ILLNESS

"Mental Illness" means a medically recognized psychological, physiological, nervous or behavioral condition, affecting the brain, which can be diagnosed and treated by medically recognized and accepted methods, but will not include Alcoholism, Chemical Dependency or other addictive behavior. Conditions recognized by the Diagnostic Statistical Manual (the most current edition) will be included in this definition.

NAMED FIDUCIARY

"Named Fiduciary" means the Plan Administrator which has the authority to control and manage the operation and administration of the Plan.

NEWBORN

"Newborn" refers to an infant from the date of his/her birth until the initial Hospital discharge or forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean section, whichever occurs first.

NON-PARTICIPATING PROVIDER

"Non-Participating Provider" means a provider who is not a Participating Provider.

OCCUPATIONAL THERAPY

"Occupational Therapy" means a program of care 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.

ORTHOPEDIC APPLIANCE

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

OUT-OF-POCKET MAXIMUM

"Out-of-Pocket Maximum" means the maximum dollar amount, as stated in the Schedule of Medical Benefits, or Pharmacy Benefit, that any Covered Person or Family will pay in any Benefit Period for covered services, treatments or supplies.

OUTPATIENT

"Outpatient" means a Covered Person who is receiving medical care, treatment, services or supplies at a clinic, a Physician's office, a Licensed Health Care Provider's office or at a Hospital if not a registered bedpatient at that Hospital, Psychiatric Facility or Alcoholism and/or Chemical Dependency Treatment Facility.

PARTIAL HOSPITALIZATION

"Partial Hospitalization" means care in a day care or night care facility for a minimum of twenty (20) hours per week, during which therapeutic clinical treatment is provided.

PARTICIPANT

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

PARTICIPATING PROVIDER

"Participating Provider" means a provider that agrees to provide services as part of an agreement.

PHYSICAL THERAPY

"Physical Therapy" means a plan of care provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

PHYSICIAN

"Physician" means a person holding the degree of Doctor of Medicine, Dentistry or Osteopathy, or Optometry who is legally licensed as such.

"Physician" does not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

PLACEMENT OR PLACED FOR ADOPTION

"Placement" or "Placed for Adoption" means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

PLAN

"Plan" means the Health Benefit Plan for Employees of the District, the Plan Document/Summary Plan Description and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

"Plan Administrator" means the District and/or its designee which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purposes of the Employee Retirement Income Security Act of 1974, as amended, and any applicable state legislation of a similar nature, the District will be deemed to be the Plan Administrator of the Plan unless by action of the Board of Trustees, the District designates an individual or committee to act as Plan Administrator of the Plan.

PLAN SUPERVISOR

"Plan Supervisor" means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Plan Supervisor is Allegiance Benefit Plan Management, Inc. The Plan Supervisor provides ministerial duties only, exercises no discretion over Plan assets and will not be considered a fiduciary as defined by State or Federal law or regulation.

PREGNANCY

"Pregnancy" means a physical condition commencing with conception and ending with miscarriage or birth.

PREVENTIVE CARE

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

PRIMARY CARE PHYSICIAN

"Primary Care Physician" (PCP) includes Family Practice, General Practice, Internal Medicine, Obstetrics and Gynecology (OB/Gyn) or Pediatrics, and their associated Physician Assistants, Licensed Nurse Practitioners, Licensed Vocational Nurse and Certified Nurse Midwives.

PROCEDURE BASED LIMIT

A "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, usual, customary and reasonable 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 Plan Supervisor and the Plan.

For non-contracted providers for emergency services, air ambulance and non-contracted providers providing services in a contracted facility, the Procedure Based Limit is equal to and used as the Qualified Payment Amount for No Surprises Billing Act purposes.

PROSTHETIC APPLIANCE

"Prosthetic Appliance" means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of covered dental benefit, means any device which replaces all or part of a missing tooth or teeth.

PSYCHIATRIC CARE

"Psychiatric Care," also known as psychoanalytic care, means treatment for a Mental Illness or disorder, a functional nervous disorder, Alcoholism or drug addiction by a licensed psychiatrist, Psychologist, Licensed Social Worker or Licensed Professional Counselor acting within the scope and limitations of his/her respective license, provided that such treatment is Medically Necessary as defined by the Plan, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

"Psychiatric Facility" means a licensed institution that provides Mental Illness treatment and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

"Psychologist" means a person currently licensed in the state in which services are rendered as a psychologist and acting within the scope of his/her license.

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means an Employee, former Employee or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA or in relation to QMCSO.

"Qualified Beneficiary" will also include a child born to, adopted by or Placed for Adoption with an Employee or former Employee at any time during COBRA Continuation Coverage.

QMCSO

"QMCSO" means Qualified Medical Child Support Order.

REGISTERED NURSE

"Registered Nurse" (RN) means an individual who has received specialized nursing training and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

RESIDENTIAL TREATMENT FACILITY

"Residential Treatment Facility" means an institution which:

1. Is licensed as a 24-hour residential facility for Mental Illness and Chemical Dependency and/or Alcoholism treatment, although not licensed as a hospital;

2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a Physician or a Ph.D. Psychologist; and

3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

RETIREE

"Retiree" means an Employee who retires under a retirement program authorized by law and eligible to continue coverage with the Employer pursuant to the terms of 2-18-704 MCA as amended from time to time.

ROOM AND BOARD

"Room and Board" refers to all charges which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SKILLED NURSING FACILITY

"Skilled Nursing Facility" means an institution, or distinct part thereof, which meets all of the following conditions:

1. It is licensed to provide, on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN) and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities; and

2. The Facility's services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse; and

3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse; and

4. It maintains complete medical records on each patient; and

5. It has an effective utilization review plan; and

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; and

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, Convalescent Nursing Home, or any such other similar nomenclature.

SPECIALTY CARE PHYSICIAN

"Specialty Care Physician" (SCP) includes any Physician who is practicing any branch of medicine or medical specialty who is not identified as a Primary Care Physician.

SPEECH THERAPY

"Speech Therapy" means a course of treatment to treat speech deficiencies or impediments.

TELEMEDICINE

"Telemedicine" means the practice of medicine by electronic means, only for the purposes of diagnosis, providing medical advice and treatment to the Covered Person (patient), requiring direct contact between the Covered Person's Physician or other Licensed Health Care Providers or entities in a different location. The Covered Person's direct participation or physical presence is not a prerequisite for coverage if there is documentation that the consultation was conducted on behalf of the Covered Person for the purpose of diagnosing, providing medical advice or treatment to the Covered Person.

URGENT CARE FACILITY

"Urgent Care Facility" means a free-standing facility which is engaged primarily in diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention. A clinic or office located in or in conjunction with or in any way made a part of a Hospital will be excluded from the terms of this definition.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act, as amended.

RETIREMENT OF PUBLIC EMPLOYEES

Unless otherwise provided for by collective bargaining agreement or District policy, for groups composed of public employees and officers, an Employee who retires from Active Service while the Plan is still in force and subject to the terms of 2-18-704 MCA, or other applicable law, may continue to remain a member of the Health Benefits Plan.

SPOUSE AND DEPENDENT CHILDREN COVERAGE

The spouse of a retired covered Employee may remain a member of the group subject to the terms of 2-18-704 MCA, or other applicable law.

The surviving spouse of a retired covered Employee shall be provided the opportunity to remain a member of the group as long as the spouse is eligible for retirement benefits accrued by the deceased covered Employee.

The surviving children of a deceased covered Employee may remain members of the group as long as they are eligible for retirement benefits accrued by the deceased covered Employee unless they have equivalent coverage in another group plan or are eligible for health coverage under a surviving parent's or legal guardian's employee health benefit plan.

NOTICES

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

IDENTIFICATION OF FUNDING: Benefits under this Plan will be paid from Employee or Employer contributions up to the limits defined in the Plan Document/Summary Plan Description (SPD). Benefits in excess of the amount stated in the stop loss policy are reimbursable to the Employer by stop loss insurance, pursuant to the stop loss insurance contract or policy, subject, however, to the terms of this Plan and the stop loss insurance contract.

WOMEN'S HEALTH AND CANCER RIGHTS ACT: This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Plan Administrator for more information.

HIPAA PRIVACY AND SECURITY STANDARDS

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

"Protected Health Information" (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to the physical or mental health of an individual, health care that individual has received, or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an Employer.

"Summary Health Information" means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the ZIP Code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or plan participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Document/Summary Plan Descriptions have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Document/Summary Plan Descriptions or as required by law. Such uses or disclosures may be for the purposes of Plan administration including, but not limited to, the following:

   A. Operational activities such as quality assurance and utilization management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.

   B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for Medical Necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.

   C. For purposes of this certification, Plan administration does not include disclosing Summary Health Information to help the Plan Sponsor obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a participant in; is an enrollee of or has disenrolled from the group health plan.

2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;

6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;

7. Make available the information required to provide an accounting of disclosures as required by the regulations;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document/Summary Plan Description or employees designated by the Plan Administrator(s) who need to know that information to perform plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

<u>SECURITY CERTIFICATION</u>

The Plan Sponsor hereby certifies that its Plan Document/Summary Plan Descriptions have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.

2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.

3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.

4. Report to the Plan Administrator or the Named Fiduciary of the Plan any attempted breach, or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

PLAN SUMMARY

The following information, together with the information contained in this booklet, form the Plan Document/Summary Plan Description.

1. PLAN NAME

   The name of the Plan is the HEALTH BENEFIT PLAN FOR EMPLOYEES OF HELENA SCHOOL DISTRICT #1, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

   This Plan provides benefits for covered Expenses Incurred by eligible participants for: Hospital, Surgical, Medical, Maternity, other eligible medically related, necessary expenses.

3. PLAN EFFECTIVE DATE

   This Plan was established effective October 1, 1994; restated October 1, 2025.

4. PLAN SPONSOR

   Name: Helena School District #1
   Address: 1325 Poplar Street
   Helena, MT 59601
   Phone: (406) 324-2008

5. PLAN ADMINISTRATOR

   Name: Helena School District #1
   Address: 1325 Poplar Street
   Helena, MT 59601
   Phone: (406) 324-2008

6. NAMED FIDUCIARY

   Name: Helena School District #1
   Address: 1325 Poplar Street
   Helena, MT 59601
   Phone: (406) 324-2008

7. PLAN FISCAL YEAR

   The Plan fiscal year ends September 30.

8. PLAN YEAR

   The Plan Year will commence October 1 of each year and end on September 30 of each succeeding year.

9. PLAN TERMINATION

   The right is reserved by the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

10. IDENTIFICATION NUMBER

Plan Number:	501
Group Number:	3000684
Employer Identification Number:	81-6000557

11. PLAN SUPERVISOR

Name:	Allegiance Benefit Plan Management, Inc.
Address:	2806 South Garfield Street Missoula, Montana 59801

12. ELIGIBILITY

Employees and Dependents of Employees of the Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

13. PLAN FUNDING

The Plan is funded by contributions from the Employer and Employees.

14. AGENT FOR SERVICE OF LEGAL PROCESS

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

****