PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

MONTANA CREDIT UNION LEAGUE GROUP BENEFITS TRUST EMPLOYEE HEALTH BENEFIT PLAN

RUBY PPO OPTION

EFFECTIVE: JANUARY 1, 2012

RESTATED: JANUARY 1, 2023

NOTICE

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

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INTRODUCTION

This document is a description of **Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan** (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

Where a court order, administrative order, judgement, new or changed law or regulation applies to a provision of this Plan, the Plan will be deemed to have been automatically amended (without further action on the part of the Plan Administrator), to ensure that the Plan conforms to such change to the extent applicable. For the avoidance of doubt, it is the intent of the Plan Administrator that the Plan conform at all times to the requirements of any and all controlling law, including by way of example and not exclusion, the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, eligibility, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the Claims Review Procedures have been exhausted. Specifically, before filing a lawsuit, the Plan Participant must exhaust all available administrative remedies as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

The Care Management Administrator and the Claims Administrator utilize both InterQual Criteria and Aetna's Clinical Policy Bulletins (CPBs) to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The InterQual Criteria and CPBs are based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals and guidelines from nationally recognized health care organizations. These InterQual Criteria and CPBs are reviewed on a regular basis based upon a review of currently available clinical information.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Charges incurred before termination, amendment, or elimination.

This Plan is an employee welfare benefit plan within the meaning of ERISA. This Plan is a self-funded medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Plan Participant through this Plan, are not taxable income to the Plan Participant. The specific tax treatment of any Plan Participant will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Plan Participants are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes. This Plan is "self-funded," which means benefits are paid from the Employer's general assets and are not guaranteed by an insurance company.

The Plan is administered by the Plan Administrator, within the purview of ERISA and in accordance with these provisions. The Plan Administrator may delegate certain responsibilities for the operation and administration of the Plan. The Plan Administrator shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service Providers, adjust their compensation (if any), and exercise general administrative authority over them. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder, unless otherwise delegated herein.

This document serves as both the written Plan Document and the Summary Plan Description ("SPD") required under ERISA.

Certain Federal laws apply to most group health programs. The following is an overview of the laws and their impact. Should there be any conflict between the law and Plan provisions, the law will prevail.

Pregnancy Discrimination Act of 1978. Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent Spouse of an Employee.

Omnibus Budget Reconciliation Act of 1993 ("OBRA"). OBRA 1993 requires that an eligible Dependent child of an Employee will include a child who is adopted by the Employee or placed with him for adoption prior to age 18 and a child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies the QMCSO requirements of ERISA (section 609(a)). Plan Participants may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

Newborns' and Mothers' Health Protection Act of 1996. The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn children following delivery, as follows: All applicable benefit provisions still apply, including existing deductibles, copayments and/or coinsurance.

Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

The Civilian Reservist Emergency Workforce Act of 2021 (CREW). Beginning September 29, 2022, the CREW Act provides eligible Employees, who are called to service by the Federal Emergency Management Agency (FEMA) to respond to and perform services responding to natural disasters and emergencies, rights under the Uniformed Employment and Reemployment Rights Act (USERRA). *See the Employee's on Military Leave provision in the Termination of Coverage subsection of the Eligibility, Funding, Effective Date and Termination section for additional information regarding benefits and coverage during such leave.*

No Surprises Act. The No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits Physicians, Providers, health care Facilities and air ambulance companies from balance billing Plan Participants or otherwise holding Plan Participants liable for any more than the applicable cost sharing amounts they would have owed for Network care. Specifically, these balance billing protections apply when a Plan Participant receives Emergency Services from a Non-Network Provider or Facility, when a Plan Participant receives non-Emergency Services from a Non-Network Provider at a Network Facility, and when a Plan Participant receives Non-Network air ambulance services.

However, these protections against balance billing do not apply if the Plan Participant consents to treatment by a Non-Network Provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services without pre-certification; cover Emergency Services by Non-Network Providers; base cost sharing amounts on Network benefits; and count any cost sharing amounts for Emergency Services or Non-Network services toward a Plan Participant's out-of-pocket limit.

If a Plan Participant believes he or she has received a balance bill that is protected under the No Surprises Act, please contact Employee Benefit Management Services, LLC for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

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

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

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

Medical Benefits. Explains when the benefit applies and the types of charges covered.

Claim Review and Audit Program. Program of claim review and auditing to identify charges billed in error, excessive or unreasonable fees, and charges for services which are not Medically Necessary.

Care Management Services. Explains the methods used to curb unnecessary and excessive charges.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

How To Submit A Claim. Explains the rules for filing claims and the claim appeal process.

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

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person because of injuries sustained.

COBRA Continuation Coverage. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Certain Plan Participant Rights Under ERISA. Explains the Plan's structure and the Plan Participants' rights under the Plan.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule of Benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are reasonable and customary (as defined as an Allowable Charge); and services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all Covered Charges and/or exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments, or procedures.

PRE-CERTIFICATION REQUIREMENTS

Medical Rehabilitation Consultants, Inc. will provide pre-certification as required by the Plan.

For medical benefits requiring pre-certification, please contact Medical Rehabilitation Consultants, Inc. at the phone number listed on the EBMS/Montana Credit Union League Group Benefits Trust identification card.

Pre-certification is not a guarantee of benefits, eligibility, payment, nor a medical treatment decision or advice. Please see the Care Management Services section in this booklet for details regarding this pre-certification process.

ASSIGNMENT OF BENEFITS

A Plan Participant may assign benefits for medical expenses covered under this Plan to a provider as consideration in full for services rendered; however, whether such benefits are paid directly to the Plan Participant or to the provider, the Plan will be deemed to have fulfilled its obligations with respect to such benefits.

The Plan will not be responsible for determining whether any such Assignment of Benefits is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment has been received before the proof of loss is submitted.

The Plan Participant may not, at any time either during a period of participant in the Plan or following a coverage termination, assign the Plan Participant’s right to sue to recover benefits under the Plan, to enforce rights due under the Plan, or to any other causes of action which the Plan Participant may have against the Plan or its fiduciaries.

A provider which accepts an Assignment of Benefits does so in accordance with this Plan and does so as consideration in full for services rendered. Any such provider is bound by the rules and provisions set forth within the terms of this document.

PROVIDER INFORMATION

This Plan has entered into an agreement with certain Hospitals, Physicians, and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to Plan Participants, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Plan Participant uses a Network Provider, that Plan Participant will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Plan Participant’s choice as to which provider to use.

To access a list of Network Providers, please refer to the Preferred Provider Organization (PPO) website and/or toll-free number listed on the **Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan** identification card. Prior to receiving medical care services, the Plan Participant should confirm with the provider and the PPO that the provider is a participant in this Network.

For all Non-Network Providers, the Plan will identify the reasonable cost for the services and supplies through its Claim Review and Audit Program.

Covered Charges will be reimbursed at the Network Provider benefit level based on the Allowable Charge. The Plan Participant may be balance billed by the Non-Network Provider for any amount over the Allowable Charge.

NO SURPRISES ACT (NSA)

For Non-Network Provider charges subject to the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), the Plan Participant cost-sharing will be the Network benefit level which will be calculated as if the Allowable Charge was the Recognized Amount. The NSA prohibits Non-Network Providers from pursuing payment from the Plan Participant for the difference between the Allowable Charge and the Non-Network Provider's billed charge for services, except for any applicable cost-sharing.

Non-Network Provider charges subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Network Facility:
  - Provided the Plan Participant has not provided Notice and Consent (as explained below) to waive the applicability of the NSA;
  - Including the furnishing of equipment/devices, labs, imaging, telehealth, pre-operative, and post-operative services regardless of being physically located at the Network Facility; and
- Covered Charges for air ambulance services.

Benefit determinations for Non-Network Provider claims subject to the NSA will be made within 30 days of the Claims Administrator's receipt of the claim and if applicable, reimbursement will be submitted directly to the Non-Network Provider.

Notice and Consent. Exceptions to the NSA balance billing protections may apply when the Plan Participant receives non-emergency services (other than ancillary services) from a Non-Network Provider and gives written consent to receive those services as Non-Network Provider benefits. Ancillary services include anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and items and services related to emergency medicine.

PROVIDER DIRECTORIES

If a Plan Participant seeks care based on incorrect information indicating that the provider was a Network Provider at the time the treatment or service was received, the Plan Participant's cost share will be limited to the Network benefit level if the Plan Participant can provide proof within 30 days that they sought care based on the incorrect information.

CONTINUING CARE PROVISION

In accordance with the Consolidated Appropriations Act of 2021, when a Plan Participant is a receiving treatment from a Network Provider, and that provider's relationship with the Plan is terminated, not renewed, or otherwise ends for any reason (other than the Provider's failure to meet applicable quality standards or for fraud), the Plan Participant has rights to elect Continuing Care from the former Network Provider.

The Plan shall notify the Plan Participant in a timely manner that the Network Provider's contractual relationship with the Plan has terminated. If the Plan Participant **elects in writing** to receive Continuing Care, benefits will apply under the same terms and conditions as would have applied had the termination not occurred. This Continuing Care Provision becomes available as of the date of the letter received by the Plan Participant that the former Network Provider is no longer associated with the Plan. The Continuing Care Provision will cease 90 days after that date or when the Plan Participant ceases to receive Continuing Care, whichever occurs first.

Under the Continuing Care Provision, the former Network Provider or former Network Facility must: (1) accept reimbursement from the Plan and any applicable cost sharing from the Plan Participant as payment in full; and (2) continue to adhere to all policies, procedures, and standards of care imposed by the Plan in the same manner as if the Network Provider termination had not occurred.

For purposes of this provision, a "Continuing Care" Plan Participant is:

(1) undergoing a course of treatment for a serious and complex condition from a specific Network Provider;

(2) undergoing a course of institutional or inpatient care from a specific Network Provider;

(3) scheduled to undergo non-elective surgery from a specific Network Provider, including postoperative care;

(4) pregnant and undergoing a course of treatment for the Pregnancy from a specific Network Provider; or

(5) terminally ill and receiving treatment for such illness from a specific Network Provider.

DEDUCTIBLES/COPAYMENTS/COINSURANCE PAYABLE BY PLAN PARTICIPANTS

Deductibles/Copayments are dollar amounts that the Plan Participant must pay before the Plan pays.

A **deductible** is an amount of money that is paid once a Calendar Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges (except for Covered Charges that are not subject to the deductible).

Each **January 1st**, a new deductible amount is required.

The deductible ***will*** *apply* to the maximum out-of-pocket amount.

A **copayment** is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Copayments ***do not*** *apply toward the deductible.*

Copayments (excluding Prescription Drug copayments) ***will*** *apply* to the maximum out-of-pocket amount.

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Schedule of Benefits and is the Plan Participant's responsibility. Coinsurance ***does not*** apply to the deductible and ***does not*** include copayment amounts.

Coinsurance is payable by the Plan Participant until the maximum out-of-pocket amount, as shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the remainder of the Calendar Year.

MEDICAL BENEFITS SCHEDULE

IMPORTANT NOTE: Except as otherwise indicated, benefits for Non-Network providers will be based upon Allowable Claim Limits which are determined under the Claim Review and Audit Program.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Claims must be received by the Claims Administrator within **365 days** from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Plan Participant	$500	
Per Family Unit	$1,000	
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Plan Participant	$3,000	
Per Family Unit	$5,500	
The Plan will pay the designated percentage of Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%. • Amounts over Allowable Charge; • Any charges incurred due to failure to pre-certify; • Expenses incurred for non-covered services; • Prescription maximum out-of-pocket amounts, coinsurance, or copayment; • Discounts, coupons, Pharmacy discount programs or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.		
SERVICES REQUIRING PRE-CERTIFICATION		

The following services require pre-certification:
 	
• Inpatient admissions to a Hospital, Skilled Nursing Facility, or a free-standing Mental Disorder/Substance Abuse Facility;
  o Pre-certification is required for a routine maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery;
  o Pre-certification of an inpatient admission from the Emergency Room is required.
• Inpatient or outpatient surgical procedures;
• Chemotherapy and radiation treatment, including medications;
• Renal dialysis;
• Genetic testing;
• Injectables;
• Home Health Care;
• Hospice;
• Durable Medical Equipment (DME) over $2,000;
• Organ transplants; and
• Travel expenses.		

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network Providers.		
Alternative Care (Acupuncture, acupressure, massage therapy, and spinal manipulation / chiropractic services)	60%, no deductible applies	50% after deductible
	$750 combined Calendar Year maximum	
Note: Related diagnostic x-rays for Alternative Care services are payable as any other diagnostic test and does not apply to the $750 Calendar Year maximum.		
Ambulance Service	60% after deductible	
Applied Behavioral Analysis *(ABA) services for Autism Spectrum Disorders*		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Chemotherapy or Radiation Treatment		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Note: Pre-certification of Chemotherapy or Radiation Treatment, including medications, is required prior to service. See the Care Management Services section for more information.		
Colonoscopies *(Non-routine)*	100%, no deductible applies up to $1,200 per Calendar Year thereafter;	
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Convalescent Home / Skilled Nursing Facility	60% after deductible	50% after deductible
	60 days Calendar Year maximum	
Note: *Pre-certification of all inpatient admissions is necessary to avoid a penalty. See the Care Management Services section for more information.*		
Diagnostic Testing (X-ray & Lab)		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Diagnostic Imaging Services (MRI, CT/PET Scans, etc.)		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Durable Medical Equipment, Orthotics, and Prosthetics	60% after deductible	50% after deductible
Note: Pre-certification of Durable Medical Equipment over $2,000 is required prior to service. See the Care Management Services section for more information.		
Emergency Room Visit - Facility and Physician	60% after deductible	
Note: Pre-certification of an inpatient admission from the Emergency Room is required. See the Care Management Services section for more information.		
HealthJoy Telemedicine	100%, no deductible applies	
Note: Please see the HealthJoy Telemedicine benefit in the Covered Charges section for more information.		
Home Health Care	60% after deductible	50% after deductible
	180 visits Calendar Year maximum	
Note: Pre-certification of Home Health Care is required prior to service. See the Care Management Services section for more information.		
Hospice Care	100%, no deductible applies	
	Up to 6 months per 3 calendar years	
Note: Pre-certification of Hospice Care is required prior to service. See the Care Management Services section for more information.		

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
HOSPITAL FACILITY SERVICES		
Room and Board	60% after deductible	50% after deductible
Intensive Care Unit	60% after deductible	50% after deductible
Outpatient Hospital Services	60% after deductible	50% after deductible
Outpatient Surgical Center	60% after deductible	50% after deductible
Note: Pre-certification of an inpatient admission and inpatient/outpatient surgical procedure is required prior to service. See the Care Management Services section for more information.		
Mental Disorders & Substance Abuse		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Note: Pre-certification of an inpatient admission is required prior to service. See the Care Management Services section for more information.		
Organ Transplant		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Note: Refer to the Organ transplant benefit listed in the Covered Charges section for more information. ***Note:*** Pre-certification of Organ Transplant services, including travel, is required prior to service. See the Care Management Services section for more information.		
Orthotic Appliances		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Note: Coverage is limited to 1 pair of prescribed custom foot orthotics per Calendar Year. Refer to the Orthotic Appliances benefit listed in the Covered Charges section for more information.		
PHYSICIAN SERVICES		
Inpatient visits	60%, no deductible applies	50% after deductible
Office visits	60%, no deductible applies	50% after deductible
Surgery	60%, no deductible applies	50% after deductible
Allergy serum and injections	60%, no deductible applies	50% after deductible
Pregnancy		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
- Routine prenatal office visits (covered Employee or Spouse)	100%, no deductible applies *If global maternity fee:* 40% of Covered Charges will be payable at 100%, no deductible applies; thereafter 60%, no deductible applies	100%, no deductible applies *If global maternity fee:* 40% of Covered Charges will be payable at 100%, no deductible applies; thereafter 50% after deductible
- Routine prenatal office visits (covered Dependent child)	100%, no deductible applies *If global maternity fee:* 40% of Covered Charges will be payable at 100%, no deductible applies; thereafter **Not Covered**	**Not Covered**
Note: Refer to the Coverage of Pregnancy benefit listed in the Covered Charges section for more information regarding routine prenatal office visits. ***Note:*** Pre-certification of a routine maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required. See the Care Management Services section for more information.		

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Preventive Care		
Routine Well Care (birth through adult)	100%, no deductible applies	

Routine Well Care Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF), *unless otherwise specifically stated in this Schedule of Benefits*, and which can be located using the following website:

http://www.healthcare.gov/center/regulations/prevention.html

Routine Well Care Services will include, but will not be limited to, the following routine services:
Office visits, routine physical exams, prostate screening, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations.

Note: If applicable, this Plan may comply with a state vaccine assessment program.

Women's Preventive Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Schedule of Benefits*, and which can be located using the following websites:

http://www.healthcare.gov/center/regulations/prevention.html; and
http://www.healthcare.gov/preventive-care-women

Women's Preventive Services, will include, but will not be limited to, the following routine services:
Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

Dental - Preventive - Up to age 19 - Age 19 and older	100%, no deductible applies Up to 2 exams and cleanings per Calendar Year maximum $100 Calendar Year maximum
Diabetes Education	100%, no deductible applies 3 visits Calendar Year maximum
Mammograms (Routine or Medical)	100%, no deductible applies The minimum mammography examination recommendations are: - 1 baseline mammogram for women ages 35 through 39. - 1 mammogram every 2 years for women ages 40 through 49, or more frequently as recommended by a Physician. - 1 mammogram every year for women age 50 or older. **Note:** Any subsequent Medically Necessary mammograms, in addition to the above list, will be payable subject to normal Plan provisions.
Nutritional Education Counseling	100%, no deductible applies 3 visits Calendar Year maximum
Weight Management for Plan Participants age 18 and older	100%, no deductible applies 26 visits Calendar Year maximum
Note: Medically Necessary Diagnostic Testing (X-ray & Lab services) rendered in connection with Weight Management will be payable subject to the separate Diagnostic Testing benefit under this Plan. Refer to the Weight Management benefit in the Covered Charges section for more information.	
Tobacco/Nicotine Cessation Counseling	100%, no deductible applies 3 visits Calendar Year maximum

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Rehabilitation Services - Inpatient		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
	30 day Calendar Year maximum.	
Outpatient Therapy: Physical, Occupational, Speech, or Cardiac Therapies		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Renal Dialysis Services	50% after deductible	
Note: Please see Renal Dialysis Services under the Covered Charges section for additional information regarding this benefit. ***Note:*** Pre-certification of Renal Dialysis Services is required prior to service. See the Care Management Services section for more information.		
Routine Well Newborn Nursery Care - (while hospital confined at birth)		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
Urgent Care Services		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible
VezaHealth - Second Opinion	No Cost to Plan Participant	
Note: For more information regarding this benefit, refer to the VezaHealth provision listed in the Covered Charges of the Medical Benefits section.		
Wig After Chemotherapy or Radiation Treatment	60% after deductible	50% after deductible
	1 wig Lifetime maximum	
All Other Covered Charges		
- Facility fee	60% after deductible	50% after deductible
- Physician fee	60%, no deductible applies	50% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE

As Administered by SmithRx

If applicable, this Plan will make a retroactive adjustment to a claim based on a discount, coupon, Pharmacy discount program or similar arrangement provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.

Prescription Drug Maximum Out-Of-Pocket Amounts:

per Plan Participant.....$1,450 per Calendar Year

per Family Unit.....$2,900 per Calendar Year

The Prescription Drug copayment amounts for the Retail, Specialty and Mail Order Pharmacies listed below **will apply** to the separate Prescription Drug maximum out-of-pocket amount until this amount shown above has been met; thereafter, covered Prescription Drugs will continue to be payable subject to 100% (not including ineligible charges, such as Prescription Drug dispense as written (DAW) penalties) for the remainder of the Calendar Year. **The Prescription Drug maximum out-of-pocket amount will not apply to the Medical Maximum Out-Of-Pocket Amount as shown in the Schedule of Benefits.**

Retail Pharmacy – Available at any Participating Pharmacy Retail location – available up to a 90-day supply per prescription **or**

Mail Order Pharmacy – Available through Serve Your Rx – available up to a 90-day supply per prescription

Copayment per prescription (1 to 30-day supply):

Tier 1 drugs (Generic and some lower cost brand products).....	$10 copayment, no deductible applies
Tier 2 drugs (Preferred brand products).....	$25 copayment, no deductible applies
Tier 3 drugs (Non-preferred brand products).....	$50 copayment, no deductible applies

Copayment per prescription (31 to 90-day supply):

Tier 1 drugs (Generic and some lower cost brand products).....	$20 copayment, no deductible applies
Tier 2 drugs (Preferred brand products).....	$50 copayment, no deductible applies
Tier 3 drugs (Non-preferred brand products).....	$100 copayment, no deductible applies

Non-Participating Pharmacy

Coinsurance per prescription (limited to a 30-day supply):

Tier 1 drugs (Generic and some lower cost brand products).....	50% coinsurance, no deductible applies
Tier 2 drugs (Preferred brand products).....	50% coinsurance, no deductible applies
Tier 3 drugs (Non-preferred brand products).....	50% coinsurance, no deductible applies

Preventive Drugs – Available at any Participating Pharmacy Retail location – available up to a 90-day supply per prescription **or**

Certain preventive drugs (contact **SmithRx** toll-free at (844) 454-5201 for more information regarding a list of these drugs).....	$0 copayment, no deductible applies

Mandatory Specialty Pharmacy Program – Available through US Bioservices, Senderra Rx

Copayment per prescription (limited to a 30-day supply):

First fill only (through retail pharmacy).....	$100 copayment, no deductible applies
Subsequenet fills (through Specialty Pharmacy).....	$100 copayment, no deductible applies

For more information regarding the Specialty Pharmacy Program, please contact **SmithRx** toll-free at (844) 454-5201.

Coverage for certain medications is only applicable if patient advocacy program fails to provide a solution. Advocacy solutions come from a variety of sources, including manufacturer assistance programs, copay cards, grants, and mail order pharmacies. The Plan may cover the cost of these options so that your out-of-pocket cost will not exceed the cost under the pharmacy benefit. The Plan may also allow for a 60-day grace period for urgent medications to allow time to complete the advocacy process. Prior authorization is required on all specialty medications.

Dispense As Written (DAW) penalty:

If a Plan Participant requests a brand name drug instead of a generic drug (and a generic drug is available), then the Plan Participant will be responsible for the difference in cost between a generic drug and applicable brand name drug in addition to the applicable copayment amount as stated above. The difference in cost **will not** apply to the Prescription Drug maximum out-of-pocket amount shown in the Schedule of above.

For more information regarding the Prescription Drug Benefits, refer to the separate PRESCRIPTION DRUG BENEFITS section under this Plan.

SELF-AUDIT BILLING CREDIT

Effective for Covered Charges incurred on or after February 1, 2015.

The Plan offers an incentive credit to all covered Employees to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by the provider or service accurately reflect the services and supplies received by the covered Employee or a covered Dependent.

The covered Employee is voluntarily asked to review all Hospital and doctor bills and verify that he or she has received each itemized service and the bill does not represent either an overcharge, or a charge for services never received, regardless of the reason.

The Claims Administrator agrees to assist the covered Employee (at his or her request) in determination of errors, and recovery attempts.

Plan Participants may receive a refund if they discover an overcharge on their medical bill that:

(1) Was not detected by the provider of services; and
(2) Was not detected by the Plan; and
(3) Was part of the charges for services which are covered under this Plan.

In the event a covered Employee's self-audit results in elimination or reduction of charges, up to 50% of the amount eliminated or reduced may be paid directly to the covered Employee provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Claims Administrator (e.g., a copy of the incorrect bill and a copy of the corrected billing). The maximum credit available shall not exceed $5,000.

- The credit could be up to a maximum $1,000 refund based on an overcharge of $2,000. The minimum overcharge eligible to qualify under the Self-Audit Program is a $50 overcharge with a minimum refund of $25.

If an overcharge is discovered by the Plan Participant, they should ask the provider to correct the overcharge and send the Plan Participant a revised itemized bill. The Plan Participant should clearly mark both itemized bills "Self-Audit Program" and send them to the Claims Administrator at:

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

This self-audit credit is in addition to the payment of all other applicable Plan benefits for legitimate medical expenses.

Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Plan Participant, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the Plan Participant's liability) on an incorrect billing.

This credit will not be payable for charges in excess of the Allowable Charge regardless of whether the charge is or is not reduced and may not be payable for Covered Charges.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees.

- All Active Employees of the Employer;
- All Retired Employees of the Employer.

ELIGIBILITY REQUIREMENTS

(1) Eligibility Requirements for Active Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(a) Is a Full-Time, Active Employee of the Employer. The Employee shall be considered "Full-Time" if he or she normally works at least the minimum number of hours per week as designated by the Employer, but no less than 20 hours per week, and is on the regular payroll of the Employer for that work.

For Employees of a Large Employer:

An Applicable Large Employer is an Employer with 50 full-time equivalents or more (combination of full-time and part-time Employees) in the prior Calendar Year.

An Applicable Large Employer may use a look-back measurement method or a monthly measurement method to determine the Full-Time status. For more information on the measurement method elected by the Employer, contact the Employer's Human Resources staff.

(b) Completes the applicable employment Waiting Period imposed by the Employer. A "Waiting Period" is the time between the first day of employment (or change in status) as an otherwise eligible Employee and the first day of coverage under the Plan. A Waiting Period may be waived only if required by applicable law or regulation.

For more information on minimum number of hours required, benefit measurement periods, or the Employer's applicable Waiting Period, contact the Employer's Human Resources Department.

(2) Eligibility Requirements for Retired Employee (Retiree) Coverage. An individual is eligible for Retired Employee Coverage if the Retired Employee:

(a) Has worked 10 continuous years as an Active Employee for the participating Employer;

(b) Has been a covered Employee under the Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan for three consecutive years prior to retirement;

(c) Is younger than the limiting age of 65 years; and

(d) Is at least age 60 and has not yet reached age 65.

When the Retired Employee reaches the limiting age of 65, coverage will end on the first day of the Retired Employee's birthday month. A Retired Employee's coverage will end prior to reaching the limiting age of 65 if he or she becomes eligible for Medicare prior to that time as set forth below. Any Dependents covered under the Retired Employee's coverage at that time will have an additional 18 months of coverage before their coverage terminates as long as they continue to satisfy the eligibility requirements for said coverage.

For Credit Unions joining the Montana Credit Union League Group Benefits Trust as a participating Employer, those eligible Employees must meet the same requirements as set forth above, and to satisfy item (b) as set forth above they must be covered under their prior plan for three consecutive years to be eligible. If there was no prior plan or the Employee was not on the prior plan for the three consecutive previous years, the Employee will not be eligible for Retired Employee coverage until they satisfy the eligibility requirements set forth herein.

Upon Retirement: For Employers that are subject to COBRA Continuation Coverage, a Retired Employee can choose between COBRA Continuation Coverage or continuing coverage under the terms of the Plan as a Retired Employee if the Retired Employee satisfies the criteria as set forth above. If the Employee is eligible and chooses to continue coverage under the terms of the Plan as a Retired Employee, they will forfeit their right to elect COBRA Continuation Coverage at a later date. If the Employee elects COBRA Continuation Coverage, they will forfeit their right to elect continuing coverage under the terms of the Plan as a Retired Employee.

Dependents: If a Retired Employee and his or her Spouse and/or Dependent child(ren) satisfy the criteria as set forth herein, his or her Spouse and/or Dependent child(ren) will be eligible for coverage if the Retired Employee elects Retired Employee coverage. Any Spouse and/or Dependent child otherwise eligible must have also been covered under the Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan for the three consecutive years prior to being eligible for the Retired Employee coverage.

Spouses and Dependent child(ren) will not be eligible for Retired Employee coverage under this Plan if they have access to employer sponsored health care elsewhere, regardless if they are enrolled in the other employer sponsored coverage. The Spouse and/or Dependent child(ren) must notify the Plan when he or she becomes eligible for employer sponsored coverage when enrolled under the Retired Employee's coverage.

Retired Employees and their Spouse and/or Dependent child(ren) who become eligible for Medicare for any reason will no longer be eligible for the Retired Employee coverage regardless if they are enrolled in Medicare.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered **Employee or Retired Employee's Spouse or Domestic Partner** and **children** from birth to the limiting age of 26 years. When the child reaches the limiting age, coverage will end on the last day of the child's birthday month.

The term "**Spouse**" shall mean an individual of the opposite or same sex recognized as the covered Employee or Retired Employee's husband or wife by the laws of the state in which the marriage was formalized and **will** also include a common-law Spouse or the person who is currently registered with the Employer as the Domestic Partner of the Employee or Retired Employee.

An individual is a **Domestic Partner** of an Employee or Retired Employee if that individual and the Employee or Retired Employee meet each of the following requirements:

(a) The Employee or Retired Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee or Retired Employee and the individual are not married to anyone.

(c) The Employee or Retired Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The Employee or Retired Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least 12 consecutive months and be continuing during the period that the applicable benefit is provided. The Employee or Retired Employee and the individual must have the intention that their relationship will be indefinite.

(e) The Employee or Retired Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee or Retired Employee must contact the Plan Administrator.

In the event the domestic partnership is terminated, either partner is required to inform Montana Credit Union League Group Benefits Trust of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

Unless otherwise specified, all references to "Spouse" shall also include Domestic Partner.

The term "**children**" shall include natural children or step-children of the covered Employee, Retired Employee or Domestic Partner, adopted children, children placed with the covered Employee, Retired Employee or Domestic Partner in anticipation of adoption or Foster Children. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

If a covered Employee, Domestic Partner or Retired Employee is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents. The Plan Administrator may require documentation proving a legal guardianship.

The phrase "**child placed with a covered Employee, Retired Employee or Domestic Partner in anticipation of adoption**" refers to a child whom the Employee, Retired Employee or Domestic Partner intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee, Retired Employee or Domestic Partner of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax-free benefits (i.e., Domestic Partner or non-IRC Section 152 Dependent). There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

(2) A covered Dependent child who reaches the limiting age and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee, Retired Employee or Domestic Partner for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: Other individuals living in the covered Employee's or Retired Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retired Employee; any former Domestic Partner of the Employee or Retired Employee; or any person who is covered under the Plan as an Employee or Retired Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father or Domestic Partner are Employees or Retired Employees, their children will be covered as Dependents of the mother or father or Domestic Partner, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

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

FUNDING

Cost of the Plan. The Employer shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Employer.

The level of any Employee contributions is set by the Employer. The Employer reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If Dependent coverage is desired, the covered Employee is also required to enroll for Dependent coverage.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee **will be** automatically enrolled in this Plan from the date of birth. Coverage will continue for the child unless within **60** days of birth, the Employee notifies the Plan to terminate the child's coverage or does not pay the additional contributions to continue the child's coverage. However, after **60** days, coverage will not continue for any newborn child of a covered dependent child unless the Employee adopts the newborn child or is the Legal Guardian of the newborn child.

Coverage for the newborn will be provided only if the Plan Participant remains covered on the Plan during the **60** day period. If the Plan Participant does not remain covered for **60** days, the newborn will only be covered for the amount of time (during the **60** days) that the Plan Participant is effective.

TIMELY, LATE, OR OPEN ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period or no later than **60** days after birth, Foster Child placement, adoption, or placement for adoption.

If two Employees or Retired Employees (husband and wife or Domestic Partners) are covered under the Plan and the Employee or Retired Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee or Retired Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

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

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

(i) **Open Enrollment** - Each year there is an annual open enrollment period designated by the Employer during which eligible Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan or covered Employees may change their and their covered Dependents' benefit elections under the Plan.

Benefit choices made during the open enrollment period will become effective **January 1** and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, domestic partnership, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

(3) **Enrollment Following Benefit Measurement Period** - Employees who were determined to be Full-Time Active Employees during the applicable measurement period (and their eligible Dependents) may enroll in the Plan the first day of the first full calendar month of the following stability period. Employees will be credited for time previously satisfied toward the employment Waiting Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, domestic partnership, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the marriage or domestic partnership, or **60** days of the birth, Foster Child placement, adoption, or placement for adoption.

The Special Enrollment rules are described in more detail below. **To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.**

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. *(**Note:** A Retired Employee who declines coverage at retirement and later loses other coverage will not be entitled to special enrollment, nor will the Retired Employee's eligible Spouse, Domestic Partner, or Dependent children.)*

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions (**Note:** The following provisions will not be applicable to a Retired Employee and/or their Spouse, Domestic Partner, or Dependent children):

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g.: part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), or

(b) The Retired Employee is a participant under this Plan; and

(c) A person becomes a Dependent of the Employee or Retired Employee through marriage, registration of domestic partnership, birth, adoption, or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage.

In the case of marriage, domestic partnership, birth, adoption, or placement for adoption, the Spouse, Domestic Partner, or Dependent child of a covered Retired Employee may be enrolled as a Spouse, Domestic Partner or Dependent child of the covered Retired Employee if the Spouse, Domestic Partner, or Dependent child is otherwise eligible for coverage under the Plan.

If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. *If the Retiree is not enrolled at the time of the event, this Special Enrollment right will not be applicable.*

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage or the date of registration of domestic partnership; or 60 days that begins on the date of Foster Child placement, birth, adoption, or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee or Retired Employee must request enrollment during this period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) In the case of marriage, the day of marriage, or

(b) In the case of Domestic Partner relationship, on the date of registration of the Domestic Partner relationship; or

(c) In the case of a Dependent's birth, as of the date of birth; or

(d) In the case of a Dependent's adoption, placement for adoption, or Foster Child placement, the date of the adoption, placement for adoption, or Foster Child placement.

(3) Medicaid or Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan, but who are not enrolled, can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility:

(a) The eligible person ceases to be eligible for Medicaid or Children’s Health Insurance Program (CHIP) coverage; or

(b) The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent and if not otherwise enrolled, the Employee, Spouse, and otherwise eligible Dependent children may be enrolled under this Plan.

This Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. *The effective date of coverage will be the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer, and its Employees.

For more information regarding special enrollment rights, contact the Plan Administrator.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the first calendar month or as otherwise dictated by the Employer, and under no circumstances to exceed the 91st day following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. **If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.** The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes, or if the Employer is a large employer (more than 50 full-time employees), the last day of the benefit stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(6) As otherwise specified in the Eligibility section of this Plan.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled "COBRA Continuation Coverage."

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff in accordance with the Employer's policies and procedures. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance, or 90 days from the first day of approved disability leave, whichever comes first. This 90-day period may be extended if required by applicable law.

For leave of absence or layoff only: the date the Employer ends the continuance, or 90 days from the first day of approved leave of absence or layoff, whichever comes first. This 90-day period may be extended if required by applicable law.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations. This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired prior to the end of a 13 consecutive week period after the date of termination will be credited with time met towards the employment Waiting Period as of the date of termination. Coverage will begin the first day of the first calendar month following the date of rehire or the first day of the first calendar month following completion of the Waiting Period.

Otherwise, a terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

However, if the Employee is returning to work directly from COBRA Continuation Coverage, this Employee will be credited with time met towards the employment Waiting Period as of the date the Employee elected COBRA Continuation Coverage.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage may pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA Continuation Coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Montana National Guard Members. Participants performing State active duty as a Montana National Guard member may elect to continue Plan coverage subject to the terms of the Montana Military Service Employment Rights Act (MMSERA) under the following circumstances:

(1) The period of coverage of a person under such an election shall be the period of time beginning on the date on which the person’s absence for State active duty begins, and ending:

(a) The next regularly scheduled day of employment following travel time plus 8 hours, if State active duty is 30 days or less; or

(b) The next regularly scheduled day of employment following 14 days after termination of State active duty, if State active duty is not more than 180 days; or

(c) The next regularly scheduled day of employment following 90 days after termination of State active duty, if State active duty is more than 180 days.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except that a person on State active duty for less than 180 days may not be required to pay more than the regular Participant’s share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of 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.

When Retired Employee Coverage Terminates. Retired Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated;

(2) The date the covered Retired Employee's Eligible Class is eliminated;

(3) The date the Retired Employee's coverage under the Plan terminates due to death;

(4) The last day of the calendar month in which the Retired Employee reaches age 65 or becomes eligible for Medicare for any reason;

(5) If a Retired Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Retired Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage;

(6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

(7) As otherwise specified in the Eligibility section of this Plan.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.)

(3) The last day of the calendar month a covered Spouse or Domestic Partner loses coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.) *In the event the domestic partnership is terminated either partner is required to inform the Plan Administrator of the termination of the domestic partnership.*

(4) The last day of the calendar month in which the Spouse of a Retired Employee reaches age 65.

(5) The last day of the calendar month in which the Spouse or Dependent child of a Retired Employee becomes eligible for Medicare for any reason or become eligible for other employer-sponsored coverage.

(6) The last day of the calendar month in which the Dependent child ceases to meet the applicable eligibility requirements. (See the section entitled COBRA Continuation Coverage.)

(7) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(8) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(9) As otherwise specified in the Eligibility section of this Plan.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled "COBRA Continuation Coverage."

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

Claims must be received by the Claims Administrator within **365 days** from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Plan Participant must meet the deductible shown in the Schedule of Benefits.

The deductible will apply to the maximum out-of-pocket amount.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT AND COINSURANCE

Each Calendar Year, benefits will be paid for the Covered Charges of a Plan Participant after the Plan Participant has met his or her Calendar Year deductible and any applicable copayment(s).

Benefit payment made by the Plan will be at the percentage rate shown in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

Once the Plan has made the applicable benefit payment, the remaining percentage owed is the Plan Participant's "Coinsurance" responsibility. For example, if the Plan's reimbursement rate is 60%, the Plan Participant's responsibility (or coinsurance) is 40%.

Coinsurance *does not* include any deductible or copayment amounts. Coinsurance will apply to the maximum out-of-pocket amount.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable by the Plan at the percentages shown each Calendar Year until the maximum out-of-pocket amount shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. In the case of an Employee or Dependent who receives benefits under the Plan in connection with a Mastectomy or Lumpectomy and who elects breast reconstruction (in a manner determined in consultation with the attending Physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which the Mastectomy or Lumpectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the Mastectomy and Lumpectomy, including lymphedemas.

This coverage will be subject to the same annual deductible and coinsurance provisions that currently apply to Mastectomy and Lumpectomy coverage.

COVERED CHARGES

Covered Charges of the types listed below will be eligible for reimbursement as shown in the Schedule of Benefits. The expenses must be for Medically Necessary services and supplies that are not otherwise limited or excluded under the Plan terms and will be the Allowable Charge or the negotiated rate at the Plan Administrator's sole discretion.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital, Outpatient Surgical Center, or Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at the average private room rate.

Charges for an Intensive Care Unit stay are payable as shown in the Schedule of Benefits.

Note: Pre-certification of an inpatient admission and inpatient/outpatient surgical procedure is required prior to service. See the Care Management Services section for more information.

(2) **Coverage of Pregnancy.** The Allowable Charge for the care and treatment of Pregnancy are covered the same as any other Illness for a covered Employee or covered Spouse and will be payable as shown in the Schedule of Benefits.

Note: Routine prenatal office visits will be payable as shown under the Pregnancy benefit in the Schedule of Benefits section.

The following services will continue to be payable per normal Plan provisions (but will not apply to the Pregnancy of a Dependent child):

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of Pregnancy (as defined under this Plan), delivery, and post-partum care.

There is no coverage of Pregnancy for a Dependent child. However, the following services are available to all female Plan Participants and are payable as shown in the Medical Benefits Schedule, patient education and counseling for all women with reproductive capacity, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth, and any other service required to be covered as preventive for pregnant women under the Affordable Care Act (ACA).

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

Note: Pre-certification of a routine maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required. See the Care Management Services section for more information.

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) The Plan Participant is confined as a bed patient in the Facility; and

(b) The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Plan Participant's care in these Facilities are payable as shown in the Schedule of Benefits.

Note: Pre-certification of all inpatient admissions is necessary to avoid a penalty. See the Care Management Services section for more information.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for multiple surgical procedures are subject to the following provisions in the absence of a negotiated amount established by a provider Network arrangement or other discounting or negotiated arrangement:

(a) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Allowable Charge.

Note: Pre-certification of inpatient or outpatient surgery is required prior to service. See the Care Management Services section for more information.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Outpatient private duty nursing care is not covered.

(6) **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Illness. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide, and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Note: Pre-certification of Home Health Care is required prior to service. See the Care Management Services section for more information.

(7) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as shown in the Schedule of Benefits.

Bereavement counseling services by a healthcare provider acting within the scope of his or her license for the Plan Participant's immediate family (covered Employee, covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the Plan Participant's death.

Note: Pre-certification of Hospice Care is required prior to service. See the Care Management Services section for more information.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Allergy Testing and Injections.** Covered Charges will include testing, injections, serum, and syringes.

(b) **Alternative Care.** Alternative Care includes the following and will be payable up to the limits as shown in the Schedule of Benefits:

- **Acupressure**
- **Acupuncture**
- **Massage Therapy**
- **Spinal Manipulation/Chiropractic Services**

(c) **Ambulance.** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(d) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) **Applied Behavioral Analysis** or other similar services, including Habilitative and Rehabilitative Care when provided by an individual licensed by the behavioral analyst certification board or certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

Note: Benefits are limited to treatment that is prescribed by a Physician and documented by a written Plan of Care provided by the treating Physician. The Plan Administrator may request periodic documentation of continued progress to goals identified in the Plan of Care.

(f) Breast Pump, Breast Pump Supplies, Lactation Support and Counseling.

Breast pump, breast pump supplies
A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.
- For female Plan Participants using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.
- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered every three Calendar Years following a subsequent Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Schedule of Benefits section.

Note: Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered eligible only for the purposes of this benefit. The Claims Administrator will require the following documentation: Claim form with proof of purchase to include purchase price and item description.

Lactation support and counseling
Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Plan Participants for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

Note: Payment will be made for Covered Charges for lactation support and counseling under the Preventive Care benefits in the Schedule of Benefits section.

(g) Cardiac Rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery, or other cardiac condition; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(h) Chemotherapy or Radiation Treatment with radioactive substances. The materials and services of technicians are included.

Pre-certification of services, by the Plan Participant, for cancer treatment services is required. The pre-certification request to Medical Rehabilitation Consultants, Inc. should include the Plan Participant's Plan of Care and treatment protocol. Pre-certification of services should occur at least seven days prior to the initiation of treatment.

For pre-certification of services, call Medical Rehabilitation Consultants, Inc. at the following numbers:

Toll Free in the United States: (800) 827-5058 or (509) 328-9700

Note: Pre-certification of Chemotherapy or Radiation Treatment, including medications, is required prior to service. See the Care Management Services section for more information.

(i) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained website www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial.
- The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
- The Plan Participant has signed an Informed Consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent.
- The trial is approved by the Institutional Review Board of the institution administering the treatment.
- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

Routine patient services do not include, and reimbursement will not be provided for:

- The Investigational service, supply, or drug itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant (e.g., monthly CT scans for a condition usually requiring only a single scan);
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

(j) **Colonoscopy.** Covered Charges for a colonoscopy with a medical diagnosis will be payable as shown in the Schedule of Benefits. *Coverage includes reimbursement for the following: CT Colonography (virtual colonoscopy and flexible sigmoidoscopy).* For routine colonoscopies, see the Preventive Care benefit in the Schedule of Benefits.

(k) Initial **Contact Lenses** or **Glasses** required following cataract surgery.

(l) **Contraceptives.** All Food and Drug Administration (FDA) approved contraceptive methods when prescribed by a Physician, including but not limited to intrauterine devices (IUDs), and implants, (including insertion and removal when applicable), injections, and any related Physician and Facility charges including complications.

Refer to the separate Prescription Drug Benefits of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Plan Participants.

(m) **Diabetes Education.** Inpatient and outpatient self-management training and education services for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, will be payable up to the limits as shown in the Schedule of Benefits.

(n) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Plan Participant;
- Does NOT have significant non-medical uses (i.e., air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Plan Participant's needs, Plan benefits are only available for the least cost alternative as determined by the Claims Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Plan Participant.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Plan Participant if the Plan Participant were to purchase the item directly. The acquisition cost of the item may be prorated over a six month period, subject to prior approval by the Claims Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every four Calendar Years.

- Subject to prior approval of the Claims Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Plan Participant's medical condition occurs sooner than the four Calendar Year period.

- Subject to prior approval of the Claims Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Plan Participant's medical condition occurs sooner than the four Calendar Year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the four Calendar Year limit.

Note: Pre-certification of Durable Medical Equipment over $2,000 is required prior to service. See the Care Management Services section for more information.

The Claims Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

(o) **Foot care.** Treatment of weak, strained, flat, unstable, or unbalanced feet; metatarsalgia or bunions; and treatment of corns, calluses, or toenails.

(p) **Gender Dysphoria/Gender Identity Disorder.** Medically Necessary treatment, supplies, and services for the diagnosis of gender dysphoria.

(q) **HealthJoy Telemedicine.** The HealthJoy Telemedicine benefit offers Plan Participants unlimited telephone access to experienced board-certified licensed Physicians as a convenient alternative to in person health care for certain common medical issues. HealthJoy Telemedicine Physicians are available 24 hours a day, including weekends and holidays and are able to provide diagnoses, medical advice, and treatment recommendations, including prescription medications for non-DEA controlled substances or narcotics.

Plan Participants also have access to Healthcare Concierge services offered through HealthJoy. These services are available Monday-Friday 7:00 am - 12:00 am CST and Saturday and Sunday 10:00 am - 6:00 pm CST (hours are subject to change). These services include General Benefits Assistance, Provider Recommendations, Facility Recommendations, Appointment Scheduling, Bill Review, Prescription Savings Review, and Healthcare Cost Guidance.

For more information about these services contact HealthJoy at (855) 947-6900, or contact the Plan Administrator for details to download the HealthJoy app.

Telemedicine services not incurred through HealthJoy will be a Covered Charge subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.

(r) **HealthJoy EAP.** Plan Participants will have access to the HealthJoy EAP program 24 hours a day, including weekends and holidays. Plan Participants will be provided with an intake assessment including, but not limited to:

1. Gathering psychosocial history including presenting problem;
2. Treatment history and Substance Abuse history;
3. Completing a risk assessment of the Plan Participants and their HealthJoy EAP eligible beneficiaries and dependent(s) and determining the appropriate level of care.

If the presenting issue can be resolved within the framework of the HealthJoy EAP's short-term counseling model, HealthJoy will provide clinical consultation and individual case management to all Employees which will include:

1. Crisis counseling for Plan Participants and their HealthJoy EAP eligible beneficiaries and dependent(s).
2. Assessment, short-term counseling and/or referrals. These counseling sessions may be delivered either in-person or via the HealthJoy EAP eConnect® platform.
3. Post-case referral to an appropriate professional or helping agency.
4. Follow-up on each case to determine success of the rehabilitation process or need for further assistance.

If the initial assessment reveals that treatment is required beyond the scope of the EAP, the case manager will provide the Plan Participants with the appropriate referrals for mental health or Substance Abuse providers or Facilities that are in the Network.

HealthJoy EAP also offers the following work/life services to all Plan Participants: Legal Assist Services and Materials, Integrated Identity Recovery Program, Financial Assist Services, Child Care Resource and Referral Services, Elder Care Resource and Referral Services, and Convenience Resource and Referral Services.

For more information about these services contact HealthJoy at (888) 731-3EAP (3327) or visit the website at eap.healthjoy.com; username: mcultrust.

(s) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and are required for the administration of a home infusion therapy regimen when ordered by and are part of a formal written plan prescribed by a Physician. The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, Prescription Drugs, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor a response to therapy.

(t) **Inborn Errors of Metabolism.** Treatment under the supervision of a Physician for inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standards 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 nutritional supplements in any form that are used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

(u) **Infertility.** Care, supplies, and services for diagnosis only. *Infertility treatment and medication are not a Covered Charge under this Plan.*

(v) **Jaw Joint Conditions, including Temporomandibular Joint syndrome (TMJ).** Medically Necessary surgical services for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome (TMJ).

Note: Pre-certification of inpatient or outpatient surgery is required prior to service. See the Care Management Services section for more information.

(w) **Laboratory Studies.** Covered Charges for diagnostic lab testing and services.

(x) **Medical Supplies.** The following supplies for use outside of a Hospital when prescribed by a Physician and deemed Medically Necessary to treat an Illness or Injury covered under this Plan:

- Syringes and related supplies for conditions such as diabetes.
- Injection aids, visual reading and urine test strips, glucagon emergency kits for treatment of diabetes. **Note:** Insulin pump and supplies will be payable under the separate Durable Medical Equipment benefit under this Plan.
- Sterile or surgical dressings.
- Catheters.
- Splints, casts, and other devices used in the reduction of fractures and dislocations.
- Colostomy bags and related supplies.
- Supplies for renal dialysis equipment or machines.

(y) **Mental Disorders and Substance Abuse Treatment.** Covered Charges for care, supplies, and treatment of Mental Disorders and Substance Abuse.

Note: Pre-certification of an inpatient admission is required prior to service. See the Care Management Services section for more information.

(z) Injury to or care of **Mouth, Teeth, and Gums.** Charges for Injury to or care of the mouth, teeth, gums, and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth.

- Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands, or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, and preparing the mouth for the fitting of or continued use of dentures.

Services and supplies provided by a Hospital in conjunction with dental treatment will be covered only when a non-dental physical Illness or Injury exists which makes Hospital care Medically Necessary to safeguard the Plan Participant's health. Dental treatment provided in a Hospital unrelated to a non-dental physical Illness or Injury will not be a Covered Charge regardless of the complexity of dental treatment and length of anesthesia.

(a1) **Naturopathy.** Care, treatment, and services that are described as a Covered Charge under this Plan.

(b1) **Nutritional Education Counseling.** Care, treatment, and services when provided by a health care provider acting within the scope of his or her license, will be payable up to the limits as shown in the Schedule of Benefits. *This benefit will not include weight loss medications or nutritional supplements whether or not prescribed by a Physician.*

Note: Additional benefits may be available if approved in advance through VezaHealth. For more information, please contact VezaHealth by calling (800) 970-6571, via email at consultant@vezahealth.com, or by visiting www.vezahealth.com.

(c1) **Obesity Interventions.** See the **Weight Management** benefit below.

(d1) **Occupational Therapy.** Therapy must be ordered by a health care provider acting within the scope of his or her license, result from an Injury or Illness, and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy. All treatment is subject to the benefit payment limits shown in the Schedule of Benefits.

Note: Additional benefits may be available if approved in advance through VezaHealth. For more information, please contact VezaHealth by calling (800) 970-6571, via email at consultant@vezahealth.com, or by visiting www.vezahealth.com.

(e1) **Organ Transplant.** Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant, which are not considered Experimental or Investigational, are subject to the following criteria (and are subject to the limits as shown in the Schedule of Benefits):

- The transplant must be performed to replace an organ or tissue.
- **Organ transplant benefit period.** A period of 365 continuous days beginning five days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.
- **Organ procurement limits.** Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Plan Participant. When the donor has medical coverage, his or her plan will pay first. Charges incurred by the organ donor for a covered transplant will be eligible under this Plan if the charges are not covered by any other medical expense coverage.

The donor benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

(i) Evaluating the organ or tissue;
(ii) Removing the organ or tissue from the donor; and
(iii) Transportation of the organ or tissue from within the United States or Canada to the Facility where the transplant is to be performed.

Note: Expenses related to the purchase of any organ will not be covered.

Note: Pre-certification of Organ Transplant services, including travel, is required prior to service. See the Care Management Services section for more information.

- In the event a Network Provider transplant Facility is utilized, benefits will be payable at the Network Provider benefit level.

- In the event a Network Provider transplant Facility is unavailable and the providing transplant Facility is a Center of Excellence Facility, benefits will be payable at the Network Provider benefit level.

- In the event a Non-Network Provider transplant Facility is utilized and the providing transplant Facility is not a Center of Excellence Facility, benefits will be payable at the Non-Network Provider benefit level.

There is no obligation to the Plan Participant to use either a Network Provider or a Center of Excellence Facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Network Provider or a Non-Network Provider and whether or not a Center of Excellence Facility is utilized.

A **Center of Excellence** is a licensed healthcare Facility that has entered into a participation agreement with a national transplant Network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Plan Participant may contact Medical Rehabilitation Consultants, Inc. to determine whether or not a Facility is considered a Center of Excellence.

Special Transplant Benefits

Under certain circumstances, there may be special transplant benefits available when the group health plan and/or a Plan Participant participates in a special transplant program and/or contracts with a specific transplant Network. Therefore, it is very important to contact Medical Rehabilitation Consultants, Inc. at (800) 827-5058 or (509) 328-9700 as soon as reasonably possible so that the Plan can advise the Plan Participant or his or her Physician of the transplant benefits that may be available.

Transplant Exclusions

Coverage for the following procedures, when Medically Necessary, will be provided under the regular medical benefits provision under this Plan, subject to any Plan provisions and applicable benefits limitations as shown in the Schedule of Benefits.

(1) Cornea transplantation
(2) Skin grafts
(3) Artery
(4) Vein
(5) Valve
(6) Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

(f1) **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness.

Orthopedic devices, a rigid or semi rigid supportive device which restricts or eliminates motion of a weak or diseased body part, will be limited to braces, corsets, and trusses.

Foot orthotics, up to the limit shown in the Schedule of Benefits, including impression casting for orthotic appliances, padding, strapping and fabrication *will* be a Covered Charge.

(g1) **Physical Therapy.** The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. All treatment is subject to the benefit payment limits shown in the Schedule of Benefits.

Note: Additional benefits may be available if approved in advance through VezaHealth. For more information, please contact VezaHealth by calling (800) 970-6571, via email at consultant@vezahealth.com, or by visiting www.vezahealth.com.

(h1) **Prescription Drugs** (as defined)**.** Outpatient Prescription Drugs will be payable under the separate Prescription Drug Benefits section under this Plan.

(i1) **Routine Preventive Care/Routine Well Care.** Covered Charges under Medical Benefits are payable for Preventive Care/Routine Well Care as described in the Schedule of Benefits. Preventive Care shall be provided as required by applicable law and includes services with an "A" or "B" rating from the United States Preventive Services Task Force.

Preventive Care/Routine Well Care is care by a Physician that is not for an Injury or Illness and will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.

Consult with your Physician at the time services are rendered as to whether or not the services provided will be considered Preventive Care/Routine Well Care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations or the Women's Preventive Services as required by the Health Resources and Services Administration (HRSA).

Otherwise, services rendered which are not considered or billed by the Physician as Preventive Care/Routine Well Care (as stated above) will be subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided.

(j1) **Routine Preventive Dental Care.** Covered Charges under Medical Benefits for Current Dental Terminology (CDT) are payable for limited routine Preventive Dental Care as described in the Schedule of Benefits for dental examinations (D0120, D0145, D0150, D0160, D0170, D0180) and oral prophylaxes ((cleanings) D1110 D1120).

(k1) **Prosthetic Devices.** The initial purchase, fitting, and repair of fitted prosthetic devices which replace body parts if deemed Medically Necessary. Covered Charges for deluxe prosthetics and computerized limbs will be based on the Allowable Charge for a standard prosthesis.

Computer-assisted communication devices and replacement of lost or stolen prosthesis *will not* be a Covered Charge.

(l1) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) Reconstruction of the breast on which a Mastectomy or Lumpectomy has been performed,

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) Coverage of prostheses and physical complications during all stages of Mastectomy or Lumpectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the Plan Participant.

Note: Pre-certification of inpatient or outpatient surgery is required prior to service. See the Care Management Services section for more information.

(m1) **Rehabilitation Services** up to the limits shown in the Schedule of Benefits. Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

Inpatient Care. Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation Facility approved by the Plan. This benefit only covers care the Plan Participant received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

(n1) **Renal Dialysis Services.** Renal dialysis visits shall include dialysis, Facility services, supplies, and medications provided during treatment. Laboratory testing and Physician visits will be payable per normal Plan provisions.

Note: Pre-certification of Renal Dialysis Services is required prior to service. See the Care Management Services section for more information.

(o1) **Speech Therapy.** Therapy must be ordered by a health care provider acting within the scope of his or her license and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a person; (ii) an Injury; (iii) an Illness. All treatment is subject to the benefit payment limits shown in the Schedule of Benefits.

Note: Additional benefits may be available if approved in advance through VezaHealth. For more information, please contact VezaHealth by calling (800) 970-6571, via email at consultant@vezahealth.com, or by visiting www.vezahealth.com.

(p1) **Sterilization Procedures.** Sterilization procedures for female Plan Participants will be payable as shown under the Preventive Care benefit as shown in the Schedule of Benefits.

The following charges will be payable per normal Plan provisions:

- Hysterectomies; and
- Sterilization procedures for male Plan Participants.

(q1) **Surgical Dressings**, splints, casts, and other devices used in the reduction of fractures and dislocations.

(r1) **Tobacco/Nicotine Cessation Counseling.** Care and treatment for tobacco/nicotine cessation counseling, will be payable up to the limits as shown in the Schedule of Benefits. Refer to the Prescription Drug Benefits section regarding coverage of tobacco/nicotine cessation medications and products.

(s1) **Travel.** Medically Necessary travel may be approved under certain circumstances by the Plan Administrator for covered services, up to a maximum of $5,000.

(t1) **VezaHealth.** VezaHealth is a medical appropriateness and clinical education program which allows Plan Participants to receive clinical consulting services and remote second opinions from specialized Physicians, when appropriate and approved by the Plan Administrator.

Given the high rate of misdiagnosis and the variation and waste prevalent in health care, Plan Participants are highly encouraged to seek a remote second opinion when they receive a diagnosis and/or a course of treatment that they are uncertain about, or if they would simply like additional information to better understand what options are available and what may best suit their individual health care needs. A remote second opinion obtained through VezaHealth, is at no cost to the Plan Participant. Travel expenses, if necessary, may also be covered at the discretion of the Plan Administrator, when mutually beneficial to the Plan Participant and the Plan.

To utilize VezaHealth, Plan Participants should first connect with a VezaHealth Registered Nurse by calling (800) 970-6571 or via email at consultant@vezahealth.com.

VezaHealth, and certain Covered Charges recommended through VezaHealth are only available when mutually beneficial to the Plan Participant and the Plan, or when otherwise approved by the Plan Administrator. Certain cost-sharing amounts and visit limits may also be waived if recommended through VezaHealth and consistent with applicable law. The Plan Administrator, in its sole discretion, shall determine whether this benefit is available to a Plan Participant on a case-by-case basis.

(u1) **Weight Management.** This benefit is being provided consistent with the Affordable Care Act preventive services requirement. Covered Charges include nutritionist or dietician led programs, along with Physician-directed intensive, multicomponent behavioral interventions, including weight loss clinics, for weight management for Plan Participants age 18 and older.

Intensive, multicomponent behavioral interventions for weight management will include group and individual sessions of high intensity (up to 26 visits per Calendar Year) encompassing the following:

- Behavioral management activities such as setting weight loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency, and duration of treatment and/or treatment protocol for the Plan Participant's specific condition.

Medically Necessary Diagnostic Testing (X-ray & Lab services) rendered in connection with Weight Management will be payable subject to the separate Diagnostic Testing benefit under this Plan.

Surgical care and treatment and Physician prescribed weight loss medications **will not** be a covered benefit.

This Plan **will not** cover weight loss meals, food programs, nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

Note: Additional benefits may be available if approved in advance through VezaHealth. *For more information, please contact VezaHealth by calling (800) 970-6571, via email at* consultant@vezahealth.com*, or by visiting* www.vezahealth.com*.*

(v1) Well Newborn Nursery/Physician Care.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board, and other normal care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Plan Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to the Allowable Charge for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

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

Charges for Routine Physician Care. The benefit is limited to the Allowable Charge made by a Physician for normal newborn child, including circumcision, while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(w1) Wigs. Charges associated with the initial purchase of a wig after chemotherapy or radiation treatment will be payable up to the limits as shown in the Schedule of Benefits.

(x1) X-rays. Charges for diagnostic x-rays and imaging services.

CLAIM REVIEW AND AUDIT PROGRAM – MEDICAL BENEFITS

The Plan has arranged for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees, and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a usual, customary, or reasonable fee determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits and allowed the rights and privileges to file an appeal of the determination which are the same rights and privileges accorded to Plan Participants; and, in return, the provider must agree not to bill the Plan Participant for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the Plan Participant to file an appeal under the Plan. Please refer to the section, "Internal and External Claims Review Procedures" for additional information regarding Plan Participant and provider appeals.

Any Plan Participant who receives a balance-due billing from a medical care provider for these charges should contact the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Plan Information section of this Plan Document and Summary Plan Description.

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as deductibles, coinsurance and copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Charges that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Plan Participant. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under applicable regulations, it will be necessary to deny the claim. Should such a denial be necessary, the Plan Participant and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Internal and External Claims Review Procedures" in this Plan Document and Summary Plan Description.

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

(1) **Errors, Unbundled and/or Unsubstantiated Charges.** Allowable Claim Limits will not include the following amounts:

(a) Charges identified as improperly coded, duplicated, unbundled, and/or for services not performed;

(b) Charges for treating Injuries sustained or Illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the provider;

(c) Charges that cannot be identified or understood; and

(d) Charges that cannot be verified from audits of medical records.

(2) **Guidelines.** The following guidelines will be used when determining Allowable Claim Limits:

(a) **Facilities.** The Allowable Claim Limit for claims by a Facility, including but not limited to, Hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. The Allowable Claim Limit for (I) shall not exceed 250% of the federal non-commercial Medicare allowed amount, except for children's Hospitals, which shall not exceed 350% of the federal non-commercial Medicare allowed amount. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

(b) **Outpatient Surgical Centers.** The Allowable Claim Limit for Outpatient Surgical Centers, including ambulatory surgery centers, which are independent Facilities, shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%.

(c) **Professional Providers.** The Allowable Claim Limits for professional providers shall be determined using the following:

(i) For general medical and primary care claims, the Medicare allowed amount in the geographic area plus an additional 40%;

(ii) For specialist medical and surgical care claims, the Medicare allowed amount in the geographic area plus an additional 55%;

(iii) For anesthesiologist claims, the Medicare allowed amount in the geographic area plus an additional 100%;

(iv) For ambulance and air ambulance claims, the Medicare allowed amount in the geographic area plus an additional 20%; or

(v) For other non-facility claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level providers, etc.), the Medicare allowed amount in the geographic area.

For purposes of determining the proper Allowable Claim Limits for professional providers in categories (i), (ii), (iii), (iv), or (v) above, the Plan Administrator shall determine the applicable category for each claim based on the taxonomy code used by the professional provider for that claim. The Plan Administrator determines in its sole discretion the type of provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth, and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

(d) **Directly Contracted Providers.** The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

(e) **Insufficient Information to Determine Allowable Claim Limit.** In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, the Plan Administrator may apply the following guidelines:

i. **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered service may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.

ii. **Medical and Surgical Supplies, Implants, Devices.** The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

iii. **Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Plan Participant.

In the event that a determination of Allowable Claim Limit for a claim exceeds the actual charges billed for the services and/or supplies, the actual charges billed for the claim shall be the Allowable Claim Limit.

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Plan Participants in understanding and becoming involved with their diagnosis and medical Plan of Care, and advocates patient involvement in choosing a medical Plan of Care. Utilization Management begins with the pre-certification process.

PRE-CERTIFICATION REQUIREMENTS

Pre-certification is required by the Plan for the specific services outlined below. Pre-certification provides information regarding coverage before the Plan Participant receives treatment, services, and/or supplies. *A pre-certification of services by Medical Rehabilitation Consultants, Inc. is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided.*

HOW PRE-CERTIFICATION WORKS

Before a Plan Participant receives treatment for services included on the pre-certification list, the Plan Participant and/or their attending Physician must contact Medical Rehabilitation Consultants, Inc. who, in conjunction with the attending Physician, will obtain information for the purpose of pre-certifying the care as appropriate for Plan reimbursement.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

Pre-certification must occur in advance of the proposed admission or service. In the case of an inpatient admission directly from the emergency room, notification must occur following the emergency room admission. A maternity admission that does not exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery will not require pre-certification.

SERVICES THAT REQUIRE PRE-CERTIFICATION

- Inpatient admissions to a Hospital, Skilled Nursing Facility, or a free-standing Mental Disorder/Substance Abuse Facility;
  - Pre-certification is required for a routine maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery;
  - Pre-certification of an inpatient admission from the Emergency Room is required.
- Inpatient or outpatient surgical procedures;
- Chemotherapy and radiation treatment, including medications;
- Renal dialysis;
- Genetic testing;
- Injectables;
- Home Health Care;
- Hospice;
- Durable Medical Equipment (DME) over $2,000;
- Organ transplants; and
- Travel expenses

The following information will be requested by Medical Rehabilitation Consultants as part of the pre-certification process:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number, and address of the Plan Participant
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The Plan of Care, treatment protocol and/or informed consent, if applicable

Hospital observation room stays in excess of 23 hours are considered an admission for purposes of this program, therefore Medical Rehabilitation Consultants, Inc. must be notified.

Medical Rehabilitation Consultants, Inc. will determine the number of days of Hospital confinement or use of other listed medical services that may be authorized for payment.

Obtaining pre-certification of a particular service does not guarantee that a claim will be reimbursed by the Plan. Benefit payments are subject to the eligibility and other terms, conditions, limitations, and exclusions of the Plan in effect at the time services are provided.

Benefits for services deemed not Medically Necessary or when it is determined that a lesser procedure may be more appropriate, may be reduced or denied.

If a pre-certification request is denied, the Plan Participant may appeal that determination. Please refer to the Internal and External Claims Review Procedures section for more information.

Contact the Care Management Administrator:

Medical Rehabilitation Consultants, Inc. (800) 827-5058 or (509) 328-9700

PRE-NOTIFICATION OF SERVICES

(Applies to certain services other than those for which pre-certification is required.)

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services and/or supplies. A benefit determination on a claim will be made only after the claim has been submitted. A pre-notification of services by Medical Rehabilitation Consultants, Inc. is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in this Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures section.

All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided.

PRE-ADMISSION AND POST DISCHARGE CARE CALLS

A Medical Rehabilitation Consultants, Inc. nurse will contact the Plan Participant to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan, and post-discharge follow-up.

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

The Plan Administrator or its designee, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within 15 days of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Plan Administrator or its designee will notify the Plan Participant or the Physician. The time for making a determination on the request will be deferred from the date that the additional information is requested until the date that the information is received.

The Physician and Plan Participant will be provided notice of the Plan's determination. If the pre-notification request is denied, written notice will provide the reason for the adverse pre-notification determination.

As a reminder, a pre-notification of services by Medical Rehabilitation Consultants, Inc. is not a determination by the Plan that a claim will be paid.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within 30 days of the receipt of the adverse pre-notification determination and include a statement as to why the Plan Participant disagrees with the adverse pre-notification determination. The Plan Participant may include any additional documentation, medical records, and/or letters from the Plan Participant's treating Physician(s).

The request for reconsideration should be addressed to:

Medical Rehabilitation Consultants, Inc.
111 W. Cataldo, Suite 200
Spokane, WA 99201-3203
Phone: (800) 827-5058 or (509) 328-9700
Fax: (509) 328-9777

The Plan Administrator or its designee will perform the reconsideration review. The Plan Administrator or its designee will review the information initially received and any additional information provided by the Plan Participant and determine if the pre-notification determination was appropriate. If the adverse pre-notification determination was based upon the Medical Necessity, the Experimental/Investigational nature of the treatment, service or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. Written or electronic notice of the determination upon reconsideration will be provided within 30 days of the receipt of the request for reconsideration.

CASE MANAGEMENT

If a Plan Participant has an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor this Plan Participant, and to work with the attending Physician and Plan Participant to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Plan Participant, the family, and the attending Physician in order to assist in coordinating the Plan of Care approved by the Plan Participant's attending Physician and the Plan Participant.

This Plan of Care may include some or all of the following:

- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

Case Management is not a requirement of the Plan. There are no reductions of benefits or penalties if the Plan Participant and family choose not to participate.

Each treatment plan is individualized to a specific Plan Participant and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Plan Participant and the attending Physician.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time or part-time basis.

Allowable Charge. Except as otherwise set forth herein, Allowable Charge means the amount for a treatment, service, or supply that is (a) the negotiated amount established by a provider Network arrangement or other discounting or negotiated arrangement; or in the absence of any such arrangement, Allowable Charge means (b) Allowable Claims Limit as determined by the Claim Review and Audit Program.

In the event the Non-Network Provider disputes the Plan's Allowable Charge for any claim subject to the No Surprises Act (NSA) through the Independent Dispute Resolution (IDR) process, the Allowable Charge may be determined by a Certified IDR Entity.

Allowable Claim Limits means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of a covered Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program – Medical Benefits" for additional information regarding Allowable Claim Limits.

Applied Behavioral Analysis, also known as Lovaas therapy, is therapy provided by an individual who is licensed by the behavior analyst certification board or is certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

For purposes of Applied Behavioral Analysis, care shall include Medically Necessary interactive therapies derived from evidence-based research, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

Birthing Center means any freestanding health Facility, place, professional office, or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This Facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the Facility is located.

The Birthing Center must provide Facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Claims Administrator means Employee Benefit Management Services, LLC (EBMS).

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

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Covered Charge(s) means any Medically Necessary item of expense, for which the charge is reasonable and necessary, within Allowable Claim Limits, or is based on the contracted fee schedule of an alternate care delivery system. The Covered Charge will be determined by the Plan Administrator, in its sole discretion.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Direct Agreement means a complete agreement with a Directly Contracted Provider that contains the terms and conditions under which the Plan Participant may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for claims submitted by a Directly Contracted Provider.

Directly Contracted Provider means a medical provider, supplemental benefit provider, and/or supplemental network partner which has entered into a Direct Agreement to provide certain medical services to Plan Participants at agreed upon Allowable Claim Limits.

Durable Medical Equipment (DME) means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in: (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer means any credit union that i) has been approved by the Plan Administrator to participate in the MCUL Group Benefits Trust and ii) has executed a Subscription Agreement.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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

(2) If the drug, device, medical treatment or procedure, or 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) Except as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Charges section, if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

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

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Facility means a healthcare institution which meets all applicable state or local licensure requirements. For the purposes of the Claim Review and Audit Program, Facility includes, but is not limited to, Hospitals, emergency, rehabilitation and skilled nursing centers, Outpatient Surgical Centers, laboratories, X-ray, MRI or other CT facilities, and any other health care facility.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county, or private foster care agency.

A covered Foster Child is <u>not</u> a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Habilitative and Rehabilitative Care shall include Medically Necessary interactive therapies derived from evidence-based research, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed Facility, home care, and family counseling during the bereavement period.

Hospice Unit is a Facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic Facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour a day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized Facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A Facility operating legally as a psychiatric Hospital or residential treatment Facility for mental health and licensed as such by the state in which the Facility operates.
- A Facility operating primarily for the treatment of Substance Abuse if it has received accreditation from Commission of Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC), or if it meets these tests: maintains permanent and full-time Facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and Facilities for treatment of Substance Abuse.

Independent Freestanding Emergency Department means a health care Facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Centers or Clinics.

Illness means a bodily disorder, disease, physical sickness, or Mental Disorder.

For a covered Employee and covered Spouse: Illness includes Pregnancy, childbirth, miscarriage, or Complications of Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its Complications.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: Facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the initial period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lumpectomy means the surgical removal of a small tumor, which may be benign or cancerous.

Mastectomy means the surgical removal of all or part of a breast.

Medical Care Facility means a Hospital, a Facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

Medically Necessary or Medical Necessity care and treatment is recommended or approved by a Physician practicing within the scope of his or her license; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the patient's condition; is approved by the FDA, if applicable; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Network: Facilities, providers, and suppliers who have by contract with a Network agreed to allow the Plan access to discounted fees for service(s) provided to the Plan Participant, and by whose terms the Network's Providers have agreed to accept assignment of benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Charges. The applicable Network of providers may be identified on the Plan Participant's identification card.

Network Provider/Network Facility means a healthcare institution or healthcare provider who has by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network Provider/Non-Network Facility means a healthcare institution or healthcare provider who does not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray Facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed Facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Naturopathic Doctor (N.D.), Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan, which is a benefits plan for certain Employees of the Employer and is described in this document.

Plan of Care is a written plan that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency, and duration of treatment and/or treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including Complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

Qualifying Payment Amount (QPA) means the median of the contracted rates recognized by the Plan or recognized by all Plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a QPA, said amount will be determined by referencing an applicable state all-payer claims database or any eligible third-party database in accordance with applicable law.

Recognized Amount, except for Non-Network Provider air ambulance services, means an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable, and for Non-Network Provider air ambulance services, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

Retired Employee (Retiree) is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Skilled Nursing Facility is a Facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial Care, or educational care.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a Facility referring to itself as an extended care Facility, convalescent nursing home, rehabilitation hospital, long-term acute care Facility or any other similar nomenclature.

Spinal Manipulation / Chiropractic Services means skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco/nicotine and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an Illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits section.

The following are not covered under this Plan:

(1) **Abortion.** Services, supplies, care, or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy, or the Pregnancy is the result of rape or incest. In addition, this Plan will not cover abortions where prohibited by applicable law.

(2) **Adoption expenses.** Charges in connection with adoption, including surrogate Pregnancy expenses (whether or not the mother is a Plan Participant under this Plan), will not be a Covered Charge.

(3) **Biofeedback.** Care, services, supplies, and treatment in connection with biofeedback.

(4) **Coding guidelines.** Charges for inappropriate coding in accordance to the industry standard guidelines in effect at the time services were received.

(5) **Complications of non-covered treatments.** Care, services, or treatment required as a result of complications from a treatment not covered under the Plan.

(6) **Computerized items.** Charges for computerized items including, but not limited to, Durable Medical Equipment, prosthetic limbs, and communication devices. Payable for deluxe prosthetics and computerized limbs will be payable based on the Allowable Charge for a standard prosthesis.

(7) **Cosmetic components of gender dysphoria treatment.** Treatment, services, or supplies performed as a component of gender transition that are considered cosmetic.

(8) **Cosmetic surgery.** Services, supplies, drugs, and devices related to non-covered cosmetic and reconstructive services or treatment.

(9) **Counseling.** Care and treatment for marital or pre-marital counseling; education, social, behavioral, or recreational therapy except as specifically stated as a benefit under this Plan; sex or interpersonal relationship counseling; or counseling with participant's friends, employer, school counselor, or schoolteacher.

(10) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, or Custodial Care except as specifically stated as a benefit under this Plan.

(11) **Educational or vocational testing.** Services for educational or vocational testing or training except as specifically stated as a benefit under this Plan.

(12) **Errors.** Charges based on billing mistakes, improprieties, or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible, or improper based on any applicable law, regulation, rule or professional standard; it is in the Plan Administrator's sole discretion to determine what constitutes an error under the terms of this Plan.

(13) **Excess charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Allowable Charge.

(14) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(15) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(16) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be specifically stated as a benefit under this Plan.

Vision benefits may be covered under the vision plan offered through VSP. A preventive vision eye exam benefit is available through VSP once every 12 months. Tell the VSP provider that coverage is provided through VSP Exam Plus. Contact VSP at vsp.com or (800) 877-7195. This benefit is designed to cover an eye examination only.

(17) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the primary purpose of obtaining medical services, except as approved through VezaHealth.

(18) **Gender affirming surgery reversal.** Treatment, services, or supplies performed as part of reversal of gender affirming surgery used to treat gender dysphoria.

(19) **Government coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(20) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy or radiation treatment.

(21) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be specifically stated as a benefit under this Plan.

(22) **Hazardous activities.** Charges for services received that result from engaging in a hazardous pursuit, hobby, or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Plan Participant's customary occupation or if it involves activities commonly considered as involving unusual or exceptional risks, characterized by a threat of danger or risk of bodily harm including reckless operation of machinery, travel to countries with advisory warnings, use of weapons and explosives, and other activities reasonably deemed hazardous by the Plan Administrator, in its sole discretion.

(23) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or Facility for the service.

(24) **Illegal acts.** Charge s for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed.

This Plan also excludes charges for services, supplies, care or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant operating a motor vehicle while under the influence of alcohol or drugs or a combination thereof or operating a motor vehicle with a blood or breath alcohol content (BAC) above the legal limit. The arresting officer's determination of inebriation will be sufficient for this exclusion. Such charges will be excluded regardless of whether such motor vehicle operation rises to the level of a Serious Illegal Act. Expenses will be covered for injured Plan Participants other than the person operating the vehicle while under the influence or a BAC above the legal limit, and expenses may be covered for chemical dependency treatment as specified in this Plan.

This exclusion does not apply if the Injury resulted from being the victim of an act of domestic violence or from a medical (including both physical and mental health) condition whether or not diagnosed before the incident.

(25) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.

(26) **Incarcerated.** Care, treatment, services, and supplies incurred and/or provided to a Plan Participant by a government entity while housed in a governmental institution.

(27) **Infertility.** Care, supplies, services, and treatment for Infertility, artificial insemination, or in vitro fertilization.

(28) **Intraoperative Neuromonitoring.** Charges associated with intraoperative neuromonitoring, intraoperative electromyographic monitoring, and/or intraoperative neurophysiology monitoring.

(29) **Invalid charges.** Charges: (a) that are found to be based on errors, unbundled charges, misidentification or unclear description; (b) charges for fees or services determined not to have been Medically Necessary or (c) charges found by the Plan Administrator to be in excess of the Allowable Claim Limits (d) charges that are otherwise determined by the Plan Administrator to be invalid or impermissible based on any applicable law, regulation, rule, or professional standard; and/or (e) charges in excess of the negotiated rate.

(30) **Learning disabilities.** Behavioral modifications or developmental delay services or treatment, except when provided as treatment for an autism spectrum disorder.

(31) **Mailing or sales tax.** Charges for mailing, shipping, handling, postage, conveyance and/or sales tax.

(32) **Maintenance.** Treatment or services for maintenance or supportive level of care, or when maximum therapeutic benefit (no further objective improvement) has been attained.

(33) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(34) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(35) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

(36) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-medical emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(37) **Non-traditional.** Medical services supplies, drugs, devices, treatments and supplies for homeopathy, hypnotherapy, rolfing, and holistic medicine.

(38) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(39) **Obesity.** Surgical and non-surgical care and treatment of obesity, including morbid obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness, except as provided consistent with the Affordable Care Act preventive services requirements.

(40) **Occupational Injury.** Care and treatment of an Injury or Illness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies regardless of the availability of or coverage by Workers' Compensation or occupational disease benefits, even if the Plan Participant:

(a) Has waived his/her rights to Workers' Compensation benefits;

(b) Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits;

(c) Is permitted to elect not to be covered under Workers' Compensation but has failed to properly file for such election; or

(d) Executed a disputed liability settlement with Worker's Compensation.

(41) **Personal comfort items.** Personal comfort items, patient convenience, or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, girdles, corsets, abdominal binders and belts, first-aid supplies, and non-hospital adjustable beds.

(42) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document or that exceed the limits as shown under this Plan.

(43) **Pregnancy of Dependent other than Spouse.** Care and treatment of Pregnancy and Complications of Pregnancy for a covered Dependent other than a Spouse unless required by applicable law.

(44) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is the Plan Participant's family member or relative.

(45) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

(46) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(47) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(48) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(49) **Temporomandibular Joint Syndrome.** Treatment services related to the treatment of jaw joint problems including Temporomandibular Joint (TMJ) syndrome, except for surgical services as stated as a benefit under this Plan.

(50) **Travel and accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined or as otherwise specifically stated as a Covered Charge (including travel or accommodations approved by the Plan Administrator as part of a VezaHealth Episode of Care).

(51) **Unbundled charges.** Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

(52) **Vitamins and supplements.** Charges for vitamins, except when deemed Medically Necessary for the treatment of an Illness. Food supplements will not be covered except for treatment of Inborn Errors of Metabolism or Enteral Nutrition services.

(53) **War.** Any loss that is due to or aggravated by any a declared war or undeclared act of war.

Claims must be received by the Claims Administrator within **365 days** from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

PRESCRIPTION DRUG BENEFITS

The Coordination of Benefits provision will not apply to prescriptions purchased at a Participating Pharmacy.

Participating Pharmacy

Prescription drug coverage for members is administered by SmithRx, which is a pharmacy benefits manager. SmithRx provides a nationwide network of participating Pharmacies and a drug Formulary. The presence of a drug on this Formulary does not guarantee coverage and the drugs listed on the Formulary are subject to change. To find out if a medication you are prescribed is covered under the Plan, visit the member portal at https://portal.mysmithrx.com/login or call (844) 454-5201 for the most current Formulary information.

Prescription Drug Copayments and Prescription Drug Maximum Out-of-Pocket Amount

The Prescription Drug copayment amounts for the Retail, Specialty and Mail Order Pharmacies **will apply** to the separate Prescription Drug maximum out-of-pocket amount (as shown in the Prescription Drug Benefit Schedule). Once the Prescription Drug maximum out-of-pocket amount has been met, covered Prescription Drugs will continue to be payable subject to 100% (not including ineligible charges, such as Prescription Drug dispense as written (DAW) penalties) for the remainder of the Calendar Year.

The Prescription Drug maximum out-of-pocket amount will not apply to the Medical Maximum Out-Of-Pocket Amount (as shown in the Schedule of Benefits).

Any one retail Pharmacy prescription is available up to a 90-day supply.

If a drug is purchased from a non-Participating Pharmacy, or a Participating Pharmacy when the Plan Participant's ID card is not used, the Plan Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to **SmithRx** for reimbursement (less applicable copayments and medical deductible as shown in the Schedule of Benefits section).

Mandatory Specialty Pharmacy Program

The Specialty Pharmacy Program is a program that has been determined by the administrator of the Pharmacy drug plan to **require reimbursement only through an approved specialty Pharmacy vendor(s)** for medications determined to be part of the Specialty Pharmacy Program. The Pharmacy benefit administrator will review and modify the list of products included in the Specialty Pharmacy Program periodically as new information becomes available.

All specialty medications **must** be filled through the Special Pharmacy Program.

Prescriptions under the Specialty Pharmacy Program will be limited to a 30-day fill and will be payable at the Specialty Pharmacy Program copayment level (after satisfaction of the medical deductible) and will be payable up to the maximum as shown in the Prescription Drug Benefit Schedule.

Note: Some specialty medications may be subject to split-fills at 15 days for up to the first three months. Contact SmithRx for more information regarding split-fills.

For more information regarding the Specialty Pharmacy Program, please contact **SmithRx** toll-free at (844) 454-5201 or visit www.mysmithrx.com.

Mail Order Pharmacy

The Mail Order Pharmacy benefit is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). For more information regarding the mail order drug benefit option contact **SmithRx** toll-free at (844) 454-5201.

Covered Prescription Drugs

Note: Some quantity limitations and/or prior approval may apply.

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law, excluding any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. *A prior authorization is required for compounds costing $100 or greater.*

(3) Insulin and other injectable diabetic medications and the following diabetic supplies, when prescribed by a Physician: lancets, lancet devices, alcohol swabs, blood glucose meters, blood glucose and test strips, blood test strips, and insulin syringes and needles.

(4) Topical and oral acne medications, when prescribed by a Physician. A prior authorization is required for Plan Participants ages 40 years and over.

(5) Injectables.

(6) Certain over the counter (OTC) medications are available when prescribed by a Physician and only when purchased through a Participating Pharmacy. Contact SmithRx for more information regarding a list of medications.

(7) Certain over the counter (OTC) COVID-19 diagnostic tests authorized by the Food and Drug Administration (FDA), as required by federal law.

The following will be covered at 100%, no copayment required for Generic or Formulary drugs.

Benefits may be subject to prescription Generic or Formulary and/or quantity limitations.

(1) Physician-prescribed tobacco/nicotine cessation products. Physician-prescribed tobacco/nicotine replacement products (nicotine patch, gum, lozenges) and Physician-prescribed medications (Zyban, Chantix).

(2) Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Plan Participants with reproductive capacity.

Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.

(3) Certain vaccinations/immunizations as recommended by applicable federal law will be covered only when rendered through a Participating Pharmacy. **Note:** Not all Participating Pharmacies may be providing vaccinations/immunizations or may vary in what they offer. It is important to check with the Participating Pharmacy to determine availability, age restrictions, any prescription requirements, or hours of service. Please contact **SmithRx** toll-free at (844) 454-5201 for more information regarding this benefit.

(4) Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance or deductible will be required, and will only be available when utilizing a Participating Pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact **SmithRx** toll-free at (844) 454-5201 for more information regarding which medications are available. **Note:** Age and/or quantity limitations may apply:

http://www.healthcare.gov/center/regulations/prevention.html

Limits To This Benefit

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, insulin pumps and pump supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Immunization.** Immunization agents or biological sera.

(9) **Infertility.** A charge for Infertility medication.

(10) **Impotence.** A charge for impotence medication.

(11) **Inpatient medication.** A drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a Facility for the dispensing of drugs and medicines on its premises.

(12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use."

(13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state, or federal programs. In addition, discounts, coupons, Pharmacy discount programs or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs will not be a Covered Charge under this Plan.

(15) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

(16) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT PHARMACY CLAIMS

For prescription claim questions or to obtain a claim form please call:

SmithRx toll-free (844) 454-5201
or access their website at www.mysmithrx.com

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show his or her **EBMS/Montana Credit Union League Group Benefits Trust** identification card to the provider. Network Providers may submit claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from his or her health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number (**Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan**, Group #**0000530**)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: *A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at www.ebms.com.*

WHERE TO SUBMIT CLAIMS

Employee Benefit Management Services, LLC is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

WHEN CLAIMS SHOULD BE FILED

Claims must be received by the Claims Administrator within **365 days** from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A "Claim" means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain services is strongly recommended, but not required by the Plan. A pre-notification of services is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits and cannot be appealed under this section. Please refer to the Care Management Services section.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are two types of claims:

Concurrent Care Determination

A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. If Case Management is appropriate for a Plan Participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services section.

Post-Service Claim

A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. 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 involving specialized medical knowledge or judgment. Full and final authority to adjudicate Claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and applicable law.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

Initial Benefit Determination

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.** If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45-day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information. Under the No Surprises Act, the Plan will have up to 30 calendar days to send a notice of denial of payment or an initial payment to the Non-Network Provider from the time the Claim is resubmitted with additional information.

Notice of Adverse Benefit Determination

If a Claim is denied in whole or in part ("Adverse Benefit Determination"), the Plan shall provide written or electronic notice of the determination that will include the following:

(1) Information to identify the claim involved.

(2) Specific reason(s) for the denial, including the denial code and its meaning.

(3) Reference to the specific Plan provisions on which the denial was based.

(4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

(5) Description of the Plan's Internal Appeal Procedures and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once Claimant has exhausted all available internal and external review procedures.

(6) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

(7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

(9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively or is a retroactive cancellation or discontinuance because of the Plan Participant's failure to timely pay required premiums.

Claims Review Procedure – General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records, and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Note: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Non-Network Provider, and the provider has no recourse against the Plan Participant under the No Surprises Act, the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with a Non-Network Provider's payment dispute through the IDR process.

Internal Appeal Procedure

First Level of Internal Review

The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
c/o Employee Benefit Management Services, LLC (EBMS)
Attn: Claims Appeals
P.O. Box 21367
Billings, MT 59104

An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The First Level of Internal Review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

Second Level of Internal Review

If the Claimant does not agree with the determination from the First Level of Internal Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review (or 15 days for an appeal of a Concurrent Care Determination), along with any additional supporting information to:

Plan Administrator
c/o Employee Benefit Management Services, LLC (EBMS)
Attn: Claims Appeals
P.O. Box 21367
Billings, MT 59104

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above. All decision-making and discretionary authority to make appeal determinations lies with the Plan Administrator; however, the Plan Administrator may delegate to the Claims Administrator responsibility to process appeals in accordance with the terms of the Plan and the Plan Administrator's direction.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the first level of review. In certain circumstances, the Claimant may also request an expedited External Review.

External Review Procedure

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within four months from the date of receipt of the notice of the final internal Adverse Benefit Determination or the first day of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or service is not Medically Necessary;
- Determination that a treatment is Experimental or Investigational;
- Rescission of coverage, whether or not the rescission involved a Claim;
- Application of treatment limits to a Claim for a Mental Disorder; or
- Determination on whether the Plan is complying with the No Surprises Act, as applicable.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within six business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four-month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. **Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.**

Generally, a Plan Participant must exhaust the Plan's Claims Procedures in order to be eligible for the external review process. However, in some cases the Plan provides for an expedited external review if:

(1) The Plan Participant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedures would seriously jeopardize the Plan Participant's life or health or ability to regain maximum function and the Plan Participant has filed a request for an expedited internal review; or

(2) The Plan Participant receives a final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Plan Participant's life or health or the Plan Participant's ability to regain maximum function, or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Plan Participant received Emergency Services, but has not been discharged from a Facility.

Immediately upon receipt of a request for expedited external review, the Plan must determine and notify the Plan Participant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Plan Participant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Plan Participant and the Plan.

PROVIDER OF SERVICE APPEAL RIGHTS – CLAIM REVIEW AND AUDIT PROGRAM

A Claimant may appoint the provider of service as the authorized representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Claimant to a provider of service will not constitute appointment of that provider as an authorized representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an authorized representative, the Plan will consider an appeal received from the provider in the same manner as a Claimant's appeal and will respond to the provider and the Claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Internal and External Claims Review Procedures" above. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Charges directly from the Plan, waiving any right to recover such Covered Charges from the Claimant, and comply with the conditions of the section, "Internal and External Claims Review Procedures" above.**

For purposes of this section, the provider's waiver to pursue Covered Charges does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the Plan, "Claim Review and Audit Program."** The provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB04 or on a CMS – 1500 Form (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeal rights.

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or non-group insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and non-group coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical components of long-term care contracts, such as skilled nursing care;

(6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;

(7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;

(8) Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

Allowable Charge(s). See "Allowable Charge" and "Allowable Claims Limit" in the Defined Terms section.

In the case of Health Maintenance Organization (HMO) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or Network Provider has agreed to accept as payment in full. Also, when an HMO or Network plan is primary and the Plan Participant does not use an HMO or Network Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or Network plan had the Plan Participant used the services of an HMO or Network Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

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

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:

(a) The benefits of the plan which covers the person directly (that is, as an Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B"). For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is Retired), THEN Plan B will pay first.

(b) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated, or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's Spouse does, the plan of that parent's Spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree;
- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

1st The plan covering the custodial parent,
2nd The plan covering the Spouse of the custodial parent,
3rd The plan covering the non-custodial parent, and
4th The plan covering the Spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

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, Rule (e) applies. If 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 parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's Spouse.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor Retired or as a Dependent of an Employee who is neither laid off nor Retired are determined before those of a plan which covers that person as a laid-off or Retired Employee. This rule does not apply if Rule (a) can be used to determine the order of benefits. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(d) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor Retired or a Dependent of an Employee who is neither laid off nor Retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (a) can be used to determine the order of benefits.

(e) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer and the Plan Participant is enrolled under Part A, Part B or both, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan.

Applicable to Active Employees and Spouses Ages 65 and Over. An active Employee and his or her Spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Plan Participants Eligible for Medicare Benefits. To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor. If the Provider accepts assignment with Medicare, Covered Charges will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan. If any Plan Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

Applicable to Small Employer(s), Exception. If an Employer having fewer than 20 full and/or part-time Employees applies and is approved for an MSP Small Employer Exception, benefits will be payable pursuant to such Exception. If, however, an Employer having fewer than 20 full and/or part time Employees does not apply and/or is not approved for an MSP Small Employer Exception, such Exception shall not apply to such Employer.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Participant shall be a trustee over those Plan assets.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Participant(s) fails to so pursue said rights and/or action.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

(1) The responsible party, its insurer, or any other source on behalf of that party.

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

(3) Any policy of insurance from any insurance company or guarantor of a third party.

(4) Workers' compensation or other liability insurance company.

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant's/Plan Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Plan Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Plan Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Plan Participant's/Plan Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease, or disability.

PLAN PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

Any Plan Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Plan Participant understands that he or she is required to:

(1) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

(2) Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

(3) In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment, or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

(4) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Participant disputes this obligation to the Plan under this section, the Plan Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Plan Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

RELEASE OF LIABILITY

The Plan's right to reimbursement extends to any incident related care that is received by the Plan Participant(s) (Incurred) prior to the liable party being released from liability. The Plan Participant's/Plan Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Plan Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Illness, disease, or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

(1) The responsible party, its insurer, or any other source on behalf of that party.

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

(3) Any policy of insurance from any insurance company or guarantor of a third party.

(4) Workers' compensation or other liability insurance company.

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

Obligations

It is the Plan Participant's/Plan Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

(1) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

(2) To provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.

(3) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

(4) To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

(5) To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received.

(6) To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

(7) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

(8) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

(9) To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

(10) In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

(11) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved.

If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant's/Plan Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Plan Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan. This provision applies even if the Plan Participant has disbursed settlement funds.

Minor Status

In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Defined Terms for this section:

Incurred. A Covered Charge is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire procedure or course of treatment are not Incurred upon commencement of the stage of the procedure or course of treatment.

COBRA CONTINUATION COVERAGE

Note: Not all Employers are subject to COBRA. If your Employer is not subject to COBRA, you will not be eligible for COBRA CONTINUATION COVERAGE. You must check with your Employer to determine whether COBRA Continuation Coverage is available to you and your Dependents.

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). If applicable, COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept Late Enrollees.

COBRA Continuation Coverage will not be available to those Retired Employees that elected, at the time of retirement, to continue coverage under the terms of the Plan as a Retiree. However, the following COBRA Continuation Coverage may apply to a Retired Employee's Qualified Beneficiaries.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

Domestic Partners and Dependent children of a covered Employee's Domestic Partner, who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision and are covered under this Plan, will also be offered the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated.

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the Plan as a "Dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18 month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination of employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18 month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage will end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family 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. You can learn more about many of these options at www.healthcare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

Plan Administrator
League Services Group
101 N Rodney St.
Helena, MT 59601-4226
(406) 442-9081

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA CONTINUATION COVERAGE
FOR RETIREES DEPENDENTS

Note: Not all Employers are subject to COBRA. If your Employer is not subject to COBRA, you will not be eligible for COBRA CONTINUATION COVERAGE. You must check with your Employer to determine whether COBRA Continuation Coverage is available to you and your Dependents.

COBRA Continuation Coverage will not be available to those Retired Employees that elected, at the time of retirement, to continue coverage under the terms of the Plan as a Retiree. However, the following COBRA Continuation Coverage may apply to a Retired Employee's Qualified Beneficiaries.

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). If applicable, COBRA Continuation Coverage can become available to certain Plan Participants when group health coverage would otherwise end.

The Retired Employee's family members may have other options available when they lose group health coverage. For example, they may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, an individual may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which the individual is eligible (such as a Spouse's plan), even if that plan generally doesn't accept Late Enrollees.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." Certain covered family members could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

Domestic Partners and children of a covered Retiree's Domestic Partner, who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision and are covered under this Plan, will also be offered the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated.

If you are the Spouse of a covered Retired Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Dependent children of the covered Retired Employee will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-covered Retired Employee dies;
- The parent-covered Retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the Plan as a "Dependent child."

Filing a proceeding in bankruptcy with respect to the Employer under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is death of the covered Retiree, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Retirees may elect COBRA Continuation Coverage on behalf of their Spouse and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally lasts for 18 months. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

If the Qualifying Event is the death of the covered Retiree, divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Retiree dies, gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage will end before the end of the maximum period on the earliest of the following dates:

- The date your former Employer ceases to provide a group health plan to any Retired Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

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Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family 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. You can learn more about many of these options at www.healthcare.gov.

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Plan Administrator
League Services Group
101 N Rodney St.
Helena, MT 59601-4226
(406) 442-9081

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
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For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan is the benefit plan of Montana Credit Union League Group Benefits Trust, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Montana Credit Union League Group Benefits Trust to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies, or is otherwise removed from the position, Montana Credit Union League Group Benefits Trust shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary, or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

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

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

DISTRIBUTION OF ASSETS

Subject to the requirements of ERISA §402, in the event of a termination or partial termination of the Plan or Trust (if applicable), Montana Credit Union League Group Benefits Trust by action of its Trustees, shall direct the disposition of Plan assets, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending, or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created, or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

(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 PHI 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 PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Executive Director MCUL Group Benefits Trust
Human Resource Benefits, MCUL Group Benefits Trust
Insurance Agent

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

Contact Information

Privacy Officer Contact Information:
Privacy Officer
League Services Group
101 N Rodney St.
Helena, MT 59601-4226
(406) 442-9081

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "SECURITY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

(4) Report to the Plan any security incident of which it becomes aware.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or Dependents may have to pay for such coverage.

- Review this Summary Plan Description and the documents governing the Plan or the rules governing COBRA Continuation Coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME: Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 37-6420195

PLAN EFFECTIVE DATE: January 1, 2012

PLAN YEAR ENDS: December 31

PLAN ADMINISTRATOR

League Services Group
101 N Rodney St.
Helena, MT 59601-4226
(406) 442-9081

NAMED FIDUCIARY

Montana Credit Union League Group Benefits Trust
101 N Rodney St.
Helena, MT 59601-4226

AGENT FOR SERVICE OF LEGAL PROCESS

Montana Credit Union League Group Benefits Trust
101 N Rodney St.
Helena, MT 59601-4226

Service of process may also be made on the Plan Administrator.

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, LLC
PO Box 21367
Billings, MT 59104-1367
(406) 245-3575 or (800) 777-3575

Plan Name: Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan

Plan Option: Ruby PPO

Effective Date: January 1, 2012

Restatement Date: January 1, 2023

I, TRACIE KENYON (Name), certify that I am the CHAIRMAN (Title) of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms described herein and am hereby authorizing the implementation of the restated Plan as of the restatement date noted above.

Signature: Tracie Kenyon

Print Name: TRACIE KENYON

Date: 1-11-2023

WELLNESS PROGRAM

This Wellness Program is integrated with the Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan (the "Plan") which is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self-funded multiple employer welfare arrangement.

WELLNESS PROGRAM

The Plan Sponsor/Plan Administrator encourages participation in the Wellness Program to promote health and prevent disease. This document describes the Wellness Program available for Credit Union Employees that participate in the Plan. Participants in the Wellness Program should also refer to program communications for additional details regarding the Wellness Program.

ELIGIBILITY

Credit Union Employees who are eligible and enrolled as Plan Participants in the MCUL Group Benefits Trust Employee Health Benefit Plan are eligible to participate in the Wellness Program.

Note: Dependents of enrolled Wellness Program Participants who are 18 years of age or older are also eligible to attend the annual biometric screening and complete the health questionnaire.

ENROLLMENT

Plan Participants in the MCUL Group Benefits Trust Employee Health Benefit Plan are automatically enrolled in the Wellness Program as of the effective date of their MCUL Group Benefits Trust Employee Health Benefit Plan coverage.

TERMINATION OF PARTICIPATION

Wellness Program participation for the Participant will terminate on the earlier of:

1. The last day of the calendar month in which the Employee is enrolled in health coverage with the MCUL Group Benefits Trust Employee Health Benefit Plan;
2. The date the Employee retires;
3. The date the Employee dies; or
4. The date the Wellness Program is terminated by the MCUL Group Benefits Trust.

Note: Except in certain circumstances, a Plan Participant may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see Appendix B entitled COBRA CONTINUATION COVERAGE.

WELLNESS PROGRAM BENEFITS

Benefits under the Wellness Program are administered by the Wellness Administrator, It Starts With Me Health (ISWM).

Participation in the Wellness Program is voluntary.

Annual Biometric Screening and Health Risk Assessment

Annual Biometric Screening

The Wellness Program offers an annual biometric screening which will include a blood test for a comprehensive metabolic panel, a complete blood count, a lipid panel, hemoglobin A1C, iron, and TSH screening. The annual biometric screening also includes vital signs and body composition testing (e.g., height, weight, BMI, % body fat). The screenings are provided at no cost to Participants and are offered once per year.

Health Risk Assessment

The Health Risk Assessment asks a series of questions about a Participant's health-related activities and behaviors and whether a Participant has or has had certain medical conditions (e.g., cancer, diabetes, or heart disease). It will be available during the screening registration process at www.itstartswithme.com.

The information from the Participant's Health Risk Assessment and the results from the Participant's annual health screening will be used to provide the Participant with information to help understand their current health and potential risks, and may also be used to offer services through the Wellness Program, such as wellness coaching and nicotine cessation programs. Participants also are encouraged to share their results or concerns with their own doctor.

LIMITATIONS

Other than the benefits described herein, the Wellness Program offers no other medical benefits. Specifically, no benefits are payable for preventive screening tests, physical exams, or any other expense that would be covered by another group health plan or health insurance policy for which the Trust sponsors.

CLAIMS REVIEW PROCEDURE

Since there is no cost to a Participant for the Wellness Program, there are no claims to file for benefits. However, if the Participant believes that they or a family member were denied benefits, the Participant has specific rights and responsibilities for appealing the denial. This section describes how to appeal a denial.

If the Participant believes that they or a family member were wrongfully denied benefits, they should submit, in writing, an appeal regarding the denied benefits to the Wellness Administrator on behalf of the Plan Administrator:

It Starts With Me Health
29 Fort Missoula Road
Missoula, MT 59804
(406) 541-2036 or (866) 932-6467

The Participant may request a review up to 180 days after the date on the notice, but they are encouraged to submit the request as soon as reasonably possible. The Participant may also request copies of all relevant documents used in the original denial.

The Wellness Administrator's review will take into account all comments, documents, records, and other information related to the claim, even if not considered in the initial decision. The decision on the appeal will be independent from the previous decision and, therefore determined by an individual or individuals who were not involved with that initial decision. The decision on appeal will be made within 60 days after receipt of the request for review.

After review, the Wellness Administrator will provide a written notice that includes the following:

- The reason for the decision;
- References to the specific requirement(s) that was not achieved;
- A statement that you may request copies of all relevant documents, free of charge; and
- A description of additional appeal rights, if any, and a statement that you have the right to bring a civil action under applicable law, once you have exhausted all rights of appeal.

NON-DISCRIMINATION

Participants may not be discriminated against in employment because of the medical information provided as part of participating in the Wellness Program, nor may they be subjected to retaliation if they choose not to participate.

COBRA

In the event the applicable Employer is subject to COBRA, if a Participant terminates employment or experience a reduction in hours with the Employer, the Wellness Program will be provided at the Participant's individual cost to each Qualified Beneficiary who elects to continue coverage in the Wellness Program. The cost for each Qualified Beneficiary is the full cost of the Wellness benefit plus an additional 2% for administration and will be due on the date the Wellness benefit is incurred. For more information, see Appendix B or contact the Employer.

AMENDMENT AND TERMINATION

The Plan Sponsor/Plan Administrator reserves the sole discretionary right to modify, amend, or terminate the Wellness Program at any time and from time to time. You will be notified of any modification to, amendment of, or the termination of the Wellness Program.

FUNDING

The Wellness Program is funded by the Trust.

GENERAL PLAN ADMINISTRATION

Contact information for the Plan Administrator and Wellness Administrator is as follows:

Plan Administrator:
League Services Group
101 N. Rodney St.
Helena, MT 59601
(406) 442-9081

Wellness Administrator:
It Starts With Me Health
29 Fort Missoula Road
Missoula, MT 59804
(406) 541-2036 or (866) 932-6467

HIPAA PRIVACY AND SECURITY STANDARDS

The Plan Administrator and the Wellness Administrator are required by law to maintain the privacy and security of a Participant's personally identifiable health information. Although the Plan may use aggregated information it collects to design a program based on identified health risks in the workplace, the Plan will never disclose any Participant's personal information either publicly or to the Employer, except as necessary to respond to a request from the Participant for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies the Participant that is provided in connection with the Wellness Program will not be provided to a Participant's supervisor or manager and may never be used to make decisions regarding your employment.

A Participant's health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and they will not be asked or required to waive the confidentiality of their health information as a condition of participating in the Wellness Program or receiving an incentive. Anyone who receives Participant information for purposes of providing services as part of the Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive a Participant's personally identifiable health information are service providers contracted to promote and support health.

In addition, all medical information obtained through the Wellness Program will be maintained separate from Participant personnel records, information stored electronically will be encrypted, and no information the Participant provides as part of the Wellness Program will be used in making any employment decision.

Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving the Participant's information provided in connection with the Wellness Program, the Participant will be notified immediately.

Contact the Employer for a copy of the Notice of Privacy Practices for the MCUL Group Benefits Trust.

STATEMENT OF ERISA RIGHTS

All individuals eligible to participate in the Wellness Program are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as outlined in Appendix A.

HEALTH PLAN INTEGRATION

This Wellness Program is integrated with the Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan (the "Plan"). Under no circumstances is the Wellness Program intended to modify the terms and conditions of the Plan. The Wellness Program is a supplemental voluntary benefit that is limited in scope. In the event there is conflicting language in the Wellness Program documentation and the governing Plan Document, the Plan Document will control.

APPENDIX A:

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Participants in this Wellness Program are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Participants or Dependents may have to pay for such coverage.

Review this Summary Plan Description and the documents governing the Plan or the rules governing COBRA Continuation Coverage rights.

If a Plan Participant believes he or she has been denied benefits under this Wellness Program, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Once the Plan Participant completes his or her rights to appeal under this Plan, he or she may file suit in state or federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

APPENDIX B:

COBRA CONTINUATION COVERAGE

Note: Not all Employers are subject to COBRA. If your Employer is not subject to COBRA you will not be eligible for COBRA CONTINUATION COVERAGE.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Wellness Program coverage when that coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary," if coverage under the Wellness Program is lost because of the Qualifying Event.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

When the Qualifying Event is the death of the Employee, divorce or legal separation of the Employee and spouse, or a dependent child reaching the limiting age of 26, the Employer must be notified of the Qualifying Event to continue coverage under the Wellness Program. The Employee must notify the Employer in writing within 60 days after the Qualifying Event occurs. The Employee must provide this notice in writing to:

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Trust receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their dependent children.

If the Employer determines that the individual is not entitled to COBRA Continuation Coverage, the Employer will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

When the Qualifying Event is the end of employment or retirement, the Employee and any eligible family members will automatically remain covered under the Wellness Program for 18 months.

Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the Employee (or former Employee), divorce or legal separation from the Employee, or a dependent child's losing eligibility by reaching the limiting age of 26, COBRA Continuation Coverage can last for up to a total of 36 months.

Disability extension of 18-month period of COBRA Continuation Coverage

If the Employee or anyone in the Employee's family covered under the Wellness Program is determined by the Social Security Administration (SSA) to be disabled and the Employee notifies the Trust as described in this section, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months. The disability must have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Written notice of the disability determination must be provided to the Trust by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under Wellness Program as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Wellness Program's Summary Plan Description of the requirement to give notice and the Wellness Program's procedures to provide such notice to the Employer.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to the Trust at the address listed in the section above, "When is COBRA Continuation Coverage available?"

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If the Employee's family experiences another Qualifying Event during the first 18 months of COBRA Continuation Coverage, the Employee's spouse and dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Trust is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA Continuation Coverage if the Employee or former Employee dies, divorces or becomes legally separated from the spouse, or if the dependent child reaches the limiting age of 26. This extension is only available if the second Qualifying Event would cause the spouse or dependent child to lose coverage under the Wellness Program if the first Qualifying Event did not occur.

Notice of a second Qualifying Event must be provided in writing to the Trust by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Wellness Program as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Wellness Program's Summary Plan Description, of requirement to give notice and the Wellness Program's procedures to provide such notice to the Employer.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description and date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice. The Employee must provide this notice to the Employer at the address listed in the section above, "When is COBRA Continuation Coverage available?"

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date the Trust ceases to provide a Wellness Program to any Employee;
- The date on which coverage ceases because of the Qualified Beneficiary's failure to make timely payment of any required premium; or
- On the same basis that the Wellness Program can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, the Employee must make his or her first payment within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Additional Information

Additional information about the Wellness Program is available from the Trust at the address listed in the section above, "When is COBRA Continuation Coverage available?"

For more information about a Participant's rights under the Employee Retirement Income Security Act (ERISA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

Current Addresses

To protect an Employee and his or her family's rights, the Employee should let the Trust know about any changes in the addresses of family members. The Employee should also keep a copy, for his or her records, of any notices sent by the Employee to the Trust.