

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION



EMPLOYEE BENEFITS PROGRAM

CITY OF KALISPELL PLAN

PLAN DOCUMENT EFFECTIVE DATE:
July 1, 2024

PLAN SPONSOR'S IDENTIFICATION NUMBER:
81-0436312

GROUP NUMBER
8001036

COVER/SIGNATURE PAGE

Effective July 1, 2024, Montana Municipal Interlocal Authority (MMIA) restates its self-funded Health Care Plan for the benefit of eligible Employees of MMIA Member Entities and their eligible Dependents entitled, CITY OF KALISPELL PLAN (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 eligible Employees of MMIA Member Entities and their eligible Dependents. MMIA, in conjunction with any required contributions by MMIA Member Entities and the Employees of MMIA Member Entities, agree 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.

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

MONTANA MUNICIPAL INTERLOCAL AUTHORITY

BY: _____

TITLE: _____

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INTRODUCTION

Effective July 1, 2024, Montana Municipal Interlocal Authority (MMIA), restates the benefits, rights and privileges which will pertain to Employees of participating MMIA Member Entities, referred to as Participants, and the eligible Dependents of such Participants, as defined, and which benefits are provided through a fund established by MMIA and referred to as the Plan. This booklet describes the Plan in effect as of July 1, 2024.

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

Montana Municipal Interlocal Authority (the Plan Sponsor) has retained the services of an independent Plan Supervisor, experienced in claims processing, to handle health claims. The Plan Supervisor for the Plan is:

Allegiance Benefit Plan Management, Inc.
P.O. Box 5066
Missoula, MT 59806-5066

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 which is available for review in the Personnel Office, at the office of the Plan Supervisor, or call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions concerning the Plan.

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

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

Prior Authorization by the Plan is strongly recommended for certain services. If Prior Authorization 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 when the claim is submitted.

Prior Authorization is required by the Plan Supervisor for certain services. If Prior Authorization is not obtained, the charge will be denied when the claim is submitted.

This Plan Document/Summary Plan Description is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state.

**SCHEDULE OF MEDICAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS**

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

THE BENEFIT PERIOD IS A CALENDAR YEAR

MEDICAL BENEFIT COST SHARING PROVISIONS	
DEDUCTIBLE (Embedded)	
Per Covered Person per Benefit Period	\$1,000
Per Family per Benefit Period	\$2,000
Deductible, whether for Participating Provider or Non-Participating Provider, applies to all benefits unless specifically indicated as waived	
COPAYMENT	
Copayments apply as specifically stated in this Schedule of Medical Benefits and are payable by the Covered Person. Copayment applies only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other Outpatient setting). Additional charges for services that are performed at the time of the visit, e.g. diagnostic lab, office surgery, diagnostic miscellaneous testing, allergy injections, are payable at 100%, Deductible Waived.	
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 no longer apply for the remainder of the Benefit Period.	
BENEFIT PERCENTAGE ALL MONTANA PROVIDERS AND NON-MONTANA PARTICIPATING PROVIDERS	
Before satisfaction of Out-of-Pocket Maximum	70%
After satisfaction of Out-of-Pocket Maximum	100%
BENEFIT PERCENTAGE NON-MONTANA NON-PARTICIPATING PROVIDERS	
Before satisfaction of Out-of-Pocket Maximum	50%
After satisfaction of Out-of-Pocket Maximum	100%
Benefit Percentage for all Montana Providers and Non-Montana Participating Providers applies to all benefits unless specifically stated otherwise.	
Benefit Percentage for Non-Montana Non-Participating Provider applies to all benefits.	

MEDICAL BENEFIT COST SHARING PROVISIONS	
OUT-OF-POCKET MAXIMUM (Embedded)	
Per Covered Person per Benefit Period	\$3,000
Per Family per Benefit Period	\$6,000
<p>Out-of-Pocket Maximum, whether for Participating Provider or Non-Participating Provider, applies to all benefits unless specifically stated otherwise and subject to all Plan provisions, limitations and exceptions based upon the Plan Document/Summary Plan Description.</p> <p>Out-of-Pocket Maximum includes the Deductible, Medical Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not apply toward the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments do apply toward the applicable Pharmacy Benefit Deductible and Out-of-Pocket Maximum.</p> <p>Charges for Montana and Non-Montana Participating Providers services will cross accumulate between the Montana and Non-Montana Participating Providers and Non-Montana Non-Participating Providers Out-of-Pocket Maximums.</p>	
MAXIMUM BENEFIT FOR ALL CAUSES	Not applicable
<p>PRIOR AUTHORIZATION:</p> <p>Prior Authorization by the Plan is strongly recommended for certain services. If Prior Authorization 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 when the claim is submitted.</p> <p>Prior Authorization is required by the Plan Supervisor for certain services. If Prior Authorization is not obtained, the charge will be denied when the claim is submitted.</p> <p>See Benefit Management for further details.</p>	

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	BENEFIT PERCENTAGE ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
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ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS - CERTIFIED

Office Visit Services and Outpatient Professional Provider Expenses	100% after \$25 Copayment, Deductible Waived
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ALCOHOLISM AND/OR CHEMICAL DEPENDENCY TREATMENT

Outpatient Professional Provider Expenses	100% after \$25 Copayment, Deductible Waived
Inpatient Professional Provider Expenses	100%, Deductible Waived
Inpatient and Outpatient Facility Provider Expenses	70% after Deductible

ALTERNATIVE MEDICINE BENEFIT

	100% after \$25 Copayment, Deductible Waived
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Benefit Limits: Treatments/Office Visit Maximum per Benefit Period / **\$500. Benefit limits are for services received from all Providers.** Benefits are limited to acupuncture, neuro-feedback and bio-feedback services provided by a Physician, Naturopath or Licensed Health Care Provider. Over-the-counter remedies are not covered.

AMBULANCE SERVICE

	70% after Deductible
Ambulance Service is payable as stated regardless of Participating Provider status.	

ANESTHESIA SERVICES

	100%, Deductible Waived
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AUTISM SERVICES

Professional Provider Expenses	100%, Deductible Waived
Includes certain treatments associated with Autism Spectrum Disorder (ASD), pursuant to 33-22-515, MCA.	

COLONOSCOPY

	100%, Deductible Waived
Charges for the first Colonoscopy during a Benefit Period regardless of diagnosis or for any routine colonoscopy are payable at 100%. Subsequent Colonoscopies when performed for diagnostic purposes are payable subject to the Medical Deductible and Benefit Percentage.	

COVID-19 VACCINE

	100%, Deductible Waived
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DENTAL ACCIDENT SERVICES

Office Visit Services	100% after \$25 Copayment, Deductible Waived
Inpatient Professional Provider Expenses	100%, Deductible Waived
Facility Provider Expenses	70% after Deductible

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	BENEFIT PERCENTAGE ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
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DIABETIC EDUCATION/TRAINING AND EQUIPMENT/SUPPLIES BENEFIT

Diabetic Education/Training	100%, Deductible Waived
Diabetic Equipment/Supplies	70%, Deductible Waived
Benefit Limits: 20 Visits Maximum Benefit per Benefit Period. For purposes of this benefit, the term "Visit" refers to all services provided during the same day. Coverage for Diabetic Equipment and Supplies may also be available through the Pharmacy Benefit as stated in the Pharmacy Benefit section of the Plan.	

DIAGNOSTIC SERVICES - INPATIENT AND OUTPATIENT

Professional Provider Expenses	100%, Deductible Waived
Facility Provider Expenses	70% after Deductible

DIALYSIS TREATMENTS - OUTPATIENT

	70% after Deductible
Benefit Limits: Maximum Benefit per dialysis session* / \$550 or PBME (Referenced Based Pricing) as applicable** . Benefit limits are for services received from all Providers. *Dialysis session includes charges for the dialysis, use of facility, professional fees and any and all drugs provided during the administration of a single course of dialysis. **PBME (Referenced Based Pricing) applies if the \$550 benefit payment will result in a balance due to the Covered Person except for Deductible and Out-of-Pocket expenses provided the Covered Person has taken all actions available to prevent a balance due.	

DURABLE MEDICAL EQUIPMENT

Rental (up to purchase price) or purchase	70%, Deductible Waived
Repair and Replacement	70%, Deductible Waived

EMERGENCY ROOM CARE

Facility Provider Expenses for Emergency	100% after \$100 Copayment/visit, Deductible Waived
Professional Provider Expenses for Emergency	100%, Deductible Waived
Facility Expenses for non-emergency	No Benefit
Professional Provider Expenses for non-emergency	100%, Deductible Waived
Emergency Room Care is payable as stated regardless of Participating Provider status. As with all benefits, the PBME (Referenced Based Pricing) still applies. If admission occurs as a result of the condition requiring Emergency services, the emergency room Copayment will be waived and payment will be made according to the Hospital Inpatient Care Services benefit.	

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	BENEFIT PERCENTAGE ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
FERTILITY PRESERVATION SERVICES (See Medical Benefits for further details)	
	70% after Deductible
HEARING AIDS (Including Exam and Fitting)	
	70% after Deductible
Benefit Limits: Hearing Aids limited to Dependent child up to age eighteen (18).	
HOME HEALTH CARE	
	70%, Deductible Waived
HOSPICE CARE	
	100%, Deductible Waived
HOSPITAL SERVICES	
Outpatient Professional Provider Expenses	100% after \$25 Copayment, Deductible Waived
Inpatient Professional Provider Expenses	100%, Deductible Waived
Inpatient and Outpatient Facility Provider Expenses	70% after Deductible
Inpatient Room and Board or Intensive Care Unit, as with all benefits, limited to the PBME (Referenced Based Pricing).	
INFUSION SERVICES - OUTPATIENT	
	100%, Deductible Waived
MAMMOGRAMS (Routine or Diagnostic)	
	100%, Deductible Waived
MATERNITY SERVICES	
Outpatient Professional Provider Expenses	100% after \$25 Copayment, Deductible Waived
Inpatient Professional Provider Expenses	100%, Deductible Waived
Inpatient and Outpatient Facility Provider Expenses	70%, Deductible Waived
See Preventive Care Benefit for well-women prenatal visits.	
MEDICAL SUPPLIES (For use outside of a Hospital and not provided in an office)	
	70% after Deductible
MENTAL ILLNESS	
Outpatient Professional Provider Expenses	100% after \$25 Copayment, Deductible Waived
Inpatient Professional Provider Expenses	100%, Deductible Waived
Inpatient and Outpatient Facility Provider Expenses	70% after Deductible

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	BENEFIT PERCENTAGE ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
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NEWBORN INITIAL CARE

Professional Provider Expenses	100%, Deductible Waived
Facility Provider Expenses	70%, Deductible Waived
Applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.	

NON-AMBULANCE TRAVEL BENEFIT FOR ORGAN AND TISSUE TRANSPLANT

	70% after Deductible
<p>Benefit Limits: Maximum Lifetime Benefit / \$5,000, limited to the following: Coach airfare. The current IRS medical travel reimbursement mileage rate for automobile travel. Meals limited to a maximum of \$50 per day per person. Overnight accommodations, not to exceed \$125 per night.</p> <p>For the Participant and one (1) companion, limited to travel to a Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable).</p>	

NUTRITIONAL ASSESSMENT/COUNSELING BENEFIT (Not otherwise covered under Preventive Care)

	100% after \$25 Copayment, Deductible Waived
<p>Benefit Limits: Treatments/Office Visit Maximum per Benefit Period / 10. Benefit limits are for services received from all Providers. Charges rendered by a registered dietician or other Licensed Health Care Provider for nutritional assessment/counseling. Services are not eligible for the purposes of specialty diets for athletic training or other non-medical purposes.</p>	

OBESITY BENEFIT

Surgical Facility and Professional Provider Expenses	70% after Deductible
<p>Benefit Limits: Combined Surgical and Non-Surgical Maximum Lifetime Benefit / \$30,000; Maximum procedure per lifetime / 1. Benefit limits are for services received from all Providers.</p> <p>Prior Authorization and enrollment through the utilization management company required. See Obesity Benefit for further details.</p> <p>Non-surgical expenses related to obesity or bariatric surgery are payable the same as any other medical condition only if incurred while enrolled in the obesity program through the utilization management company.</p>	

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	BENEFIT PERCENTAGE ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
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OFFICE VISITS

	100% after \$25 Copayment, Deductible Waived
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Copayment applies only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other Outpatient setting). Additional charges for services that are performed at the time of the visit, e.g. diagnostic lab, office surgery, diagnostic miscellaneous testing, allergy injections, are payable at 100%, Deductible Waived.

ORGAN/TISSUE TRANSPLANTS (Limited to Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable))

Inpatient Professional Provider Expenses	100%, Deductible Waived
Facility Provider Expenses	70% after Deductible
Provider other than Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable)	No Benefit

Benefit Limits: \$10,000 Maximum Benefit for Ground Ambulance Travel per Transplant. For Air Ambulance and travel services obtained from Non-Participating Providers, as with all benefits, the PBME (Referenced Based Pricing) applies.

ORTHOPEDIC DEVICES

	100% after \$25 Copayment, Deductible Waived
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ORTHOTICS

	70% after Deductible
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Benefit Limits: Maximum Benefit per Benefit Period / **\$500. Benefit limits are for services received from all Providers.** Benefit limited to custom made rigid inserts for shoes, with a medical diagnosis and prescribed by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning.

PRESCRIPTION DRUGS

	See Pharmacy Benefit for Details
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SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	BENEFIT PERCENTAGE ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
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PREVENTIVE CARE BENEFIT

	100%, Deductible Waived
<p>Covered Services:</p> <ul style="list-style-type: none"> ◆ Well-Child Care ◆ Physical examinations ◆ Pelvic examination and pap smear ◆ Laboratory and testing ◆ Hearing and vision screening ◆ Mammogram ◆ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ◆ Cardiovascular screening blood tests ◆ Colorectal cancer screening tests ◆ Vaccinations and Immunizations recommended by Physician ◆ BRCA1 and BRCA2 when medically indicated ◆ Nutritional counseling ◆ Well Women Preventive Care subject to Plan limitations on sterilization procedures <p>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. Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>	

PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY

Inpatient Professional Provider Expenses	100%, Deductible Waived
Inpatient Facility Provider Expenses	70% after Deductible

PROFESSIONAL PROVIDER SERVICES

Office Visit Services (Outpatient Professional Provider Expenses)	100% after \$25 Copayment, Deductible Waived
Inpatient Professional Provider Expenses	100%, Deductible Waived

PROSTHETIC APPLIANCES

Purchase of Prosthetic Appliance	70%, Deductible Waived
Repair and Replacement of Prosthetic Appliance	70%, Deductible Waived

RESIDENTIAL TREATMENT FACILITY

	70% after Deductible
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SKILLED NURSING FACILITY

	70% after Deductible
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SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	BENEFIT PERCENTAGE ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
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SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES

	70% after Deductible								
<p>Benefit Limits: Maximum Benefit per Implant for the following:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding-left: 20px;">Orthopedic Implants</td> <td style="text-align: right; padding-left: 20px;">\$40,000</td> </tr> <tr> <td style="padding-left: 20px;">Cardiac Implants (except for LVAD and RVAD)</td> <td style="text-align: right; padding-left: 20px;">\$60,000</td> </tr> <tr> <td style="padding-left: 20px;">Cochlear Implants</td> <td style="text-align: right; padding-left: 20px;">\$85,000</td> </tr> <tr> <td style="padding-left: 20px;">LVAD / RVAD Implants</td> <td style="text-align: right; padding-left: 20px;">\$200,000</td> </tr> </table> <p>Maximums apply to any implantable device and all supplies associated with that implantable device. Benefit limits apply to Non-Participating Provider services only. For Participating Providers, payment will be made pursuant to the provider contract. As with all benefits, the PBME (Referenced Based Pricing) still applies.</p> <p>Prior Authorization by the Plan is strongly recommended for all surgical implant procedures. If Prior Authorization 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 when the claim is submitted.</p>		Orthopedic Implants	\$40,000	Cardiac Implants (except for LVAD and RVAD)	\$60,000	Cochlear Implants	\$85,000	LVAD / RVAD Implants	\$200,000
Orthopedic Implants	\$40,000								
Cardiac Implants (except for LVAD and RVAD)	\$60,000								
Cochlear Implants	\$85,000								
LVAD / RVAD Implants	\$200,000								

SURGICAL SERVICES

Professional Provider Expenses	100%, Deductible Waived
Facility Provider Expenses	70% after Deductible

THERAPY BENEFIT

Office Visit Services	100% after \$25 Copayment, Deductible Waived
Inpatient Professional Provider Expenses	100%, Deductible Waived
Inpatient and Outpatient Facility Provider Expenses	70% after Deductible
Outpatient Expenses include Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehabilitation Therapy.	

TOBACCO CESSATION BENEFIT (Not otherwise covered under Preventive Care Benefit)

	100% after \$25 Copayment, Deductible Waived
Services must be provided by a Physician or Licensed Health Care Provider.	

URGENT CARE FACILITY

	100% after \$50 Copayment/visit, Deductible Waived
Copayment applies to all charges billed by an Urgent Care Facility when treatment has been rendered.	

PHARMACY BENEFIT

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

The Pharmacy Benefit is designed so that a Covered Person can obtain covered prescription drugs by using the identification card. If covered drugs are purchased at a Participating Pharmacy, the Participant must pay a Copayment and/or Deductible as stated in Cost Sharing Provisions. In addition, the Participant must pay an Ancillary Charge if a Brand-Name drug is purchased when a Generic substitute is available.

If covered Prescription Drug Products are purchased at a nonparticipating pharmacy, the Covered Person will need to pay for the prescription at the time of dispensing and then file a drug claim form with the Pharmacy Benefit Manager for reimbursement. The Participant will be reimbursed based on the amount that would have been paid to a Participating Pharmacy less any applicable Deductible and/or Copayment.

The Plan uses a Formulary for preferred Prescription Drug Products. The Copayment is higher if a Non-formulary Prescription Drug Product is purchased.

If covered maintenance Prescription Drug Products are purchased through the mail service pharmacy, the Covered Person must send an order form and the prescription to the address listed on the mail service form and pay the required Deductible and/or Copayments. Instructions are on the mail service claim form.

COST SHARING PROVISIONS

Pharmacy Deductible per Benefit Period

Per Covered Person \$300

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 \$3,600
Per Family \$7,200

Pharmacy Out-of-Pocket Maximum includes Pharmacy Deductible and any applicable Pharmacy Copayments. Pharmacy Copayments do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. Pharmacy Benefits are payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum for the remainder of the Benefit Period.

Copayment per Prescription after Deductible is met		
Drug Type	Retail PBM Network 1-34 day supply	Mail Order up to 90-day supply
Generic	\$10	\$20
Brand-Name(Formulary)	\$20	\$40
Brand-Name (Non-Formulary)	\$40	\$80

Copayment per Prescription after Deductible is met		
Specialty Drug	See ProActPLUS Prescription Drug Program	Not Applicable
<p>The following are payable at 100% and are not subject to any Deductible or Copayment:</p> <ol style="list-style-type: none"> 1. Prescribed generic contraceptives or brand if generic is unavailable; 2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; 3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act; 4. Breast cancer preventive treatment(s) prescribed by a Physician or Licensed Health Care Provider; and 5. Colonoscopy bowel preparation products prescribed by a Physician or Licensed Health Care Provider. <p>Preventive Service covered under the Affordable Care Act can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.</p> <p>Please refer to the Plan's formulary at https://secure.proactrx.com/resource-pages/drug-lists for the full list of products payable at 100%, as not all drugs and supplies are covered at 100%.</p>		

PROACT DIABETIC MANAGEMENT PROGRAM

The ProAct Diabetic Management Program is a special mail order service which provides diabetic testing supplies at no cost to the Covered Person. To receive diabetic testing supplies through the ProAct Diabetic Management Program the Covered Person must contact ProAct to enroll in the program. Supplies received at a regular pharmacy are subject to applicable Deductible and Copayments.

PROACTPLUS PRESCRIPTION DRUG PROGRAM

The ProActPLUS Prescription Drug Program targets various specialty and non-specialty medications across several different therapy categories to apply manufacturer programs to reduce Covered Persons costs by up to 100%. ProActPLUS will determine enrollment in a specific program and will coordinate to enroll the Covered Person. Contact ProActPLUS Program Coordinator at (877) 635-9545 or proactplus@proactrx.com for further information and a current list of medications. Failure to enroll in the ProActPLUS Prescription Drug Program may result in a penalty.

DISPENSING LIMITATIONS

The Plan will cover Outpatient Prescription drugs for the amount normally prescribed by a Physician, not to exceed a 34-day supply, except for certain maintenance prescription drugs that may be dispensed for up to a 90-day supply and not to exceed recommended dose as determined by the U.S. Food and Drug Administration (FDA).

Prescription Drug Products obtained through the mail service pharmacy approved by the Plan will be provided in full after the Participant has paid any Deductible or Copayment as stated in Cost Sharing Provisions. Prescription Drug Products furnished by the mail service pharmacy will be limited to a 90-day supply per purchase. To obtain Benefits, the Participant must send an order form and the prescription to the address listed on the mail service pharmacy order form. A Participant may obtain a list of approved pharmacies from the Pharmacy Benefit Manager.

BENEFITS

The Plan provides Benefits for a Prescription Drug Product if all of the following conditions are met:

1. It is Medically Necessary;
2. It is obtained through a Participating Pharmacy, either retail or mail order, or a retail nonparticipating pharmacy; and
3. It is provided while the person is a Participant;
4. Are approved for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed;
5. Are listed in the American Medical Association Drug Evaluation, Physicians Desk Reference, or Drug Facts and Comparisons;
6. Require a Physician's written prescription;
7. It is considered an eligible Prescription Drug Product.
8. Any drugs 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/>.

Certain Prescription Drug Products require Prior Authorization. Please refer to the section entitled Benefit Management.

If Primary coverage is under another Plan charges for prescription drugs must be submitted to the primary carrier first.

In order to receive reimbursement, the drug receipt must be submitted to the Pharmacy Benefit Manager. For all purposes, this Plan will be primary to Medicare Part D.

COVERED PRESCRIPTION DRUGS

The following Prescription Drug Products when obtained through the Pharmacy Benefit are covered:

1. Legend drugs - Drugs and medications requiring written prescriptions and dispensed by a licensed pharmacist for treatment of an Illness or Injury.
2. Compounded medication of which at least one ingredient is a legend drug. The national drug code (NDC) number must be provided for reimbursement.
3. Specialty Pharmaceuticals are a benefit only when obtained through a Specialty Care Pharmacy.
4. Blood glucose monitors, diabetic supplies, insulin, insulin syringes, insulin injecting devices, and Glucagon Auto injection. Diabetic drugs and supplies are covered only when obtained through the ProAct Diabetic Management Program, except for the first fill at a retail pharmacy.
5. Tretinoin, all dosage forms (e.g., Retin-A, Renova), for individuals through age 25.
6. Self-administered contraceptives, injectable contraceptives and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider. **Female contraceptives and Contraceptive Management are also covered under the Preventive Care Benefit.**

7. Any other drug which, under the applicable state law, may only be dispensed upon the written prescription of a Physician or other lawful prescriber and is a covered medical expense.
8. Smoking deterrents 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/>.
9. 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/>.
10. Breast cancer preventive treatment(s) prescribed by a Physician or Licensed Health Care Provider.
11. Colonoscopy bowel preparation products prescribed by a Physician or Licensed Health Care Provider.

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

EXCLUDED PRESCRIPTION DRUGS

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

1. Non-legend drugs other than insulin, except as covered.
2. Anabolic Steroids.
3. Any drug used for the purpose of weight loss, unless Prior Authorization is obtained through the Bariatric Resource Services program administered by the utilization management company.
4. Fluoride supplements.
5. Minerals. Certain minerals, requiring a prescription may be covered, if Medically Necessary and the Participant receives Prior Authorization.
6. Prescription drugs for which a therapeutic equivalent is available as an over-the-counter drug. Certain prescription drugs, for which a therapeutic equivalent is available as an over-the-counter drug may be covered, if Medically Necessary and the Participant receives Prior Authorization.
7. Drugs for Cosmetic purposes, including the treatment of alopecia (hair loss) (e.g., Minoxidil, Rogaine).
8. Vitamins, singly or in combination. Certain vitamins, requiring a prescription may be covered, if Medically Necessary and the Participant receives Prior Authorization.
9. Drugs used for erectile dysfunction. Certain drugs used for erectile dysfunction may be covered, if Medically Necessary and the Participant receives Prior Authorization.
10. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those otherwise covered under this section.

11. Diabetic infusion sets, which include a cassette, needle and tubing, and one insulin pump during the warranty period. Diabetic infusion sets and accessories for insulin pumps are covered under the medical supply benefit. Insulin pumps are covered under the Durable Medical Equipment benefit.
12. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Participant is charged for the drug.
13. Immunization agents, biological sera, blood, or blood plasma.
14. Medication which is to be taken by or administered to the Participant, in whole or in part, while the Participant is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility's charge.
15. Outpatient prescription drugs dispensed from a pharmacy within a Hospital or other facility.
16. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
17. Smoking deterrent medications or aids, except as covered.
18. Replacement prescriptions due to loss, theft or spoilage.
19. Prescription that a Participant is entitled to receive without charge from any Workers' Compensation laws, or any municipal state, or federal program.
20. Non-sedating antihistamines.
21. Abortifacient drugs.
22. COVID-19 home tests.

PROVIDERS OF CARE

The participation or non-participation of providers from whom a Participant receives services and supplies impacts the amount the Plan will pay and the Participant's responsibility for payment. Professional Providers and Facility Providers are either Participating Providers or non-Participating Providers.

Professional Providers include, but are not limited to: Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, nurse specialists, Advanced Practice Registered Nurses, Physician assistants, naturopathic Physicians and physical therapists.

Facility Providers include, but are not limited to: Hospitals, Home Health Care Agencies, convalescent homes, Skilled Nursing Facilities, freestanding facilities for the treatment of Alcoholism, Chemical Dependency or Mental Illness, and freestanding surgical facilities (surgery center).

To determine if a Physician, health care provider, or Facility Provider qualifies as an eligible Participating Provider under this Plan, please consult Allegiance's website at: www.askallegiance.com/MMIA to access links for directories of Participating Providers or call customer service at (866) 339-4308.

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.

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 Participating Provider affiliation, the Plan will pay the provider at the Participating Provider benefit level and allowable amount for a period of up to ninety (90) days after the date the provider terminates its Participating Provider affiliation:

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

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

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

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 a Covered Person is confined in the Hospital on the last day of the Benefit Period and continuously confined through the first day of the next Benefit Period, only one Deductible will be applied to that stay. If the Covered Person satisfied the Deductible prior to that Hospital stay, no Deductible will be applied to that stay.

DEDUCTIBLE CARRYOVER PROVISION

Expenses Incurred for Medical Benefits during the last three months of a Benefit Period which are applied to the Deductible will be "carried over" and applied against the Deductible applicable in the following Benefit Period. This provision does not apply to the Prescription Deductible for the Pharmacy Benefit.

BENEFIT PERCENTAGE

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, is stated in the Schedule of Medical Benefits and includes the Deductible, Medical Copayment amounts and amounts in excess of the Benefit Percentage paid by the Plan. Expenses Incurred in a single Benefit Period after satisfaction of the Out-of-Pocket Maximum per Covered Person or per Family, whichever is applicable, will be paid at 100% of the Eligible Expense for the remainder of the Benefit Period.

If the Covered Person is in the Hospital on the last day of the Benefit Period and continuously confined through the first day of the next Benefit Period, Deductible and amounts in excess of the Benefit Percentage for the entire stay will only apply to the Out-of-Pocket Maximum of the Benefit period in which the Inpatient stay began. If the Covered Person satisfied the Out-of-Pocket Maximum prior to that Hospital stay, no Deductible and expenses for the Hospital stay will be paid at 100% of the Eligible Expense.

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.

COPAYMENT

The Copayment applies to certain services as stated in the Schedule of Medical Benefits. The Copayment is a specific dollar amount payable by the Participant which may be required to be paid at the time of service. Medical Copayments do not apply towards the Medical Benefits Deductible but do apply towards the Medical Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Medical Copayments will no longer apply for the remainder of the Benefit Period.

MAXIMUM BENEFIT

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

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

Deductibles will be applied to 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.

NEW YORK STATE EXPENSES

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

MEDICAL BENEFITS

Prior Authorization by the Plan is strongly recommended for certain services. If Prior Authorization 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 when the claim is submitted. See Benefit Management for further details.

Prior Authorization is required by the Plan Supervisor for certain services. If Prior Authorization is not obtained, the charge will be denied when the claim is submitted. See Benefit Management for further details.

The following Medical Benefits are payable as stated in the Schedule of Benefits and subject to all terms and conditions of this Plan:

1. Charges made by an Ambulatory Surgical Center when treatment has been rendered.
2. Charges made by an Urgent Care Facility when treatment has been rendered.
3. Charges for services and supplies furnished by a Birthing Center.
4. Charges for the services of a licensed Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.

Charges are eligible for drugs intended for use in a Physicians' office or settings other than home use that are billed during the course of an evaluation or management encounter.

5. Charges for Surgical Procedures.

For non-Participating Providers, 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.

For Participating Providers, payment will be made pursuant to the PBME (Reference Based Pricing).

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

7. 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.

8. Charges for services provided by a licensed naturopathic provider. This does not include acupuncture, neuro-feedback or bio-feedback services provided by a Naturopath which are specifically covered under the Alternative Medicine Benefit.
9. 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.
10. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs not available through the Pharmacy Benefit regardless of Medical Necessity and FDA approved over-the-counter female contraceptives prescribed by a Physician or Licensed Health Care Provider. **Conditions of coverage for Outpatient prescription drugs and supplies are stated in the Pharmacy Benefit section of the Plan.**
11. Charges for radiation therapy or treatment and chemotherapy.
12. 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.
13. Charges for oxygen and other gases and their administration.
14. Charges for the cost and administration of an anesthetic.
15. Charges by a Physician or Licensed Health Care Provider for dressings, sutures, casts, splints, crutches, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies.
16. Charges for diabetic supplies not available through the Pharmacy Benefit. Insulin pumps and accessories to insulin pumps are covered under the Durable Medical Equipment benefit. See also Insulin and Medically Necessary Equipment and Supplies Benefit for further details.
17. Charges for adhesive tape, bandages, antiseptics or other over-the-counter first aid supplies only if approved by the Plan based on guidelines of cost effectiveness and Medically Necessary treatment of an Illness or Injury.
18. Charges for voluntary vasectomy for Participant and Dependent spouse only. Charges for sterilization procedures for females are covered under the Preventive Care Benefit.

19. 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.
20. Charges for Contraceptive Management, regardless of Medical Necessity.
21. Charges for dental services provided by Physicians, dentists, oral surgeons and/or any other provider are excluded under this Plan; however, benefits will be payable for Medically Necessary services required because of Accidental Injury to natural teeth. Such Expenses must be Incurred within one (1) year from the date of the accident except in the event that it is medically impossible for service to be completed within that time frame because of the age of the Covered Person or because of the healing process of the Injury. Dental implants provided as the result of an accident will be covered within one (1) year from the date of accident, subject to Medical Necessity. This benefit will not in any event be deemed to include charges for orthodontics, dentofacial orthopedics or related appliances, or treatment for the repair or replacement of a denture. **For any charges covered under this Plan and that may also be covered under a separate dental plan, this Plan will be primary.**
22. 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.
23. Charges for the following Alcoholism 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.
24. 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, the 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.

- 25. Charges for services that are related to or as a result of Telemedicine, 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.

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

26. 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.
27. Charges for midwife services by a Certified Nurse Midwife (CNM) who is a registered nurse and enrolled in either the certification maintenance program or the continuing competency assessment program through the American College of Nurse Midwives (ACNM).

ALTERNATIVE MEDICINE BENEFIT

The Schedule of Medical Benefits describes special payment provisions for these services.

Coverage under this benefit is limited to charges for acupuncture, neuro-feedback and bio-feedback services provided by a Physician, Naturopath or Licensed Health Care Provider. Over-the-counter remedies are not covered.

COLONOSCOPY BENEFIT

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.

DIABETIC EDUCATION/TRAINING BENEFIT

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

Coverage under this benefit includes Medically Necessary prescribed diabetic Outpatient self-management training and education for the treatment of diabetes in either an individual or group setting if the Covered Person has not previously received the education. Any education must be provided by a Licensed Health Care Provider with expertise in diabetes.

DIAGNOSTIC SERVICES

Coverage under this benefit includes charges for diagnostic x-ray examination, laboratory and tissue diagnostic examinations, and medical diagnostic procedures (machine tests such as EKG, EEG) including, but not limited to, the following:

1. X-rays and other radiology;
2. Laboratory tests; and
3. Diagnostic testing to diagnose an Illness or Injury such as electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally accepted by Physicians throughout the United States..

This benefit does not include biopsies which are covered under the surgery benefit.

DIALYSIS TREATMENTS - OUTPATIENT

The Schedule of Medical Benefits describes special payment provisions for these services.

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

Prior Authorization is strongly recommended for Outpatient Renal Dialysis. Failure to obtain Prior Authorization may result in significant out-of-pocket expenses not covered by the Plan.

DURABLE MEDICAL EQUIPMENT

Coverage under this benefit includes charges for the Durable Medical Equipment as follows:

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

Prior Authorization is strongly recommended for Durable Medical Equipment. Failure to obtain Prior Authorization may result in significant out-of-pocket expenses not covered by the Plan.

FERTILITY PRESERVATION SERVICES

Coverage includes charges for Medically Necessary Standard Fertility Preservation Services when a Covered Person is diagnosed with cancer and the standard of care involves Medical Treatment That May Directly or Indirectly Cause Latrogenic Infertility.

For purposes of this benefit, the term “Standard Fertility Preservation Services” means procedures consistent with established medical practices and professional guidelines published by a national association for practitioners of reproductive medicine or clinical oncology.

For purposes of this benefit, the term “Medical Treatment That May Directly or Indirectly Cause Latrogenic Infertility” means treatment with a potential side effect of impaired fertility, as established by a national association for practitioners of reproductive medicine or clinical oncology.

For purposes of this benefit, the term “Latrogenic Infertility” means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation or other medical treatment.

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.

HEARING AIDS AND EXAMINATION**Benefit limits apply as stated in the Schedule of Medical Benefits.**

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

HOME HEALTH CARE BENEFIT

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

1. Part-time or intermittent nursing care by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN) or public health nurse who is under the direct supervision of a Registered Nurse;
2. Home health aides.
3. Hospice services.
4. Physical Therapy, Occupational Therapy and Speech Therapy.
5. Medical social worker services.
6. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.
7. Medically Necessary personal hygiene, grooming and dietary assistance.

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. Transportation services.
4. "Meals-on-Wheels" or similar food arrangements.
5. Domestic or housekeeping services.
6. Maintenance or Custodial Care.
7. Services for mental or nervous conditions.

HOSPICE SERVICES

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

1. Daily Room and Board.
2. Nursing care by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), a public health nurse who is under the direct supervision of a Registered Nurse.

3. Physical Therapy and Speech Therapy, when rendered by a licensed therapist.
4. Medical supplies, including drugs and biologicals and the use of medical appliances.
5. Physician's services.
6. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
7. Counseling and other support services, including bereavement counseling, provided to meet the physical, psychological, spiritual, and social needs of the terminally ill patient.
8. Instructions for care of the Participant, counseling and other support services for the Participant's immediate family.

HOSPITAL SERVICES

Coverage under this benefit includes charges billed by a Hospital for:

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

INBORN ERRORS OF METABOLISM

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

"Medical Foods" means nutritional substances in any form that are:

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

INSULIN AND MEDICALLY NECESSARY EQUIPMENT AND SUPPLIES BENEFIT

Coverage includes charges for diabetic equipment and supplies that is limited to insulin, syringes, injection aids, devices of self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States Food and Drug Administration, and glucagon emergency kits. Coverage for insulin must limit the Covered Person's required Copayment or other cost-sharing requirement as described in the Pharmacy Benefit section in this document regardless of the amount or type of insulin prescribed. The limitation applies to insulin covered by the Plan's formulary.

MAMMOGRAMS

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

MATERNITY SERVICES

Coverage under this benefit includes charges for the following services related to Pregnancy:

1. Prenatal and postpartum care.
2. Delivery of one or more newborns, miscarriage, and any medical complications arising out of or resulting from Pregnancy.
3. Hospital Inpatient care for conditions related directly to the Pregnancy.

NEWBORN INITIAL CARE

Coverage under this benefit includes charges for the following services:

1. The initial care of a Newborn at birth provided by a Physician, including circumcision performed within six (6) months from birth.
2. Standby care provided by a pediatrician at a cesarean section.
3. Nursery Care - Includes Room and Board and Hospital Miscellaneous expenses for the Newborn, including circumcision performed within six (6) months from birth.

NON-AMBULANCE TRAVEL BENEFIT FOR ORGAN AND TISSUE TRANSPLANT

The Schedule of Medical Benefits describes special payment provisions for these services.

Charges for the Participant and one (1) companion. Benefit is limited to travel to a Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable).

NUTRITIONAL ASSESSMENT/COUNSELING

The Schedule of Medical Benefits describes special payment provisions for these services.

Charges rendered by a registered dietician or other Licensed Health Care Provider for nutritional assessment/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, and hyperlipidemias. Services are not eligible for the purposes of specialty diets for athletic training or other non-medical purposes.

OBESITY BENEFIT

The Schedule of Medical Benefits describes special payment provisions for these services.

This benefit is only available if Prior Authorized and enrolled in the obesity program through the utilization management company. Charges for services related to obesity or bariatric surgery are not covered that are incurred prior to enrollment.

Charges for bariatric surgery and directly related pre-surgical assessment and or counseling, and directly related post-surgical follow-up care and complications as a result of bariatric surgery are covered up to the limits set out in the Schedule of Medical Benefits.

Coverage under this benefit includes charges incurred while the Covered Person is enrolled in the obesity program for non-surgical treatment of morbid obesity including, but not limited to, office visits, diagnostic testing, nutritionist or dietician services related to obesity or bariatric surgery.

Coverage also includes charges for surgical expenses only if the obesity program determines that all of the following conditions have been met:

1. Has a Body Mass Index (BMI) of 40, or 35 with at least 2 co-morbid conditions present; and
2. Is at least 21 years of age; and
3. Is a non-tobacco user, or has successfully completed a tobacco cessation program; and
4. Has completed a twelve (12) consecutive month Physician supervised weight loss program; and
5. Has completed a pre-surgical psychological evaluation; and
6. Has been enrolled under the health plan for at least two (2) consecutive plan years.

ORGAN/TISSUE TRANSPLANTS

The Schedule of Medical Benefits describes special payment provisions for these services. Provider other than Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable) is Not Covered.

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

1. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.
2. If the donor is covered under this Plan, Expenses Incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.
3. If the recipient is covered under this Plan, 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 Eligible Expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the applicable benefit limits still available to the recipient.

4. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.
5. The cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered for payment.

ORTHOPEDIC DEVICES

Coverage under this benefit includes charges for Orthopedic Devices, limited to braces, corsets and trusses.

ORTHOTICS

The Schedule of Medical Benefits describes special payment provisions for these services.

Coverage under this benefit includes charges for foot Orthotics that are custom made rigid inserts for shoes, with a medical diagnosis and prescribed by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning.

PREVENTIVE CARE BENEFIT

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

1. Routine Wellness care for children and adults for the following:
 - A. Routine physical examinations by a Physician or Licensed Health Care Provider, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician or Licensed Health Care Provider and associated routine testing provided or ordered at the time of the examination; and
 - B. Routine immunizations according to the schedule of immunizations which is recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention.
2. Prostate Specific Antigen (PSA) test for men.
3. Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at: <https://www.healthcare.gov/coverage/preventive-care-benefits/>.
4. Office visit charges only if the primary purpose of the office visit is to obtain a recommended Preventive Care service identified above.
5. Women's Preventive Care for the following:
 - A. Well-women annual visits for women 18 years of age and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits as medically appropriate.
 - B. Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

- C. Human papillomavirus (HPV) DNA testing.
- D. Annual counseling on sexually transmitted infections (STI) and human immune-deficiency virus (HIV) screening for all sexually active women.
- E. All Food and Drug Administration approved prescription contraceptives and female over-the-counter contraceptives when prescribed by a Physician or Licensed Health Care Provider, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Self-administered contraceptives are available only through the Pharmacy Benefit as outlined in the Pharmacy Benefit section of this Plan.
- F. Breast feeding support, supplies, and counseling, including comprehensive lactation support and counseling by a trained provider during Pregnancy and/or in the postpartum period, and costs for breast feeding equipment and related supplies.
- G. Annual screening and counseling for interpersonal and domestic violence.

Expenses payable under the Preventive Care benefit will not be subject to the Medical Necessity provisions of this Plan. Charges for Preventive Care that involve excessive, unnecessary or duplicate tests are specifically excluded. Charges for treatment of an active illness or injury are subject to the Plan Provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

PREVENTIVE/PROPHYLACTIC MASTECTOMY OR OOPHORECTOMY

Coverage includes charges for a preventive/prophylactic mastectomy or oophorectomy regardless of Medical Necessity for treatment of individuals at high risk of developing breast cancer when any ONE of the following criteria is met:

Individuals with a personal history of cancer as noted below:

1. Individuals with a personal history of breast cancer when any ONE of the following criteria is met:
 - A. Diagnosed at age forty-five (45) or younger;
 - B. Diagnosed at age fifty (50) or younger with at least one close blood relative* with breast cancer at any age;
 - C. Diagnosed with two breast primaries (includes bilateral disease or cases where there are two or more clearly separate ipsilateral primary tumors) when the first breast cancer diagnosis occurred prior to age fifty (50);
 - D. Diagnosed at age sixty (60) or younger with a triple negative breast cancer;
 - E. Diagnosed at age fifty (50) or younger with a limited family history (e.g., fewer than two first- or second degree female relatives or female relatives surviving beyond forty-five (45) years in the relevant maternal and/or paternal lineage);
 - F. Diagnosed at any age and there are at least two close blood relatives* with breast cancer diagnosed at any age;
 - G. Diagnosed at any age and there is at least one close blood relative* with breast cancer at age fifty (50) or younger;
 - H. Diagnosed at any age and there are at least two close blood relatives* with pancreatic cancer or prostate cancer (Gleason score ≥ 7) at any age;

- I. Diagnosed at any age with one or more close blood relatives* with epithelial ovarian cancer, fallopian tube, or primary peritoneal cancer;
 - J. Close male blood relative* with breast cancer;
 - K. An individual of Ashkenazi Jewish descent;
 - L. Development of invasive lobular or ductal carcinoma in the contralateral breast after electing surveillance for lobular carcinoma in situ of the ipsilateral breast;
 - M. Lobular carcinoma in situ confirmed on biopsy;
 - N. Lobular carcinoma in situ in the contralateral breast;
 - O. Diffuse indeterminate microcalcifications or dense tissue in the contralateral breast that is difficult to evaluate mammographically and clinically;
 - P. A large and/or ptotic, dense, disproportionately-sized contralateral breast that is difficult to reasonably match the ipsilateral cancerous breast treated with mastectomy and reconstruction.
2. Personal history of epithelial ovarian, fallopian tube, or primary peritoneal cancer;
 3. Personal history of pancreatic cancer or prostate cancer (Gleason score ≥ 7) at any age with two or more close blood relatives* with breast, ovarian, pancreatic cancer, or prostate cancer (Gleason score ≥ 7) at any age;
 4. Personal history of pancreatic cancer at any age with Ashkenazi Jewish ancestry and one or more close blood relatives* with breast, ovarian, pancreatic cancer, or prostate cancer (Gleason score ≥ 7) at any age;
 5. Personal history of male breast cancer.

Individuals with no personal history of breast or epithelial ovarian cancer when any ONE of the following is met:

1. Known breast risk cancer antigen (BRCA1 or BRCA2), or PTEN mutation confirmed by genetic testing;
2. Close blood relative* with a known BRCA1, BRCA2 or PTEN mutation;
3. First- or second-degree blood relative* meeting any of the above criteria for individuals with a personal history of cancer;
4. Third-degree blood relative with breast and/or epithelial ovarian/fallopian tube/primary peritoneal cancer with two or more close blood relatives* with breast and/or ovarian cancer (with at least one close blood relative with breast cancer prior to age fifty (50));
5. History of treatment with thoracic radiation;
6. Atypical ductal or lobular hyperplasia, especially if combined with a family history of breast cancer;
7. Dense, fibronodular breasts that are mammographically or clinically difficult to evaluate, several prior breast biopsies for clinical and/or mammographic abnormalities, and strong concern about breast cancer risk.

*A close blood relative/close family member includes first-, second-, and third-degree relatives on the same side of the family.

A first-degree relative is defined as a blood relative with whom an individual shares approximately 50% of his/her genes, including the individual's parents, full siblings, and children.

A second-degree relative is defined as a blood relative with whom an individual shares approximately 25% of his/her genes, including the individual's grandparents, grandchildren, aunts, uncles, nephews, nieces and half-siblings.

A third-degree relative is defined as a blood relative with whom an individual shares approximately 12.5% of his/her genes, including the individual's great-grandparents and first-cousins.

PROSTHETIC APPLIANCES

Coverage under this benefit includes charges for Prosthetic Appliances as follows:

1. Purchase of Prosthetic Appliances including, but not limited to, artificial limbs, eyes, larynx.
2. Replacement or repair of Prosthetic Appliances.

Prior Authorization is strongly recommended for Prosthetic Appliances. Failure to obtain Prior Authorization may result in significant out-of-pocket expenses not covered by the Plan.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

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

1. Reconstruction of the breast(s) upon which the mastectomy was performed, including implants;
2. Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants;
3. Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry.

Specifically excluded from this benefit are expenses for the following:

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

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.

SKILLED NURSING FACILITY

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

1. Daily Room and Board.
2. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.
3. Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent confinement, but no other supplies.

SPINAL SURGERY BENEFIT

Coverage includes charges for spine surgery if the following requirements are met:

1. Spine surgery in the absence of one the following conditions or diagnoses shall be subject to, and require proof of a minimum of three (3) consecutive months of unsuccessful conservative therapy within the six (6) months immediately prior to the scheduled date of surgery:
 - A. Acute trauma;
 - B. Tumor;
 - C. Infection;
 - D. Cauda equina syndrome;
 - E. Severe disease and rapidly progressing neurologic deficit;
 - F. Situation where the patient risks permanent neurological or functional deficit if not operated on urgently.
2. Conservative therapies are non-operative treatments such as Physical Therapy, epidural injections, non-steroidal anti-inflammatory medications and other recommended regimens by a Physician.

Benefits of all spine surgeries shall be covered based upon published national current best practices guidelines, such as by the North American Spine Society (NASS) guidelines or by the International Society for the Advancement of Spine Surgery (ISASS) guidelines, as applied to the specific surgical procedure recommended. This includes, but is not limited to, all requirements or guidelines for prior conservative treatments, including the above, before surgery is performed.

3. Use of tobacco products or nicotine replacement products within the three (3) weeks immediately prior to a spinal fusion operation of any kind is a contraindication to surgery. A Covered Person using tobacco or nicotine products must undergo a nicotine test and demonstrate that it is negative prior to approval for surgery. This excludes a Covered Person with conditions defined above that require surgery on a non-elective basis who cannot abstain from the use of nicotine or tobacco products for a minimum of three (3) weeks because of the specific condition and diagnosis.

None of the requirements above will be waived, except by written request of the attending surgeon, with two unanimous, concurrent, independent board certified spine surgeon reviews, either by a neurosurgeon or by an orthopedic spine surgeon. At least one (1) of the reviews must be done by a surgeon outside the attending surgeon's background (e.g. A neurosurgeon must have at least one (1) review by an orthopedic spine surgeon). The review must state that the non-operative treatment requirements of this Plan or recommended guidelines are not medically appropriate for the specific patient's diagnosis and condition, as reported in the records submitted.

SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES

The Schedule of Medical Benefits describes special payment provisions for these services.

Charges for surgical implants and/or devices and related supplies are payable as specifically outlined in the Schedule of Medical 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.

Prior Authorization by the Plan is strongly recommended for all implantable procedures. If Prior Authorization 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 when the claim is submitted.

THERAPIES FOR DOWN SYNDROME BENEFIT

Coverage under this benefit includes charges for diagnosis and treatment of Down Syndrome for a covered Dependent eighteen (18) years of age or younger. Coverage must include:

1. Habilitative or rehabilitative care that is prescribed, provided, or ordered by a Physician, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child; and
2. Medically Necessary therapeutic care that is provided as follows:
 - A. Speech Therapy up to one hundred four (104) sessions per Benefit Period;
 - B. Physical Therapy up to fifty-two (52) sessions per Benefit Period; and
 - C. Occupational Therapy up to fifty-two (52) sessions per Benefit Period.

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention.

Coverage provided under this benefit may not be construed as limiting physical health benefits that are otherwise available to the covered child. Coverage under this benefit is subject to the same cost sharing provisions as other medical care covered under this Plan

Therapy has been prescribed by a Physician and includes a written treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The treatment plan must be based on evidence-based screening criteria. The Plan may request that the treatment plan be updated every six (6) months.

As used in this benefit, "Medically Necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician licensed in the state in which services are rendered or provided 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.

THERAPY BENEFIT

Coverage includes charges for the following services:

1. Physical Therapy or Occupational Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Inpatient or Outpatient basis. Physical Therapy or Occupational Therapy must be ordered by a Physician and rendered by a licensed physical or occupational therapist.
2. Charges made by a licensed speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders.
3. Cardiac Rehabilitation Therapy, which is the process of restoring optimal function status after a cardiac event, including an ECG-monitored exercise component.

TOBACCO CESSATION BENEFIT

Coverage under this benefit includes charges for services provided by a Physician or Licensed Health Care Provider. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider are covered under the Pharmacy Benefit.

EXPERIMENTAL COVERAGE

Treatment that would otherwise be considered Experimental/Investigational will be covered if the proposed Experimental/Investigational treatment has been reviewed by three (3) unrelated, independent board certified Physicians actively practicing within the same speciality as the attending Physician and at least two (2) out of the three (3) reviewing Physicians agree 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. If the patient is considered to be terminal, the patient will not continue to be considered terminal if the patient receives the proposed Experimental treatment; or
6. If applicable, 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.

PROVIDER SELF-AUDIT INCENTIVE PROGRAM

MMIA offers an incentive to all Covered Persons to encourage thorough examination of medical charges. The Covered Person should review all medical charges and verify each itemized service was actually received. If this self-audit exposes a charge for a service not received or an overcharge, an incentive may be awarded.

This payment error must meet the following criteria:

1. Not detected by the provider of services; and
2. Not detected by the Plan; and
3. Part of the charges for services which are covered under this Plan.

If all of these elements are met, contact the provider of services so that the overcharge or incorrect charge is corrected. Submit a copy of the documentation examined to find the error and clearly mark it "Self-Audit Incentive". Send all pertinent documentation to:

Allegiance Benefit Plan Management, Inc.
Attention: Claims Department
Self-Audit Incentive Program
P.O. Box 3018
Missoula, MT 59806-3018

The Plan will 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 is \$50 which would result in a \$25 refund.

GENERAL EXCLUSIONS AND LIMITATIONS

All Expenses Incurred under this Plan are subject to the following General Exclusions and limitations. **Except as otherwise provided by this Plan, the Plan will not pay for the following:**

1. Charges for any services or supplies not necessary for treatment of an actual Illness or Injury including, but not limited to, annual physical examinations; insurance, premarital, athletic, and employment physicals; routine examinations and routine immunizations, except as specifically covered otherwise.
2. Charges in connection with the care or treatment of, surgery performed for, or as the result of, a Cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury or an Illness, or when rendered to correct a congenital anomaly.**
3. Charges for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a covered benefit of this Plan.
4. Charges for elective abortions. However, abortion services in any jurisdiction where the service is illegal by the law of that jurisdiction are excluded regardless.
5. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury.
6. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician, except as specifically covered as 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 as Telemedicine.
8. Charges for special duty nursing services are excluded:
 - A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or
 - B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.
9. Charges in connection with eye refractions, the purchase or fitting of eyeglasses or contact lenses, except as specifically listed as a covered service.
10. Charges in connection with hearing aids, supplies and tinnitus maskers or such similar aid device, except as specifically listed as a covered service.
11. Charges for dental services except as specifically covered due to Accidental Injury to natural teeth.

12. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, in-vitro fertilization, or any other assisted reproductive technique, except as specifically covered under the Fertility Preservation Benefit.
13. Charges resulting from or in connection with the reversal of a sterilization procedure.
14. Charges for services or supplies for the medical and/or surgical treatment of obesity, except as specifically covered under the Nutritional Assessment/Counseling or Obesity Benefit.
15. Charges for services of a licensed chiropractor.
16. Charges for services or supplies related to any of the following treatments or related procedures:
 - A. Acupressure.
 - B. Homeopathy.
 - C. Hypnotherapy.
 - D. Rolfing.
 - E. Holistic medicine.
 - F. Religious counseling, recreational counseling or milieu therapy.
 - G. Self-help programs.
 - H. Stress management.
17. Charges for foot care including, but not limited to:
 - A. Routine foot care.
 - B. Treatment or removal of corns or callosities.
 - C. Hypertrophy, hyperplasia of the skin or subcutaneous tissues.
 - D. Cutting or trimming of nails.
 - E. Any treatment of congenital flat foot.
 - F. Injections and non-surgical treatment of acquired flat foot, fallen arches, or chronic foot strain.
 - G. Any treatment of flat foot purely for the purpose of altering the foot's contour where no medical or functional impairment exists.
 - H. Padding and strapping.
 - I. Fabrication.
18. Charges for hair transplant procedures, wigs and artificial hairpieces, or drugs which are prescribed to promote hair growth or remove hair.

19. Charges for any services, care or treatment for sexual dysfunction, including medications, surgery, medical, counseling or Psychiatric Care or treatment, except as specifically stated in the Pharmacy Benefit.
 20. 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.
 21. Charges related to Custodial Care.
 22. Charges for nonhuman organ or artificial organ implant procedures.
 23. Charges for non-prescription supplies, except as specifically covered under the Preventive Care Benefit.
 24. Charges for services of a direct-entry midwife or lay midwife or the practice of direct-entry midwifery. A Direct-entry midwife is one practicing midwifery and licensed pursuant to 37-27-101 et seq, MCA. "Direct-entry midwife" means a person who advises, attends, or assists a woman during Pregnancy, labor, natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.
 25. 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.
 26. 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.
 27. Charges for services or supplies which the Covered Person is entitled to receive or does receive from the United States or any city, county, state, or country. This exclusion applies to any programs of any agency or department of any government. This exclusion is not intended to exclude from coverage if a Covered Person is a resident of a Montana state institution when services are provided.
- Note:** Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Covered Person from the Plan. When such a circumstance occurs, the Covered Person will receive an explanation of benefits.
28. Charges by the Covered Person for all services and supplies which are provided to treat any Illness or Injury arising out of employment or in the course of an occupation. **However, this exclusion does not apply to charges for services and supplies as the result of an Illness or Injury which occurs in the course of employment if the Participant is a corporate officer, sole proprietor, working partner of a partnership or working member of a member-managed limited liability company who is not required to have Workers' Compensation coverage and either the Participant or their employer has not elected to obtain Workers' Compensation coverage pursuant to the provisions of Title 39, Chapter 71, MCA, or in cases in which it is legally impossible to obtain Workers' Compensation coverage for a specific Illness or Injury.**
 29. 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.
 30. Charges for vitamins or food nutritional supplements, whether or not prescribed by a Physician, except as specifically covered under the Preventive Care Benefit.

31. 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.
32. Charges for non-medical expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician, except as specifically covered.
33. Expenses Incurred by persons other than the Covered Person receiving treatment.
34. Charges in excess of the Eligible Expense.
35. 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.
36. 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.
37. Charges for services, treatment or supplies not considered legal in the United States.
38. Charges for travel Expenses Incurred by any person for any reason, except as specifically covered under the Non-Ambulance Travel Benefit.
39. 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.
40. Charges for surgical and non-surgical operation or treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction (TMJ) anterior or internal dislocations, derangements and myofascial pain syndrome, orthodontics dentofacial orthopedics), or related appliances.
41. Charges for preparation of reports or itemized bills in connection with claims, unless specifically requested and approved by the Plan.
42. Charges for services or supplies that are not specifically listed as a covered benefit of this Plan.
43. 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.
44. 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.
45. 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.
46. Charges for dental braces or corrective shoes.

47. Charges for the following treatments, services or supplies:
 - A. Charges related to or connected with treatments, services or supplies that are excluded under this Plan.
 - B. Charges that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan.
48. Charges for treatment, services or supplies not actually rendered to or received and used by the Covered Person.
49. Charges for computerized items including, but not limited to: Durable Medical Equipment, prosthetic limbs and communication devices.
50. 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.
51. 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.
52. 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.
53. 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.
54. Charges for nutrition-based therapy for Alcoholism or drug addiction.
55. Charges for health care services to treat alcohol or drug co-dependency.
56. Charges for examinations for employment, licensing, insurance, school, camp, sports or adoption purposes.
57. Charges for court-ordered examinations or treatment, except when Medically Necessary and as ordered by a Physician.
58. Expenses for examinations and treatment conducted for the purpose of medical research.
59. Charges for FAA and DOT Physicals.
60. 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.
- 61. 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.
 - 62. 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.
 - 63. Charges for services of a massage therapist.
 - 64. Charges for all medical examinations for firefighters in the state of Montana pursuant to 39-71-101, MCA et. seq.
 - 65. Charges for COVID-19 home tests.

BENEFIT MANAGEMENT

PRE-CERTIFICATION AND PLAN NOTIFICATION

“Pre-Certification” is a determination of the medically appropriate number of Inpatient days for any particular Inpatient treatment or service. Pre-Certification is not a determination that treatment is Medically Necessary or is a covered service under the Plan.

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

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

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

A benefit determination on a claim will be rendered only after the claim has been submitted to adjudicate whether it is eligible for coverage under the terms and conditions of the Plan. If it is determined not to be eligible, the Covered Person will be responsible to pay for all charges that are determined to be ineligible. Therefore, although not required, pre-certification and Plan notification of emergency admissions is strongly recommended to obtain coverage information prior to incurring the charges.

PRE-ADMISSION CERTIFICATION REVIEW

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

To pre-certify, contact 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 pre-certification will be sent to the Physician, to the Covered Person, to the Plan Supervisor and to the Hospital.

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.

To notify the Plan of a continued stay certification, contact the utilization management company at (800) 342-6510.

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, contact the utilization management company at (800) 342-6510 for emergency admission certification.**

MATERNITY NOTIFICATION

The Covered Person or her representative should notify the maternity management company at **(800) 746-2970, extension 0**, when Pregnancy is diagnosed or as soon after as possible, in order to participate in the Plan's maternity management program. Notification is encouraged within the first trimester.

PRIOR AUTHORIZATION

"Prior Authorization" is a determination that a particular treatment or service may be a covered expense under the Plan based solely upon proposed treatment information obtained from the provider. It is not a guarantee of payment or a guarantee of eligibility and the eligibility of all claims is determined only after services are provided and the actual claim has been submitted for claims adjudication.

Prior Authorization is **strongly recommended** for some services and supplies to help the Covered Person identify potential expenses, payment reductions, or claim denials the Covered Person may have if the proposed services, supplies, medications, or ongoing treatment are not Medically Necessary or not a covered medical expense of the Plan. For Prior Authorization of services and/or supplies, the Participant should contact the utilization management company. Prior Authorization is not a guarantee of payment by the Plan.

Prior Authorization is **recommended** for the following services:

1. All elective Inpatient hospitalizations.
2. All elective Inpatient surgeries.
3. Transplants.
4. Gender Identity Disorder/Gender Dysphoria Services.
5. Residential Treatment Facility.
6. Blepharoplasty.
7. Accidental dental surgeries.
8. Preventive/prophylactic mastectomy or oophorectomy.
9. Abdominoplasty.
10. Cosmetic/Experimental surgeries.
11. Dialysis treatment.
12. Joint replacement procedures.
13. Outpatient renal dialysis.
14. Durable Medical Equipment.
15. Prosthetic appliances.
16. Implantable procedures.

Prior Authorization and enrollment is **required** for obesity surgery. Please refer to the Obesity Benefit for further details.

The Prior Authorization process may require additional documentation from the Covered Person's health care provider or pharmacist for some services. In these cases, the review nurse will request the specific information that is necessary from the Covered Person's Physician or facility and may include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc.

If a Covered Person does not obtain Prior Authorization a retrospective review will be performed after the claims have been submitted to determine whether or not the services, supplies, or treatment were Medically Necessary and performed in the appropriate setting. The Participant will be responsible for charges for any services, supplies, or treatment which were not performed in the appropriate setting or which were not Medically Necessary.

Contact the utilization management company at (800) 342-6510 for Prior Authorization.

NOTE: PRE-CERTIFICATION AND PRIOR AUTHORIZATION 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, NETWORK PROVIDER DESIGNATION, MEDICAL NECESSITY, PATIENT ELIGIBILITY, DEDUCTIBLES, CO-PAYMENTS AND ANY PLAN LIMITATIONS OR MAXIMUMS IN EFFECT WHEN THE SERVICES ARE PROVIDED. PROVIDERS AND COVERED PERSONS ARE INFORMED AT THE TIME CLAIMS ARE PRE-CERTIFIED OR AUTHORIZED THAT PRE-CERTIFICATION OR AUTHORIZATION OF A COURSE OF TREATMENT BY THE PLAN DOES NOT GUARANTEE PAYMENT OF CLAIMS FOR THE SAME.

COORDINATION OF BENEFITS

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

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 does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- C. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.

5. Longer or Shorter Length of Coverage

- A. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
- B. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.
- C. The start of a new plan does not include:
 - 1) A change in the amount or scope of a plan's benefits;
 - 2) A change in the entity that pays, provides or administers the plan's benefits; or
 - 3) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
- 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 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 when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment.

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

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

Medicare is primary for the Retiree's Dependent when the Retiree is not enrolled for Medicare Part A or Part B as a result of age and the Retiree's Dependent is enrolled in Medicare Part A or Part B as a result of age or 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 veteran's 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 P.O. Box 5066, Missoula, Montana 59806-5066, (406) 721-2222 or (800) 877-1122 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 MMIA Member Entity's participation in the Plan or 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 judgment of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
 - B. In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

2. **Pre-Service Claims** - Pre-Service Claims must be submitted to the Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Covered Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are procedures stated in the Plan Document/Summary Plan Description which, the Plan recommends be utilized before a Covered Person obtains medical care.
3. **Post-Service Claims** - A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

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

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

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

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

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

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

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

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

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. First Level of Benefit Determination Review

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

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

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

A sub-committee consisting of any three (3) of the fifteen (15) active members of the MMIA Board of Directors (Pre-service Appeals Sub-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 the Pre-Service Appeals Sub-Committee who is neither the original decisionmaker nor the decisionmaker's subordinate. The Pre-Service Appeals Sub-Committee cannot give deference to the initial benefit determination. The Pre-Service Appeals Sub-Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the Pre-Service Appeals Sub-Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination nor his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

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

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

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

INDEPENDENT EXTERNAL REVIEW FOR A PRE-SERVICE CLAIM

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

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

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

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

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

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

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

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

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

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

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. First Level of Benefit Determination Review

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

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

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

The Executive Committee of MMIA Board of Directors 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 Executive Committee of MMIA Board of Directors who is neither the original decisionmaker nor the decisionmaker's subordinate. The Executive Committee of MMIA Board of Directors cannot give deference to the initial benefit determination. The Executive Committee of MMIA Board of Directors 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 Executive Committee of MMIA Board of Directors will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

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

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

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

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

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

INDEPENDENT EXTERNAL REVIEW FOR A POST-SERVICE CLAIM

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

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

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

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

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

ELIGIBILITY PROVISIONS

If both spouses are employed by an MMIA Member Entity, and both are eligible for Dependent Coverage, spouse, but not both, may elect Dependent Coverage for their eligible Dependents. No one can be covered under this Plan as both an Employee and a Dependent. No one can be covered under this Plan as a Dependent by more than one Participant. No one can be covered under this Plan by more than one Member Entity under MMIA.

EMPLOYEE ELIGIBILITY

An eligible Employee under this Plan is defined by the applicable MMIA Member Entity.

An Employee becomes eligible under this Plan for each classification of Employee as stated in the MMIA Member Entity's written personnel policy and in the eligibility statement provided by the MMIA Member Entity to the MMIA.

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

ELECTED OFFICIAL ELIGIBILITY

An Elected Official of a MMIA Member Entity is eligible under this Plan, provided the applicable MMIA Member Entity passes a resolution to allow such coverage.

An eligible Elected Official includes a person whose service with the MMIA Member Entity is as a result of election to an official governmental office as required by Montana law, or as a result of appointment to such an official governmental office to serve out the remainder of an unexpired term of an Elected Official who has resigned or been removed from an official governmental office, as allowed by Montana law. A person will be considered an Elected Official only during the legal term of office for any such official governmental office.

WAITING PERIOD

With respect to an eligible Employee, coverage under the Plan will not start until the Employee completes the applicable Waiting Period (applicable probationary period). The Waiting Period is the period of time as defined by the applicable MMIA Member Entity. The Waiting Period commences with the Enrollment Date (eligibility date) and ends with a period of time, as designated by the Eligible Employer in the MMIA Member Entity's written personnel policy and in the eligibility statement provided by the MMIA Member Entity to the MMIA, starting from the Enrollment Date or the end of the Measurement Period whichever is applicable as defined in the MMIA Member Entity's written personnel policy and in the eligibility statement provided by the MMIA Member Entity to the MMIA. If elected, coverage under this section shall continue for a period of time equal to the Measurement Period, provided the Participant remains employed by the Employer, but regardless of the number of hours worked during that time period. This period of time is the Coverage Period.

With respect to an Elected Official, the Enrollment Date is the date the Elected Official takes the oath of office.

The Waiting Period selected by the MMIA Member Entity will apply to all Employees of the MMIA Member Entity.

CONTRACTED MUNICIPAL GOVERNMENT PUBLIC OFFICER ELIGIBILITY

Municipal government public officers, identified in title 7 MCA, performing municipal government services of a nature generally related to municipal government operations, who contract under a service contract with an MMIA Member Entity are also eligible for coverage if such coverage is requested by the MMIA Member Entity. A Contracted Municipal Government Public Officer covered under this Plan shall have the same rights and shall be subject to the same responsibilities and all of the terms and conditions of the this Plan in the same manner as an Eligible Employee or Participant.

RETIREE ELIGIBILITY

A former covered Employee whose employment with an MMIA Member Entity terminates due solely to retirement from a MMIA Member Entity can continue coverage under the Plan as a Retiree. Requirements to be eligible as a Retiree are determined by the applicable MMIA Member Entity's written personnel policy and Montana law pursuant to 2-18-704 MCA. Coverage will continue for as long as the Retiree is enrolled under this Plan and the applicable premiums are paid, provided a break in coverage does not occur. If a break in coverage occurs, the Retiree is no longer eligible to participate or re-enroll in this Plan.

The Retiree's termination of coverage from the Plan does not apply to the Retiree's spouse or eligible Dependent child, provided the Retiree is terminating because of Medicare coverage. The spouse or eligible Dependent child of a Retiree is permitted to maintain coverage under this Plan, unless the spouse or eligible Dependent child is also eligible for Medicare coverage or the spouse or eligible Dependent child has or is eligible for equivalent coverage. The health plan for the spouse or Dependent child of the Retiree must be the same as the Retiree.

The covered spouse or Dependent child of a Retiree may continue coverage under this Plan on a self-pay basis if the Retiree pre-deceases the spouse or Dependent child, unless the spouse or Dependent child is also eligible for Medicare coverage or the spouse or Dependent child has or is eligible for equivalent coverage. The health plan for the spouse or Dependent child of the Retiree must be the same as the Retiree.

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 MMIA Member Entity, 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, 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 a Retiree and has a court order or decree stating such from a court of competent jurisdiction.

2. 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 with the Participant for adoption and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

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

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

- 3. The Participant's or Retiree's domestic partner and their children only if eligibility is allowed by the Member Entity as specifically stated in the applicable Member Entity's written personnel policy.

Domestic partner means the person, regardless of gender, named in the Affidavit of Domestic Partnership that has been submitted to and approved by the Employer.

A domestic partner may only be eligible for coverage under this Plan, subject to the applicable Member Entity's written personnel policy to determine eligibility for domestic partner, and provided the following "Required Eligibility Conditions" are met:

- A. Neither partner is or has been for the past six (6) months, married, legally separated, a cohabiter or a domestic partner to another;
- B. The partners have cohabitated for at least six (6) months and continue to cohabit;
- C. The partners are at least eighteen (18) years of age and mentally competent to consent to contract and mentally competent to execute the required Affidavit of Domestic Partnership;
- D. The partners are not related by blood to a degree that would bar marriage in the State of Montana;
- E. The partners are each other's sole domestic partner and intend to remain so indefinitely; and
- F. The partners are responsible for each other's common welfare and have a financial interdependent relationship evidenced by any of the following:
 - 1) Mutually granted financial or health care powers of attorney;
 - 2) Designation of each other as primary beneficiary in wills, life insurance policies or retirement plans;
 - 3) Executed a joint lease, mortgage or deed; or
 - 4) Have joint ownership of a banking account.

Refer to the applicable Member Entity's written personnel policy to determine eligibility for domestic partner or children of a domestic partner.

A Dependent spouse/domestic partner or Dependent child of a peace officer, game warden, firefighter or volunteer firefighter who dies within the course and scope of employment while this Plan is in effect is eligible for coverage under this Plan.

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.

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 as determined by the applicable MMIA Member Entity's written personnel policy and in the eligibility statement provided by the MMIA Member Entity to the MMIA. 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 Employer, Plan Administrator or Plan Supervisor.

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

A variable hour Employee will remain covered for during the Coverage Period, regardless of the number of hours worked and applicable leave, as long as the individual remains employed by the Eligible Employer. At the end of the Coverage Period, if the individual remains employed as a variable hour Employee and averages at least one hundred thirty (130) hours per month during the Coverage Period, the individual will remain covered for a period of time equal to the original Coverage Period.

"Coverage Period" is the maximum period of time variable hour Employees can be covered under the Plan as active Employees after completion of a Measurement Period as defined 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 form 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 form 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 May 15 through June 15 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 or changes requested during any Open Enrollment Period will begin on July 1 following the Open Enrollment Period. Coverage must be requested on a form approved by the Plan.

If a MMIA Member Entity offers multiple health benefit plans, Employees may choose a different health plan during an Open Enrollment Period. Such change must be requested on a form approved by the Plan. Change in the Deductible Option will become effective on July 1 following the Open Enrollment Period. In addition to the Open Enrollment Period allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below.

SPECIAL ENROLLMENT PERIOD

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

Coverage will become effective on the date of the event if the Employee makes a special enrollment request, verbally or in writing, within thirty (30) days of any special enrollment event and application for such coverage is made on the Plan's enrollment form within thirty-one (31) days of the event.

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

3. The spouse of a Participant (Covered Employee), or the spouse of a Retiree who is covered at the time of the Special Enrollment event, may enroll and will become covered on the date of the following specific events:
 - A. Marriage to the Participant or Retiree; or
 - B. Birth of the Participant's or Retiree's child; or
 - C. Adoption of a child by the Participant or Retiree, provided the child is under the age of 19; or
 - D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

4. A Retiree who is covered at the time of a special enrollment event may enroll his/her eligible Dependents, including step children who are acquired under the circumstances below:
 - A. Marriage to the Retiree; or
 - B. Birth of the Retiree's child; or
 - C. Adoption of a child by the Retiree, provided the child is under the age of 19; or
 - D. Placement for Adoption with the Retiree, provided such Retiree has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

5. The following individuals may enroll and become covered when coverage under another health care plan or health insurance terminates:
 - A. If the eligible Employee's coverage terminates, the eligible Employee who lost coverage may enroll and become covered.
 - B. If an eligible Dependent's coverage terminates, the eligible Dependent who lost coverage may enroll and become covered.
 - C. If an eligible Dependent of a Retiree's coverage terminates, the eligible Dependent who lost coverage may enroll and become covered.

6. Individuals may enroll and become covered when coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 is terminated due to loss of eligibility, subject to the following:
 - A. A request for enrollment must be made either verbally or in writing within sixty (60) days after this special enrollment event, and written application for such coverage must be made within ninety (90) days after such event.
 - B. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
 - C. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.
 - D. If an eligible Dependent of a Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.

7. 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 health plans to any plan offered by the MMIA Member Entity. The health plan 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 an MMIA Member Entity, he/she may continue his/her coverage as a Dependent 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 an MMIA Member Entity, 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 form, within thirty-one (31) 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 cause a reduction or increase of 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

Pursuant to the Public Health Service Act (PHSA), 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. Employer adopts ERISA standards to comply with child support enforcement obligation of Part D of Title IV of the Social Security Act of 1975 as amended.

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 the MMIA 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 Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

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

1. The Plan Administrator will promptly notify the 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 a maximum combined total of twenty-six (26) workweeks during any twelve (12) month period for certain family and medical reasons and for a serious injury or illness of a member of the Armed Forces to allow the Employee, who is the spouse, son, daughter, parent, or next of kin to the member of the Armed Forces, to care for that member of the Armed Forces. In certain cases, this leave may be taken on an intermittent basis rather than all at once, or the Employee may work a part-time schedule.

DEFINITIONS

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

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

ADVANCE NOTICE AND MEDICAL CERTIFICATION

Ordinarily, an Employee must provide 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. For Member Entities:
 - A. On the last day of the month in which the Participant's employment terminates if termination occurred between the 1st and the 15th of the month; or
 - B. On the last day of the month following the month in which the Participant's employment terminates if termination occurred any day beyond the 15th day of the month; 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 MMIA Member Entity 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 full-time Employee.
10. For an Elected Official, on the date he/she ceases to be an Elected Official.

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 MMIA Member Entity's written personnel policy 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 MMIA Member Entity 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, 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. The date the Retiree or their Dependents are no longer eligible to receive benefits in accordance with the applicable MMIA Member Entity's written personnel policy; 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 MMIA Member Entity 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; or
7. The date the Retiree is eligible for Medicare; or
8. The date the Retiree attains age sixty-five (65) years of age.

REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of termination of employment or reduction in hours and who again becomes eligible for coverage under the Plan within a thirteen (13) week period immediately following the date of such termination of employment or reduction in hours will become eligible for reinstatement of coverage on the date of renewed eligibility. Coverage will be reinstated for the Employee and eligible Dependents in accordance with the applicable MMIA Member Entity's written personnel policy, provided that application for such coverage is made on the Plan's enrollment form within thirty-one (31) days after the date of renewed eligibility. Reinstatement of Coverage is subject to the following:

1. Credit will be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.
2. All prior accumulations toward annual or lifetime benefit maximums will apply.

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

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

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.

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 MMIA Member Entity terminates the Dependent's coverage; or
7. On the last day of the month in which the Participant dies; or
8. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Dependent whose coverage is to be terminated; or
9. The date the Dependent of a Retiree is eligible for Medicare; or
10. The date the Dependent of a Retiree attains age sixty-five (65) years of age.

HEALTH PLAN OPTIONS

For any Plan option changes as a result of Dependent termination, the Participant may also elect to change health plan options to any Plan option offered by the MMIA Member Entity when dropping Dependent Coverage.

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 the Public Health Service Act, 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 is not eligible for COBRA Continuation Coverage.**

The Plan Administrator is Montana Municipal Interlocal Authority (MMIA); 3115 McHugh; P.O. Box 6669; Helena, MT 59604-6669; (406) 443-0907. 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 following the date of the Qualifying Event.

1. Qualifying Events for Participants, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:
 - A. The termination (other than by reason of gross misconduct) of the Participant's employment.
 - B. The reduction in hours of the Participant's employment.
2. Qualifying Events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:
 - A. Death of the Participant or Retiree.
 - B. Termination of the Participant's employment.
 - C. Reduction in hours of the Participant's employment.
 - D. The divorce or legal separation of the Participant or Retiree from his or her spouse.
 - E. A covered Dependent child ceases to be a Dependent as defined by the Plan.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Employer of the following Qualifying Events within sixty (60) days after the date the event occurs. The Employer must notify the Plan Administrator of any of the following:

1. Death of the Participant or Retiree.
2. The divorce or legal separation of the Participant or Retiree from his or her spouse.
3. A covered Dependent child ceases to be a Dependent as defined by the Plan.

The 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.

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

ELECTION OF COVERAGE

When 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 (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the 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 in hours, of employment occurs, the maximum period for COBRA Continuation Coverage for the spouse and Dependent children ends on the later of:

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

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

WHEN COBRA CONTINUATION COVERAGE ENDS

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

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

3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to 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 in hours, of employment;
 - B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen month period entitling that Dependent to an additional eighteen (18) months;
 - C. For the Dependent who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment of the former Employee if that former Employee enrolled in Medicare before termination, or reduction in hours, of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.
 - D. On the first day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.
 - E. Twenty-nine (29) months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.
 - F. Thirty-six (36) months for all other Qualified Beneficiaries.
7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

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

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

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

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

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

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

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

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

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was responsible or liable for payment of those medical expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid.

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

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from any third party who is liable to the Covered Person for a loss or benefits paid by the Plan. The Plan may proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover benefits paid under the Plan.

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

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

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

1. Under the terms of this Plan, the Plan Supervisor is not required to pay any claim where there is evidence of liability of a third party unless the Covered Person signs the Plan's Third-Party Reimbursement Agreement and follows the requirements of this section. However, the Plan, in its discretion, may instruct the Plan Supervisor not to withhold payment of benefits while the liability of a party other than the Covered Person is being legally determined. If a repayment agreement is requested to be signed, the Plan's right of recovery through Reimbursement and/or Subrogation remains in effect regardless of whether the repayment agreement is actually signed.
2. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any liable third party, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment.
3. The Covered Person will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any benefits paid by the Plan from any liable third party. This cooperation includes, but is not limited to, make full and complete disclosure in a timely manner of all material facts regarding the accident, Injury, condition or Illness to the Plan Administrator; report all efforts by any person to recover any such monies; provide the Plan Administrator with any and all requested documents, reports and other information in a timely manner, regarding any demand, litigation or settlement involving the recovery of benefits paid by the Plan; and notify the Plan Administrator of the amount and source of funds received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.
4. Covered Persons will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers including, but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.
5. The Covered Person will not act, fail to act, or engage in any conduct directly, indirectly, personally or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Covered Person will not conceal or attempt to conceal the fact that recovery has occurred or will occur.
6. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, except as limited by 2-18-901 and 902, MCA, as amended.

RIGHT OF OFF-SET

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

PLAN ADMINISTRATION

PURPOSE

The purpose of the 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, Retirees and their covered Dependents.

It is the intention of the Employer to establish a program of benefits constituting an "Employee Welfare Benefit Plan" under the Public Health Service Act, Section 1310, and any amendments thereto.

EFFECTIVE DATE

The effective date of the Plan is July 1, 2006, and restated July 1, 2024.

PLAN YEAR

The Plan Year is July 1 through June 30 of each succeeding year.

PLAN SPONSOR

The Plan Sponsor is Montana Municipal Interlocal Authority (MMIA).

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 Montana Municipal Interlocal Authority (MMIA), an entity organized and existing under an interlocal governmental agreement, which 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 amount of contributions to the Plan are to be made on the following basis:

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

The MMIA Member Entity and the Member Entity's Employees provide contributions for coverage under this Plan. No portion of contributions for COBRA Continuation Coverage will be paid by the MMIA Member Entity or the Plan. Specific information regarding the actual amount of any contribution for coverage under this Plan may be obtained from the Plan Sponsor, by contacting the MMIA Employee Benefits Program Manager and requesting that information. The amount of any contribution for coverage, except the amounts for COBRA Continuation Coverage, may be increased, decreased or modified at any time by the Plan.

PLAN 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 to the Chief Executive Officer or his or her equivalent, whichever is applicable, of the MMIA. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the Chief Executive Officer or his or her equivalent, whichever is applicable, of the MMIA, granting that individual the authority to amend, modify, revoke or terminate this Plan. 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

MMIA reserves the right at any time to terminate the Plan by a written notice. All previous contributions by an MMIA Member Entity 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 have continuous access to 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, at the expense of the Plan, whenever Injury or Illness is the basis of a claim when and so often as it may reasonably require to adjudicate the claim. The Plan will also have the right to have an autopsy performed in case of death to the extent permitted by law.

PAYMENT OF CLAIMS

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

The Plan will not recognize assignments of payment of benefits from non-Participating Providers. The Plan, at the discretion of the Plan Administrator, will pay the Procedure Based Maximum Expense (PBME) (Referenced Based Pricing) amount to the Covered Person or to the Covered Person and the provider jointly who incurred the claim (or the Participant, Qualified Beneficiary or Alternate Recipient if the Covered Person is a minor), and will notify the provider that the Plan does not recognize or accept assignments for payment of claims from non-Participating Providers.

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

LEGAL PROCEEDINGS

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

NO WAIVER OR ESTOPPEL

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

VERBAL STATEMENTS

Verbal statements or representations of 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 licensed Physician, Licensed Health Care Provider or surgeon and the patient-provider relationship will be maintained.

WORKERS' COMPENSATION NOT AFFECTED

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

CONFORMITY WITH LAW

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

MISCELLANEOUS

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

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

FACILITY OF PAYMENT

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

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

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If 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 an MMIA Member Entity the right to be retained in the service of an MMIA Member Entity, or to interfere with the right of an MMIA Member Entity to discharge or otherwise terminate the employment of any Participant.

GENERAL DEFINITIONS

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

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

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

ACCIDENTAL INJURY

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

ACTIVE SERVICE

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

ADVANCED PRACTICE REGISTERED NURSE

“Advanced Practice Registered Nurse” means nurses who have additional professional education beyond the basic nursing degree required of a registered nurse and who are considered Advanced Practice Registered Nurses by applicable state law. Advanced Practice Registered Nurses include nurse practitioners, nurse-midwives (Certified Nurse Midwife), nurse-anesthetists, and clinical nurse specialists.

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 infirmity-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.

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.

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.

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 Medical 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 Medical 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 day the Maximum Lifetime Benefit applicable to the Covered Person becomes paid; or
3. 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.

CARDIAC REHABILITATION THERAPY

“Cardiac Rehabilitation Therapy” means the process of restoring optimal functional status after a cardiac event.

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, or in-laws of the Covered Person.

COBRA

“COBRA” means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. § 300bb-1 through § 300bb-8], which contains provisions similar to 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”.

CONVALESCENT NURSING FACILITY

See “Skilled Nursing Facility”.

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.

COPAYMENT

“Copayment” means the specific dollar amount payable by the Covered Person for covered medical expenses. The applicable Copayments are stated in the Schedule of Medical Benefits.

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.

DEPENDENT

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

DEPENDENT COVERAGE

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

DURABLE MEDICAL EQUIPMENT

“Durable Medical Equipment” means equipment which is:

1. Able to withstand repeated use, 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.

ELECTED OFFICIAL

“Elected Official” means a person whose service with the MMIA Member Entity is as a result of election to an official governmental office of the MMIA Member Entity as required by Montana law, or as a result of appointment to such an official governmental office to serve out the remainder of an unexpired term of an elected official who has resigned or been removed from an official governmental office, as allowed by Montana law. A person will be considered an Elected Official only during the legal term of office for any such official governmental office.

ELIGIBLE EXPENSES

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

EMERGENCY

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

EMPLOYEE

“Employee” means a person employed by a Member Entity as a common-law W-2 payroll Employee and a common-law W-2 payroll Employee of any political subdivision adjunct of a Member Entity to which a Member Entity has allowed to be covered under the Member Entity’s health benefit plan through MMIA (pursuant to a written agreement between the Member Entity and the political subdivision).

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 MMIA Member Entity as a contract worker or independent contractor if such persons are not on the MMIA Member Entity’s W-2 payroll, or any individual who performs services for the MMIA Member Entity but who is paid by a temporary or other employment agency such as “Kelly,” “Manpower,” etc.

EMPLOYER

“Employer” means an MMIA Member Entity, and any related board or agency for which the MMIA Member Entity provided group health coverage from a source other than MMIA, on the day immediately prior to becoming covered under MMIA.

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.

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 its 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) if another facility studying substantially the same drug, device, medical treatment or procedure; or the informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

FAMILY

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

FMLA

“FMLA” means Family and Medical Leave Act.

GENDER IDENTITY DISORDER/GENDER DYSPHORIA

DSM-V diagnosis in children:

1. A definite difference between experienced/expressed gender and the one assigned at birth of at least six (6) months duration. At least six (6) of the following must be present:
 - A. Persistent and strong desire to be of the other sex or insistence that they belong to the other sex.
 - B. In male children, a strong preference for cross-dressing and in female children, a strong preference for wearing typical masculine clothing and dislike or refusal to wear typical feminine clothing.
 - C. Fantasizing about playing opposite gender roles in make-belief play or activities.
 - D. Preference for toys, games or activities typical of the opposite sex.

- E. Rejection of toys, games and activities conforming to one's own sex. In male children, avoidance of rough-and-tumble play, and in female children, rejection of typically feminine toys, games and activities.
 - F. Preference for playmates of the other sex.
 - G. Dislike for sexual anatomy. Male children may hate their penis and testes, and female children may dislike urinating sitting.
 - H. Desire to acquire the primary and/or secondary sex characteristics of the opposite sex.
2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

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

DSM-V diagnosis in adolescents and adults:

1. A definite mismatch between the assigned gender and experienced/expressed gender for at least six (6) months duration as characterized by at least two (2) or more of the following features:
- A. Mismatch between experienced or expressed gender and gender manifested by primary and/or secondary sex characteristics at puberty.
 - B. Persistent desire to rid oneself of the primary or secondary sexual characteristics of the biological sex at puberty.
 - C. Strong desire to possess the primary and/or secondary sex characteristics of the other gender.
 - D. Desire to belong to the other gender.
 - E. Desire to be treated as the other gender.
 - F. Strong feeling or conviction that he or she is reacting or feeling in accordance with the identified gender.
2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

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

HIPAA

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

HOME HEALTH CARE AGENCY

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

HOME HEALTH CARE PLAN

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

HOSPICE

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

HOSPICE BENEFIT PERIOD

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

HOSPITAL

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

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an emergent or Inpatient basis at the patient's expense; and
2. It is licensed as a Hospital or a critical access Hospital under the laws of the jurisdiction in which the facility is located; and
3. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an Illness or an Injury or provides for the facilities through arrangement or agreement with another Hospital; and
4. It provides treatment by or under the supervision of a Physician or osteopathic Physician with nursing services by registered nurses as required under the laws of the jurisdiction in which the facility is licensed; and
5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and
6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

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

ILLNESS

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

INCURRED EXPENSES OR EXPENSES INCURRED

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

INITIAL ENROLLMENT PERIOD

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

INJURY

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

INPATIENT

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

INTENSIVE CARE UNIT

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

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

LICENSED HEALTH CARE PROVIDER

“Licensed Health Care Provider” means any provider of health care services who is licensed or certified by any applicable governmental regulatory authority to the extent that services are within the scope of the license or certification and are not specifically excluded by this Plan.

LICENSED PRACTICAL NURSE

“Licensed Practical Nurse” (LPN) means an individual who has received specialized nursing training and practical nursing experience, and is licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LICENSED 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.

MAXIMUM LIFETIME BENEFIT

“Maximum Lifetime Benefit” means the maximum benefit payable while a person is covered under this Plan. The Maximum Lifetime Benefit will not be construed as providing lifetime coverage, or benefits for a person’s Illness or Injury after coverage terminates under this Plan.

MEDICAID

“Medicaid” means that program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.

MEDICALLY NECESSARY/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 are consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and
3. Are not primarily for the convenience of the Covered Person, Physician or other Licensed Health Care Provider; and
4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person and are in accordance with the Plan’s Medical Policy; and
5. Are not of an Experimental/Investigational or solely educational nature; and
6. Are not provided primarily for medical or other research; and
7. Do not involve excessive, unnecessary or repeated tests; and
8. Are commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and

9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration (FDA) or Centers For Medicare/Medicaid Services (CMS), pursuant to that entity’s program oversight authority based upon the medical treatment circumstances.

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.

MMSERA

“MMSERA” means the Montana Military Service Employment Rights Act (MMSERA), as amended.

MMIA MEMBER ENTITY

“MMIA Member Entity” means those individual government entities that make up the members of the Plan Administrator who have adopted this Plan for its Employees.

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.

OCCUPATIONAL THERAPY

“Occupational Therapy” means a program of care ordered by a Physician which is for the purpose of improving the physical, cognitive and perceptual disabilities that influence the Covered Person’s ability to perform functional tasks related to normal life functions or occupations, and which is for the purpose of assisting the Covered Person in performing such functional tasks without assistance.

ORTHOPEDIC DEVICE

“Orthopedic Device” means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

OUT-OF-POCKET MAXIMUM

“Out-of-Pocket Maximum” means the maximum dollar amount, as stated in the Schedule of Medical Benefits, 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 bed-patient 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 an MMIA Member Entity who is eligible and enrolled for coverage under this Plan. “Participant” may also mean a Contracted Municipal Government Public Officer as specifically described in the Eligibility Provisions section of this Plan.

PHYSICAL THERAPY

“Physical Therapy” means a plan of care ordered by a Physician and provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

PHYSICIAN

“Physician” means a person holding the degree of Doctor of Medicine, 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 MMIA Member Entities, the Plan Document/Summary Plan Description and any other relevant documents pertinent to its operation and maintenance of the Plan.

PLAN ADMINISTRATOR

“Plan Administrator” means MMIA 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 Public Health Service Act, Section 1310, as amended, and any applicable state legislation of a similar nature, the MMIA will be deemed to be the Plan Administrator of the Plan unless by action of the board of directors, the MMIA designates an individual or committee to act as the 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 the Public Health Service Act, Section 1310, or any other 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.

PROCEDURE BASED MAXIMUM EXPENSE or PBME (REFERENCED BASED PRICING)

“Procedure Based Maximum Expense” or “PBME” (Referenced Based Pricing) means the maximum amount the Plan will pay under any circumstances for any treatment, service or supply or combination of any treatments, services, or supplies that comprise a procedure covered by this Plan. The PBME (Referenced Based Pricing) will apply to all charges from all providers. The PBME (Referenced Based Pricing) shall be based upon a publicly available payment schedule including Medicare allowable amounts when applicable and other similar schedules in circumstances in which Medicare allowable amounts are inapplicable or unavailable. The specific PBME (Referenced Based Pricing) for any treatment, service or supply shall be based upon a mathematical formula using a multiple or percentage of the payment schedules referred to above and adopted by the Plan Supervisor and the Plan. In addition, the PBME (Referenced Based Pricing) will be determined based upon the geographical location and other considerations related to each specific provider and based upon the adequacy and quality of specific services and supplies.

The PBME (Referenced Based Pricing) will apply whether a provider agrees to accept the PBME (Referenced Based Pricing) as full payment for the claim or not. Providers who agree, in writing, to accept the PBME (Referenced Based Pricing) as full payment are defined as Participating Providers. Providers who are not Participating Providers will be reimbursed based upon the lowest PBME (Referenced Based Pricing) for a geographic area as established by the Plan based upon the physical location where the Covered Person received services or supplies.

The PBME (Referenced Based Pricing) for Emergency Services will apply to both Participating Providers and Non-Participating Providers, but only during the time that the medical Emergency exists and will cease to apply when the Covered Person’s condition is stable and no longer emergent. When the PBME (Referenced Based Pricing) for Emergency Services ceases to apply, the PBME (Referenced Based Pricing) for the applicable additional services, if any, will apply.

For non-contracted providers for emergency services, air ambulance and non-participating providers providing services in a contracted facility, the PBME (Referenced Based Pricing) 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.

PSYCHIATRIC CARE

“Psychiatric Care,” also known as psychoanalytic care, means treatment for a Mental Illness or disorder, a functional nervous disorder, Alcoholism or drug addiction by a licensed psychiatrist, Psychologist, Licensed Social Worker or licensed professional counselor acting within the scope and limitations of his/her respective license, provided that such treatment is Medically Necessary as defined by the Plan, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

“Psychiatric Facility” means a licensed institution that provides Mental Illness treatment and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

“Psychologist” means a person currently licensed in the state in which services are rendered as a psychologist and acting within the scope of his/her license.

QMCSO

“QMCSO” means Qualified Medical Child Support Order as defined by the Public Health Service Act, as amended.

QUALIFIED BENEFICIARY

“Qualified Beneficiary” means an Employee, former Employee or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of the Public Health Service Act.

“Qualified Beneficiary” will also include a child born to, adopted by or Placed for Adoption with an Employee or former Employee at any time during COBRA Continuation Coverage.

REGISTERED NURSE

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

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 multi-disciplinary 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

For Montana governmental entities: “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 currently licensed as a long-term care facility or skilled nursing facility in the state in which the facility is located;
2. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders; and

3. It is certified by Medicare.

This term also applies to Incurred Expenses in an institution known as a Convalescent Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

SPECIAL ENROLLMENT PERIOD

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

SPEECH THERAPY

“Speech Therapy” means a course of treatment, ordered by a Physician, 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.

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).

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 PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;
6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;
7. Make available the PHI required to provide an accounting of disclosures as required by the regulations;
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document/Summary Plan Description or Employees designated by the Plan Administrator(s) who need to know that information to perform Plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any Employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan 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 CITY OF KALISPELL PLAN, 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 July 1, 2006, and restated July 1, 2024.

4. PLAN SPONSOR

Name: Montana Municipal Interlocal Authority (MMIA)
Phone (406) 443-0907
Address: 3115 McHugh, P.O. Box 6669
Helena, MT 59604-6669

5. PLAN ADMINISTRATOR

The Plan Administrator is the Plan Sponsor.

6. NAMED FIDUCIARY

Name: Montana Municipal Interlocal Authority (MMIA)
Phone (406) 443-0907
Address: 3115 McHugh, P.O. Box 6669
Helena, MT 59604-6669

7. PLAN FISCAL YEAR

The Plan fiscal year ends June 30.

8. 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.

9. IDENTIFICATION NUMBER

Group Number: 8001036
Plan Sponsor's Identification Number: 81-0436312

10. PLAN SUPERVISOR

Name: Allegiance Benefit Plan Management, Inc.
Address: P.O. Box 5066
Missoula, MT 59806

11. ELIGIBILITY

Employees and Dependents of Employees of the Plan Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

12. PLAN FUNDING

The Plan is funded by contributions from MMIA Member Entities and its Employees.

13. AGENT FOR SERVICE OF LEGAL PROCESS

The Plan Administrator is the agent for service of legal process.
