OFFICIAL AGENDA
TUESDAY October 21, 2025
Meeting Start Time: 9:00 a.m.
Board of County Commissioners
Yellowstone County, Montana
Stillwater Building
316 N. 26th Street, Room 3108
Billings, MT
8:45 a.m. Agenda Setting

Pledge to the Flag: Moment of Silence: Minutes

REGULAR AGENDA

9:00 a.m. BID OPENING

Bid Opening for MetraPark Upper Lot Crack Sealing

PUBLIC COMMENTS ON REGULAR, CONSENT AND FILED AGENDA ITEMS

1. **FINANCE**

   RSID Final FY25 Budget Adjustment

2. **PUBLIC WORKS**

   Variance Appeal - Approach - 5337 Abbey Road

CLAIMS

CONSENT AGENDA

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1. **CLERK AND RECORDER**
   - **a.** Plat of Platinum Commercial Park Subdivison and the S.I.A.
   - **b.** Termination and Revocation of Agricultural Covenant for Tract 1, Certificate of Survey 3861.
   - **c.** Quit Claim Deed Acceptance for Utility Lot 7, Platinum Commercial Park Subdivision.
   - **d.** Plat of Olive Grove Minor Subdivision and the S.I.A.

2. **COUNTY ATTORNEY**
   - **a.** Resolution 25-124 Requesting Prosecutorial Assistance in State v. O.M.H.
   - **b.** Addendum to Ivy Medical Contract, STDF

3. **FINANCE**
   - **a.** Finance Contract - Hulteng CCM, Inc - Courthouse Renovation Professional Services
   - **b.** Recommendation of Award - Courthouse Renovation RFQ/RFP
   - **c.** Request for Proposals - Metra Crowd Management Services

d. Resolution 25-121 to Create RSID 919M to Maintain a Drainfield System in Platinum Commercial Park Subdivision

e. Resolution 25-122 to Create RSID 920M to Maintain Roads in Platinum Commercial Park Subdivision

f. Resolution 25-123 to Create RSID 921M to Maintain the Dry Hydrant in Platinum Commercial Park Subdivision

4. HUMAN RESOURCES

a. Traditional and High Deductible Plan Documents

b. **PERSONNEL ACTION REPORT - Detention Facility** - 1 Appointment

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FILE ITEMS

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1. CLERK OF DISTRICT COURT

Checks and Disbursements for September 2025

2. COMMISSIONERS

Board Minutes - Tax Appeal Board 10/14/25

3. COUNTY ATTORNEY

Memo Regarding the Transition Plan with Stonerock Business Solutions

PUBLIC COMMENTS ON COUNTY BUSINESS

Public comment is an opportunity for individuals to address the Board, however, the Board cannot engage in discussion or take action on items not properly noticed on the agenda.

B.O.C.C. Regular
Meeting Date: 10/21/2025
Title: Bid Opening for MetraPark Upper Lot Crack Sealing
Submitted By: Teri Reitz, Board Clerk

TOPIC:
Bid Opening for MetraPark Upper Lot Crack Sealing

BACKGROUND:
N/A

RECOMMENDED ACTION:
Refer to staff.

B.O.C.C. Regular
Meeting Date: 10/21/2025
Title: FY25 Final Budget Adjustment
Submitted By: Teri Reitz, Board Clerk

TOPIC:
RSID Final FY25 Budget Adjustment

BACKGROUND:
Additional budget adjustment for RSID activity in FY25.

RECOMMENDED ACTION:
Approve.

Attachments

RSID Budget

Yellowstone County

FINANCE
(406) 256-2754
(406) 254-7929 (FAX)

P.O. Box 35003
Billings, MT 59107-5003

October 8, 2025

Board of Yellowstone County Commissioners

Dear Board Members:

Please accept this letter as a written request for you to formally approve one end of year budget adjustment to keep us in compliance with budget statutes. This request will be presented to you at a public discussion meeting on October 16, 2025, then as a regular item requiring your formal approval at your public agenda meeting on October 21, 2025. This action on your part is authorized under MCA 7-6-4006 (4).

1. Requesting to increase spending authority for the following with unanticipated revenue as the offset:
    a. RSID Maint-- $26,000 for various RSID repairs where the revenue/cash has already been received for those repairs.

Thank you,

Jennifer Jones
Finance & Budget Director

FINAL FY25 PROPOSED BUDGET AMENDMENTS:

2500.000.000.430200.362	BE27:RSID MAINT REPAIRS	26,000.00	-
2500.000.000.363010.000	BE27:RSID MAINT ASSESSMENTS	-	26,000.00

B.O.C.C. Regular

Meeting Date: 10/21/2025

Title: Variance Appeal - Approach - 5337 Abbey Road

Submitted For: Monica Plecker, Public Works Director

Submitted By: Monica Plecker, Public Works Director

TOPIC:

Variance Appeal - Approach - 5337 Abbey Road

BACKGROUND:

Mackenzie Sparks has requested a variance to exceed the allowable approach width from the County's Road Policy. The applicant received a permit granting the authority for a 30' approach. County staff was in the vicinity when the site was being prepped. Ronni Tallerico a PW staff member stopped at the site and informed one of the workers on site the driveway should not be poured. She asked who the builder was and asked the worker to call Sam Sparks and inform him. Within 24 hours the approach was poured at a width of 55 feet. Upon review of the request, staff has denied the variance request. As such, the determination is being appealed and the Board of County Commissioners shall determine whether it will approve or deny the variance request. The applicant's request is attached to this staff report and provides their proposed justification for the variance.

Justification for staff denial:

1. The property does not present any unusual or unique physical features that require a driveway approach to be nearly twice the allowable width. 30' is a statewide standard that allows for sufficient access.
2. To be consistent with adopted standards, the driveway approaches should be uniform. Maintaining, order, property distancing and managing stormwater.
3. While it is recognized that non-compliant driveways exist throughout the county, many were constructed without permits or without the County’s knowledge. The presence of past violations is not justification for approving new ones.
4. Oversized approaches create wider conflict points between vehicles and pedestrians along subdivision roads.

The Board of County Commissioners may approve or deny the appeal. It is recommended if the Board approves the appeal, they should provide justification for doing so.

RECOMMENDED ACTION:

The BOCC may either approve or deny the appeal. Staff has recommended denial.

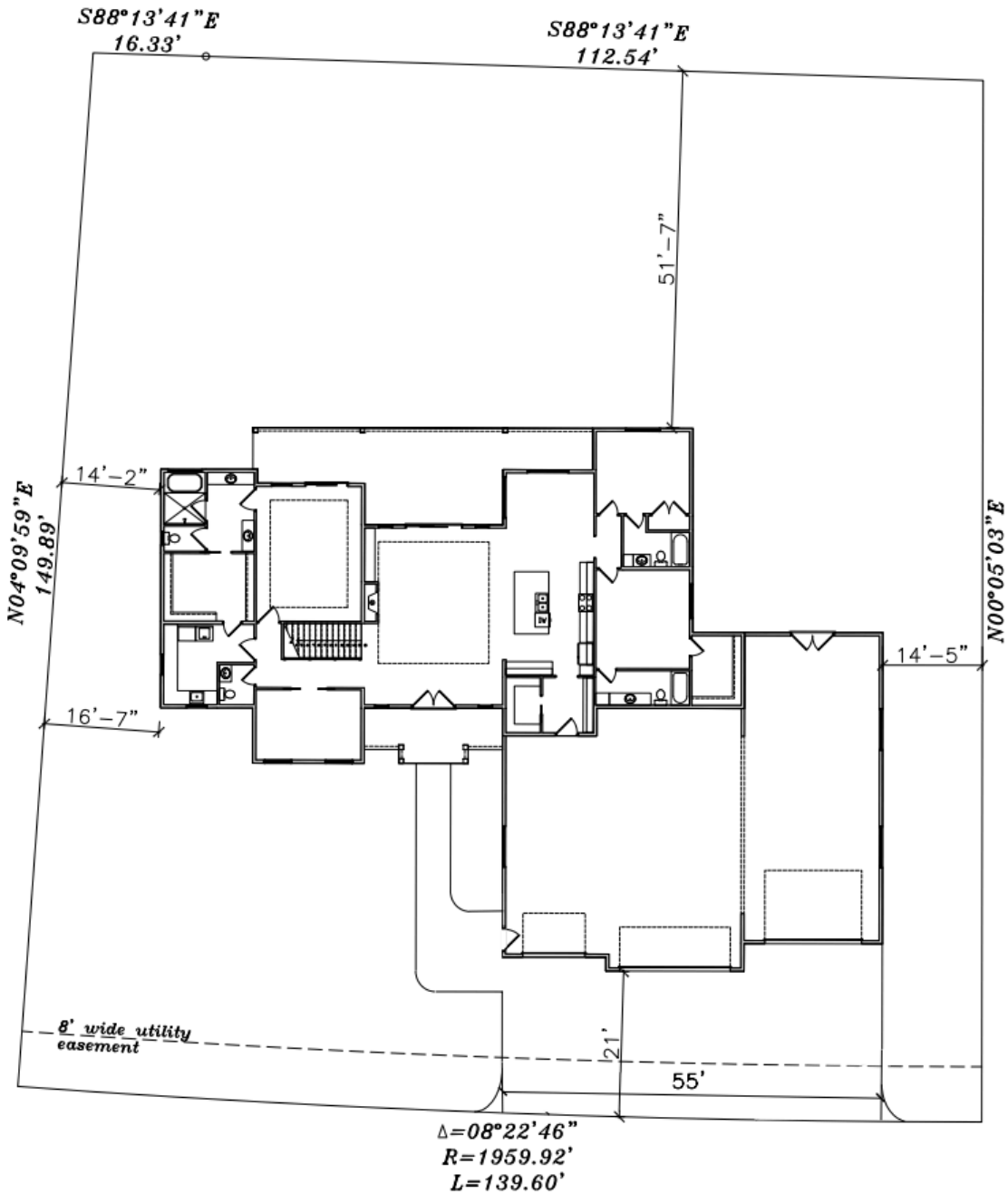
Attachments

Site Plan

Appeal Request

SITE PLAN

SCALE: 1" = 10'



Mackenzie Meadows Subdivision
2nd filing
Block 6, Lot 8
20,272 sq.ft.

ABBY ROAD

Monica Plecker

From: Mackenzie Sparks <mackenzie@sparksinc.us>
Sent: Thursday, September 11, 2025 4:07 PM
To: Monica Plecker
Subject: 5337 Abby Rd

Monica,

I am writing to request reconsideration of the removal of the extra footage of driveway at 5337 Abby Road. I understand the county's commitment to maintaining county standards and safety; however, I believe keeping the existing driveway in place provides significant benefits and value to the home and safety to the community.

I often see teachers walking children around the neighborhood from the daycare located just down the road from the address, pedestrians, and dog walkers. The subdivision streets are not compatible with excess roadside parking. The larger driveway keeps most vehicles off the road, out of the way of pedestrians, and the visibility clear for other drivers to prevent accidents. Even with no pedestrians when vehicles are parked on the road, it is extremely difficult to navigate through those vehicles. Furthermore, it is impossible for 2-way traffic.

Due to the number of driveways larger than county standards in Yellowstone County, the expense encured for all homeowners to remove existing driveways whether recent or aged, would cause more harm than good on an already burdened community. As the driveway is well constructed, in good condition, and does not pose any issues such as drainage, removing the existing driveway does not provide a clear benefit.

The culvert will be removed and ditch will be re-constructed and maintained to its original condition around the driveway and the rest of the lot.

I fully understand the county's responsibility to enforce standards. I am requesting reconsideration and a variance for this driveway providing a safer and more practical solution, aligning the broader goal of keeping traffic patterns and protecting pedestrians and other vehicles.

Thank you for your time and consideration, if any additional information is needed, please feel free to reach out.

Mackenzie Sparks
(406)413-0290

B.O.C.C. Regular **1. a.**

Meeting Date: 10/21/2025

Title: Platinum Commercial Subivision

Submitted For: Jeff Martin, Clerk And Recorder

Submitted By: Jeff Martin, Clerk And Recorder

TOPIC:

Plat of Platinum Commercial Park Subdivison and the S.I.A.

BACKGROUND:

Reviewed.

RECOMMENDED ACTION:

Approve.

Attachments

Platinum Commercial SIA

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SUBDIVISION IMPROVEMENTS AGREEMENT
Platinum Commercial Park Subdivision
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(Yellowstone County)

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SUBDIVISION IMPROVEMENTS AGREEMENT

Platinum Commercial Park Subdivision

This agreement is made and entered this 23rd day of September, 2025, by and between *Cougar Investments, LLC, a Montana limited liability company*, whose address for the purpose of this agreement **PO Box 81153, Billings, MT 59108**, hereinafter referred to as "Subdivider," and YELLOWSTONE COUNTY, Montana, hereinafter referred to as "County."

WITNESSETH:

WHEREAS, the plat of *Platinum Commercial Park Subdivision*, located in Yellowstone County, Montana, was submitted to the Yellowstone County Board of Planning; and

WHEREAS, at a regular meeting conducted on _____ day of _____, 20__, the Board of Planning recommended conditional approval of a preliminary plat of *Platinum Commercial Park Subdivision*; and

WHEREAS, at a regular meeting conducted on _____ day of _____, 20___, the Yellowstone County Board of County Commissioners conditionally approved a preliminary plat of *Platinum Commercial Park Subdivision*; and

WHEREAS, a Subdivision Improvements Agreement is required by the County prior to the approval of the final plat.

WHEREAS, the provisions of this agreement shall be effective and applicable to *Platinum Commercial Park Subdivision* upon the filing of the final plat thereof in the office of the Clerk and Recorder of Yellowstone County, Montana. The Subdivision shall comply with all requirements of the Yellowstone County Subdivision Regulations, the rules, regulations, policies, and resolutions of Yellowstone County, and the laws and administrative rules of the State of Montana.

THEREFORE, THE PARTIES TO THIS AGREEMENT, for and in consideration of the mutual promises herein contained and for other good and valuable consideration, do hereby agree as follows:

I. VARIANCES

Subdivider has requested, and the County hereby grants, the following variances by the Board of County Commissioners from the strict interpretation of the County's Subdivision Regulations (Chapter 11, Yellowstone County Subdivision Regulations):

1. Variance from the Yellowstone County Subdivision Regulations, Section 4.6 Streets and Roads, B, 1 is requested to allow for a single connection to the adjacent undeveloped property north of Platinum Commercial Park Subdivision, rather than multiple connections spaced no more than 600 feet apart.

    a. This variance is sought as Platinum Commercial Park Subdivision is proposed as a commercial and industrial use development with large lots, whose traffic

characteristics may vary significantly from future development plans to the north which would intermingle residential and commercial/industrial traffic and vehicles compromising the potential safety of motorists and residents. In addition, the proposed single connection to the adjacent property to the north provides inter-connectedness between Platinum Commercial Park Subdivision and the adjacent property to limit the need to enter Danford Road or South 72nd Street West to access the future undeveloped parcel as is intended by this Subdivision Regulation. Based on the desired lot sizes and configuration of Platinum Commercial Park Subdivision, meeting the connection per 600' would also necessitate unduly splitting lots further (minimum lot width along the northern line is ~350' with a maximum lot width of 518') to comply with this requirement when large lots are desired and proposed.

2. Variance from the Yellowstone County Subdivision Regulations, Section 4.6 Streets and Roads, B, 2 is requested to allow for no connection to be made to the existing 68th Street West.

    a. This variance is sought as the existing land use of properties on the east side of 68th Street West include single family residences whose "land use in incompatible with the proposed subdivision" being a commercial/industrial development. This is a condition of waiving this requirement per the referenced section of the Subdivision Regulations.

    b. Additionally, the portion of 68th Street West that would be able to tied into is a roadway tract created with Certificate of Survey No. 1133 (Document Number 845884). This roadway tract does not appear to have been formally accepted as right-of-way by Yellowstone County.

II. CONDITIONS THAT RUN WITH THE LAND

A. Lot owners should be aware that this subdivision is being built in close proximity to prime deer and antelope habitat and it is likely that homeowners will experience problems with damage to landscaped shrubs, flowers, and gardens. The Montana Fish, Wildlife, and Parks Department does not provide damage assistance unless there is damage to commercial crops and/or a threat to public health and safety.

B. Lot owners should be aware that soil characteristics within the area of this subdivision, as described in the 1972 Yellowstone County Soil Survey, indicate that there could be potential limitations for proposed construction on the lots, which may require a geotechnical survey prior to construction.

C. There is attached hereto a Waiver waiving the right to protest the creation of the special improvement district or districts which by this reference is expressly incorporated herein and made as much a part hereof as though fully and completely set forth herein at this point. The Waiver will be filed with the plat, shall run with the land, and shall constitute the guarantee by the Subdivider and property owner or owners of the developments described herein. Said Waiver is effective upon filing and is not

conditioned by the completion of the conditions set forth in the Agreement. The Subdivider and owner specifically agree that they are waiving valuable rights and do so voluntarily.

D. Culverts and associated drainage swales shall not be filled in or altered by the Subdivider or subsequent lot owners.

E. When required by road improvements, all fences and irrigation ditches in the public right-of-way adjacent to this subdivision shall be removed or relocated outside of the public right-of-way and any relocation outside of the public right-of-way shall be subject to securing and recording easements.

F. Future maintenance of all public (or common) improvements shall be done through one (1) or more RSID(s) created as part of the SIA for this subdivision.

G. Individual lot owners should be aware that Best Management Practices for stormwater control shall be required for new construction on lots. Best Management Practices are detailed within the MDEQ Montana Post-Construction Storm Water BMP Design Guidance Manual and the MDEQ Storm Water Management During Construction Field Guide for Best Management Practices.

H. No water rights have been transferred to the lot owners. Irrigation ditches that exist on the perimeter of this development are for the benefit of other properties. Perimeter ditches and drains shall remain in place and shall not be altered by the Subdivider or subsequent owners without permission of said adjacent properties.

III. TRANSPORTATION

A. Access

Access to the Subdivision shall be from proposed approaches on Danford Road and South 72nd Street West as approved by the Yellowstone County Public Works Department. Danford Road and South 72nd Street West are both Yellowstone County roadways within 60-foot wide and 120-foot wide road easements, respectively, that will be perpetuated with this Subdivision. An RSID will be formed for ongoing maintenance, repair, and replacement of internal roadways of the subdivision, including Resource Way (74' right-of-way and 34' wide asphalt road) and Palladium Way (60' right-of-way and 24' asphalt road). Public right-of-way for each roadway will be dedicated with the platting of the subdivision.

B. Traffic Control

Traffic control for the proposed roadway approaches to the Subdivision will be implemented as recommended within the Traffic Impact Study (TIS) for the Subdivision. Said TIS shall be prepared and paid for by the Subdivider.

IV. EMERGENCY SERVICE

The Subdivision is located within the Billings Urban Fire Service Area, and as such the City of Billings Fire Department currently provides fire protection services for the subdivision.

At a minimum, the following is required:

- An unobstructed gravel road or gravel road base must be within 150 feet of the furthest portion of a building under construction as measured along the approved route.

- Being a major subdivision and planned commercial use, a 30,000-gallon dry hydrant fire tank is required for the subdivision and will be constructed as part of the Subdivision public improvements. An RSID will be formed for ongoing maintenance, repair, and replacement of said dry hydrant fire tank.

V. STORM DRAINAGE

All drainage improvements shall comply with the provisions of the Section 4.7, Yellowstone County Subdivision Regulations, and a stormwater management plan shall be submitted to and approved by the Montana Department of Environmental Quality (MDEQ), or its designee.

VI. UTILITIES

A. Water

In accordance with Section 4.9 of the Yellowstone County Subdivision Regulations, all proposed water systems must obtain Approval by Montana Department of Environmental Quality, or its designee.

Municipal public water service is not available in the subdivision at this time. The subdivision will be served by individual wells or alternative water source as approved by the Montana Department of Environmental Quality, or its designee.

Individual lot water supply is the responsibility of the lot owner at the time of development.

B. Septic System

In accordance with Section 4.8 of the Yellowstone County Subdivision Regulations, all sanitary sewer systems must obtain approval by the Montana Department of Environmental Quality, or its designee.

Municipal public sanitary sewer service is not available in the subdivision at this time. The subdivision will be served by wastewater disposal systems as submitted to and approved by Montana Department of Environmental Quality. These systems shall be

located and installed as shown on the site layout approved by Montana Department of Environmental Quality, or its designee.

The Subdivision is proposed to be served by a community wastewater treatment system located on Utility Lot 7, Block 3, which will be dedicated to the public in accordance with Yellowstone County Subdivision Regulations Section 4.8, E. An RSID will be formed to provide maintenance, repair, and replacement of said community wastewater treatment system.

C. Power, Telephone, Gas, and Cable Television

Power, natural gas, telephone, and cable services will be extended into the subdivision through utility easements along each lot's frontage along Resource Way and Palladium Way at the time of construction of subdivision roadways.

VII. PARKS/OPEN SPACE

Section 76-3-621 (3) (a-e) of the Montana Code Annotated (MCA) provides for when park land dedication may not be required. As the Subdivision is proposed as a Commercial/Industrial use subdivision (all non-residential), the Yellowstone County Subdivision Regulations Section 10.8 and said MCA does not require parkland dedication. While the Utility Lot 7, Block 3 is not considered parkland per the Yellowstone County Subdivision regulations, this ~3.612 acre piece of land will provide for open space within the Subdivision.

VIII. IRRIGATION

Subdivider agrees there will be no irrigation water, outside that reviewed and appropriated by DNRC in approval of the Subdivision, available to this Subdivision. No irrigation water shares shall be transferred to individual lot owners.

IX. WEED MANAGEMENT

All noxious weeds on the latest Yellowstone County Noxious Weed List shall be controlled on all properties in the subdivision.

- A Weed Management Plan must be filed and updated as needed for approval by the Yellowstone County Weed Department. Said weed management plan shall contain the noxious weeds being addressed and the plan for the control of those weeds. All associated cost for noxious weed control is the responsibility of the owner of record.
- A revegetation plan shall be submitted as part of the management plan. A seeding recommendation can be obtained from the Yellowstone County Weed Department pursuant to Section 7-22-2152, MCA. The Yellowstone County Weed Department reserves the right to revise these recommendations based on the required site inspection.

X. SOILS/GEOTECHNICAL STUDY

A geotechnical study is not required by the Yellowstone County Subdivision Regulations as part of this plat. Lot owners should be aware that soil characteristics within the area of this subdivision, as described in the 1972 Yellowstone County Soil Survey, indicate that there could be potential limitation for proposed construction on the lots, which may require a geotechnical survey prior to construction.

XI. PHASING OF IMPROVEMENTS

There are no intended phasing improvements.

XII. FINANCIAL GUARANTEES

Except as otherwise provided, Subdivider shall install and construct said required improvements by private contracts secured by bonds, irrevocable letters of credit, sequential development, or any other method that may be acceptable to the Planning Board and Board of County Commissioners. All engineering and legal work in connection with such improvements shall be paid by the contracting parties pursuant to said private contract, and the improvements shall be designed by and constructed under the supervision of a professional engineer competent in civil engineering, licensed in the state of Montana. Upon completion of the improvements, the consulting Engineer shall file with the Public Works Department, a statement certifying that the improvements have been completed in accordance with approved, seal stamped, record drawings, along with all required post-construction certification per Section 4.6.C. of the Yellowstone County Subdivision Regulations..

XIII. LEGAL PROVISIONS

A. Subdivider agrees to guarantee all public improvements for a period of one year from the date of final acceptance by Yellowstone County.

B. The owners of the properties involved in this proposed Subdivision by signature subscribed herein below agree, consent, and shall be bound by the provisions of this Agreement.

C. The covenants, agreements, and all statements in this Agreement apply to and shall be binding on the heirs, personal representatives, successors and assigns of the respective parties.

D. In the event it becomes necessary for either party to this Agreement to retain an attorney to enforce any of the terms or conditions of this Agreement or to give any notice required herein, then the prevailing party or the party giving notice shall be entitled to reasonable attorney fees and costs.

E. Any amendments or modifications of this Agreement or any provisions herein shall be made in writing and executed in the same manner as this original document and shall after execution become a part of this Agreement.

F. Subdivider shall comply with all applicable federal, state, and local statutes, ordinances, and administrative regulations during the performance and discharge of its obligations. Subdivider acknowledges and agrees that nothing contained herein shall relieve or exempt it from such compliance.

G. Subdivider agrees to create any required (or expansion of existing) RSID(s) for future maintenance of all public (or common) constructed improvements prior to final plat approval.

IN WITNESS WHEREOF, the parties hereto have set their hands and official seals on the date first above written.

"SUBDIVIDER" *Cougar Investments, LLC, a Montana limited liability company*

By: _____

Its: Member

STATE OF MONTANA)
: ss
County of Yellowstone)

On this 23 day of September, 2025, before me, a Notary Public in and for the State of Montana, personally appeared Erin M. Kirschenmann, MEMBER authorized signatory of *Cougar Investments, LLC, a Montana limited liability company,* known to me to be the person who executed the foregoing instrument and acknowledged to me that he/she executed the same.

TAMARA FRANK NOTARIAL SEAL STATE OF MONTANA

TAMARA FRANK
NOTARY PUBLIC for the
State of Montana
Residing at Laurel, Montana
My Commission Expires
December 2, 2026

_____
Notary Public in and for the State of Montana
Printed Name: _____
Residing at: _____
My commission expires: _____

This agreement is hereby approved and accepted by Yellowstone County, this ____ day of _____, 20___.

"COUNTY"
COUNTY OF YELLOWSTONE
MONTANA

County of Yellowstone
Board of County Commissioners

By: _____
Chairman

_____
Commissioner

_____
Commissioner

Attest: _____
County Clerk and Recorder

STATE OF MONTANA)
: ss
County of Yellowstone)

On this _____ day of _____, 20___, before me, a Notary Public in and for the State of Montana, personally appeared _____, _____, _____, and _____, known to me to be the Board of County Commissioners and the County Clerk and Recorder, respectively, of Yellowstone County, Montana, whose names are subscribed to the foregoing instrument in such capacity and acknowledged to me that they executed the same on behalf of Yellowstone County, Montana.

_____
Notary Public in and for the State of Montana
Printed Name: _____
Residing at: _____
My commission expires: _____

Waiver of Right to Protest

FOR VALUABLE CONSIDERATION, the undersigned, being the Subdivider and all of the owners of the hereinafter described real property, do hereby waive the right to protest the formation of one or more Rural Special Improvement Districts (RSID's), for a period of no more than twenty years from the recording of this waiver, which Yellowstone County may require.

This Waiver and Agreement is independent from all the other agreements and is supported by sufficient independent consideration to which the undersigned are parties, and shall run with the land and shall be binding upon the undersigned, their successors and assigns, and the same shall be recorded in the office of the County Clerk and Recorder of Yellowstone County, Montana.

The real property hereinabove mentioned is more particularly describe as follows:

Platinum Commercial Park Subdivision

Signed and dated this 23 day of September, 2025

"SUBDIVIDER" *Cougar Investments, LLC, a Montana limited liability company*

By: _____

Its: Member

STATE OF MONTANA)
: ss
County of Yellowstone)

On this 23 day of September, 2025, before me, a Notary Public in and for the State of Montana, personally appeared Erin M. Kirschenmann, *+MEMBER authorized signatory of *Cougar Investments, LLC, a Montana limited liability company,* known to me to be the person who executed the foregoing instrument and acknowledged to me that he/she executed the same.

_____
Notary Public in and for the State of Montana
Printed Name: _____
Residing at: _____
My commission expires: _____

TAMARA FRANK NOTARIAL SEAL STATE OF MONTANA

TAMARA FRANK
NOTARY PUBLIC for the
State of Montana
Residing at Laurel, Montana
My Commission Expires
December 2, 2026

B.O.C.C. Regular **1. b.**

Meeting Date: 10/21/2025

Title: Ag Release Platinum Commercial

Submitted For: Jeff Martin, Clerk And Recorder

Submitted By: Jeff Martin, Clerk And Recorder

TOPIC:

Termination and Revocation of Agricultural Covenant for Tract 1, Certificate of Survey 3861.

BACKGROUND:

Platting of Platinum Commercial Park Subdivions meets the statutory criteria for the BOCC to release the subject covenant.

RECOMMENDED ACTION:

Approve.

Attachments

Ag Release Platinum

3mc

Return Address:
Performance Engineering
3412 Colton Boulevard, Suite 202
Billings, MT 59101

Termination and Revocation of Certificate of Survey-Agricultural Exemption

THIS AGREEMENT is made and entered into by **COUGAR INVESTMENTS, LLC**, a Montana limited liability company, as owners of Tract 1 of Certificate of Survey No. 3861 in Yellowstone County, Montana, and **YELLOWSTONE COUNTY**, MONTANA, as the governing body.

WHEREAS, Tract 1 of Certificate of Survey No. 3861 (Document No. 4063856), situated in the SW ¼ of Section 30, Township 01 South, Range 25 East, P.M.M., Yellowstone County, Montana, was subject to an Agricultural Restriction Covenant (Document No. 4063856); and

WHEREAS, said tract was surveyed and platted as Platinum Commercial Park Subdivision which complied with all requirements, rules, regulations, policies, and resolutions of Yellowstone County, and the laws and administrative rules of the State of Montana; and,

WHEREAS, the Plat of Platinum Commercial Park Subdivision was filed under Document No. _____, records of Yellowstone County, Montana; and

WHEREAS, Platinum Commercial Park Subdivision consists of 14 lots and the owners desire to lift the agricultural covenant on said tracts;

THEREFORE, the parties to this agreement do hereby agree that the provisions of the Agricultural Restriction Covenant imposed on Tract 1 of Certificate of Survey No. 3861 is hereby terminated and revoked.

Dated this 23 day of September 25

Signatures are provided on following pages.

Cougar Investments, LLC, a Montana limited liability company

Title: Member

9/23/2025
Date

State of Montana)
:
County of Yellowstone)

On this 23 day of September, 2025, before me, a Notary Public for the State of Montana, personally appeared, Erin M. Kirschenmann, being the Member of Cougar Investments, LLC, a Montana limited liability company, known to me to be the persons whose name is subscribed to the within instrument and acknowledged to me that they executed the same.

IN WITNESS, WHEREOF, I have hereunto set my hand and affixed my notary seal the day and year first above written.

(seal)

TAMARA FRANK NOTARIAL SEAL STATE OF MONTANA

TAMARA FRANK
NOTARY PUBLIC for the
State of Montana
Residing at Laurel, Montana
My Commission Expires
December 2, 2026

Print Name: _____
Notary Public for the State of Montana
Residing at Billings, Montana
My commission expires _____

Yellowstone County Commissioners

_____
Chairperson

_____
Commissioner

Attest:

_____
Commissioner

_____
Jeff Martin, Clerk & Recorder

State of Montana)
:
County of Yellowstone)

On this _____ day of _____, 20____, before me, a Notary Public for the State of Montana, personally appeared, _____, _____, and _____, members of the Board of County Commissioners, and Jeff Martin, County Clerk & Recorder, known to me to be the persons whose names are subscribed to the within instrument and acknowledged to me that they executed the same.

IN WITNESS, WHEREOF, I have hereunto set my hand and affixed my notary seal the day and year first above written.

(seal)

_____

Print Name: _____
Notary Public for the State of Montana
Residing at Billings, Montana
My commission expires_____

B.O.C.C. Regular **1. c.**

Meeting Date: 10/21/2025

Title: Platinum Deed

Submitted For: Jeff Martin, Clerk And Recorder

Submitted By: Jeff Martin, Clerk And Recorder

TOPIC:

Quit Claim Deed Acceptance for Utility Lot 7, Platinum Commercial Park Subdivision.

BACKGROUND:

Required for community septic system and RSID.

RECOMMENDED ACTION:

Accept.

Attachments

Platinum Deed

2

WHEN RECORDED MAIL TO:
Yellowstone County
Attn: Clerk & Recorder
316 N 26th St, Room 3501
Billings, Montana 59101

QUIT CLAIM DEED

FOR VALUE RECEIVED, **Cougar Investments, LLC**, a Montana limited liability company, whose address is P.O. Box 81153, Billings, Montana 59108, hereinafter called the **Grantor**, does hereby remise, release, and quit claim unto **Yellowstone County, Montana**, hereinafter called the **Grantee**, all right, title, interest, claim, and demand which the said Grantor has in and to the following described real property situated in **Yellowstone County, Montana**, to-wit:

Utility Lot: 7, Platinum Commercial Park Subdivision, being a subdivision of land located on Tract 1 of Certificate of Survey No. 3861 located in Government Lot 4 and the SE ¼ of the SW ¼ of Section 30, Township 1 South, Range 25 East, P.M.M., Yellowstone County, Montana, according to the official plat thereof on file and of record in the office of the Clerk and Recorder of said County.

SUBJECT TO: Covenants, conditions, restrictions, reservations, easements, rights-of-way, and encumbrances apparent or of record including the wastewater treatment system and stormwater pond serving Platinum Commercial Park Subdivision.

TO HAVE AND TO HOLD all the right, title, and interest of the Grantor in and to said premises unto the said Grantee and to its successors and assigns forever.
IN WITNESS WHEREOF, the Grantor has hereunto set its hand and seal this _____day of _____, 2025.

COUGAR INVESTMENTS, LLC
a Montana limited liability company

By: _____
Erin Kirschenmann, Member

STATE OF MONTANA)
:ss
County of Yellowstone)

On this ____day of _____, 2025, before me, a Notary Public in and for the State of Montana, personally appeared **Erin Kirschenmann**, known to me to be a Member of **Cougar Investments, LLC**, a Montana limited liability company, who executed the foregoing instrument and acknowledged to me that she executed the same on behalf of said limited liability company.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Notarial Seal the day and year first above written.

_____
Notary Public for the State of Montana
Printed Name: _____
Residing at: _____
My Commission Expires: _____

ACCEPTANCE OF QUIT CLAIM DEED
(Utility Lot 7, Platinum Commercial Park Subdivision)

_____
Mark Morse, Chair

_____
Michael J. Waters, Member

ATTEST

_____
Chris White, Member

_____
Jeff Martin, Clerk and Recorder

STATE OF MONTANA)
:
County of Yellowstone)

On the _____ day of _____, 20____, before me, a Notary Public in and for the State of Montana, personally appeared Mark Morse, Michael J. Waters, Chris White, and Jeff Martin know to me to be the Board of County Commissioners and the Clerk and Recorder of Yellowstone County, Montana, and who signed the foregoing instrument and who acknowledged to me that they executed the same.

WITNESS my hand and seal the day and year hereinabove written.

_____

B.O.C.C. Regular **1. d.**

Meeting Date: 10/21/2025

Title: Olive Grove

Submitted For: Jeff Martin, Clerk And Recorder

Submitted By: Jeff Martin, Clerk And Recorder

TOPIC:

Plat of Olive Grove Minor Subdivision and the S.I.A.

BACKGROUND:

Reviewed.

RECOMMENDED ACTION:

Approve.

Attachments

Olive Grove SIA

SUBDIVISION IMPROVEMENTS AGREEMENT

FOR

OLIVE GROVE SUBDIVISION

PROPOSED SUBDIVISION IS LOCATED IN THE SE ¼ OF SECTION 6, T1S, R25E, PMM, YELLOWSTONE COUNTY, MONTANA.

PREPARED BY:

NORTH STAR LAND SERVICES, P.C.
33 CENTENNIAL ROAD, COLUMBUS, MONTANA 59019

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SUBDIVISION IMPROVEMENTS AGREEMENT
Olive Grove Subdivision

This agreement is made and entered in to this _____ day of _____, 20___, by and between **Olive Grove, LLC** whose address for the purpose of this agreement is **3675 Nellie Christine Drive, Shepherd, Montana 59079,** hereinafter referred to as "Subdivider," and **Yellowstone County, Montana,** hereinafter referred to as "County."

WITNESSETH:

WHEREAS, the plat of Olive Grove Subdivision located in Yellowstone County, Montana, was submitted to the Yellowstone County Board of Planning; and

WHEREAS, at a regular meeting conducted on____ day of _____ 20____, the Board of County Commissioners conditionally approved a preliminary plat of Olive Grove Subdivision;and

WHEREAS, a Subdivision Improvements Agreement is required by the County prior to the approval of the final plat.

WHEREAS, the provisions of this agreement shall be effective and applicable to Olive Grove Subdivision, upon the filing of the final plat thereof in the Office of the Clerk and Recorder of Yellowstone County, Montana. The Subdivision shall comply with all requirements of the Yellowstone County Subdivisions Regulations, the rules, regulations, polices, and resolutions of Yellowstone County, and the laws and administrative rules of the State of Montana.

THEREFORE, THE PARTIES TO THIS AGREEMENT, for and in consideration of the mutual promises herein contained and for the other good and valuable consideration, do hereby agree as follows:

I. VARIANCES

A. Subdivider has requested, and the county hereby grants, the following variances by the Board of County Commissioner from the strict interpretation of the County's Subdivision Regulations. No variances are requested.

II. CONDITIONS THAT RUN WITH THE LAND

A. Lot owners should be aware that this subdivision is being built in close proximity to prime deer and antelope habitat and it is likely that homeowners will experience problems with damage to landscaped shrubs, flowers, and gardens. The Montana Fish, Wildlife, and Parks Department does not provide damage assistance unless there is damage to commercial crops and/or a threat to public health and safety.

B. Lot owners should be aware that soil characteristics within the area of this subdivision, as described in the 1972 Yellowstone County Soil Survey, indicate that there could be potential limitations for construction on the lots, which may require a geotechnical survey prior to construction.

C. No water rights shall be transferred to the lot owners. Irrigation ditches that exist in the area of the lots are for the benefit of other properties. Perimeter ditches and drains shall remain in place and shall not be altered by the Subdivider or subsequent owners.

D. There is attached hereto a Waiver waiving the right to protest the creation of the special improvement district or districts which by this reference is expressly incorporated herein and made as much a part hereof as though fully and completely set forth herein at this point. The Waiver will be filed with the plat, shall run with the land, and shall constitute the guarantee by the Subdivider and property owner or owners of the development described herein. Said Waiver is effective upon filing and is not conditioned on the completion of the conditions set forth in this Agreement. The Subdivider and owner specifically agree that they are waiving valuable rights and do so voluntarily.

E. Olive Grove Subdivision is located outside of the 100-year floodplain.

F. Culverts and associated drainage swales shall not be filled in or altered by the Subdivider or subsequent lot owners.

G. When required by road improvements, all fences and irrigation ditches in the public right-of-way adjacent to this subdivision shall be removed or relocated outside of the public right-of-way and relocation outside of the public right-of-way shall be subject to securing and recording easements.

H. Future maintenance of all (or common) improvements shall be done through one (1) or more RSID(s) created as part of the SIA for this subdivision.

I. Lot owners should be aware that there is a potential for high ground water levels in the area during times of flood irrigation in the vicinity, which may pose limitations on foundations and basements.

J. Lots 1 will used for commercial development, Lots 2,3 and 4 will be residential. All buildings will be located at least ten (10) feet from adjoining public rights-of-way and from any public or private access, and 10 feet from any perimeter property lines.

III. TRANSPORTATION

A. Streets

All rights-of-way shall be private and shall be 70 feet in width.

All interior roads shall be a private easement. All interior roads shall be constructed with 12 inches of 3-minus base course, 3 inches of 1.5 inches minus crushed base course top

course, 3 inches of asphalt pavement and constructed to adequately support a 40-ton vehicle. Finish surface of gravel base shall be 28 feet in width for an asphalt width of 24 feet. No curb or gutter shall be constructed.

Roads will have drainage swales on both sides of the road to store storm water runoff from the public roadways. Driveway culverts are proposed. Drainage swales in between drive approaches shall not be altered by the Subdivider or subsequent owners. The buy/sell agreements on all parcels of land shall include a statement that drainage swales may not be altered.

The existing approach off 64th Street West will be replaced by a permanent approach built to County Public Works Standards.

B. Traffic Control Devices
A stop sign will be erected at the intersection of 64th Street West and Olive Branch Way.

Street name signs will be erected at the intersection of 64th Street West and Olive Branch Way.

No interior stop signs or yield signs are proposed as the traffic volume will be quite low. No speed bumps or valley gutters are proposed. No speed sign signs are proposed.

C. Access
Location of existing accesses and proposed accesses are shown on the plat.

D. Billings Area Bikeways and Trail Master Plan(BABTMP)
Olive Grove Subdivision, is outside the (BABTMP).

IV. EMERGENCY SERVICES

A. BUFSA will provide fire suppression and emergency services.

B. A 30,000-gallon water storage/dry hydrant fixture is located on Block 1, Lot 7 of Fire Rock Subdivision and will service this subdivision.

C. Urban Wildland Interface Code requirements are not required as the subdivision is not located in a highly wooded area.

V. STORM DRAINAGE

A. Storm water from the public R.O.W. will be stored in the roadside swales. Individual lots will be required to provide their own storm water retention per approved plans by the Montana Department of Environmental Quality.

B. Existing drainage swales are also located along the existing road, Olive Branch Way, No improvements to the existing system are planned.

VI. UTILITIES

A. Water

Water supply will be provided by offsite domestic water supply companies and stored on each lot in cisterns that meet the Montana Department of Environmental Quality requirements.

B. Sanitary Sewer

Sewer systems for the lots will require approval from the Montana Department of Environmental Quality.

C. Power, Telephone. Gas and Cable Television

All utilities presently exist within Olive Grove Subdivision and will be extended to provide service to each.

VII. PARKS/OPEN SPACE

There is no parkland requirement for Olive Grove Subdivision, as this is a minor subdivision.

VIII. IRRIGATION

The owner will retain all water rights for Olive Grove Subdivision. No water rights will be transferred to the new lot owners. Existing ditches will be eliminated.

VIIII. WEED MANAGEMENT

All noxious weeds on the latest Yellowstone County Noxious Weed list shall be controlled on all properties in the subdivision.

A Weed management Plan must be filed and updated as needed for the approval by the Yellowstone County Weed Department. Said weed management plan shall contain the noxious s weeds being addressed and the plan for the control of those weeds. All associated cost for the noxious weed control is the responsibility of the owner of record.

A revegetation plan shall be submitted as part of the management plan. A seeding recommendation can be obtained from the Yellowstone County Weed Department pursuant to Section 7-22-2152, MCA. The Yellowstone County Weed Department reserves the right to revise these recommendations based on the required site inspection.

X. SOILS/GEOTECHNICAL STUDY

No geotechnical study was completed for this subdivision. Such a study will be the responsibility of future owners if they choose.

XI. PHASING OF IMPROVEMENTS

There will be no phasing of improvements.

XII. FINANCIAL GUARANTEES

Except as otherwise provided, Subdivider shall install and construct said required improvements by private contracts secured by bonds, irrevocable letters of credit, sequential development, or any other method that may be acceptable to the Planning board and Board of county Commissioners. All engineering and legal work in connection with such improvements shall be paid by the contracting parties pursuant to said private contract, and the improvements shall be designed by and constructed under the supervision of a professional engineer competent in civil engineering, licensed in the State of Montana. Upon completion of the improvements, the consulting engineer shall file with the Public Works Department, a statement certifying that the improvements have been completed in accordance with approved, seal stamped, record drawings, along with all post-construction certification per Section 4.6.C. of the Yellowstone County Subdivision Regulations.

XIII. LEGAL PROVISIONS

A.
Subdivider agrees to guarantee all public improvements for a period of one year from the date of final acceptance by Yellowstone County.

B.
The owners of the properties involved in this proposed Subdivision by signature subscribed herein below agree, consent, and shall be bound by the provisions of this Agreement.

C.
The covenants, agreements, and all statements in this agreement apply to and shall be binding on the heirs, personal representatives, successors and assigns of the respective parties.

D.
In the event it becomes necessary for either party to this Agreement to retain an attorney to enforce any of the terms or conditions of this Agreement or to give any notice required herein, then the prevailing party or the party giving notice shall be entitled to reasonable attorney fees and costs.

E.
Any amendments or modifications of this agreement or any provisions herein shall be made in writing and executed in the same manner as this original document and shall after execution become a part of this agreement

F.
Subdivider shall comply with all applicable federal, state, and local statutes, ordinances, and administrative regulations during the performance and discharge of its obligations. Subdivider acknowledges and agrees that nothing contained herein shall relieve or exempt it from such compliance.

IN WITNESS WHEREOF, the parties hereto have set their hands and official seals on the date first above written.

"SUBDIVIDER"

By:_____
Member, Olive Grove, LLC (sign)

Its:_____

STATE OF MONTANA)
: ss
County of Yellowstone)

On this _____day of_____, 20_____, before me a Notary Public in and for the State of Montana, personally appeared (print) _____, Member, Olive Grove, LLC, known to me to be the person who executed the forgoing instrument and acknowledges to me that they executed the same.

_____
Notary Public in and for the State of Montana.

_____
Printed Name: (seal)

Residing at:_____

My commission expires:_____

STATE OF MONTANA)
:ss
County of Yellowstone)

This agreement is hereby approved and accepted by Yellowstone County this_____ day of

_____, 20_____.

"COUNTY"
YELLOWSTONE COUNTY

By:_____
Chairman

_____
Commissioner

_____
Commissioner

Attest:_____
Clerk and Recorder

STATE OF MONTANA)
) ss
County of Yellowstone)

On this _____ day of _____, 20_____, before me, a Notary Public in and for the State of Montana personally appeared_____,
_____,
_____and
_____ known to me to be the County Commissioners and the Clerk and Recorder respectively, of Yellowstone County, Montana, whose names are subscribed to the foregoing instrument in such capacity and acknowledged to me that they executed the same on behalf of the Yellowstone County, Montana.

_____
Notary Public in and for the State of Montana.
Printed name;_____
Residing at:_____
My commission expires:_____

Waiver of Right to Protest

FOR VALUABLE CONSIDERATION, the undersigned, being the Subdivider and all of the owners of the hereafter described real property, do hereby waive the right to protest the formation of one or more Rural Special Improvement Districts (RSID), for the period of no more than twenty years from the recording of this waiver, which Yellowstone County may require.

This Waiver and Agreement is independent from all other agreements and is supported by sufficient independent consideration to which the undersigned are parties and shall run with the land and shall be binding upon the undersigned, their successors and assigns, and the same shall be recorded in the office of the County Clerk and Recorder of Yellowstone County, Montana.

The real property hereinabove mentioned is more particularly described as follows:

OLIVE GROVE SUBDIVISION

Signed and dated this 30th day of December, 2024.

Subdivider/Owner

By: Kevin W Hance
(sign)

Its: Member, Olive Grove, LLC

STATE OF MONTANA)
)ss
County of Yellowstone)

This record was acknowledged before me on this 30th day of December, 2024,
By Kevin W Hance, Member, Olive Grove, LLC
(print)

Cora Hoffer
(Signature of notarial officer)

(Seal)

CORA HOFFER NOTARIAL SEAL STATE OF MONTANA

CORA HOFFER
NOTARY PUBLIC for the
State of Montana
Residing at Billings, Montana
My Commission Expires
July 7, 2026

Title of officer (if not shown on stamp)

B.O.C.C. Regular **2. a.**

Meeting Date: 10/21/2025

Title: Prosecutorial Assistance in State v. OMH

Submitted For: Amy Tolzien **Submitted By:** Amy Tolzien

TOPIC:

Resolution 25-124 Requesting Prosecutorial Assistance in State v. O.M.H.

BACKGROUND:

Defendant is the child of a member of BPD.

RECOMMENDED ACTION:

Approve

Attachments

Resolution OMH

YELLOWSTONE COUNTY BOARD OF COUNTY COMMISSIONERS

Resolution No. 25-124

Resolution for Prosecutorial Assistance

WHEREAS, the Yellowstone County Attorney's Office has requested prosecutorial assistance in *State of Montana v. Orrin Matthew Hart* (DC 25-1120); and

WHEREAS, it is deemed appropriate that a Special Deputy County Attorney be appointed to assist in the prosecution of the aforementioned case;

IT IS HEREBY RESOLVED that attorneys for the Montana Department of Justice, Prosecution Services Bureau be appointed as Special Deputy County Attorneys for Yellowstone County for the purpose of assisting in the prosecution of the aforementioned case.

DATED this 21st day of October 2025.

BOARD OF COUNTY COMMISSIONERS
YELLOWSTONE COUNTY, MONTANA

_____
Chairman

_____
Member

_____
Member

ATTEST:

_____
Clerk and Recorder

B.O.C.C. Regular **2. b.**

Meeting Date: 10/21/2025

Title: Addendum to Ivy medical contract at YCDF for STDF

Submitted For: Melissa Williams, Deputy County Attorney

Submitted By: Melissa Williams, Deputy County Attorney

TOPIC:

Addendum to Ivy Medical Contract, STDF

BACKGROUND:

This addendum provides medical coverage for the short term detention faciltity at YCDF. This proposal was previously discussed at a BOCC discussion meeting.

RECOMMENDED ACTION:

Agenda Item

Attachments

Ivy Addendum- STDF

ADDENDUM TO PROFESSIONAL SERVICES AGREEMENT

72-HOUR HOLD UNIT

This Addendum ("Addendum") supplements the Professional Services Agreement dated on or about June 30, 2025 (the "Agreement") between Ivy Medical, PLLC dba Ivy Corrections Medicine ("Ivy") and Yellowstone County ("Client").

BACKGROUND

1. In addition to the Services provided in the Agreement, Client seeks to have Ivy provide Services in its 72-hour Hold Unit ("Unit"), including screening of Detainees who are detained in the Unit.

2. To accommodate the additional Services rendered in the Unit, the parties agree to the additional compensation set forth in this Addendum.

AGREEMENT

1. IVY RESPONSIBILITIES FOR UNIT SERVICES. Ivy shall provide the following services in the Unit through its Personnel ("Unit Services"). Ivy shall render the Unit Services to Detainees in the Unit in lieu of the Services described in Attachment 2 of the Agreement.

(a) Conduct intake screenings for all new bookings using a shortened version of the screening process currently in place at the Facility.

(b) Perform nursing rounds twice daily to identify acute medical needs, set up medications, and prepare for medication passes. All medications will be approved by an Ivy physician or APP before administration.

(c) Pass medications twice daily.

(d) Provide suicide clearances as required.

2. CLIENT RESPONSIBILITIES FOR UNIT DETAINEES. Between rounds by Ivy Personnel, detention officers will remain responsible for monitoring patients and promptly notifying Ivy Personnel if concerns about detainees arise.

3. COMPENSATION FOR UNIT SERVICES. As compensation for the additional Services performed in the Unit, Client shall compensate Ivy as follows:

3.1 General. The compensation set forth in Attachment 2 to the Agreement shall also apply to Services performed in the Unit, including but not limited to the ADP Fee contained in Section 2 of Attachment 2. Detainees in the Unit shall be included in the ADP for purposes of calculating the ADP Fee as set forth in Attachment 2.

3.2 Booking Fee. In addition to the other compensation payable under the Agreement and this Addendum, Client shall pay to Ivy the amount of Forty-Nine Dollars ($49) per booking in excess of seven hundred (700) bookings per calendar month ("Booking Fee"). The total number of bookings in the Unit, the Facility and any other location at which Ivy renders Services or Unit Services shall be included when calculating the number of bookings for the Booking Fee.

4. **ADDENDUM EFFECTIVE DATE.** This Addendum shall be effective 10-20-25, 2025 ("Addendum Effective Date"), and shall apply to all Services rendered in the Unit on or after the Addendum Effective Date.

5. **REASSESSMENT.** The parties agree to reassess this Addendum (i) 90 days after the Addendum Effective Date, and (ii) 180 days after the Addendum Effective Date to ensure that its terms are appropriate. Upon request by either party, the parties shall negotiate in good faith to amend the Addendum. If the parties cannot agree on an amendment, either party may terminate this Addendum on thirty (30) days' prior written notice.

6. **OTHER TERMS.** The remaining terms in the Agreement shall apply to Services rendered in the Unit to the extent not inconsistent with this Addendum.

Reviewed and agreed by:

Ivy

Authorized Representative

CEO
Title

10-14-25
Date

CLIENT

Authorized Representative

Title

Date

35885916_v2

B.O.C.C. Regular **3. a.**

Meeting Date: 10/21/2025

Title: Finance Contract - Hulteng CCM, Inc - Courthouse Renovation Professional Services

Submitted For: Matt Kessler, Purchasing Agent

Submitted By: Matt Kessler, Purchasing Agent

TOPIC:

Finance Contract - Hulteng CCM, Inc - Courthouse Renovation Professional Services

BACKGROUND:

The Finance Department is requesting Commissioners' approval for a contract with Hulteng CCM, Inc. to be the County's Owner's Construction Representative for the Courthouse Renovation Project. The fee for these services is $405,000.00. This expense was anticipated and included in the FY26 budget.

RECOMMENDED ACTION:

Sign contract & return a copy to Finance.

Attachments

Courthouse Contract - HCCM

PROFESSIONAL SERVICES CONTRACT

This Contract is entered into this 14th day of October 2025, by and between Yellowstone County, Billings, Montana, hereinafter referred to as the "**OWNER**" and HULTENG CCM, INC. hereinafter referred to as "**CCM**". The Owner hereby employs CCM to perform necessary duties as the Owner's Construction Representative for the Yellowstone County Courthouse Renovation Project.

SCOPE OF PROFESSIONAL SERVICES TO BE PROVIDED:

CCM agrees to perform, in a professional, timely manner, all of the duties, both expressed and implied, that relate to the following scope of services:

a) Act as the Owner's Representative in providing advisory support services for preliminary planning and cost estimating, and pre-construction, construction and post occupancy phases of the projects;

b) Provide guidance on critical time path needs for assigned projects;

c) Attend, conduct, and assist the Owner at project meetings, including meetings with the architect/engineer, contractor(s), consultants, AHJ's and the owner;

f) Facilitate open communications among all parties, to help to avoid adversarial interaction and to promote a sense of trust and teamwork in order to accomplish the execution of the project and to see that the projects are complete at the lowest possible cost and with the highest degree of quality and workmanship that are consistent with the plans and specifications for the projects;

h) Attend and advise of meetings with the Owner, consultants and contractors;

i) Assist the Owner, contractor and consultants in obtaining necessary required permits or approvals;

j) Assist the Owner in contract negotiations with consultants and contractors;

k) Assist the Owner in reviewing bid responses from consultants and contractors;

l) Meet with the Owner regularly on agreed basis, to review and discuss project progress;

M) Assist the Owner in creating proper formatted RFQ's and RFP's for Contractor selection;

N) Assist the Owner with Contracts for Designers and Contractors

O) maintain confidentiality to the extent provided in law

P) Work With the Selected design team developing mechanical system designs for maintenance life cycling to include specific equipment selections and provide recommendations to the County for design approval

Q) Work with the selected design team to recommend DDC control selections for mechanical design aligning with the County's current management systems

R) Work with the selected design team to recommend efficient lighting designs and controls for County approval.

SCOPE OF OWNER'S RESPONSIBILITIES:

To complement the scope of work of the Owners Representative, and expedite the overall project, the Owner acknowledges that it has certain tasks and responsibilities, including:

a) The Owner shall provide to CCM complete information regarding the Owner's knowledge and complete requirements for the projects. The Owner shall be responsible for the accuracy and completeness of all reports, data, and other information furnished pursuant to this paragraph. CCM may use and rely on information furnished by the Owner in performing services under this agreement, and on the reports, data and other information furnished by Owner to the design professionals.

b) The Owner shall be responsible for the remediation and dispensation at the site of any asbestos, PCB's, petroleum, hazardous materials and radioactive materials, and the consequences of such hazardous materials if present.

c) The Owner shall examine information submitted by CCM and shall render decisions pertaining thereto as soon as reasonable possible as to not delay critical decisions and impact project time constraints.

d) The Owner shall furnish required information and approvals and perform its responsibilities and activities in a timely manner to facilitate orderly progress of the work in cooperation with CCM and consistent with this agreement and in accordance with the planning and scheduling requirements and budgetary constraints of the project.

e) The Owner shall retain the services of design professional consultants whose services, duties and responsibilities shall be described in a written agreement between the Owner and design professionals. The services, duties and responsibilities set out under such agreement shall be compatible with this agreement and the contract documents. The Owner shall, in its agreement

with the design professionals, require such professionals to perform its services in cooperation with CCM, consistent with this agreement and in accordance with the planning and scheduling requirements and budgetary constraints of the project as determined by the Owner and documented by CCM. The Owner represents to CCM that the terms of that agreement have been acknowledged by and are acceptable to the design professional.

f) The Owner shall send to CCM, and shall require the design professionals to send to CCM, copies of all notices and communications sent to or received by Owner or design professionals relating to the Projects. During the construction phase of the projects, the Owner shall require that the contractors submit all notices and communications relating to the project directly to CCM.

g) The Owner shall designate in writing an officer, employee or other authorized representative to act on behalf of the Owner with respect to the projects. This representative shall have the authority to approve changes in the scope of the projects as provided for herein and shall be available during working hours and as often as may be require to render decisions and to furnish information in a timely manner.

LIMITATIONS:

Nothing in this agreement shall be construed to mean that CCM assumes any of the responsibilities or duties of the Contractors or the Design professionals. The contractors will be solely responsible for construction means, methods, techniques, sequences and procedures used in the construction for the projects, and for the safety of its personnel, property and its operations and for performing in accordance with the contract between the Owner and the contractors. The consultants are solely responsible for the overall design requirements and design criteria of the projects and shall perform in accordance with the agreement between the consultants and the Owner. CCM's services shall be rendered compatibly and in cooperation with the services provided by the consultants under the agreements between the Owner and the consultants. It is not intended that the services of the consultants and CCM be competitive or duplicative, but rather be complementary. CCM will be entitled to rely upon the consultants for the proper performance of services undertaken by the consultants pursuant to the agreement between the Owner and its consultants.

TERM:

The term of this contract will commence 10/1/2025, and terminate at a time to be determined by mutual written agreement between the Owner and CCM, but not later than the completion of the proposed project schedule in the year December 2027. Either party reserves the right to terminate this contract at any time for the other parties' failure to perform their respective responsibilities. Should either party desire to terminate this contract for the other parties failure to perform their responsibilities, the terminating party shall provide a minimum of thirty (30) days written notice to the other party defining the failure of performance.

COMPENSATION - BASIC FEE:

These Owner Construction Representative Services shall be reimbursed at a fee of 2.70%. ($405,000). This fee is representative of a total managed project budget of $15,000,000. If the scope of work changes to accommodate additional owner requested additions or additional construction schedule, CCM reserves the right for additional fee by mutual agreement between Yellowstone County and CCM to amend this contract.

Services shall mean to include:

- Support with MCA A&E selection process;
- Assist in determining the most advantageous construction delivery method for the success of the project, whether Alternative Project Delivery, Design/Bid/Build, or other;
- Support MCA "Alternative Project Delivery" selection process:
- Support preconstruction planning;
- Support with negotiating final contract terms and fee for A&E Architects, programming and full design services;
- Prepare necessary documents and facilitate the process for contractor selection;
- Assist in preparation of contract for construction after contractor selection;
- Assist in Construction Administration through project close-out.

Any additional services outside of this scope of work will be bill at the following rates:

Hourly Rates:

Principal	$192.5.00/HR
Project Manager	$160.00/HR
Project Engineer	$115.00/HR
Administrative	$ 85.00/HR

The Basic Fee does not include travel costs or other reimbursable expenses, and such expenses shall be reimbursed per the following fee table.

COMPENSATION – TRAVEL AND REIMBURSABLE EXPENSES:

In addition to Basic Fee Compensation for Professional Services, the following reimbursable expenses shall be charged at cost and include:

Air travel expenses	At cost
Travel, portal to portal each direction	$ 48.50 per trip
Lodging and meals	At Cost
Reproduction expenses	At cost
Communications	$50.00 per month of billing
Sub-Consultants if required/approved	At cost
Professional and Liability Insurance	1.14% of total billing cost

PAYMENT FOR SERVICES AND REIMBURSABLE EXPENSES:

CCM shall submit monthly invoices within 10 days after end of each month for services performed during said month, and the Owner agrees to remit payment for these invoices within 15 days after receipt. Payments due and payable to CCM which are unpaid for more than thirty (30) days from the date of the invoice shall bear interest at the legal rate from the due date, compounded annually. In addition, CCM may, after giving seven (7) days' notice to the Owner, suspend services under this agreement until CCM has been paid in full all amounts due for services, expenses and charges.

INDEPENDENT CONTRACTOR:

CCM is an independent contractor and not an employee or partner of the Owner. CCM agrees to perform the labor and terms of this contract as an independent contractor and nothing herein contained shall be construed to be inconsistent with this relationship or status. Nothing in this contract shall be in any way construed to constitute that CCM, or any of its agents or employees, are the employees of the Owner for any purpose, or to be recipients of any benefits, pensions, insurance plans, payroll taxes, worker's compensation or State or Federal withholding taxes.

WORKER'S COMPENSATION:

CCM agrees to provide all required worker's compensation coverage for its agents and employees during the term of this contract.

INSURANCE:

CCM will maintain general liability coverage of $1,000,000 per occurrence and $2,000,000 aggregate, and errors and omissions (Professional Liability) coverage of $2,000,000 and the costs for such insurance shall be reimbursed.

The Owner shall be responsible for purchasing and maintaining its own liability insurance. CCM, as an agent of the Owner, shall be named as an additional insured on any insurance policy obtained by the Owner and the subsequent contractors for the project

INDEMNITY:

CCM expressly agrees to hold harmless and indemnify the Owner, its officials, employees, and agents from liability, loss, or damage(s), including costs and reasonable attorney's fees for defense of the same that the Owner may suffer as a result of CCM's negligent acts, errors, or omissions, or the negligent acts, errors, or omissions of CCM's agents or employees in the performance of the professional services under contract.

LEGAL REMEDIES:

Should either party commence litigation, arbitration, or mediation proceedings relating to this agreement, or to enforce or interpret any provisions of this agreement, the prevailing party shall be entitled to recover all reasonable expenses, including attorney fees, witness and expert witness fees and court costs.

The parties agree that the laws of the State of Montana shall govern this contract, and that venue shall be in the Montana 13th Judicial District Court, Yellowstone County, Billings, Montana.

ASSIGNMENT:

CCM shall not sublet or assign any of the services covered by this contract without the express written consent of the Owner.

EXTENT OF AGREEMENT:

This contract constitutes the full and complete contract between the Owner and CCM. The provisions herein relating to the terms and conditions of this Professional Services Contract supersede any and all prior agreements, resolutions, practices, policies, rules and regulations concerning terms and conditions inconsistent with these provisions. Any modifications to this contract shall be made in writing signed by both parties. Any provisions of this contract found to be null and void does not constitute nullification of the remaining terms and conditions of this contract.

IN WITNESS WHEREOF:

The parties hereby set their hands and seals this 14th day of October 2025:

Yellowstone County

Shane Swandal, President
Hulteng CCM, Inc.

B.O.C.C. Regular **3. b.**

Meeting Date: 10/21/2025

Title: Recommendation of Award - Courthouse Renovation RFQ/RFP

Submitted For: Matt Kessler, Purchasing Agent

Submitted By: Matt Kessler, Purchasing Agent

TOPIC:

Recommendation of Award - Courthouse Renovation RFQ/RFP

BACKGROUND:

An Request for Qualifications/Request for Proposals for the Yellowstone County Courthouse Renovation project was released on Friday, September 12th, 2025, with submissions due on Monday, September 29th, 2025. Submissions were received from Swank Enterprises, R&R Taylor Construction, Dick Anderson Construction, Inc., Sletten Construction, Jackson Contractor Group, Inc. and Langlas & Associates. A selection committee was formed and reviewed submissions and conducted initial scoring. The top three scoring participants, Dick Anderson, Langlas, and Sletten were interviewed by the selection committee. After scoring the interviews, it is the committee's recommendation to award Sletten Construction the project.

RECOMMENDED ACTION:

Approve Notice of Intent to Award and return a copy to Finance.

Attachments

NOIA - Courthouse Renovation RFQ/RFP

YCC GCCM RFQ/RFP Scoring

Yellowstone County

Finance Department

Notice of Intent to Award

Solicitation Title: Yellowstone County Courthouse Renovation GC/CM – RFQ/RFP

Solicitation Close Date: September 29th, 2025

Notice of Intent to Award Posting Date: October 21st, 2025

Yellowstone County intends to award a contract to the apparent successful bidder/offeror of the above-mentioned solicitation. This Notice of Intent to Award shall not be considered a binding commitment by the County.

In accordance with relevant statutes and policies, the County has made available for public inspection the relevant bid tab/scoring matrix for the above-mentioned solicitation. Comments from the public regarding the proposed award must be submitted in writing to the Purchasing Agent at the email address listed below within this seven-day notice period.

Purchasing Agent/Contact Information: Matt Kessler, mkessler@yellowstonecountymt.gov

Apparent Successful Offeror(s)
Sletten Construction

Unsuccessful Offeror(s)
Langlas & Associates
Dick Anderson Construction
Swank Enterprises
R&R Taylor Construction
Jackson Contractors Group, Inc.

YC Courthouse Renovation 2025
RFP for GC/CM Selection
Scoring Summary
Review Start Date: 10/06/2025

Category	Maximum Points	Dick Anderson	Jackson	Langlas	R&R Taylor	Sletten	Swank
Presentation and interview	100	86.00	0.00	90.00	NA	94.67	0.00
Project approach, including:	100	76.33	66.33	77.67	NA	84.67	67.67
Pricing	100	98.94	100.00	99.96	NA	96.17	97.96
TOTAL		261.27	166.33	267.63	NA	275.50	165.62

B.O.C.C. Regular **3. c.**

Meeting Date: 10/21/2025

Title: Request for Proposals - Metra Crowd Management Services

Submitted For: Matt Kessler, Purchasing Agent

Submitted By: Matt Kessler, Purchasing Agent

TOPIC:

Request for Proposals - Metra Crowd Management Services

BACKGROUND:

MetraPark is requesting Commissioners' approval to release a request for proposals, seeking a contract for crowd management services. Proposals must be received no later than 3:00PM on Monday, November 10th, 2025. Proposals received after this deadline will not be considered. All timely proposals will be opened and acknowledged on Wednesday, November 12th, 2025 at 9:00AM during the Commissioners' regular board meeting.

RECOMMENDED ACTION:

Approve request and return a copy to Finance.

Attachments

RFP - Metra Crowd Management Services

YELLOWSTONE COUNTY, MONTANA
Request for Proposals
Metra Crowd Management Services

1. Introduction

Notice is hereby given that Yellowstone County is seeking proposals from qualified vendors for providing crowd management services, including ushers, parking attendants, ticketing, security and peer group security services for the MetraPark complex located at 308 6th Ave N, Billings, MT 59101. A description of the scope of work and specifications are attached further in this solicitation as Exhibit A.

2. Proposal Submission Requirements

In order to provide a complete understanding of the services to be provided, a mandatory, in-person Pre-Submittal Meeting will be held on Tuesday, November 4th, 2025, at 1:30PM at the MetraPark facility. Please meet in the MetraPark ticket lobby area at this time. Attendance will be taken. Proposals submitted without a representative attending the pre-submittal meeting will not be considered.

Offerors shall submit five (5) hard copies of the proposal in a sealed envelope. All proposals must be labeled **"Metra Crowd Management Services"**. Proposals may either be mailed or physically delivered to the following addresses.

Mail To:
Yellowstone County BOCC
PO Box 35000
Billings, MT 59107

Physically Deliver To:
Yellowstone County BOCC
City Hall Building, Room 3101, 3rd Floor
316 North 26th Street
Billings, MT 59101

All proposals must be received no later than 3:00 PM on Monday, November 10th, 2025. Proposals received after this deadline will not be considered.

All proposals must include a Bid Security made in favor of Yellowstone County in an amount of $5,000.00. The security may consist of a bid bond, cash, a cashier's check, a certified check, a bank money order, a certificate of deposit, a money market certificate, or a bank draft. The security must be: a) drawn and issued by a federally chartered or state chartered bank or savings and loan association that is insured by or for which insurance is administered by the Federal Deposit Insurance Corporation; or b) drawn and issued by a

credit union insured by the National Credit Union Share Insurance Fund; or c) a bid bond or bonds, original only, no photocopies, executed by a surety company authorized to do business in the State of Montana. Facsimiles, personal and/or business checks are not an acceptable form of security.

The awarded contractor will be required to provide the County with a performance bond in the amount of $50,000.00 within ten working days of the execution of the contract.

Timely proposals will be opened and read aloud at 9:00 AM, on Wednesday, November 12th, 2025, in Room 3108 on the 3rd Floor of the City Hall Building, 316 North 26th Street, Billings, MT 59101.

3. Timeline

Event	Date/Time
Publication Dates for RFP	Friday, October 24th, 2025 Friday, October 31th, 2025
Mandatory Pre-Bid Meeting	Tuesday, November 4th, 2025, at 1:30 PM
Deadline for Proposals	Monday, November 10th, 2025, by 3:00 PM
Review of Proposals by Selection Committee	Week of November 17th
Notice of Intent to Award Posting	Tuesday, November 25th, 2025
Notice of Award	Tuesday, December 2nd, 2025

Yellowstone County reserves the right to modify the above timeline as needed.

4. Selection Process & Scoring

A selection committee will be formed and review all proposals. The selection committee, at its sole discretion, shall determine whether offerors have the basic qualifications and experience to successfully provide the services required in this RFP. Proposals that do not meet minimum qualifications provided will be not be considered.

Proposals will be evaluated based on the following criteria:

- Proposer's previous similar experience, financial condition and capability – [35 points]
- Cost – [30 points]
- Proposed solution – [35 points]

The Board reserves the right to reject any or all proposals received, to waive informalities to evaluate the proposals submitted, and to accept the proposal that best serves the interests of Yellowstone County.

5. Amendments to Solicitation

Any interpretation, correction, or addition of this request will be published on the County website at https://www.yellowstonecountymt.gov/purchasing/.

6. Contact Information & Questions

Any questions regarding the project or proposal submittal procedures should be submitted, in writing, to Matt Kessler, Purchasing Agent, at mkessler@yellowstonecountymt.gov.

7. Miscellaneous

Compliance With Laws

Each bidder must have a current Montana Public Contractor's Registration number when submitting their proposal. The number must appear on the proposal. All subcontractors, if any, must obtain a registration number prior to beginning any work on the project. Bid only registrations are acceptable for the RFP process. No proposal may be withdrawn for at least 45 days after the scheduled deadline time for receipt of the proposals.

The successful offeror will be required to follow all the directives included in section 18-2-422 of the Montana Code Annotated concerning Prevailing Wage Rates for Nonconstruction Services 2025. Those directives are as follows:

(1) The contractor and employers shall pay the standard prevailing wage rate, including fringe benefits, for each job classification as stated in the current prevailing wage rate schedules. The current schedules are available at the State of Montana website. It is the responsibility of the contractors to obtain and use the applicable Wage Rate Schedules.
(2) each contractor and employer are required to maintain payroll records in a manner readily capable of being certified for submission under statute 18-2-423, for not less than 3 years after the contractor's or employer's completion of work on the project; and
(3) Each contractor is required to post a statement of all wages and fringe benefits in compliance with 18-2-423.

Statute 18-2-423 is as follows: If a complaint is filed with the department alleging noncompliance with 18-2-422, the department may require the project to submit to it certified copies of the payroll records for workers employed on that project. A contractor or a subcontractor shall pay employees receiving an hourly wage on a weekly basis. If a wage violation complaint is filed with the department, the contractor or subcontractor shall provide the employee's payroll records to the department within 5 days of receiving the payroll request from the department.

The Contractor is required to comply with all other applicable provisions of Title 18, Chapter 2, and Part 4 of the Montana Code Annotated.

The successful offeror will be required to give preference to the employment of bona fide Montana residents in the performance of the work on this project.

The Contractor must, in performance of work under this contract, fully comply with all applicable federal, state or local laws, rules, and regulations, including the Montana Human Rights Act, Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the American with Disabilities Act of 1990. Any subletting or subcontracting by the Contractor subjects Subcontractors to the same provisions. In accordance with Section 49-3-207, MCA, the Contractor agrees that the hiring of persons to perform the contract will be made on the basis of merit and qualifications and there will be no discrimination based upon race, color, religion, creed, political ideas, sex, age, marital status, physical or mental disability, or national origin by the persons performing under the contract.

Insurance Requirements

The Contractor shall maintain at its sole cost and expense, commercial general liability insurance naming Yellowstone County/MetraPark, as additional insured for this project against liability for damages for bodily injury, including death and completed operations and property damages in a minimum amount of Seven Hundred Fifty Thousand Dollars ($750,000.00) for each claim and One Million Five Hundred Thousand Dollars , ($1,500,000.00), in the aggregate arising from incidents which occur as the result of Contractors negligence during the project and for which Yellowstone County/MetraPark, sole basis of liability is vicarious liability for the acts or omissions of the Contractor or/and subcontractors. Contractor shall maintain for this project at its cost and expense, insurance against claims for injuries to persons or damages to property, including contractual liability which may arise from or in connection with the project by Contractor, agents, employees, representatives, assigns and sub-contractors. This insurance shall cover claims as may be caused by any negligent act or omission. The policy of insurance shall be an occurrence policy with a Best Rating of A- or better and must be in force throughout the project.

Contractor shall name on the Certificate of liability insurance Yellowstone County, as additional insured throughout the project. In addition, Contractor will furnish to Yellowstone County, a copy of the policy endorsement, CG 32 87 05 10, indicating that Yellowstone County/MetraPark, are named as an additional insured under the Contractors insurance policy for this project. Contractor agrees to furnish both the Certificate of insurance and policy endorsement at least ten (10) days prior to beginning work on the project.

Contractor agrees to defend, indemnify and hold harmless Yellowstone County/MetraPark, from and against any and all claims demands, obligations causes of action, lawsuits and all damages and liabilities fines, judgments, costs, (including settlement costs), and expenses associated there with (including reasonable attorney's fees and disbursements), arising from incidents that occur the result of Contractors negligence during this project. And for which Yellowstone County/MetraPark, sole basis of liability is vicarious liability for the acts or omissions of Contractor. The defense and indemnification obligations under this paragraph shall not be limited by any assertions or finding that Yellowstone County, is liable for any damages by reason of a non-delegable duty.

The Board reserves the right to reject any or all bids received, to waive informalities to evaluate the bids submitted, and to accept the bid that best serves the interests of Yellowstone County.

Board of County Commissioners
Yellowstone County, Montana

_____
Mark Morse
Chair

Attest:

_____
Jeff Martin
Clerk and Recorder

MetraPark Crowd Control Services Price Sheet

Include this sheet with other documents when submitting a proposal. Please place this sheet in the front of the proposal.

The rates must apply for a minimum of one year.

Hourly rate for Ushers	$_____
Hourly rate for Usher Supervisors	$_____
Hourly rate for Non-Uniform Security	$_____
Security Supervisors	$_____
Hourly rate for Peer Group Security	$_____
Hourly rate for Ticket Takers	$_____
Hourly rate for Traffic/Parking	$_____

_____	_____
Company Name	Authorized Representative
_____	_____
Mailing Address	City, State and Zip Code
_____	_____
Contractor Registration Number	Telephone Number

Exhibit A
MetraPark Crowd Control RFP Specifications

The County intends to enter into a contract with the highest scoring proposer for the exclusive right to provide ushers, security, and peer group security at the MetraPark Complex. The initial contract term is intended to be one year period, with up to three biennial option renewals. The MetraPark Complex (MetraPark) includes, but is not limited to, a 10,000-seat arena, an 80,000 square foot Expo Center, a 30,000 square foot Montana Pavilion, and a 3,400 seat Outdoor Rodeo arena all contained in a 175-acre area.

MetraPark hosts the annual Montana Fair, which is a nine (9) day event that occurs in August of each year and utilizes all of the facilities on the complex grounds.

The successful offeror will be allowed to use one room for storage and check in on the main arena floor that is designated for crowd control personnel at the arena, if they request it. The contractor will be charged $500 per month for this space and, in addition, will be expected to pay for any and all charges associated with this space that MetraPark and the successful contractor mutually agree on.

Quality personnel, thoroughly trained in all aspects of crowd safety and crowd control, are an absolute necessity for MetraPark. Ensuring guest safety, comfort and enjoyment is the primary responsibility of the firm who will be providing ushers, security, and peer group security. Services provided by a highly professional, expert and experienced contractor are essential to the public safety and to the operation of MetraPark in the public's best interest. Procedures and policies of the ushering, security and peer group security firm reflects directly upon the facilities, the facility's operator and owners. Therefore, the County will require as a condition of proposal consideration that proposers demonstrate expertise and experience in the field of major spectator event crowd management and control. The firm must demonstrate its ability to provide personnel who are trained to deliver exceptional guest services; to provide personnel who are thoroughly trained to facilitate crowd safety, control and movement; and its ability to respond to any emergencies that may occur from time to time.

Definitions

For clarification and the purpose of brevity, the following definitions will be used throughout these specifications.

A. "Ushering" or "Ushers" shall be understood to include ticket takers, parking attendants, stage doorpersons, seating ushers, perimeter doorpersons, area supervisors, guest assistance personnel, etc.
B. "Peer Group Security" shall be understood to mean casually uniformed, non- police type security, both inside and parking lot attendants
C. "Firm" shall be understood to mean ushering, security and peer group security companies submitting proposals.
D. The "MetraPark Complex" or "MetraPark," shall be understood to mean the Metra Arena, Expo Center, Montana Pavilion and the Outdoor Rodeo Arena.
E. When required for specific purposes, individual facilities will be referred to by name.
F. "County" refers to the Yellowstone County, Billings, MT.
G. "General Manager" shall refer to the General Manager of MetraPark or his designee, through whose offices the contract for services for MetraPark shall be administered, and the RFP process coordinated.
H. "Selection Committee" shall mean the appointed representatives of the MetraPark Complex and Yellowstone County who will determine the qualifications of the proposers, evaluate qualified proposals, and make recommendations to the Yellowstone County Commissioners.

Proposal Requirements

Proposals should address the information requested as outlined below. The selection committee will use this information to evaluate and score proposals.

A. Proof of Insurance: Proposer must provide proof of insurance that fully meets the requirements of the County of Yellowstone and the MetraPark facility as specified in section 7 of the RFP.

B. History of Performance: Provide demonstrated previous satisfactory performance of a contract for provision of substantially similar services to publicly owned facilities having similar guest capacities for a continuous period of not less than three (3) years. All references must include names and current address and telephone numbers of individuals who can verify this information. Financial statements and insurance history for three (3) years must be provided with the proposals. Use years 2021 through 2024 for this history.

C. Philosophy of Crowd Control: The awarded contractor will be expected to deliver exceptional customer service and treat all ticket buyers and attendees as "guests," not patrons. Proposals must explain how they will accomplish this.

D. Supervision and Management: Provide detailed information showing current employee management staff that has the ability and experience to effectively train, organize and supervise all personnel necessary to perform all functions required herein. Provide name, current city, education, work history and references of all training, supervisory and management personnel who will act for proposer in carrying out the proposed contract. All references must include current address and telephone numbers of persons who will verify the information provided. The proposer is expected to provide a liaison that will be available on an as needed basis.

E. Training Policy: Proposals must include the firm's training procedures and frequency, and shall include the following, at a minimum, as demonstrated in training manuals, plans, policies and procedures. In addition, the firm will be required to provide written documentation of ongoing training sessions to the MetraPark management for their employees by submitting a list of specific training sessions to the MetraPark management on a quarterly basis to ensure that training of their employees is a priority.

1. Guest Services
2. Crowd Psychology and Control
3. Emergency Evacuation Procedures & Responsibilities
4. Emergency Medical Treatment Procedures
5. Ticket-Taking & Admission Control
6. Alcohol Management
7. Limited Force Ejection Policies
    a) Formal Legal Complaint Procedures
    b) Arrest and Detainment Procedures
8. Facility Regulations & Enforcement Techniques

F. Enforcement: Outline methods and procedures to be used to enforce the following policies, facility regulations, and developing situations:

1. No smoking inside the facilities
    a) Reserved seat events in the Metra Arena
    b) Private trade shows in the Convention Facilities
2. No outside food or beverage in First Interstate Arena
3. Minors in possession
4. No cameras or recording devices in Metra Arena

5. Keeping fire lanes and aisles clear and free from persons sitting, standing or other obstructions

G. Peer Group Security: Personnel will be expected to conduct pre-concert door inspections of ticket holders with magnetometers, particularly at concerts at the First Interstate Arena. Proposals should detail procedures used to check for the following:

1. Cans and bottles, alcohol and drugs, fireworks
2. Weapons – guns, knives, dangerous objects, etc.
3. Video cameras and sound recorders

H. Responsibilities of Peer Group Security Crews and Ushers: Detail the responsibilities of Peer Group Security crews and Ushers for before, during and after concerts.

I. Communications Equipment: Proposer shall identify the communications and other equipment that the firm will provide, including, but not limited to the following:

1. Hand-held bullhorns or other crowd communicating equipment
2. Equipment for concert events

NOTE: MetraPark will provide radios that will be checked out for each event and then checked back on completion of the event. These radios will have two channels, one for general communication among the crowd control staff and, the second channel, on supervisory radios only, for law enforcement, venue and crowd control.
NOTE: No employees of awarded contractor will be authorized to carry any type of weapon, firearm, handgun, nightstick, baton, or mace.

J. Uniforms: All ushers, security and peer group security employed by the firm shall be clothed at the firm's expense in matching uniforms, t-shirts, slacks, blouses, blazers, etc. for easy identification. Sample uniforms, pictures or drawings must be provided during the personal interview. Peer group security uniforms must be different from ushers uniforms. Ushers for formal concerts must be attired in identical uniforms. The firm shall be responsible for maintaining the appearance of all employees' uniforms throughout the duration of the contract.

K. Name Tags: As a part of uniforms, nametags identifying all employees with first names must be provided in easily readable print. Nametags must identify the facility.

L. Personnel Pool: Proposals should indicate sources of personnel to be provided for completion of services. Firms should include the number of staff they propose to work a

typical event, knowing that roles and number of staff may vary based on the event type. The County may require background checks for staff hired by the awarded contractor.

M. Hourly Charges: Rates for services must be detailed on the price sheet provided on page six (6) of this RFP. Firms shall submit rates, which are proposed to be in effect for the first year of the contract. Rates for the three option periods of twenty-four (24) months each shall be negotiated. The firm shall include in the proposal a pay range for each employee group. Proposals should include any discounts that the firm will offer to multi-event facility presenters. The firm chosen will install a timeclock for staff check in and check out with auditing privileges by the county

N. Other: Any other information that proposer feels is pertinent to the successful implementation of outlined services at MetraPark.

- END OF RFP -

B.O.C.C. Regular **3. d.**

Meeting Date: 10/21/2025

Title: Platinum Commercial Park Sub RSID 919M- Drainfield System

Submitted For: Russell Burton, Comptroller **Submitted By:** Russell Burton, Comptroller

TOPIC:

Resolution 25-121 to Create RSID 919M to Maintain a Drainfield System in Platinum Commercial Park Subdivision

BACKGROUND:

Drainfield System (septic) RSID 919M for Platinum Commercial Park Subdivision. 13 lots @ 500.00/yr (each) subject to change. ($6,500 total)

RECOMMENDED ACTION:

Approve

Attachments

Res 25-121 Platinum Comm Park Sub - Drainfield System

YELLOWSTONE COUNTY BOARD OF COUNTY COMMISSIONERS

Resolution No. 25- 121

Resolution to Create Yellowstone County Rural Special Improvement District No. 919M

WHEREAS, pursuant to Sections 7-12-2101 through 7-12-2113 of the Montana Code Annotated, a board of county commissioners has the authority to create a rural special improvement district to maintain public improvements such as roads, dry hydrants and parks. Typically, to create a district, a board should pass a resolution of intent, set a public hearing, provide notice of the public hearing, receive protests, hold a public hearing, consider protests and pass a resolution that either creates or does not create the district.

WHEREAS, pursuant to Sections 7-12-2102(2)(a), 7-12-2105(4) and 7-12-2113(2)(d) of the Montana Code Annotated, when all the landowners in a proposed district consent to the creation of a district, the board does not have to hold a public hearing. The board can create a district with the passage of a resolution.

WHEREAS, the Yellowstone County Board of County Commissioners received a petition from Cougar Investments, LLC, the developer of Platinum Commercial Park Subdivision in Yellowstone County to create a rural special improvement district to maintain the Drainfield System installed in Platinum Commercial Park Subdivision. Cougar Investments, LLC owns all the land in the Subdivision. Attached as Exhibit 1 is the petition

Below is a summary of the specifics of the District:

District Summary

District Name:	Yellowstone County Rural Special Improvement District No. 919M
District Location:	Parcels in Platinum Commercial Park Subdivision
District Parcels:	13 parcels
District Activities:	Maintain Drainfield System in Platinum Commercial Park Subdivision
District Costs:	$500 Estimated Cost per lot per year for 13 lots, Subject to Change
District Assessment Method:	Per Parcel/Lot
District Assessment:	$6,500 Annual District Assessment, Subject to Change
District Duration:	Indefinite

Attached as Exhibit 1 is the petition for the district including the details of the District such as name, location, map, parcels, property owners, activities, costs, assessment method, assessment and engineer. The costs for the District and the assessment for the District will likely increase over time. The Board can annually adjust the assessment.

WHEREAS, the Yellowstone County Board of County Commissioners received a petition to create a rural special improvement district to maintain the Drainfield System in Platinum Commercial Park Subdivision. The Board reviewed the petition. The petition appears legally sufficient. The Board believes it would be in the best interest of the public to create the District. All the landowners in the Subdivision consented to the creation of the District. Because all the landowners consent to the creation of the District, the Board does not have to hold a public hearing to create the District.

NOW THEREFORE, BE IT RESOLVED,

The Yellowstone County Board of County Commissioners creates Rural Special Improvement District No. 919M to maintain the Drainfield System in Platinum Commercial Park Subdivision. The specifics of the District are contained in the petition attached to this Resolution.

Passed and Adopted on the 21st day of October 2025.

BOARD OF COUNTY COMMISSIONERS
YELLOWSTONE COUNTY, MONTANA

Mark Morse, Chair

Michael J Waters, Member

ATTEST:

Chris White, Member

Jeff Martin, Clerk and Recorder

Exhibit 1

Outlook

FW: Platinum Sub Follow-up

From: Jay Anderson <janderson@yellowstonecountymt.gov>
Sent: Thursday, October 16, 2025 12:00 PM
To: Jennifer Jones <jjones@yellowstonecountymt.gov>
Cc: Monica Plecker <mplecker@yellowstonecountymt.gov>; Jeff Martin <jmartin@yellowstonecountymt.gov>
Subject: Platinum Sub Follow-up

Jenn –

Public Works discussed the Platinum Subdivision comments with the commentors – Attorney Office and GIS.

Regarding the wastewater treatment system comment – utility lot 7 will house a community septic system for wastewater carried through low pressure sanitary sewer lines from the separate lots. The system is a septic system and is therefore within BOCC authority to create an RSID for maintenance and future replacement. The RSID is labeled water on the forms – it should be changed to wastewater.

Regarding utility lot 7 – this is considered open space, not park land, but is dedicated to the public and owned by the County. Future maintenance of utility lot 7 (mowing etc.) is covered under the common space in the CCRs and to be performed by the HOA.

There was a comment to clarify or include on the Plat that Utility Lot 7 is dedicated to the public – I'm not certain where or how this would be completed.

No issues with Road or Dry Hydrant RSID.

Let me know if you have any other questions.

Jay D. Anderson, PE
Deputy Public Works Director
Yellowstone County
316 N. 26th Street, Rm 3201
Billings, MT 59101
(406) 254-7926

Petition to Create Special Improvement District for Platinum Commercial Park Subdivision – Sewer System

On September 23, 2025, Mark English, a Deputy Yellowstone County Attorney assigned to the Civil Division, reviewed a petition to create a rural special improvement district to maintain the sewer system to be installed with the construction of Platinum Commercial Park Subdivision. The petition appears legally sufficient.

The petition indicates what land will be included in the district (Platinum Commercial Park Subdivision), what public infrastructure will be maintained (sewer system), what will be done to maintain the infrastructure (inspection and maintenance), the cost to maintain the infrastructure ($6,500), how the cost will be paid by the landowners in the district (per parcel) and whether all the landowners consent to the creation of the district (all consent, only developer).

Because all the landowners consented to the creation, the County does not have to hold a hearing to create the district.

The infrastructure to be maintained by the district is somewhat concerning. Should a district maintain the system? Should a water and sewer district maintain the system? The County creates districts to maintain static infrastructure such as roads and parks. Is the system like a wastewater treatment facility or a septic tank? A district can maintain a septic tank. A district should not maintain a wastewater treatment facility.

> Whenever the public interest or convenience may require, the board of county commissioners may order and create special improvement districts outside of the limits of incorporated towns and cities for the purpose of building, constructing, or acquiring by purchase one or more of the improvements of the kind described in 7-12-4102, in or for the benefit of the special improvement district.
> § 7-12-2102(1), MCA (2023)
>
> (d) create special improvement districts and order the acquisition, construction, or reconstruction within the districts of:
> ***
> (ii) sewers, ditches, drains, conduits, and channels for sanitary or drainage purposes, with outlets, cesspools, manholes, catchbasins, flush tanks, septic tanks, connecting sewers, ditches, drains, conduits, channels, and other appurtenances;
> ***
> § 7-12-4102(2)(d)(ii), MCA (2023)

Exhibit 1

PERFORMANCE ENGINEERING

3412 Colton Blvd., Suite 202
Billings, MT 59102
(406) 384-0080
performance-ec.com

LETTER OF TRANSMITTAL

DATE 9/23/25	JOB 2023-100
TO: **Yellowstone County**	
RE: **PZX-23-00217**	
Platinum Commercial Park Subdivision	
RSID Petitions	
On Line Submittal: ☒	
Email:	
Fax:	

TO **Yellowstone County Public Works**
Attn: Ronni Tallerico
316 N 26th Street
Billings, MT 59101

WE ARE SENDING YOU ☒ Attached ☐ Under separate cover via _____ the following items:

☐ Drawings ☐ Prints ☐ Plans ☐ Samples ☐ Specifications

☐ Copy of letter ☐ Change order ☐ _____

COPIES	DESCRIPTION
1	Dry Hydrant RSID Petition
1	Road RSID Petition
1	Wastewater Treatment System RSID Petition

THESE ARE TRANSMITTED as checked below:

☐ For approval ☐ Reviewed as submitted ☐ pdf copy to:

☐ For your use ☐ Reviewed as noted ☐

☒ As requested ☐ Returned for corrections ☐

☐ For review and comment ☐ _____

☐ FOR BIDS DUE _____ 20____ ☐ PRINTS RETURNED AFTER LOAN TO US

Remarks: _____

Copy to: *File*

Signed: *Taylor Kasperick*

Exhibit 1

Water

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

COVER SHEET

TO: YELLOWSTONE COUNTY BOARD OF COMMISSIONERS

This petition is respectfully submitted this 23 day of September, ~~19~~ 2025.

Petitioner/Initiator (and/or) Contact Person:

NAME: Cougar Investments, LLC

ADDRESS: PO Box 81153

Billings, MT 59108

PHONE NO: 406-855-8004

I swear that all of the information presented in this petition is true and correct and the landowner's signatures (Section F) are the original true and consenting landowners.

Petitioner's Signature

Date 9/23/2025

LIST ALL ADDITIONAL ATTACHMENTS:

Platinum Commercial Park Subdivision Plat
Platinum Commercial Park Subdivision Lot Layout

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION A
MAPS OF RURAL SPECIAL IMPROVEMENT DISTRICT BOUNDARY (ATTACHED)

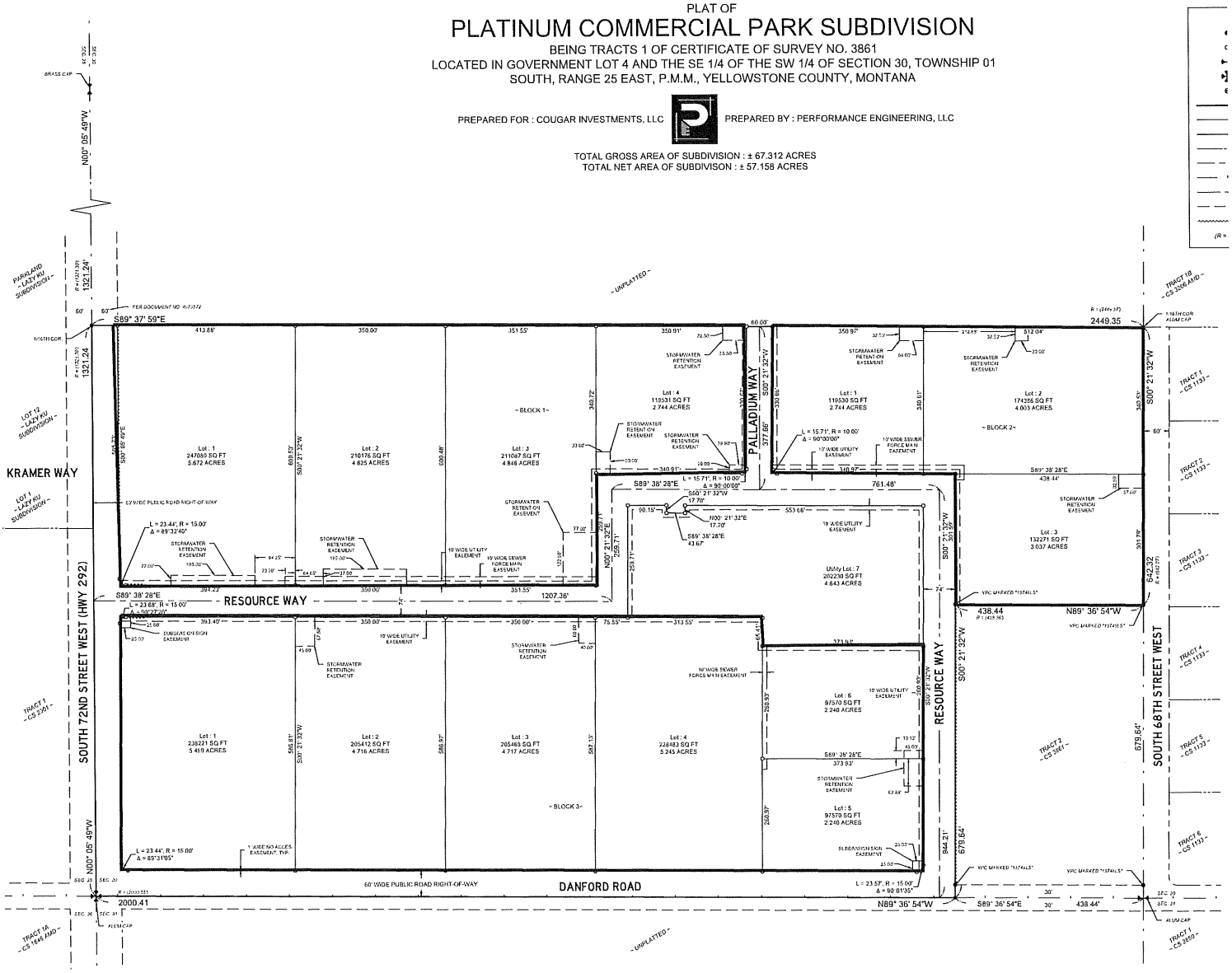
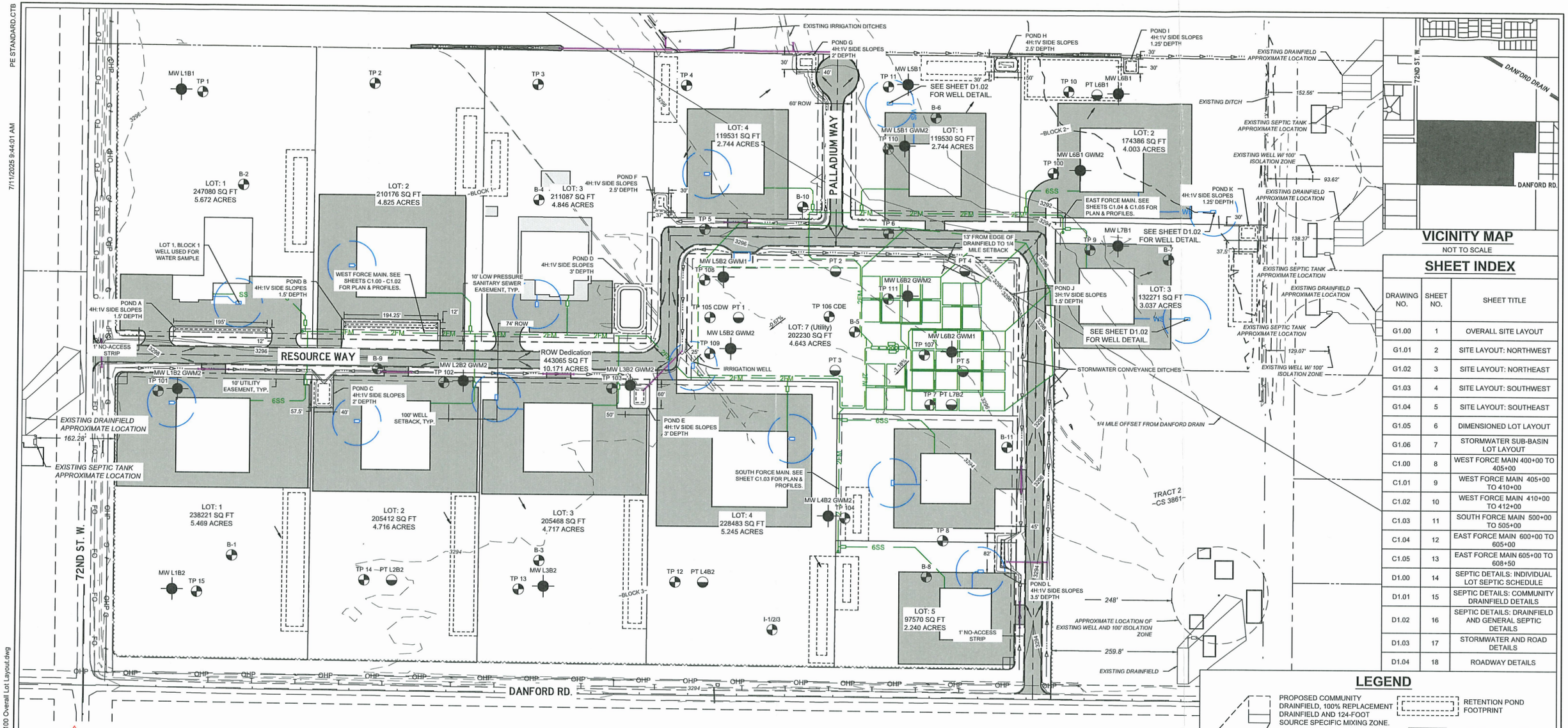


Exhibit 1



VICINITY MAP

NOT TO SCALE

SHEET INDEX

DRAWING NO.	SHEET NO.	SHEET TITLE
G1.00	1	OVERALL SITE LAYOUT
G1.01	2	SITE LAYOUT: NORTHWEST
G1.02	3	SITE LAYOUT: NORTHEAST
G1.03	4	SITE LAYOUT: SOUTHWEST
G1.04	5	SITE LAYOUT: SOUTHEAST
G1.05	6	DIMENSIONED LOT LAYOUT
G1.06	7	STORMWATER SUB-BASIN LOT LAYOUT
C1.00	8	WEST FORCE MAIN 400+00 TO 405+00
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D1.00	14	SEPTIC DETAILS: INDIVIDUAL LOT SEPTIC SCHEDULE
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D1.02	16	SEPTIC DETAILS: DRAINFIELD AND GENERAL SEPTIC DETAILS
D1.03	17	STORMWATER AND ROAD DETAILS
D1.04	18	ROADWAY DETAILS

LEGEND

- PROPOSED COMMUNITY DRAINFIELD, 100% REPLACEMENT DRAINFIELD AND 124-FOOT SOURCE SPECIFIC MIXING ZONE.
- PRIMARY SHOWN WITH A LEVEL 2 TREATMENT SYSTEM, GRAVELLESS CHAMBERS AND 25% REDUCTION.
- INDIVIDUAL COMBO SEPTIC/DOSING TANK AND SERVICE TO BUILDING
- SECONDARY SEPTIC/PRE-ANOXIC TANK, RECIRCULATION TANK, LEVEL 2 TREATMENT, POST-ANOXIC TANK AND COMMUNITY DOSING TANK
- TEST PIT LOCATION
- BOREHOLE LOCATION
- RETENTION POND FOOTPRINT
- GENERAL COMMERCIAL BUILDING FOOTPRINT AND ASSUMED PARKING LOT
- INDIVIDUAL CISTERN WITH 50-FOOT SETBACK RADIUS
- PERCOLATION TEST LOCATION
- MONITORING WELL LOCATION
- FLOW DIRECTION

REVISION 1 NOTES
1. TEST PIT ID NUMBERS UPDATED TO NOT INCLUDE DUPLICATE NUMBERS.
2. 1/4 MILE SETBACK FROM DANFORD DRAIN ADDED.
3. LOT 4, BLOCK 1 WELL LOCATION ADJUSTED.
4. BLOCK 2 WELL LOCATIONS ADJUSTED.

REVISION 2 NOTES
1. DRAINFIELD RESIZED FOR 0.15 GDP/SF APPLICATION RATE AND SHIFTED TO EAST SIDE OF UTILITY LOT.
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3. STORM PONDS ADDED TO MANAGE ROW RUNOFF.
4. EXISTING DRAINFIELDS ADJACENT TO SUBJECT PROPERTY IDENTIFIED.

REVISION 3 NOTES
1. LEVEL 2 TREATMENT DEVICE SELECTED AND LINEWORK UPDATED TO SHOW ACCURATE LAYOUT.
2. INDIVIDUAL WELLS REPLACED WITH CISTERNS.

0 100 200
IN FEET

LOT LAYOUT OF

PLATINUM COMMERCIAL PARK SUBDIVISION

BEING LOCATED ON TRACT 1 OF COS 3861 IN SECTION 30, TOWNSHIP 01 SOUTH, RANGE 25 EAST, P.M.M., YELLOWSTONE COUNTY, MONTANA

ADDENDUM/REVISION	DATE	BY	CHECKED BY
REVISIONS PER DEQ COMMENTS	02/05/2025	BGR	TJK
REVISIONS PER DEQ COMMENTS	06/20/2025	BGR	TJK
LEVEL 2 TREATMENT REVISIONS & REPLACE WELLS	07/10/2025	BGR	TJK

VERIFY SCALE!
THESE PRINTS MAY BE REDUCED. LINE BELOW MEASURES ONE-INCH ON ORIGINAL DRAWING.
MODIFY SCALE ACCORDINGLY

BGR — DESIGNED BY
BGR — DRAWN BY
QUALITY ASSURANCE
TJK — CHECKED BY

PERMIT SET

PERFORMANCE ENGINEERING
3412 COLTON BLVD, STE 202 (406) 384-0080
BILLINGS, MT 59102 performance-ec.com

PLATINUM COMMERCIAL PARK SUB.

OVERALL SITE LAYOUT

MONTANA — TAYLOR JAY KASPERICK — No. 51253 PE — LICENSED PROFESSIONAL ENGINEER — 7/9/2025

PROJECT NUMBER 2023-100
SHEET NUMBER 1 OF 19
DRAWING NUMBER G1.00

COPYRIGHT 2025 ©

PE STANDARD.CTB
7/11/2025 9:44:01 AM
Z:\KE Construction\2023-100 72nd And Danford Subd\CAD\DWG\Plans\DEQ\(01) Title Sheets\23-100 Overall Lot Layout.dwg

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION B
LEGAL DESCRIPTIONS

PROPERTY LEGAL DESCRIPTIONS

Lots 1-4, Block 1, inclusive, of Platinum Commercial Park Subdivision

Lots 1-3, Block 2, inclusive, of Platinum Commercial Park Subdivision

Lots 1-6, Block 3, inclusive, of Platinum Commercial Park Subdivision

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION C
ESTIMATED ANNUAL MAINTENANCE COST

FALL MAINTENANCE:

ACTIVITY	ESTIMATED COST
Check and inspect system; collect necessary samples; flush treatment media; vac out treatment basins.	$ 1,000
	$

WINTER MAINTENANCE:

ACTIVITY	ESTIMATED COST
Check and inspect system; collect necessary samples; flush treatment media; vac out treatment basins.	$ 1,000
	$

SPRING MAINTENANCE:

ACTIVITY	ESTIMATED COST
Check and inspect system; collect necessary samples; flush treatment media; vac out treatment basins.	$ 1,000
Anticipated replacement of drainfield at the end of 30 years ($75,000)	$ 2,500

SUMMER MAINTENANCE:

ACTIVITY	ESTIMATED COST
Check and inspect system; collect necessary samples; flush treatment media; vac out treatment basins.	$ 1,000
	$

TOTAL ESTIMATED ANNUAL MAINTENANCE COST: $6,500

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION D
METHOD OF ASSESSMENT

CHOOSE A METHOD OF ASSESSMENT:

☐	Square Footage
X	Equal Amount $500.00 per lot
☐	Front Footage
☐	Other (Describe)

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION E
PROPOSED RURAL SPECIAL IMPROVEMENT DISTRICT
RECOMMENDATIONS FOR AD HOC COMMITTEE

NAME	TELEPHONE NUMBER
1. Erin Kirschenmann (Chairman) Printed Name Signature Cougar Construction, LLC	406-850-3683
2. _____ Printed Name _____ Signature	_____
3. _____ Printed Name _____ Signature	_____
4. _____ Printed Name _____ Signature	_____
5. _____ Printed Name _____ Signature	_____

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION F

CONSENT OF PROPERTY OWNERS IN PROPOSED RURAL SPECIAL IMPROVEMENT DISTRICT

WE, THE UNDERSIGNED property owners, hereby provide the following information for consideration in the possible creation of an RSID. It is our understanding that if support exists for the RSID, information will be provided to the County and a public hearing scheduled regarding the creation of this district. Following the public hearing, the County Commissioners shall take action on whether or not to create the district. Should the County Commissioners create the district, WE, as property owners, understand that we shall bear the costs of the district as formally approved by the County Commissioners.

PROPERTY LEGAL DESCRIPTION	OWNER (PRINTED NAME)	OWNER SIGNATURE	IN FAVOR	OPPOSED
Lots 1-4, Block 1; Lots 1-3, Block 2, and Lots 1-6 Block 3 of Platinum Commercial Park Subdivision	Cougar Investments, LLC		X	

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION F (Continued)

CONSENT OF PROPERTY OWNERS IN PROPOSED RURAL SPECIAL IMPROVEMENT DISTRICT

WE, THE UNDERSIGNED property owners, hereby provide the following information for consideration in the possible creation of an RSID. It is our understanding that if support exists for the RSID, information will be provided to the County and a public hearing scheduled regarding the creation of this district. Following the public hearing, the County Commissioners shall take action on whether or not to create the district. Should the County Commissioners create the district, WE, as property owners, understand that we shall bear the costs of the district as formally approved by the County Commissioners.

PROPERTY LEGAL DESCRIPTION	OWNER (PRINTED NAME)	OWNER SIGNATURE	IN FAVOR	OPPOSED

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION G
OWNERSHIP REPORT (ATTACHED)

Exhibit 1

4090328 WD
11/15/2024 03:34 PM Page 1 of 3 Fees: $24.00
eRecorded For Yellowstone County, MT
Jeff Martin, Clerk & Recorder

AND WHEN RECORDED MAIL TO:
Cougar Investments, LLC
PO Box 81153, Billings, MT 59108

Filed for Record at Request of:
Flying S Title and Escrow of Montana, Inc.

Space Above This Line for Recorder's Use Only

Order No.: 1113052
Parcel No.: D01007B

WARRANTY DEED

FOR VALUE RECEIVED,

Roberta Burbank and Teresa Amsbaugh as tenants in common

hereinafter called Grantor(s), do(es) hereby grant, bargain, sell and convey unto

Cougar Investments, LLC, a Montana limited liability company

whose address is: **PO Box 81153, Billings, MT 59108**

Hereinafter called the Grantee, the following described premises situated in **Yellowstone** County, **Montana**, to-wit:

That part of Section 30, Township 1 South, Range 25 East, of the Principal Montana Meridian, in Yellowstone County, Montana, described as Tract 1, of Certificate of Survey No. 3861 on file in the office of the Clerk and Recorder of said County, under Document #4063856.

SUBJECT TO covenants, conditions, restrictions, provisions, easements and encumbrances apparent or of record.

TO HAVE AND TO HOLD the said premises, with its appurtenances unto the said Grantees and to the Grantee's heirs and assigns forever. And the said Grantor does hereby covenant to and with the said Grantee, that the Grantor is the owner in fee simple of said premises; that said premises are free from all encumbrances except current years taxes, levies, and assessments, and except U.S. Patent reservations, restrictions, easements of record, and easements visible upon the premises, and that Grantor will warrant and defend the same from all lawful claims whatsoever.

Dated: November 13th, 2024

Roberta Burbank

STATE OF Washington)
ss.
COUNTY OF Benton)

This instrument was acknowledged before me on November 13, 2024, by Roberta Burbank.

Notary Name Printed Erika L. Fields
Notary Public for the State of Washington
Residing at: Benton Co.
My Commission Expires: 02-01-2025

ERIKA L FIELDS
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
02/01/2025
Comm No.
189988

Dated: November 12, 2024

Teresa Amsbaugh

STATE OF Montana)
ss.
COUNTY OF Lewis & Clark)

This instrument was acknowledged before me on November 12, 2024, by Teresa Amsbaugh.

CONNIE JESTER
NOTARY PUBLIC for the
State of Montana
Residing at East Helena, Montana
My Commission Expires
February 21, 2026

Notary Name Printed Connie Jester
Notary Public for the State of Montana
Residing at: E. Helena, MT
My Commission Expires: 02-21-2026

Exhibit 1

Tax Code: D01007B Ownership Information: 2024 - 2025
2025
Primary Owner Name: COUGAR INVESTMENTS LLC Last Updated On: June 4, 2025
2024
Primary Owner Name: BURBANK, ROBERTA Last Updated On: September 29, 2024
Additional Legal Owner: AMSBAUGH, TERESA

Frequently Asked Questions

Q: I just bought a house. Why isn't my name on the property tax page?

A: The property tax page shows the name of the person or business who owned the house when the tax bills went out for the current tax year. If you bought your home after this year's tax bills went out, your name won't show on the property tax page until the next tax billing cycle.

Q: I bought or sold property before the tax bills were sent out. How long does it take for the ownership changes to show on the property tax page?

A: Once your paperwork is filed after closing, a copy is sent to the Department of Revenue. They update the information in their database, and then that data is sent to the county through nightly (Orion) or bi-weekly (tax billing) updates. It can take 2-4 weeks for all the databases to be updated. If the statements have already been billed for a tax type, the county will not receive an update until the first or second week of January of the next year. See "When are tax bills sent out, and the current tax year records locked for editing?" below for more information.

Q: I recently asked the Department of Revenue to correct name, address or legal description information for my property. Why do the corrections show up on the Orion page, but not on the property tax page?

A: Orion data is updated nightly, and our property tax ownership is updated approximately every other week until the current tax bills are sent out (and then not until the next tax billing cycle). So any changes to your name, address or legal description will show up on the Orion page before they show up on the property tax billing page.

Q: When are tax bills sent out, and the current tax year records locked for editing?

A: Normally (there are occasionally exceptions), mobile home taxes are sent out in April, personal property taxes are sent out in May, and real estate taxes are sent out in October. Paperwork filed 90 days or fewer before the locking of records will be reflected on the next tax year record. No edits will be made to these records once the tax year is locked. Any changes will be made to the next tax year record.

B.O.C.C. Regular **3. e.**

Meeting Date: 10/21/2025

Title: Platinum Commercial Park Sub RSID 920M- Road

Submitted For: Russell Burton, Comptroller **Submitted By:** Russell Burton, Comptroller

TOPIC:

Resolution 25-122 to Create RSID 920M to Maintain Roads in Platinum Commercial Park Subdivision

BACKGROUND:

Road RSID 920M for Platinum Commercial Park Subdivision. 13 lots @ 662.54/yr (each) subject to change. ($8,613 total)

RECOMMENDED ACTION:

Approve

Attachments

Res 25-122 Platinum Comm Park Sub Roads

YELLOWSTONE COUNTY BOARD OF COUNTY COMMISSIONERS

Resolution No. 25- 122

Resolution to Create Yellowstone County Rural Special Improvement District No. 920M

WHEREAS, pursuant to Sections 7-12-2101 through 7-12-2113 of the Montana Code Annotated, a board of county commissioners has the authority to create a rural special improvement district to maintain public improvements such as roads, dry hydrants and parks. Typically, to create a district, a board should pass a resolution of intent, set a public hearing, provide notice of the public hearing, receive protests, hold a public hearing, consider protests and pass a resolution that either creates or does not create the district.

WHEREAS, pursuant to Sections 7-12-2102(2)(a), 7-12-2105(4) and 7-12-2113(2)(d) of the Montana Code Annotated, when all the landowners in a proposed district consent to the creation of a district, the board does not have to hold a public hearing. The board can create a district with the passage of a resolution.

WHEREAS, the Yellowstone County Board of County Commissioners received a petition from Cougar Investments, LLC, the developer of Platinum Commercial Park Subdivision in Yellowstone County to create a rural special improvement district to maintain the roads in Platinum Commercial Park Subdivision. Cougar Investments, LLC owns all the land in the Subdivision. Attached as Exhibit 1 is the petition

Below is a summary of the specifics of the District:

District Summary

District Name:	Yellowstone County Rural Special Improvement District No. 920M
District Location:	Parcels in Platinum Commercial Park Subdivision
District Parcels:	13 parcels
District Activities:	Maintain roads in Platinum Commercial Park Subdivision
District Costs:	$662.54 Estimated Cost per lot per year for 13 lots, Subject to Change
District Assessment Method:	Per Parcel/Lot
District Assessment:	$8,613 Annual District Assessment, Subject to Change
District Duration:	Indefinite

Attached as Exhibit 1 is the petition for the district including the details of the District such as name, location, map, parcels, property owners, activities, costs, assessment method, assessment and engineer. The costs for the District and the assessment for the District will likely increase over time. The Board can annually adjust the assessment.

WHEREAS, the Yellowstone County Board of County Commissioners received a petition to create a rural special improvement district to maintain the roads in Platinum Commercial Park Subdivision. The Board reviewed the petition. The petition appears legally sufficient. The Board believes it would be in the best interest of the public to create the District. All the landowners in the Subdivision consented to the creation of the District. Because all the landowners consent to the creation of the District, the Board does not have to hold a public hearing to create the District.

NOW THEREFORE, BE IT RESOLVED,

The Yellowstone County Board of County Commissioners creates Rural Special Improvement District No. 920M to maintain the roads in Platinum Commercial Park Subdivision. The specifics of the District are contained in the petition attached to this Resolution.

Passed and Adopted on the 21st day of October 2025.

BOARD OF COUNTY COMMISSIONERS
YELLOWSTONE COUNTY, MONTANA

Mark Morse, Chair

Michael J Waters, Member

ATTEST:

Chris White, Member

Jeff Martin, Clerk and Recorder

Petition to Create Special Improvement District for Platinum Commercial Park Subdivision – Roads
On September 23, 2025, Mark English, a Deputy Yellowstone County Attorney assigned to the Civil Division, reviewed a petition to create a rural special improvement district to maintain the roads to be installed with the construction of the Platinum Commercial Park Subdivision. The petition appears legally sufficient.

Exhibit 1 Board

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

COVER SHEET

TO: YELLOWSTONE COUNTY BOARD OF COMMISSIONERS

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Platinum Commercial Park Subdivision Lot Layout

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION A
MAPS OF RURAL SPECIAL IMPROVEMENT DISTRICT BOUNDARY (ATTACHED)

PLAT OF

PLATINUM COMMERCIAL PARK SUBDIVISION

BEING TRACTS 1 OF CERTIFICATE OF SURVEY NO. 3861
LOCATED IN GOVERNMENT LOT 4 AND THE SE 1/4 OF THE SW 1/4 OF SECTION 30, TOWNSHIP 01 SOUTH, RANGE 25 EAST, P.M.M., YELLOWSTONE COUNTY, MONTANA

PREPARED FOR : COUGAR INVESTMENTS, LLC

PREPARED BY : PERFORMANCE ENGINEERING, LLC

TOTAL GROSS AREA OF SUBDIVISION : ± 67.312 ACRES
TOTAL NET AREA OF SUBDIVISON : ± 57.158 ACRES

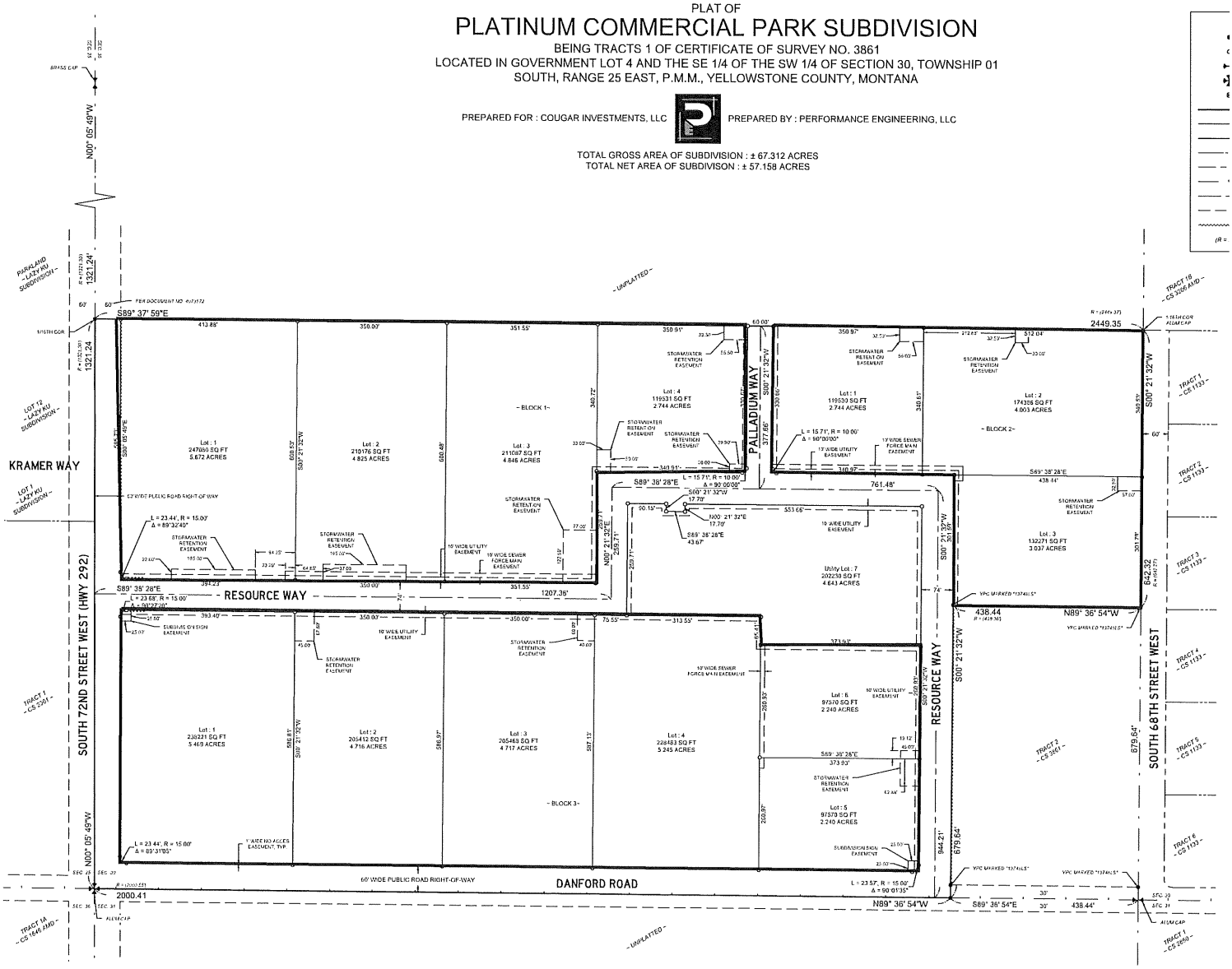
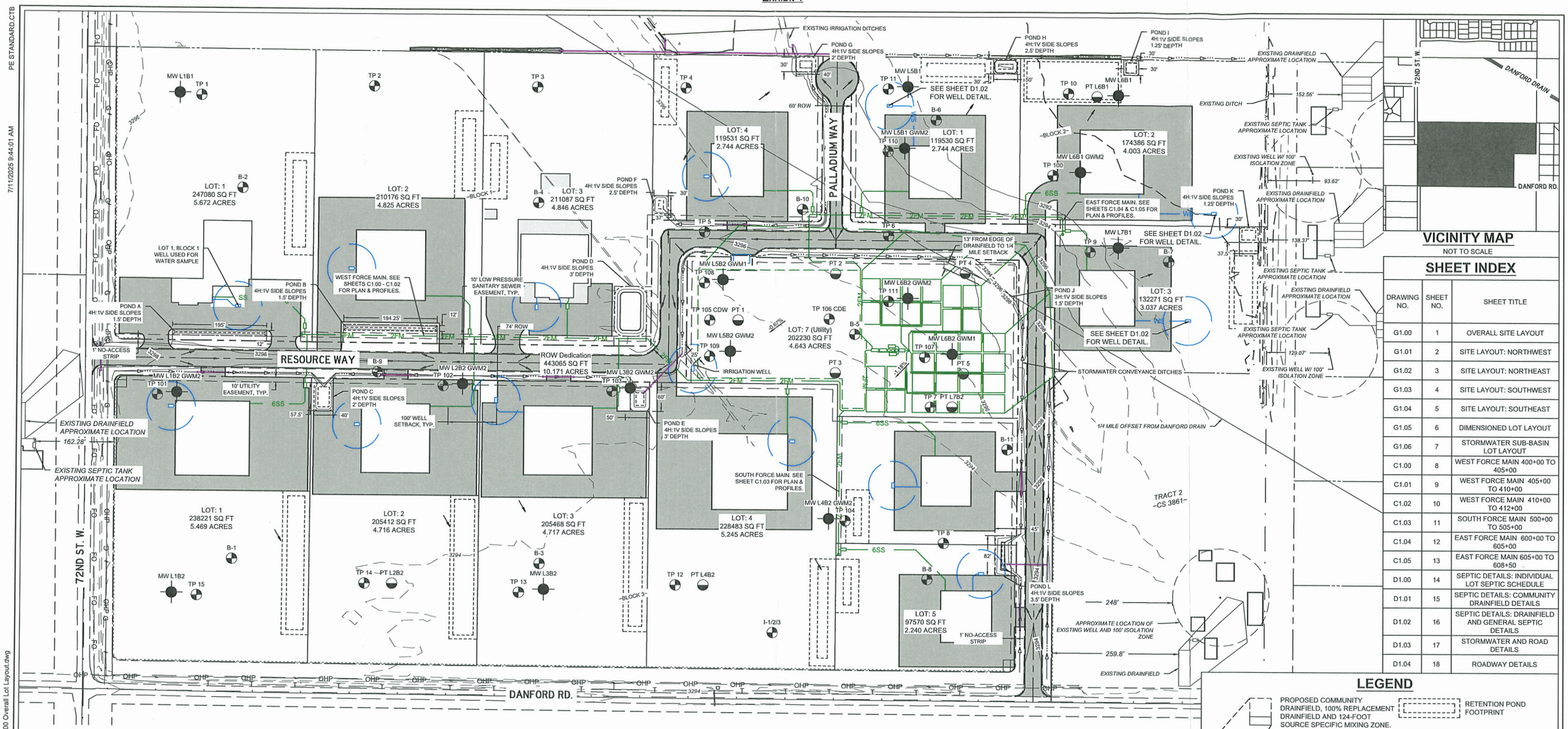


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QUALITY ASSURANCE
TJK — CHECKED BY

PERMIT SET

PERFORMANCE ENGINEERING
3412 COLTON BLVD, STE 202 (406) 384-0080
BILLINGS, MT 59102 performance-ec.com

PLATINUM COMMERCIAL PARK SUB.

OVERALL SITE LAYOUT

MONTANA — TAYLOR JAY KASPERICK — No. 51253 PE — 7/9/2025 — LICENSED PROFESSIONAL ENGINEER

PROJECT NUMBER 2023-100
SHEET NUMBER 1 OF 19
DRAWING NUMBER G1.00

COPYRIGHT 2025 ©

Z:\KE Construction\2023-100 72nd And Danford Subd\CAD\DWG\Plans\DEQ(01) Title Sheets\23-100 Overall Lot Layout.dwg

7/11/2025 9:44:01 AM

PE STANDARD.CTB

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PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION C
ESTIMATED ANNUAL MAINTENANCE COST

FALL MAINTENANCE:

ACTIVITY	ESTIMATED COST
Maintenance and repair of signage	$ As needed
	$

WINTER MAINTENANCE:

ACTIVITY	ESTIMATED COST
Snow Removal (3 times per year)	$ 1,500
	$

SPRING MAINTENANCE:

ACTIVITY	ESTIMATED COST
Maintain Roadside Ditches, Public Ponds, and Culverts	$ 1,000
	$

SUMMER MAINTENANCE:

ACTIVITY	ESTIMATED COST
Road chip seal (*every 10 years)	$ 6,113
	$

*Yellowstone County Public Works recommends an annual assessment of $0.05/SF of pavement for future chip seal. Estimate is based on approximately 122,271 SF of proposed road.

TOTAL ESTIMATED ANNUAL MAINTENANCE COST: $8,613

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SECTION D
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RECOMMENDATIONS FOR AD HOC COMMITTEE

NAME	TELEPHONE NUMBER
1. Erin Kirschenmann (Chairman) Printed Name Signature Cougar Construction, LLC	406-850-3683
2. _____ Printed Name _____ Signature	_____
3. _____ Printed Name _____ Signature	_____
4. _____ Printed Name _____ Signature	_____
5. _____ Printed Name _____ Signature	_____

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION F

CONSENT OF PROPERTY OWNERS IN PROPOSED RURAL SPECIAL IMPROVEMENT DISTRICT

WE, THE UNDERSIGNED property owners, hereby provide the following information for consideration in the possible creation of an RSID. It is our understanding that if support exists for the RSID, information will be provided to the County and a public hearing scheduled regarding the creation of this district. Following the public hearing, the County Commissioners shall take action on whether or not to create the district. Should the County Commissioners create the district, WE, as property owners, understand that we shall bear the costs of the district as formally approved by the County Commissioners.

PROPERTY LEGAL DESCRIPTION	OWNER (PRINTED NAME)	OWNER SIGNATURE	IN FAVOR	OPPOSED
Lots 1-4, Block 1; Lots 1-3, Block 2, and Lots 1-6 Block 3 of Platinum Commercial Park Subdivision	Cougar Investments, LLC		X	

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION F (Continued)

CONSENT OF PROPERTY OWNERS IN PROPOSED RURAL SPECIAL IMPROVEMENT DISTRICT

WE, THE UNDERSIGNED property owners, hereby provide the following information for consideration in the possible creation of an RSID. It is our understanding that if support exists for the RSID, information will be provided to the County and a public hearing scheduled regarding the creation of this district. Following the public hearing, the County Commissioners shall take action on whether or not to create the district. Should the County Commissioners create the district, WE, as property owners, understand that we shall bear the costs of the district as formally approved by the County Commissioners.

PROPERTY LEGAL DESCRIPTION	OWNER (PRINTED NAME)	OWNER SIGNATURE	IN FAVOR	OPPOSED

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION G
OWNERSHIP REPORT (ATTACHED)

Exhibit 1

4090328 WD
11/15/2024 03:34 PM Page 1 of 3 Fees: $24.00
eRecorded For Yellowstone County, MT
Jeff Martin, Clerk & Recorder

AND WHEN RECORDED MAIL TO:
Cougar Investments, LLC
PO Box 81153, Billings, MT 59108

Filed for Record at Request of:
Flying S Title and Escrow of Montana, Inc.

Space Above This Line for Recorder's Use Only

Order No.: 1113052
Parcel No.: D01007B

WARRANTY DEED

FOR VALUE RECEIVED,

Roberta Burbank and Teresa Amsbaugh as tenants in common

hereinafter called Grantor(s), do(es) hereby grant, bargain, sell and convey unto

Cougar Investments, LLC, a Montana limited liability company

whose address is: **PO Box 81153, Billings, MT 59108**

Hereinafter called the Grantee, the following described premises situated in **Yellowstone** County, **Montana**, to-wit:

That part of Section 30, Township 1 South, Range 25 East, of the Principal Montana Meridian, in Yellowstone County, Montana, described as Tract 1, of Certificate of Survey No. 3861 on file in the office of the Clerk and Recorder of said County, under Document #4063856.

SUBJECT TO covenants, conditions, restrictions, provisions, easements and encumbrances apparent or of record.

TO HAVE AND TO HOLD the said premises, with its appurtenances unto the said Grantees and to the Grantee's heirs and assigns forever. And the said Grantor does hereby covenant to and with the said Grantee, that the Grantor is the owner in fee simple of said premises; that said premises are free from all encumbrances except current years taxes, levies, and assessments, and except U.S. Patent reservations, restrictions, easements of record, and easements visible upon the premises, and that Grantor will warrant and defend the same from all lawful claims whatsoever.

4090328 WD
11/15/2024 03:34 PM Page 2 of 3
eRecorded For Yellowstone County, MT

Dated: November 13th, 2024

Roberta Burbank

STATE OF Washington)
ss.
COUNTY OF Benton)

This instrument was acknowledged before me on November 13, 2024, by Roberta Burbank.

Notary Name Printed Erika L. Fields
Notary Public for the State of Washington
Residing at: Benton Co.
My Commission Expires: 02-01-2025

ERIKA L FIELDS
NOTARY PUBLIC
COMMISSION EXPIRES
Comm No. 189988
02/01/2025
STATE OF WASHINGTON

4090328 WD
11/15/2024 03:34 PM Page 3 of 3
eRecorded For Yellowstone County, MT

Dated: November 12, 2024

Teresa Amsbaugh

STATE OF Montana)
ss.
COUNTY OF Lewis & Clark)

This instrument was acknowledged before me on November 12, 2024, by Teresa Amsbaugh.

CONNIE JESTER
NOTARY PUBLIC for the
State of Montana
Residing at East Helena, Montana
My Commission Expires
February 21, 2026

Notary Name Printed Connie Jester
Notary Public for the State of Montana
Residing at: E. Helena, MT
My Commission Expires: 02-21-2026

Exhibit 1

Tax Code: D01007B Ownership Information: 2024 - 2025
2025
Primary Owner Name: COUGAR INVESTMENTS LLC Last Updated On: June 4, 2025
2024
Primary Owner Name: BURBANK, ROBERTA Last Updated On: September 29, 2024
Additional Legal Owner: AMSBAUGH, TERESA

Frequently Asked Questions

Q: I just bought a house. Why isn't my name on the property tax page?

A: The property tax page shows the name of the person or business who owned the house when the tax bills went out for the current tax year. If you bought your home after this year's tax bills went out, your name won't show on the property tax page until the next tax billing cycle.

Q: I bought or sold property before the tax bills were sent out. How long does it take for the ownership changes to show on the property tax page?

A: Once your paperwork is filed after closing, a copy is sent to the Department of Revenue. They update the information in their database, and then that data is sent to the county through nightly (Orion) or bi-weekly (tax billing) updates. It can take 2-4 weeks for all the databases to be updated. If the statements have already been billed for a tax type, the county will not receive an update until the first or second week of January of the next year. See "When are tax bills sent out, and the current tax year records locked for editing?" below for more information.

Q: I recently asked the Department of Revenue to correct name, address or legal description information for my property. Why do the corrections show up on the Orion page, but not on the property tax page?

A: Orion data is updated nightly, and our property tax ownership is updated approximately every other week until the current tax bills are sent out (and then not until the next tax billing cycle). So any changes to your name, address or legal description will show up on the Orion page before they show up on the property tax billing page.

Q: When are tax bills sent out, and the current tax year records locked for editing?

A: Normally (there are occasionally exceptions), mobile home taxes are sent out in April, personal property taxes are sent out in May, and real estate taxes are sent out in October. Paperwork filed 90 days or fewer before the locking of records will be reflected on the next tax year record. No edits will be made to these records once the tax year is locked. Any changes will be made to the next tax year record.

B.O.C.C. Regular **3. f.**

Meeting Date: 10/21/2025

Title: Platinum Commercial Park Sub RSID 921M- Dry Hydrant

Submitted For: Russell Burton, Comptroller **Submitted By:** Russell Burton, Comptroller

TOPIC:

Resolution 25-123 to Create RSID 921M to Maintain the Dry Hydrant in Platinum Commercial Park Subdivision

BACKGROUND:

Dry Hydrant RSID 921M for Platinum Commercial Park Subdivision. 13 lots @ 25.00/yr (each) subject to change. ($325 total)

RECOMMENDED ACTION:

Approve

Attachments

Res 25-123 RSID 921M - Platinum Comm Park - Dry Hydrant

YELLOWSTONE COUNTY BOARD OF COUNTY COMMISSIONERS

Resolution No. 25- 123

Resolution to Create Yellowstone County Rural Special Improvement District No. 921M

WHEREAS, pursuant to Sections 7-12-2101 through 7-12-2113 of the Montana Code Annotated, a board of county commissioners has the authority to create a rural special improvement district to maintain public improvements such as roads, dry hydrants and parks. Typically, to create a district, a board should pass a resolution of intent, set a public hearing, provide notice of the public hearing, receive protests, hold a public hearing, consider protests and pass a resolution that either creates or does not create the district.

WHEREAS, pursuant to Sections 7-12-2102(2)(a), 7-12-2105(4) and 7-12-2113(2)(d) of the Montana Code Annotated, when all the landowners in a proposed district consent to the creation of a district, the board does not have to hold a public hearing. The board can create a district with the passage of a resolution.

WHEREAS, the Yellowstone County Board of County Commissioners received a petition from Cougar Investments, LLC, the developer of Platinum Commercial Park Subdivision in Yellowstone County to create a rural special improvement district to maintain the dry hydrant in Platinum Commercial Park Subdivision. Cougar Investments, LLC owns all the land in the Subdivision. Attached as Exhibit 1 is the petition

Below is a summary of the specifics of the District:

District Summary

District Name:	Yellowstone County Rural Special Improvement District No. 921M
District Location:	Parcels in Platinum Commercial Park Subdivision
District Parcels:	13 parcels
District Activities:	Maintain Dry Hydrant in Platinum Commercial Park Subdivision
District Costs:	$25.00 Estimated Cost per lot per year for 13 lots, Subject to Change
District Assessment Method:	Per Parcel/Lot
District Assessment:	$325 Annual District Assessment, Subject to Change
District Duration:	Indefinite

Attached as Exhibit 1 is the petition for the district including the details of the District such as name, location, map, parcels, property owners, activities, costs, assessment method, assessment and engineer. The costs for the District and the assessment for the District will likely increase over time. The Board can annually adjust the assessment.

WHEREAS, the Yellowstone County Board of County Commissioners received a petition to create a rural special improvement district to maintain the dry hydrant in Platinum Commercial Park Subdivision. The Board reviewed the petition. The petition appears legally sufficient. The Board believes it would be in the best interest of the public to create the District. All the landowners in the Subdivision consented to the creation of the District. Because all the landowners consent to the creation of the District, the Board does not have to hold a public hearing to create the District.

NOW THEREFORE, BE IT RESOLVED,

The Yellowstone County Board of County Commissioners creates Rural Special Improvement District No. 921M to maintain the dry hydrant in Platinum Commercial Park Subdivision. The specifics of the District are contained in the petition attached to this Resolution.

Passed and Adopted on the 21st day of October 2025.

BOARD OF COUNTY COMMISSIONERS
YELLOWSTONE COUNTY, MONTANA

Mark Morse, Chair

Michael J Waters, Member

ATTEST:

Chris White, Member

Jeff Martin, Clerk and Recorder

Exhibit 1

Petition to Create Special Improvement District for Platinum Commercial Park Subdivision – Dry Hydrant

On September 23, 2025, Mark English, a Deputy Yellowstone County Attorney assigned to the Civil Division, reviewed a petition to create a rural special improvement district to maintain a dry hydrant to be installed with the construction of Platinum Commercial Park Subdivision. The petition appears legally sufficient.

The petition indicates what land will be included in the district (Platinum Commercial Park Subdivision), what public infrastructure will be maintained (dry hydrant), what will be done to maintain the infrastructure (inspection and fill), the cost to maintain the infrastructure ($325), how the cost will be paid by the landowners in the district (per parcel) and whether all the landowners consent to the creation of the district (all consent, only developer).

Because all the landowners consented to the creation, the County does not have to hold a hearing to create the district.

Hydrant

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

COVER SHEET

TO: YELLOWSTONE COUNTY BOARD OF COMMISSIONERS

This petition is respectfully submitted this 23 day of September, ~~19~~ 2025.

Petitioner/Initiator (and/or) Contact Person:

NAME: Cougar Investments, LLC

ADDRESS: PO Box 81153

Billings, MT 59108

PHONE NO: 406-855-8004

I swear that all of the information presented in this petition is true and correct and the landowner's signatures (Section F) are the original true and consenting landowners.

Petitioner's Signature

9/23/2025
Date

LIST ALL ADDITIONAL ATTACHMENTS:

Platinum Commercial Park Subdivision Plat
Platinum Commercial Park Subdivision Lot Layout

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION A
MAPS OF RURAL SPECIAL IMPROVEMENT DISTRICT BOUNDARY (ATTACHED)

PLAT OF

PLATINUM COMMERCIAL PARK SUBDIVISION

BEING TRACTS 1 OF CERTIFICATE OF SURVEY NO. 3861
LOCATED IN GOVERNMENT LOT 4 AND THE SE 1/4 OF THE SW 1/4 OF SECTION 30, TOWNSHIP 01 SOUTH, RANGE 25 EAST, P.M.M., YELLOWSTONE COUNTY, MONTANA

PREPARED FOR : COUGAR INVESTMENTS, LLC

PREPARED BY : PERFORMANCE ENGINEERING, LLC

TOTAL GROSS AREA OF SUBDIVISION : ± 67.312 ACRES
TOTAL NET AREA OF SUBDIVISON : ± 57.158 ACRES

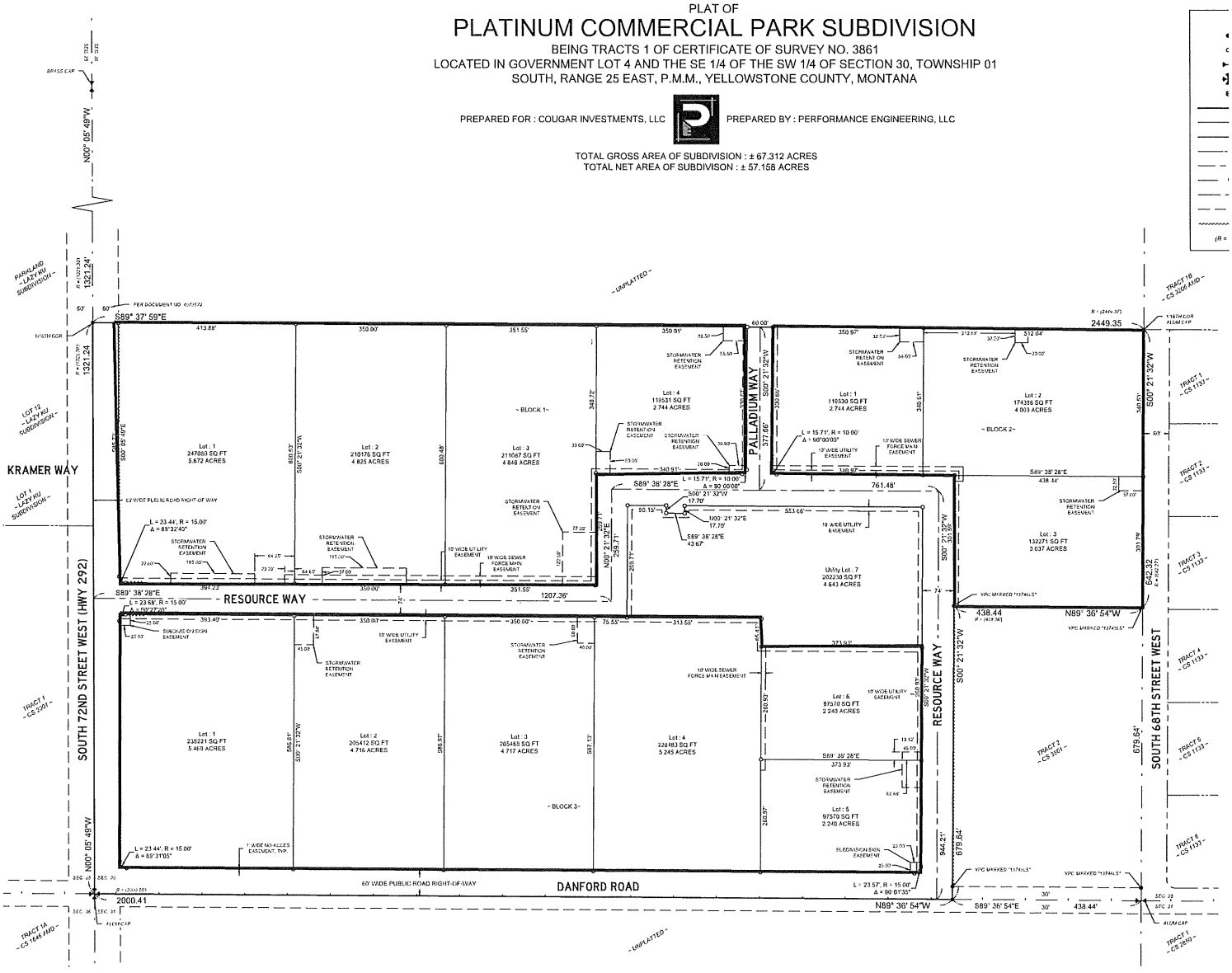
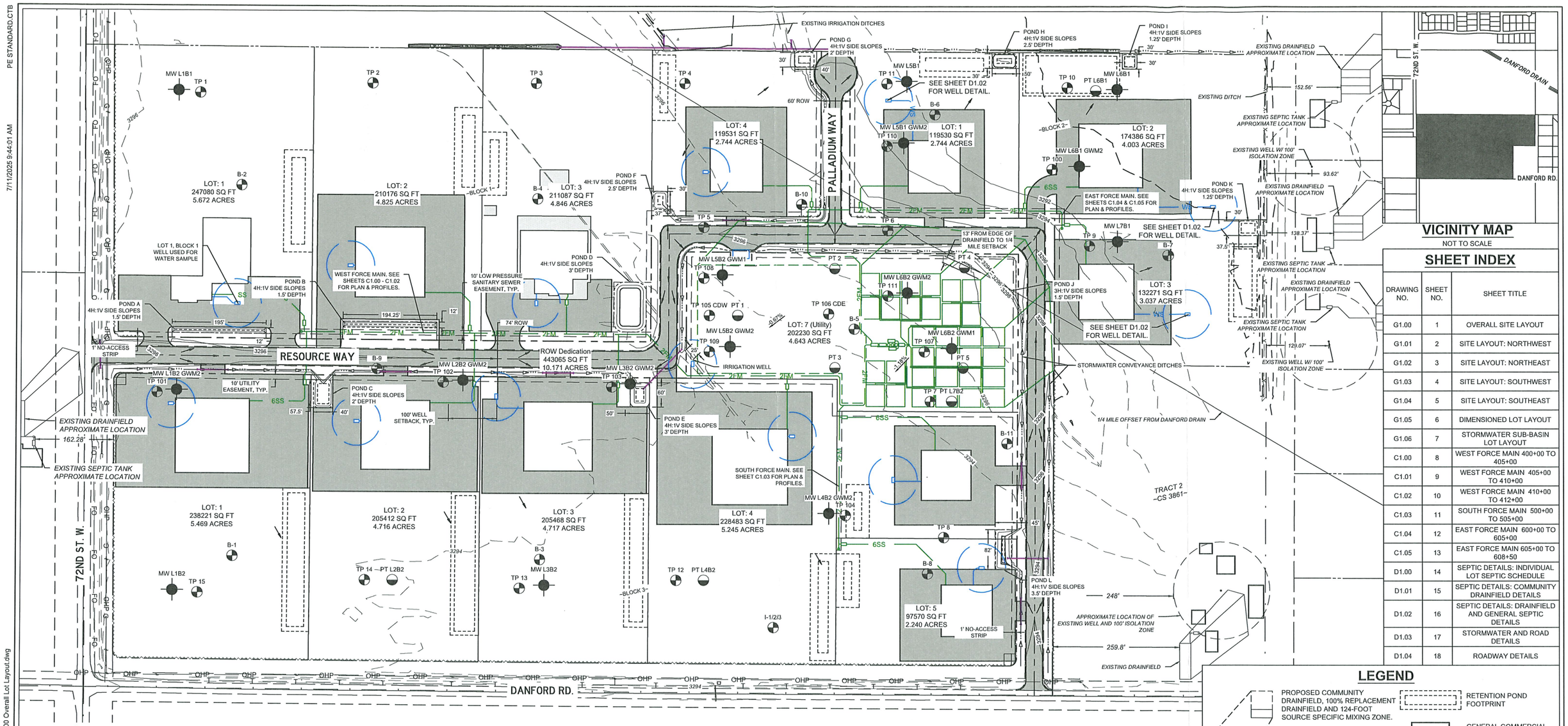


Exhibit 1



VICINITY MAP

NOT TO SCALE

SHEET INDEX

DRAWING NO.	SHEET NO.	SHEET TITLE
G1.00	1	OVERALL SITE LAYOUT
G1.01	2	SITE LAYOUT: NORTHWEST
G1.02	3	SITE LAYOUT: NORTHEAST
G1.03	4	SITE LAYOUT: SOUTHWEST
G1.04	5	SITE LAYOUT: SOUTHEAST
G1.05	6	DIMENSIONED LOT LAYOUT
G1.06	7	STORMWATER SUB-BASIN LOT LAYOUT
C1.00	8	WEST FORCE MAIN 400+00 TO 405+00
C1.01	9	WEST FORCE MAIN 405+00 TO 410+00
C1.02	10	WEST FORCE MAIN 410+00 TO 412+00
C1.03	11	SOUTH FORCE MAIN 500+00 TO 505+00
C1.04	12	EAST FORCE MAIN 600+00 TO 605+00
C1.05	13	EAST FORCE MAIN 605+00 TO 608+50
D1.00	14	SEPTIC DETAILS: INDIVIDUAL LOT SEPTIC SCHEDULE
D1.01	15	SEPTIC DETAILS: COMMUNITY DRAINFIELD DETAILS
D1.02	16	SEPTIC DETAILS: DRAINFIELD AND GENERAL SEPTIC DETAILS
D1.03	17	STORMWATER AND ROAD DETAILS
D1.04	18	ROADWAY DETAILS

LEGEND

- PROPOSED COMMUNITY DRAINFIELD, 100% REPLACEMENT DRAINFIELD AND 124-FOOT SOURCE SPECIFIC MIXING ZONE.
- PRIMARY SHOWN WITH A LEVEL 2 TREATMENT SYSTEM, GRAVELLESS CHAMBERS AND 25% REDUCTION.
- INDIVIDUAL COMBO SEPTIC/DOSING TANK AND SERVICE TO BUILDING
- SECONDARY SEPTIC/PRE-ANOXIC TANK, RECIRCULATION TANK, LEVEL 2 TREATMENT, POST-ANOXIC TANK AND COMMUNITY DOSING TANK
- TP — TEST PIT LOCATION
- B — BOREHOLE LOCATION
- RETENTION POND FOOTPRINT
- GENERAL COMMERCIAL BUILDING FOOTPRINT AND ASSUMED PARKING LOT
- INDIVIDUAL CISTERN WITH 50-FOOT SETBACK RADIUS
- PT — PERCOLATION TEST LOCATION
- MW — MONITORING WELL LOCATION
- FLOW DIRECTION

REVISION 1 NOTES

1. TEST PIT ID NUMBERS UPDATED TO NOT INCLUDE DUPLICATE NUMBERS.
2. 1/4 MILE SETBACK FROM DANFORD DRAIN ADDED.
3. LOT 4, BLOCK 1 WELL LOCATION ADJUSTED.
4. BLOCK 2 WELL LOCATIONS ADJUSTED.

REVISION 2 NOTES

1. DRAINFIELD RESIZED FOR 0.15 GDP/SF APPLICATION RATE AND SHIFTED TO EAST SIDE OF UTILITY LOT.
2. MINOR SEALED COMPONENT AND WELL LOCATION ADJUSTMENTS TO COMPLY WITH SETBACK REQUIREMENTS.
3. STORM PONDS ADDED TO MANAGE ROW RUNOFF.
4. EXISTING DRAINFIELDS ADJACENT TO SUBJECT PROPERTY IDENTIFIED.

REVISION 3 NOTES

1. LEVEL 2 TREATMENT DEVICE SELECTED AND LINEWORK UPDATED TO SHOW ACCURATE LAYOUT.
2. INDIVIDUAL WELLS REPLACED WITH CISTERNS.

0 100 200
IN FEET

LOT LAYOUT OF

PLATINUM COMMERCIAL PARK SUBDIVISION

BEING LOCATED ON TRACT 1 OF COS 3861 IN SECTION 30, TOWNSHIP 01 SOUTH, RANGE 25 EAST, P.M.M., YELLOWSTONE COUNTY, MONTANA

ADDENDUM/REVISION	DATE	BY	CHECKED BY
REVISIONS PER DEQ COMMENTS	02/05/2025	BGR	TJK
REVISIONS PER DEQ COMMENTS	06/20/2025	BGR	TJK
LEVEL 2 TREATMENT REVISIONS & REPLACE WELLS	07/10/2025	BGR	TJK

VERIFY SCALE!
THESE PRINTS MAY BE REDUCED.
LINE BELOW MEASURES ONE-INCH ON ORIGINAL DRAWING.
MODIFY SCALE ACCORDINGLY

BGR — DESIGNED BY
BGR — DRAWN BY
QUALITY ASSURANCE
TJK — CHECKED BY

PERMIT SET

PERFORMANCE ENGINEERING
3412 COLTON BLVD, STE 202 (406) 384-0080
BILLINGS, MT 59102 performance-ec.com

PLATINUM COMMERCIAL PARK SUB.

OVERALL SITE LAYOUT

MONTANA — TAYLOR JAY KASPERICK — No. 51253 PE — 7/9/2025 — LICENSED PROFESSIONAL ENGINEER

PROJECT NUMBER 2023-100
SHEET NUMBER 1 OF 19
DRAWING NUMBER G1.00

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PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION B
LEGAL DESCRIPTIONS

PROPERTY LEGAL DESCRIPTIONS

Lots 1-4, Block 1, inclusive, of Platinum Commercial Park Subdivision

Lots 1-3, Block 2, inclusive, of Platinum Commercial Park Subdivision

Lots 1-6, Block 3, inclusive, of Platinum Commercial Park Subdivision

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION C
ESTIMATED ANNUAL MAINTENANCE COST

FALL MAINTENANCE:

ACTIVITY	ESTIMATED COST
	$
	$

WINTER MAINTENANCE:

ACTIVITY	ESTIMATED COST
	$
	$

SPRING MAINTENANCE:

ACTIVITY	ESTIMATED COST
Check and fill tank.	$ 325
	$

*It is assumed once constructed, maintenance of dry hydrant will be minimal other than filling tank to replenish evaporated water. Cost is based on $25 per lot as has been used as a standard amount by Yellowstone County Public Works in the past.

SUMMER MAINTENANCE:

ACTIVITY	ESTIMATED COST
	$
	$

TOTAL ESTIMATED ANNUAL MAINTENANCE COST: $325

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION D
METHOD OF ASSESSMENT

CHOOSE A METHOD OF ASSESSMENT:

☐	Square Footage
X	Equal Amount $25 per lot
☐	Front Footage
☐	Other (Describe)

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION E
PROPOSED RURAL SPECIAL IMPROVEMENT DISTRICT
RECOMMENDATIONS FOR AD HOC COMMITTEE

NAME	TELEPHONE NUMBER
1. Erin Kirschenmann (Chairman) Printed Name Signature Cougar Construction, LLC	406-850-3683
2. _____ Printed Name _____ Signature	_____
3. _____ Printed Name _____ Signature	_____
4. _____ Printed Name _____ Signature	_____
5. _____ Printed Name _____ Signature	_____

PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION F

CONSENT OF PROPERTY OWNERS IN PROPOSED RURAL SPECIAL IMPROVEMENT DISTRICT

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PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION F (Continued)

CONSENT OF PROPERTY OWNERS IN PROPOSED RURAL SPECIAL IMPROVEMENT DISTRICT

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PETITION TO ESTABLISH A RURAL SPECIAL IMPROVEMENT DISTRICT (RSID)

SECTION G
OWNERSHIP REPORT (ATTACHED)

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11/15/2024 03:34 PM Page 1 of 3 Fees: $24.00
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SUBJECT TO covenants, conditions, restrictions, provisions, easements and encumbrances apparent or of record.

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11/15/2024 03:34 PM Page 2 of 3
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Dated: November 13th, 2024

Roberta Burbank

STATE OF Washington)
ss.
COUNTY OF Benton)

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Notary Public for the State of Washington
Residing at: Benton Co.
My Commission Expires: 02-01-2025

ERIKA L FIELDS
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
02/01/2025
Comm No.
189988

4090328 WD
11/15/2024 03:34 PM Page 3 of 3
eRecorded For Yellowstone County, MT

Dated: November 12, 2024

Teresa Amsbaugh

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ss.
COUNTY OF Lewis & Clark)

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CONNIE JESTER
NOTARY PUBLIC for the
State of Montana
Residing at East Helena, Montana
My Commission Expires
February 21, 2026

Notary Name Printed Connie Jester
Notary Public for the State of Montana
Residing at: E. Helena, MT
My Commission Expires: 02-21-2026

Exhibit 1

Tax Code: D01007B Ownership Information: 2024 - 2025
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Primary Owner Name: COUGAR INVESTMENTS LLC Last Updated On: June 4, 2025
2024
Primary Owner Name: BURBANK, ROBERTA Last Updated On: September 29, 2024
Additional Legal Owner: AMSBAUGH, TERESA

Frequently Asked Questions

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B.O.C.C. Regular **4. a.**

Meeting Date: 10/21/2025

Title: Tradition and High-Deductible Plan Documents

Submitted By: Teri Reitz, Board Clerk

TOPIC:

Traditional and High Deductible Plan Documents

BACKGROUND:

See attached.

RECOMMENDED ACTION:

Approve.

Attachments

High Deductible Plan Document

Traditional Plan Document

Yellowstone County Health Benefit Plan

HDHP

Plan Document

Effective July 1, 2025

MEDICAL BENEFITS
FOR CUSTOMER SERVICE
Call 1-855-258-3489

FOR PRIOR AUTHORIZATION
Call 1-855-313-8914 or Fax 1-866-589-8256 for Non-Behavioral Health
Call 1-855-313-8909 or Fax 1-855-649-9681 for Behavioral Health
For Outpatient Dialysis call 1-844-242-1400

FOR INPATIENT ADMISSIONS
Call 1-855-313-8914 or Fax 1-866-589-8256 for Non-Behavioral Health
Call 1-855-313-8909 or Fax 1-855-649-9681 for Behavioral Health

DENTAL BENEFITS
FOR CUSTOMER SERVICE
Call 1-866-739-4090

www.bcbsmt.com

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- Wellness
- Customer Service
- Other Online Services and Information

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1-800-810-BLUE (2583) – http://provider.bcbs.com

FOR MEDICAL APPEALS
Send via fax:
Non-Behavioral Health: 1-866-589-8256
Behavioral Health: 1-855-649-9681
or
Mail to:
Blue Cross and Blue Shield of Montana
PO Box 660255
Dallas, TX 75266-0255

FOR PRESCRIPTION DRUG BENEFITS

Pharmacy Benefit Manager (PBM)

- Prime Therapeutics 1-855-258-8471
- For Prior Authorizations, fax: 1-877-243-6930

PBM Website www.myprime.com
Claim Forms www.myprime.com
Pharmacy Locator 1-866-325-5230
Specialty Care Pharmacy (BCBSMT Specialty Network) 1-833-721-1619

- www.bcbsmt.com or www.myprime.com
- Prescriber Fax 1-888-302-1028

Mail-Order Services

- **Express Scripts** 1-833-715-0942
  PO Box 66577
  St. Louis, MO 63166-6577
- **Ridgeway Mail-Order Pharmacy** 1-800-630-3214
  2824 US Hwy 93 North
  Victor, MT 59875

Blue Cross and Blue Shield of Montana
3645 Alice Street, Helena, MT 59601
PO Box 660255
Dallas, TX 75266-0255

FOR CLAIMS
Blue Cross and Blue Shield of Montana
PO Box 660255
Dallas, TX 75266-0255

HEALTH BENEFIT PLAN FOR EMPLOYEES OF YELLOWSTONE COUNTY

PLAN OPERATION

Plan Name

Yellowstone County Employee Health Benefit Plan

Type of Plan

Yellowstone County maintains the Employee Health and Dental Benefit Plan, a separate legal entity from Yellowstone County, for the exclusive benefit of and to provide health benefits to its eligible Employees, their legal Spouses, and eligible Dependents. The Plan provides Hospital, Medical, Dental and surgical coverage for eligible Participants.

Type of Participants Covered by the Plan

Employees, their legal Spouses, and their eligible Dependent children may participate based upon the eligibility requirements set forth in the Plan.

Plan Sponsor

Yellowstone County Human Resources
217 North 27th Street Room 106
Billings, MT 59101-5041
Phone: 406-256-2705
Fax: 406-254-7908

Plan Sponsor's Identification Number

81-6001449

Plan Effective Date

July 1, 2025

Plan Benefit Year

January 1 through December 31

Plan Year

July 1 through June 30

Plan Administrator

Yellowstone County Human Resources
217 North 27th Street Room 106
Billings, MT 59101-5041
Phone: 406-256-2705
Fax: 406-254-7908

Named Fiduciary(ies)

Yellowstone County Human Resources
217 North 27th Street Room 106
Billings, MT 59101-5041
Phone: 406-256-2705
Fax: 406-254-7908

Type of Administration

The Plan is a self-funded Health and Dental Plan established to reimburse Participants for Covered Medical Expenses. The Plan Sponsor contracts with a Claim Administrator to process claims, provide claims payment and provide other claims management functions, under the direction of the Plan Administrator. The Plan reimburses the Claim Administrator after claims are paid.

Claim Administrator

Blue Cross and Blue Shield of Montana
P.O. Box 660255
Dallas, TX 75266-0255
1-855-258-3489

Claim Administrator's Disclosures

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

The Plan Sponsor, on behalf of itself and its employees, hereby expressly acknowledges its understanding that the "Agreement" constitutes an agreement solely between the Plan Sponsor and Blue Cross and Blue Shield of Montana, that Blue Cross and Blue Shield of Montana is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, which is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Health Care Service Corporation to use the Blue Cross and Blue Shield Service Marks in the state of Montana, and that Blue Cross and Blue Shield of Montana is not contracting as the agent of the Association. The Plan Sponsor further acknowledges and agrees that it has not entered into the "Agreement" based upon representations by any person other than Blue Cross and Blue Shield of Montana and that no person, entity, or organization other than Blue Cross and Blue Shield of Montana shall be held accountable or liable to the Plan Sponsor for any of the Blue Cross and Blue Shield of Montana obligations to the Plan Sponsor created under the "Agreement." This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Montana other than those obligations created under the provisions of the "Agreement" with the Plan Sponsor.

Certain Responsibilities of the Employer and the Claim Administrator

Employer responsibility

The Employer retains full and final authority and responsibility for the Plan and its operation. The Claim Administrator is empowered to act on behalf of the Employer in connection with the Plan only as expressly stated in this Plan Document or as mutually agreed to in writing by the parties hereto.

Claim Administrator responsibility

The Claim Administrator shall have no responsibility for or liability with respect to the compliance or non - compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and the Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including but not limited to local, state or federal taxes, penalties, surcharges or other fees or amounts regardless of whether payable directly by the Employer or by or through the Claim Administrator; provided, however, the Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to the Claim Administrator in connection with the performance of its obligations under this Agreement.

Relationship of Parties

The Claim Administrator is an independent contractor with respect to the Employer. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venture nor employee of the other. Further, nothing in this Plan Document shall create or be construed to create the relationship of employer and employee between the Claim Administrator and the Employer; nor shall the Employer's agents, officers or employees be considered or construed to be considered employees of the Claim Administrator for any purpose whatsoever.

Funding Mechanism

Benefits under this Plan are funded from Employee and Employer contributions up to the Benefit limits defined in the Plan Document. Payments are made from this fund to pay Benefits.

Source of Contribution

Coverage for Employees is non-contributory for full-time Employees. Benefits for part-time Employees are available on a contributory basis. Benefits for eligible retirees, COBRA participants and dependents are also available on a contributory basis.

Agent for Service of Legal Process

Yellowstone County Civil Attorney, Attn: Plan Sponsor
PO Box 35041
Billings, MT 59107-5041
Phone: 406-256-2705
Fax: 406-254-7908

Amendment, Termination, or Modification of the Plan

The Plan Administrator reserves the right to amend, modify or terminate the Plan in whole or in part at any time.

Expenses incurred prior to the effective date of any amendment are based on the provisions in effect at the time the expenses were incurred.

Plan Coverage Status

This Plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act (The Affordable Care Act).

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Certain terms in this Plan Document are defined in the Definitions section. Defined terms are capitalized.

SCHEDULE OF BENEFITS

Employee Health Benefit Plan PPO

Group Name:	**Yellowstone County**	
Group Number:	**252392**	
Effective Date:	**July 1, 2025**	
Benefit Period:	**Calendar Year**	

The Benefits are subject to the Benefit Period unless otherwise specified.

Deductible:	**Individual:**	**$3,300**
	Family:	**$6,600**
Deductible (Effective 01-01-2026):	**Individual:**	**$3,400**
	Family:	**$6,800**

The Dental Services (Non-Accident) has a separate Deductible. Refer to the specific Benefits.

Deductible does not apply to the following Benefits:

- Preventive Services
- Tobacco Cessation Counseling*
- Obesity Intervention Counseling*
- Diabetic Education*

*See limits listed below.

Coinsurance:	**In-Network:**	**None**
	Out-of-Network:	**None**
Copayment:	**Varies**	

Some Benefits may have payment limitations. Refer to the specific Benefit in this Schedule of Benefits for additional information. In addition:

- For Emergency Services provided by an Out-of-Network provider, Benefits will be provided as if such services were provided by an In-Network provider. Nonemergency services for Mental Illness or Substance Use Disorder provided in an emergency setting will be paid the same as Emergency Services.
- Out-of-Network providers may bill the Participant the difference between the Allowable Fee and the provider's charge, in addition to any applicable Deductible, Copayment and/or Coinsurance, even if Prior Authorization is obtained for the service, or if treatment is provided for Emergency Services.

Out of Pocket:	**Individual:**	**$3,300**
	Family:	**$6,600**
Out of Pocket (Effective 01-01-2026):	**Individual:**	**$3,400**
	Family:	**$6,800**

Charges in excess of the Allowable Fee do not accumulate to help meet the Out of Pocket Amount. In addition, Prescription Drugs do not apply to the Out of Pocket Amount and will never be paid at 100%. The Prescription Drugs Benefit has a separate Out of Pocket Amount. Refer to the Prescription Drugs section.

Term of Plan Document:	**Monthly**

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Accident		
Professional Provider Services	None	None
Facility Services	None	None
Acupuncture Services	None	None
Ambulance	None	None
Autism Spectrum Disorders	None	None
Services, except medications/prescription drugs and Applied Behavior Analysis (ABA) services that are described in the Benefit section entitled Autism Spectrum Disorders are covered under medical Benefits.		
Medications/prescription drugs are covered under Prescription Drugs.		
Benefits for Autism Spectrum Disorders are not subject to any applicable Physical, Occupational or Speech Therapy visit maximum.		
Breast Examinations		
Preventive	None, No Deductible	None, No Deductible
Medical	None	None
Chiropractic Services	None	None
Convalescent Home Services	None	None
Maximum Per Benefit Period – 90 Days		
Diabetic Education Benefit		
First $250	None	None
After the first $250 in payment	None	None
Diagnostic Services		
Professional Provider Services	None	None
Facility Services	None	None
Dialysis Services - Outpatient		
See the separately issued Outpatient Dialysis Plan Document		
Durable Medical Equipment	None	None
Prior Authorization from the Plan is recommended for the original purchase or replacement of durable medical equipment over $2,000. Please refer to the Utilization Management section.		
Emergency Room Care	None*	None*
***Nonemergency Mental Illness and Substance Use Disorder services provided by an In-Network provider or an Out-of-Network provider pay as Emergency Room Care.		
Emergency Room Care not related to an Emergency Medical Condition, accidental Injury, Mental Illness or Substance Use Disorder.	None	None
Foot Orthotics	None	None
Hearing Aid Coverage for Adults 19+		
Evaluation	None	None
Maximum - $2,500 per ear every 5 years.		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Hearing Coverage for Dependent Children Under Age 19	None	None
Maximum one Amplification Device per ear every 3 years or as required by an audiologist.		
Home Health Care	None	None
Maximum Per Benefit Period – 100 Visits		
Hospice Care	None	None
Hospital		
Professional Provider Services (when the professional provider is employed by the Hospital)		
Outpatient	None	None
Inpatient	None	None
Facility Services		
Outpatient	None	None
Inpatient	None	None
Maternity Services		
Professional Provider Services		
Outpatient	None	None
Inpatient	None	None
Facility Services		
Outpatient	None	None
Inpatient	None	None
Medical Supplies	None	None
Mental Health		
Professional Provider Services		
Outpatient	None	None
Inpatient	None	None
Facility Services		
Outpatient	None	None
Inpatient	None	None
Newborn Initial Care		
Professional Provider Services	None	None
Facility Services	None	None
Office Visit	None*	None*
*Deductible and Coinsurance do not apply to the Preventive Health Care services. Refer to the section entitled Preventive Health Care.		
Orthopedic Devices/Orthotic Devices	None	None
Prior Authorization from the Plan is recommended for the original purchase or replacement of orthopedic devices over $2,000. Please refer to the Utilization Management section.		
Other Facility Services – Inpatient and Outpatient	None	None
Physician Medical Services	None	None
Prescription Drugs		
Refer to the last page of this Schedule of Benefits.		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Preventive Health Care		
Preventive Services	None, No Deductible	None, No Deductible
Nutritional Education Counseling		
Tobacco Cessation Counseling – Maximum 3 visits per Benefit Period		
*Obesity Intervention Counseling for Participants – Maximum 26 visits per Benefit Period		
*18 or older with minimum BMI of 30		
Prostheses Benefit	None	None
Prior Authorization from the Plan is recommended for the original purchase or replacement of prosthetics over $2,000. Please refer to the Utilization Management section.		
Rehabilitation Therapy		
Professional Provider Services		
Outpatient	None	None
Inpatient	None	None
Facility Services		
Outpatient	None	None
Inpatient	None	None
Second Surgical Opinion	None	None
Substance Use Disorder		
Professional Provider Services		
Outpatient	None	None
Inpatient	None	None
Facility Services		
Outpatient	None	None
Inpatient	None	None
Surgery Center Services – Outpatient		
Professional Provider Services	None	None
Facility Services	None	None
Telehealth	None	None
Temporomandibular Joint Dysfunction	None	None
Lifetime maximum of $1,000 for surgical and nonsurgical services and supplies.		
Therapies – Outpatient		
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy		
Professional Provider Services	None	None
Facility Services	None	None
Refer to the Autism Spectrum Disorders section for information on autism spectrum disorder therapies.		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Transplants		
Professional Provider Services		
Outpatient	None	None
Inpatient	None	None
Facility Services		
Outpatient	None	None
Inpatient	None	None
Maximum Benefit for Organ Procurement, Including Donor Searches Per Transplant – $25,000		
Maximum Benefit for Commercial Air Travel Per Transplant – $10,000		
Urgent Care Urgent Care visit and any covered services provided during the urgent care visit. Deductible and Coinsurance apply to services provided during the Urgent Care visit. *Deductible and Coinsurance do not apply to the Preventive Health Care services. Refer to the section entitled Preventive Health Care.	None*	None*
Well-Child Care Services	None, No Deductible	None, No Deductible

PRESCRIPTION DRUG INFORMATION

	DEDUCTIBLE	COPAYMENT/ COINSURANCE
Prescription Drugs (The Prescription Drugs Benefit utilizes a Drug List.) Any Deductible, Copayment and/or Coinsurance do not apply to certain contraceptive products. Refer to the Preventive Health Care Benefit. Any Deductible and Coinsurance also do not apply to prescription smoking cessation products and over-the-counter smoking cessation aids/medications, for two 90-day treatment regimens.		
Deductible	Applies	
Out of Pocket Amounts		
Individual	$1,650	
Family	$3,300	
Once the HDHP Medical Deductible and Out of Pocket maximum has been satisfied, drugs will be covered as indicated below:		
Retail Pharmacy Prescriptions Copayments and/or Coinsurance for a 30-day supply are:		
Generic Drug:		$15
Preferred Brand-Name Drug:		$40
Non-Preferred Brand-Name Drug:		50%
Specialty Medications purchased at participating Specialty Pharmacies in the Blue Cross and Blue Shield Specialty Network Copayments and/or Coinsurance for a 30-day supply are:		
Generic Drug:		$150
Preferred Brand-Name Drug:		$150
Non-Preferred Brand-Name Drug:		$150
Mail Service Maintenance Prescriptions Copayments and/or Coinsurance for a 90-day supply are:		
Generic Drug:		$30
Preferred Brand-Name Drug:		$80
Non-Preferred Brand-Name Drug:		50%
Extended Supply Network Copayments and/or Coinsurance for up to a 90-day supply are:		
Generic Drug:		$45
Preferred Brand-Name Drug:		$120
Non-Preferred Brand-Name Drug:		50%
ACA Preventive Medications	Does Not Apply	

A covered insulin drug, regardless of the amount or type that is prescribed, will not exceed a $35 Copayment for a 30-day supply. Copayment accumulates to the Deductible.

Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

Please refer to Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefits section of this Plan Document for additional information.

SCHEDULE OF BENEFITS, continued

ADDITIONAL INFORMATION	MAXIMUM	DEDUCTIBLE	COINSURANCE
Dental Services (Non-Accident)			
Deductible:			
Individual		$25	
Type 1 – Diagnostic and Preventive Services		Applies	20%*
Type 2 – Basic Dental Services		Applies	20%*
Type 3 – Major Restorative Services		Applies	20%*
Maximum Benefit Per Benefit Period	$3,000		
*80% payment is based on allowable charges.			
Any Deductible and Coinsurance amounts do not apply to any other Deductible or Coinsurance amounts or to the Out of Pocket Amount provision.			

PROVIDERS OF CARE FOR PARTICIPANTS

The participation or nonparticipation of providers from whom a Participant receives services, supplies, and medication impacts the amount the Plan will pay and the Participant's responsibility for payment. Professional providers and facility providers are either In-Network or Out-of-Network providers. In-Network providers include Participating Providers and PPO providers. Out-of-Network providers are nonparticipating and non-PPO providers.

In-Network and Out-of-Network Professional Providers and Facility Providers

Professional providers include, but are not limited to, Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, audiologists, Advanced Practice Registered Nurses, midwives, physician assistants, naturopathic physicians, chiropractors, acupuncturists and physical therapists.

Facility providers include, but are not limited to, Hospitals, Rehabilitation Facilities, Home Health Agencies, Convalescent Homes, skilled nursing facilities, freestanding facilities for the treatment of Substance Use Disorder or Mental Illness, and free standing surgical facilities (surgery center).

The Participant may obtain a list of Participating Providers from the Claim Administrator free of charge by contacting the Plan at the number listed on the inside cover of this Plan Document.

Yellowstone County has established a separate program for the administration and payment of benefits for Outpatient Dialysis. The Outpatient Dialysis Program is described in the separately issued Outpatient Dialysis Plan Document. Please review that document for information about coverage for and administration of claims for Outpatient Dialysis.

PPO Providers

The Claim Administrator has a PPO Network of Hospitals and surgery centers in Montana that is utilized under this Benefit Plan. Outside of the state of Montana, there are also Blue Cross and/or Blue Shield PPO Hospitals and surgery centers nationwide. The Participant receives the In-Network Benefit when utilizing the PPO Network or the nationwide Blue Cross and/or Blue Shield PPO Hospitals and surgery centers. If the Participant obtains services or supplies from a non-PPO Network provider, the Out-of-Network Deductible and Coinsurance and Out of Pocket Amount will apply as indicated on the Schedule of Benefits.

The exceptions to the Benefit reduction are:

1. Emergency Services provided when a Participant cannot reasonably reach a PPO Network provider;
2. Nonemergency services for treatment of Mental Illness and/or Substance Use Disorder provided in an emergency setting; and/or
3. Services that are unavailable within the PPO Network.

If a Participant receives services from an out-of-state provider, then services must be provided by:

- Blue Cross and/or Blue Shield PPO facility providers; and/or
- Blue Cross and/or Blue Shield participating professional providers* or PPO professional providers.

*Some Blue Cross and/or Blue Shield Plans require services to be provided by a PPO professional provider for the Participant to receive the In-Network Benefits. Contact the Plan for additional information on out-of-state services. Emergency Services and services that are unavailable within the PPO Network will be covered as In-Network.

However, any nonparticipating provider or non-PPO provider can bill the Participant for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus any Deductible, Copayment and/or Coinsurance even if Prior Authorization was obtained for such services. The Participant will be responsible for the balance of the nonparticipating provider's or non-PPO provider's charges after payment by Blue Cross and Blue Shield of Montana and payment by the Participant of any Deductible, Copayment and/or Coinsurance.

Out of PPO Network Referrals

There may be circumstances under which the most appropriate treatment for the Participant's condition is not available through the PPO Network. When this occurs, it is recommended the Participant's attending Physician contact the Claim Administrator for an out of PPO Network referral. If the referral is not approved, and the Participant

chooses to obtain services from a non-PPO Network provider, the Participant will be responsible for the Out-of-Network Deductible and Coinsurance, in addition to any difference between the Blue Cross and Blue Shield of Montana Allowable Fee and the provider's billed charges.

If the Claim Administrator approves the referral, those services will process with the In-Network Deductible, Copayment and/or Coinsurance. However, any nonparticipating provider or non-PPO provider can bill the Participant for the difference between payment by the Claim Administrator and provider charges plus Deductible, Copayment and/or Coinsurance even if the Claim Administrator approves the referral.

How Providers are Paid by the Claim Administrator and Participant Responsibility

Payment by the Claim Administrator for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield of Montana provider network.

An **In-Network Provider** agrees to accept the payment of the Allowable Fee from the Claim Administrator for Covered Medical Expenses, together with any Deductible, Copayment and/or Coinsurance from the Participant, as payment in full. Generally, the Claim Administrator will pay the Allowable Fee for a Covered Medical Expense directly to Participating Provider or PPO Provider. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

Out-of-Network providers do not have to accept the Claim Administrator's payment as payment in full. Payment to a nonparticipating provider or a non-PPO provider for Covered Medical Expenses is based on the Allowable Fee. The nonparticipating provider or a non-PPO provider can bill the Participant for the difference between payment by the Claim Administrator and provider charges plus any Deductible, Copayment and/or Coinsurance. The Participant will be responsible for the balance of the nonparticipating provider's or a non-PPO provider's charges after payment by the Claim Administrator and payment of any Deductible, Copayment and/or Coinsurance.

Generally, the Claim Administrator will pay the Allowable Fee for Covered Medical Expenses directly to the Participant. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

How Providers are Paid by the Claim Administrator and Participant Responsibility Outside of Montana

Payment by the Claim Administrator for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield provider network in the state where services are provided.

An **In-Network Provider** agrees to accept payment of the Allowable Fee from the Claim Administrator for Covered Medical Expenses, together with any Deductible, Copayment and/or Coinsurance from the Participant, as payment in full. Generally, the Claim Administrator will pay the Allowable Fee for a Covered Medical Expense directly to Participating Provider or PPO Provider. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

Out-of-Network providers do not have to accept the Claim Administrator's payment as payment in full. Payment to a nonparticipating provider or a non-PPO provider for Covered Medical Expenses is based on the Allowable Fee. The nonparticipating provider or a non-PPO provider can bill the Participant for the difference between payment by the Claim Administrator and provider charges plus any Deductible, Copayment and/or Coinsurance. The Participant will be responsible for the balance of the nonparticipating provider's or a non-PPO provider's charges after payment by the Claim Administrator and payment of any Deductible, Copayment and/or Coinsurance.

The Claim Administrator will not pay for any services, supplies or medications which are not a Covered Medical Expense, or for which a Benefit maximum has been met, regardless of whether provided by a Participating Provider or a nonparticipating provider. The Participant will be responsible for all charges for such services, supplies, or medications.

Claim Payment Assignment

All benefits payable to the Participant which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Participant.

Claim Dispute

Once Covered Medical Expenses are rendered by a provider, the Participant has no right to request the Claim Administrator not to pay the claim submitted by such provider and no such request by a Participant or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Participant or any other person because of its rejection of such request.

Continuity of Care and Transitional Care

Although each Participant has a Primary Care Provider, a Participant may continue to receive services from the Participant's previous provider if the Participant is a new enrollee to the Plan, if the Blue Options Provider's or Participating Provider's contract is terminated without cause, or when the Blue Options Provider or Participating Provider voluntarily terminates the contract with the Plan, and the Participant:

1. Has a life threatening, disabling, or degenerative condition, or a serious acute condition requiring complex ongoing care. Coverage by the previous provider will be allowed for 90 days beginning on the date of the Participant's enrollment or the provider's termination.
2. Has a terminal illness with life expectancy of less than 6 months. Coverage by the previous provider will be allowed for 6 months from the date of the Participant's enrollment or to the date of death, whichever occurs first. If death does not occur within the first 6 months, the situation will be evaluated to determine if transition to the selected Primary Care Provider is appropriate.
3. Is in the second or third trimester of pregnancy. Coverage by the previous provider will be allowed through the completion of the postpartum period.

The previous provider must agree to meet the contractual terms applicable to comparable Blue Options Providers or Participating Professional Providers.

OUT-OF-AREA SERVICES – THE BLUECARD PROGRAM

Out-of-Area Services

Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever a Plan Participant obtains healthcare services outside of the Blue Cross and Blue Shield of Montana service area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program. The Inter-Plan Arrangements available to Participants under this Plan Document are described generally below.

Typically, when accessing care outside the Blue Cross and Blue Shield of Montana service area, the Plan Participant will obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, the Plan Participant may obtain care from nonparticipating healthcare providers. Blue Cross and Blue Shield of Montana payment practices in both instances are described below.

1. **BlueCard® Program**

   Under the BlueCard® Program, when a Plan Participant incurs Covered Medical Expenses within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Montana will remain responsible for fulfilling Blue Cross and Blue Shield of Montana's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   For inpatient facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the provider, and the Participant will be held harmless for the provider sanction.

Whenever the Plan Participant incurs Covered Medical Expenses outside the Blue Cross and Blue Shield of Montana service area and the claim is processed through the BlueCard Program, the amount the Plan Participant pays for Covered Medical Expenses is calculated based on the lower of:

a. The billed covered charges for the Plan Participant's covered services; or

b. The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Montana.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Plan Participant's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Plan Participant's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield of Montana uses for the Plan Participant's claim because they will not be applied retroactively to claims already paid.

Federal laws or the laws in a small number of states may require the Host Blue to add a surcharge to the Plan Participant's calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Blue Cross and Blue Shield of Montana would then calculate the Plan Participant's liability for any Covered Medical Expenses according to applicable law.

2. Value-Based Programs

a. BlueCard® Program

If a Plan Participant receives Covered Medical Expenses under a Value-Based Program inside a Host Blue's service area, the Plan Participant will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Cross and Blue Shield of Montana through average pricing or fee schedule adjustments.

b. Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Blue Cross and Blue Shield of Montana has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan Participant's employer on their behalf, Blue Cross and Blue Shield of Montana will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

3. Nonparticipating Healthcare Providers Outside of the Blue Cross and Blue Shield of Montana Service Area

a. Plan Participant Liability Calculation

When the Plan Participant incurs Covered Medical Expenses outside of the Blue Cross and Blue Shield of Montana service area for services provided by nonparticipating healthcare providers, the amount the Plan Participant pays for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Plan Participant may be liable for the difference between the amount that the nonparticipating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

b. Exceptions

In certain situations, Blue Cross and Blue Shield of Montana may use other payment bases, such as (i) The provider's billed charges for Covered Medical Expenses, (ii) the payment Blue Cross and Blue Shield of Montana would make if the Covered Medical Expenses had been received within the Blue Cross and Blue Shield of Montana service area, (iii) a special negotiated payment, or (iv) the lesser of any of the foregoing payment methods or the Allowable Fee determined for nonparticipating providers outside of Montana to pay for services provided by nonparticipating providers. In these situations, the Plan Participant may be liable for

the difference between the amount that the nonparticipating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

4. Blue Cross Blue Shield Global® Core

If the Participant is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), the Participant may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists the Participant with accessing a network of inpatient, Outpatient and professional providers, the network is not served by a Host Blue. As such, when the Participant receives care from providers outside the BlueCard service area, the Participant will typically have to pay the providers and submit the claims himself/herself to obtain reimbursement for these services.

If the Participant needs medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, the Participant should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if the Participant contacts the service center for assistance, Hospitals will not require the Participant to pay for covered inpatient services, except for the cost-share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Participant's claims to the service center to begin claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to receive reimbursement for Covered Medical Expenses.

The Participant must contact Blue Cross and Blue Shield of Montana to obtain Prior Authorization to verify that inpatient services are for the treatment of an Emergency Medical Condition.

b. Outpatient Services

Outpatient Services are available for the treatment of an Emergency Medical Condition. Physicians, urgent care centers and other Outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require the participant to pay in full at the time of service. The Participant must submit a claim to obtain reimbursement for Covered Medical Expenses.

c. Submitting a Blue Cross Blue Shield Global Core Claim

When the Participant pays for Covered Medical Expenses outside the BlueCard service area, the Participant must submit a claim to obtain reimbursement. For institutional and professional claims, the Participant should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the Participant claim. The claim form is available from the Plan, service center or online at www.bcbsglobalcore.com. If the Participant needs assistance with the Participant claim submission, the Participant should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

COMPLAINTS AND GRIEVANCES

Complaints and Grievances

The Plan has established a Complaint and Grievance process. A complaint involves a communication from the Participant expressing dissatisfaction about the Plan's services or lack of action or disagreement with the Plan's response. A grievance will typically involve a complaint about a provider or a provider's office and may include complaints about a provider's lack of availability or quality of care or services received from a provider's staff.

Most problems can be handled by calling Customer Service at the number appearing on the inside cover of this Plan Document. The Participant may also file a written complaint or grievance with the Claim Administrator. The fax number, email address, and mailing address of the Claim Administrator appears on the inside cover of this Plan Document. Written complaints or grievances will be acknowledged within 10 days of receipt. The Participant will be

notified of the Claim Administrator's response within 60 days from receipt of the Participant's written complaint or grievance.

APPEALS

Claims Procedures

Types of Claims

Claims are classified by type of claim and the timeline in which a decision must be decided and a notice provided depends on the type of claim involved. The initial Benefit claim determination notice will be included in the Participant's Explanation of Benefits (EOB) or in a letter from the Claim Administrator, whether adverse or not. There are five types of claims:

1. **Pre-Service Claims**

   A pre-service claim is any claim for a Benefit that, under the terms of this Plan Document, requires authorization or approval from the Claim Administrator or the Claim Administrator's subcontracted administrator prior to receiving the Benefit.

2. **Urgent Care Claims**

   An Urgent Care claim is any pre-service claim where a delay in the review and adjudication of the claim could seriously jeopardize the Participant's life or health or ability to regain maximum function or subject the Participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

3. **Post-Service Claims**

   A post-service claim is any claim for payment filed after a Benefit has been received and any other claim that is not a pre-service claim.

4. **Rescission Claims**

   A rescission of coverage is considered a special type of claim. A rescission is defined as any cancellation or discontinuation of coverage that has a retroactive effect and is based upon the Participant's fraud or an intentional misrepresentation of a material fact. A cancellation or discontinuance of coverage that has a retroactive effect is not a rescission if and to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage or to routine changes, such as eligibility updates. A cancellation or discontinuance with a prospective effect only is not a rescission.

5. **Concurrent Care Claim**

   A Concurrent Care decision represents a decision of the Claim Administrator approving an ongoing course of medical treatment for the Participant to be provided over a period of time or for a specific number of treatments. A Concurrent Care claim is any claim that relates to the ongoing course of medical or emergency treatment (and the basis of the approved Concurrent Care decision), such as a request by the Participant for an extension of the number of treatments or the termination by the Claim Administrator of the previously approved time period for medical treatment.

Initial Claim Determination by Type of Claim

1. **Pre-Service Claim Determination and Notice**

   a. Notice of Determination

      Upon receipt of a pre-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial determination, but no later than 15 days after receiving the claim.

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

The Claim Administrator may extend the 15-day time period for an additional 15 days for reasons beyond the Claim Administrator's control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which the Claim Administrator expects to render a decision.

2. For receipt of information from the Participant to decide the claim

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the Participant will be given 45 days from receipt of the notice within which to provide the specified information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

c. Notice of Improperly Submitted Claim

If a pre-service claim request was not properly submitted, the Claim Administrator will notify the Participant of the improper submission as soon as practicable, but no later than 5 days after the Claim Administrator's receipt of the claim and will advise the Participant of the proper procedures to be followed for filing a pre-service claim.

2. Urgent Care Claim Determination and Notice

a. Designation of Claim

Upon receipt of a pre-service claim, the Claim Administrator will make a determination if the claim involves Urgent Care. If a Physician with knowledge of the Participant's medical condition determines the claim involves Urgent Care, the Claim Administrator will treat the claim as an Urgent Care claim.

b. Notice of Determination

If the claim is treated as an Urgent Care claim, the Claim Administrator will provide the Participant with notice of the determination, either verbally or in writing, as soon as possible consistent with the Participant's medical exigencies but no later than 72 hours from the Claim Administrator's receipt of the claim. If verbal notice is provided, the Claim Administrator will provide a written notice within 3 days after the date the Claim Administrator notified the Participant.

c. Notice of Incomplete or Improperly Submitted Claim

If an Urgent Care claim is incomplete or was not properly submitted, the Claim Administrator will notify the Participant about the incomplete or improper submission no later than 24 hours from the Claim Administrator's receipt of the claim. The Participant will have at least 48 hours to provide the necessary information. The Claim Administrator will notify the Participant of the initial claim determination no later than 48 hours after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

3. Post-Service Claim Determination and Notice

a. Notice of Determination

In response to a post-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial **determination, but no later than 30 days after receiving the claim.**

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

The Claim Administrator may extend the 30-day timeframe for an additional 15-day period for reasons beyond the Claim Administrator's control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which the Claim Administrator expects to render a decision in such case.

2. For receipt of information from the Participant to decide the claim

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed. The Participant will be given 45 days from receipt of the notice to provide the information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator receives the specific information requested, or the due date for the information.

4. Concurrent Care Determination and Time Frame for Decision and Notice

a. Request for Extension of Previously Approved Time Period or Number of Treatments

1. In response to the Participant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Participant's claim involves Urgent Care, the Claim Administrator will review the claim and notify the Participant of its determination no later than 24 hours from the date the Claim Administrator received the Participant's claim, provided the Participant's claim was filed at least 24 hours prior to the end of the approved time period or number of treatments.

2. If the Participant's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Participant's claim will be treated as and decided within the timeframes for an Urgent Care claim as described in the section entitled, "Initial Claim Determination by Type of Claim."

3. If the Participant's claim did not involve Urgent Care, the time periods for deciding pre-service claims or post-service claims, as applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

Other than through a Plan amendment or termination, the Claim Administrator may not subsequently reduce or terminate an ongoing course of treatment for which the Participant has received prior approval unless the Claim Administrator provides the Participant with written notice of the reduction or termination and the scheduled date of its occurrence sufficiently in advance to allow the Participant to appeal the determination and obtain a decision before the reduction or termination occurs.

5. Rescission of Coverage Determination and Notice of Intent to Rescind

If the Claim Administrator makes a decision to rescind the Participant's coverage due to a fraud or an intentional misrepresentation of a material fact, the Claim Administrator will provide the Participant with a Notice of Intent to Rescind at least thirty (30) days prior to rescinding coverage. The Notice of Intent to Rescind will include the following information:

a. The specific reason(s) for the rescission that show the fraud or intentional misrepresentation of a material fact;

b. The date when the notice period ends and the date to which coverage is to be retroactively rescinded;

c. A statement that the Participant will have the right to appeal any final decision of the Claim Administrator to rescind coverage prior to or after the thirty (30) day period, and a description of the Claim Administrator's appeal procedures;

d. A reference to the Plan provision(s) on which the rescission is based; and/or

e. A statement that the Participant is entitled to receive upon request and free of charge reasonable access to, and copies of all documents and records and other information relevant to the rescission.

Notice of an Adverse Benefit Determination

An "adverse benefit determination" is defined as a rescission or a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Benefit. If the Claim Administrator's determination constitutes an adverse benefit determination, the notice to the Participant will include:

1. Information sufficient to identify the Benefit or claim involved, including, if applicable, the date of service, the health care provider, and the claim amount;
2. The reason(s) for the adverse benefit determination. If the adverse benefit determination is a rescission, the notice will include the basis for the fraud and/or intentional misrepresentation of a material fact;
3. A reference to the applicable Plan Document provision(s), including identification of any standard relied upon in the Plan to deny the claim (such as a Medical Necessity standard), on which the adverse benefit determination is based;
4. A description of the Claim Administrator's internal appeal and external review procedures (and for Urgent Care claims only, a description of the expedited review process applicable to such claims), a description of and contact information for any consumer appeal assistance program, and if applicable, a statement of the Participant's right to file a civil action under Section 502(a) of ERISA;
5. If applicable, a description of any additional information necessary to complete the claim and why the information is necessary;
6. If applicable, a statement that any internal Medical Policy or guideline or other medical information relied upon in making the adverse benefit determination, and an explanation for the same, will be provided, upon request and free of charge;
7. If applicable, a statement that an explanation for any adverse benefit determination that is based on an experimental treatment or similar Exclusion or limitation or a Medical Necessity standard will be provided, upon request and free of charge;
8. If applicable, a statement that diagnosis and treatment codes will be provided, and their corresponding meanings, upon request and free of charge; and
9. A statement that reasonable access to and copies of all documents and records and other information relevant to the adverse benefit determination will be provided, upon request and free of charge.

How to File an Internal Appeal of an Adverse Benefit Determination

1. **Time for Filing an Internal Appeal of an Adverse Benefit Determination**

   If the Participant disagrees with an adverse benefit determination (including a rescission), the Participant may appeal the determination within 180 days from receipt of the adverse benefit determination. With the exception of Urgent Care claims, the Participant's appeal may be made verbally or in writing, should list the reasons why the Participant does not agree with the adverse benefit determination, and must be sent to the address or fax number listed for appeals on the inside cover of this Plan Document. If the Participant is appealing an Urgent Care claim, the Participant may appeal the claim verbally by calling the telephone number listed for Urgent Care appeals on the inside cover of this Plan Document.

2. **Authorized Representative**

   The Participant may name another individual to act on the Participant's behalf for purposes of an appeal or review of an adverse benefit determination, by filing a written designation with the Claim Administrator. Contact the Claim Administrator at the number listed on the inside cover of this Plan Document for information on how to designate an authorized representative.

3. **Access to Plan Documents**

   The Participant may, at any time during the filing period, receive reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination upon request and free of charge. Documents may be viewed at the Claim Administrator's office, at 3645 Alice Street, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m. Mountain Time, Monday through Friday, excluding holidays. The Participant may also request that the Claim Administrator mail copies of all documentation to the Participant free of charge.

4. **Submission of Information and Documents**

   The Participant may present written evidence and written testimony, including any new or additional records, documents or other information that are relevant to the claim for consideration by the Claim Administrator until a final determination of the Participant's appeal has been made.

5. Consideration of Comments

The review of the claim on appeal will take into account all evidence, written testimony, new and additional records, documents, or other information the Participant submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial adverse benefit determination.

If the Claim Administrator considers, relies on or generates new or additional evidence in connection with its review of the Participant's claim, the Claim Administrator will provide the Participant with the new or additional evidence free of charge as soon as possible and with sufficient time to respond before a final determination is required to be provided by the Claim Administrator. If the Claim Administrator relies on a new or additional rationale in denying the Participant's claim on review, the Claim Administrator will provide the Participant with the new or additional rationale as soon as possible and with sufficient time to respond before a final determination is required to be provided by the Claim Administrator.

6. Scope of Review

The person who reviews and decides the Participant's appeal will be a different individual than the person who decided the initial adverse benefit determination and will not be a subordinate of the person who made the initial adverse benefit determination. The review on appeal will not give deference to the initial adverse benefit determination and will be made anew. The Claim Administrator will not make any decision regarding hiring, compensation, termination, promotion or other similar matters with respect to the individual selected to conduct the review on appeal based upon how the individual will decide the appeal.

7. Consultation with Medical Professionals

If the claim is, in whole or in part, based on medical judgment, the Claim Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not have been involved in the initial adverse benefit determination (nor have been a subordinate of any person previously consulted). The Participant may request information regarding the identity of any health care professional whose advice was obtained during the review of the Participant's claim.

Time Period for Notifying Participant of Final Internal Adverse Benefit Determination

The time period for deciding an appeal of an adverse benefit determination and notifying the Participant of the final internal adverse benefit determination depends upon the type of claim. The chart below provides the time period in which the Claim Administrator will notify the Participant of its final internal adverse benefit determination for each type of claim.

Type of Claim on Appeal	Time Period for Notification of Final Internal Adverse Benefit Determination
Urgent Care Claim	No later than 72 hours from the date the Claim Administrator received the Participant's appeal, taking into account the medical exigency.
Pre-Service Claim	No later than 30 days from the date the Claim Administrator received the Participant's appeal.
Post-Service Claim	No later than 60 days from the date the Claim Administrator received the Participant's appeal.
Concurrent Care Claim	• If the Participant's claim involved Urgent Care, no later than 72 hours from the date the Claim Administrator received the Participant's appeal, taking into account the medical exigency. • If the Participant's claim did not involve Urgent Care, the time period for deciding a pre-service (non-Urgent Care) claim or a post-service claim, as applicable, will govern.
Rescission Claim	No later than 60 days from the date the Claim Administrator received the Participant's appeal.

Content of Notice of Final Internal Adverse Benefit Determination

If the decision on appeal upholds, in whole or in part, the initial adverse benefit determination, the final internal adverse benefit determination notice will include the following information:

1. Information sufficient to identify the claim involved in the appeal, including, as applicable, the date of service, the health care provider, and the claim amount;
2. The title and qualifying credentials of each health care professional participating in the appeal;
3. A statement from each health care professional participating in the appeal of their understanding of the basis for the Participant's appeal;
4. The specific reason(s) for the final internal adverse benefit determination, including a discussion of the decision. If the final internal adverse benefit determination upholds a rescission, the notice will include the basis for the fraud or intentional misrepresentation of a material fact;
5. A reference to the applicable Plan Document provision(s), including identification of any standard relied upon in the Plan Document to deny the claim (such as a Medical Necessity standard), on which the final internal adverse benefit determination is based;
6. If applicable, a statement describing the Participant's right to request an external review and the time limits for requesting an external review;
7. If applicable, a statement that any internal Medical Policy or guideline or medical information relied on in making the final internal adverse benefit determination will be provided, upon request and free of charge;
8. If applicable, an explanation of the scientific or clinical judgment for any final internal adverse benefit determination that is based on a Medical Necessity or an experimental treatment or similar Exclusion or limitation as applied to the Participant's medical circumstances;
9. If applicable, a statement that diagnosis and treatment codes will be provided, with their corresponding meanings, upon request and free of charge;
10. A description of and contact information for any consumer appeal assistance program and a statement of the Participant's right to file a civil action under Section 502(a) of ERISA; and
11. A statement that reasonable access to and copies of all documents and records and other information relevant to the final internal adverse benefit determination will be provided, upon request and free of charge.

Deemed Exhaustion of Internal Appeal Process

1. The Participant will be deemed to have exhausted the internal appeal process and may request external review or pursue any available remedies under state law or a civil action under 502(a) of ERISA, if the Claim Administrator fails to comply with its claims and appeals procedures, except that claims and appeals procedures will not be deemed exhausted based on violations that are:
    a. De minimis;
    b. Non-prejudicial to the Participant;
    c. Attributable to good cause or matters beyond the Claim Administrator's control;
    d. In the context of an ongoing, good faith exchange of information between the Participant and the Claim Administrator; and
    e. Not reflective of a pattern or practice of violations by the Claim Administrator.
2. Upon request of the Participant, the Claim Administrator will provide an explanation of a violation within 10 days. The explanation will include a description of the basis for the Claim Administrator's assertion that the violation does not result in the deemed exhaustion of the Claim Administrator's internal claims and appeals procedures.
3. If the Participant seeks external or judicial review based on deemed exhaustion of the Claim Administrator's internal claims and appeals procedures, and the external reviewer or court rejects the Participant's request, the Claim Administrator will notify the Participant within a reasonable period of time, not to exceed 10 days, of the Participant's right to resubmit the Participant's internal appeal. The timeframe for appealing the adverse benefit determination begins to run when the Participant receives the notice of the right to resubmit the Participant's internal appeal.

External Review Procedures – In General

In most cases, and except as provided in the next two sections, the Participant must follow and exhaust the internal appeals process outlined above before the Participant may submit a request for external review. In addition, external review is limited to only those adverse benefit determinations that involve:

1. Rescissions of coverage; and

2. Medical judgment, including those adverse benefit determinations that are based on requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or adverse benefit determinations that certain treatments are experimental or investigational.

External review is not available for:

1. Adverse benefit determinations that are based on contractual or legal interpretations without any use of medical judgment; and
2. Adverse benefit determinations that are based on a failure to meet requirements for eligibility under a group health plan.

Standard External Review Procedures

There are two types of external review: a standard external review and an expedited external review. An expedited external review is generally based upon the seriousness of the Participant's medical circumstances and entitles the Participant to an expedited notice and decision-making process. The procedures for requesting standard (non-expedited) external reviews are discussed in this section. The procedures for requesting expedited external reviews are discussed in the next section.

1. **Request for a Standard External Review**

   The Participant or the Participant's authorized representative (hereafter, the Participant) must submit a written request to the Claim Administrator for a standard external review within 4 Months from the date the Participant receives an adverse benefit determination or a final internal adverse benefit determination.

2. **Preliminary Review**

   The Claim Administrator must complete a preliminary review within 5 business days from receipt of the Participant's request for a standard external review to determine whether:

   a. The Participant is or was covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Participant was covered under the Plan when the health care item or service was provided;
   b. The adverse benefit determination or final internal adverse benefit determination relates to the Participant's failure to meet the Plan's eligibility requirements;
   c. The Participant has exhausted (or is not required to exhaust) the Claim Administrator's internal appeals process; and/or
   d. The Participant has provided all the information and forms required to process the external review.

   Within 1 day after completing its review, the Claim Administrator will notify the Participant in writing if the request is eligible for external review. If further information or materials are necessary to complete the review, the written notice will describe the information or materials and the Participant will be given the remainder of the 4-Month period or 48 hours after receipt of the written notice, whichever is later, to provide the necessary information or materials. If the request is not eligible for external review, the Claim Administrator will outline the reasons for ineligibility in the notice and will provide contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

3. **Assignment of an IRO**

   If the Participant's request is eligible for external review, the Claim Administrator will within 1 business day assign the request for external review to an accredited Independent Review Organization (IRO) on a random basis or using another method of assignment that ensures the independence and impartiality of the assignment process, to conduct the external review. In making the assignment, the Claim Administrator will consider whether an IRO is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination. The Claim Administrator will also take into account other circumstances, including conflict of interest concerns.

4. **Initiation of External Review and Opportunity to Submit Additional Documents**

   Within 1 business day of assigning the IRO, the Claim Administrator will notify the Participant or the Participant's authorized representative in writing that the Claim Administrator has initiated an external review and that the Participant or the Participant's authorized representative may submit additional information to the IRO within 10

business days following the date of receipt of the notice for the IRO's consideration in its external review. The IRO may accept and consider additional information submitted after the 10 business days.

5. Claim Administrator Submission of Documents to the IRO

Within 5 business days after the date the IRO is assigned, the Claim Administrator must submit the documents and any information considered in making the benefits denial to the IRO. The Claim Administrator's failure to timely provide such documents and information will not constitute cause for delaying the external review. If the Claim Administrator fails to timely provide the documents and information, the IRO may terminate the external review and reverse the adverse benefit determination or final internal adverse benefit determination. If the IRO does so, it must notify the Participant and the Claim Administrator within 1 business day after making the decision.

6. Reconsideration by Claim Administrator

On receiving any information submitted by the Participant, the IRO must forward the information to the Claim Administrator within 1 business day. The Claim Administrator may then reconsider its adverse benefit determination or final internal adverse benefit determination. If the Claim Administrator decides to reverse its adverse benefit determination or final internal adverse benefit determination, the Claim Administrator must provide written notice to the Participant and IRO within 1 business day after making the decision. On receiving the Claim Administrator's notice, the IRO must terminate its external review.

7. Standard of Review

In reaching its decision, the IRO will review the claim and will not be bound by any decisions or conclusions reached under the Claim Administrator's internal claims and appeals process. In addition to the documents and information timely received, and to the extent the information or documents are available, the IRO will consider the following in reaching a decision:

a. The Participant's medical records;
b. The Participant's treating provider(s)'s recommendations;
c. Reports from appropriate health care professionals and other documents, opinions, and recommendations submitted by the Claim Administrator and the Participant;
d. The terms and conditions of the Plan, including specific coverage provisions, to ensure that the IRO's decision is not contrary to the terms and conditions of the Plan, unless the terms and conditions do not comply with applicable law;
e. Appropriate practice guidelines, which must include applicable Evidence-Based Standards;
f. Any applicable clinical review criteria developed and used by the Claim Administrator unless the criteria are inconsistent with the terms and conditions of the Plan or do not comply with applicable law;
g. The applicable Medical Policies of the Claim Administrator; and/or
h. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider them appropriate.

8. Written Notice of the IRO's Final External Review Decision

The IRO will send written notification of its decision to the Participant and to the Claim Administrator within 45 days after the IRO's receipt of the request for external review. The notice will include:

a. A general description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;
b. The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
c. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and Evidence-Based Standards;
d. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any Evidence-Based Standards relied on in making the decision;
e. A statement that the IRO's determination is binding, unless other remedies are available to the Claim Administrator or the Participant under state or federal law; and
f. A statement that judicial review may be available, to the Participant and the Plan.

9. Compliance with IRO Decision

If the IRO reverses the Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator will immediately provide coverage or issue payment according to the written terms and Benefits of the Plan Document.

Expedited External Review Procedures

In general, the same rules that apply to standard external review apply to expedited external review, except that the timeframe for decisions and notifications is shorter.

1. Request for Expedited External Review

Under the following circumstances, the Participant may request an expedited external review:

- **a.** If the Participant received an adverse benefit determination that denied the Participant's claim and: (1) the Participant filed a request for an internal Urgent Care appeal; and (2) the delay in completing the internal appeal process would seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function; or
- **b.** Upon receipt of a final internal adverse benefit determination which involves: (1) a medical condition of the Participant for which a delay in completing the standard external review would seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function; or (2) an admission, availability of care, a continued stay, or a health care item or service for which the Participant received Emergency Services, but has not been discharged from a facility.

2. Preliminary Review

Upon receiving the Participant's request for expedited external review, the Claim Administrator will immediately determine whether the request is eligible for external review, considering the same preliminary review requirements set forth in the Preliminary Review paragraph, Standard External Review Procedures section. After the preliminary review is complete, the Claim Administrator will immediately notify the Participant or the Participant's authorized representative in writing of its eligibility determination. If the request is not eligible for external review, the Claim Administrator will outline the reasons for ineligibility in the notice and will provide contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

3. Assignment of an IRO

If a request is eligible for expedited external review, the Claim Administrator will assign an IRO pursuant to and in compliance with the independence and other selection requirements set forth in the Assignment of an IRO paragraph, Standard External Review Procedures section. The Claim Administrator will transmit all documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO in as expeditious of a manner as possible (including by phone, facsimile, or electronically).

4. Standard of Review

In reaching its decision, the IRO will review the claim and will not be bound by any decisions or conclusions reached under the Claim Administrator's internal claims and appeals process. In addition to the documents and information timely received, and to the extent the information or documents are available, the IRO will consider the same documents and information set forth in the Standard of Review paragraph, Standard External Review Procedures section.

5. Notice of Final External Review Decision

The IRO will provide the Participant and the Claim Administrator with notice of its final external review decision as expeditiously as the Participant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO must provide written confirmation of its decision to the Participant and to the Claim Administrator within 48 hours after the date the IRO verbally conveyed the decision. The written notice will include:

- **a.** A description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;
- **b.** The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

c. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and Evidence-Based Standards;
d. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any Evidence-Based Standards relied on in making the decision;
e. A statement that the IRO's determination is binding, unless other remedies are available to the Claim Administrator or the Participant under state or federal law; and
f. A statement that judicial review may be available to the Participant or the Claim Administrator.

6. Compliance with IRO Decision

If the IRO reverses the Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator will immediately approve coverage that was the subject of the adverse benefit determination or final internal adverse benefit determination according to the written terms and Benefits of the Plan Document.

7. Inapplicability of Expedited External Review

An expedited external review may not be provided for retrospective adverse benefit determinations or retrospective final internal adverse benefit determinations.

UTILIZATION MANAGEMENT

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, inpatient admission and length of stay is based on the Claim Administrator's Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services being rendered, during the course of care, or after care has been completed as a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity Review. If requested, services normally subject to a Post-Service Medical Necessity Review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Refer to the definition of Medically Necessary in the Definitions section of this Plan Document for additional information regarding any limitations and/or special conditions pertaining to the Participant's Benefits.

Prior Authorization

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services described below for which the Participant has obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

If Prior Authorization is required, the review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions of this Plan Document. The Plan recommends the Participant confirm with the provider if Prior Authorization has been obtained.

To determine if a specific service or category requires Prior Authorization, visit the Claim Administrator's website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. The Participant can also call the Claim Administrator's Customer Service at the number on the back of the Participant's identification card.

Prior Authorization Responsibility

Participating Provider (In-Network) Prior Authorization

The Participant's Participating Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held financially responsible and will not be able to bill the Participant for the services.

For additional information about Prior Authorization for services outside of the Blue Cross and Blue Shield of Montana service area, see the section entitled, Out-of-Area Services – The BlueCard Program.

NOTE: Providers that contract with other Blue Cross and Blue Shield Plans may not be familiar with the Prior Authorization requirements of the Plan. Unless a provider contracts directly with the Plan as a Participating Provider, the provider is not responsible for being aware of the Plan's Prior Authorization requirements, except as described in the section entitled Out-of-Area Services – The BlueCard® Program.

Nonparticipating Provider (Out-of-Network) Prior Authorization

If any provider outside of Montana (except for those contracting as Participating Providers directly with the Plan) or any nonparticipating provider recommends an admission or a service that requires Prior Authorization, the provider is not obligated to obtain the Prior Authorization for the Participant. In such cases, it is the Participant's responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, the Participant may be entirely responsible for the charges if the service is determined to not be Medically Necessary. If the services were determined to be Medically Necessary, Out-of-Network Benefits will apply. The provider may call on the Participant's behalf, but it is the Participant's responsibility to ensure that the Plan is called.

Inpatient Admissions

The Participant's provider will need to obtain Prior Authorization from the Plan for an inpatient admission, if inpatient admissions are identified as needing a Prior Authorization. In the case of an elective inpatient admission, if services require an authorization it is recommended that the call for Prior Authorization should be made at least two working days before the Participant is admitted. If the admission is due to an Emergency Medical Condition and obtaining Prior Authorization would delay Emergency Services, it is recommended that Prior Authorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

If Prior Authorization is not obtained for inpatient services and the services are denied as not Medically Necessary, the Participating Provider will be held financially responsible and will not be able to bill the Participant for the services.

If the provider is not a network provider then the Participant, the Participant's provider, or the Participant's authorized representative should obtain Prior Authorization by the Plan by calling the toll-free number shown on the back of the Participant's identification card. The call should be made between 8:00 a.m. and 5:00 p.m., Mountain Time, on business days. After business hours or on weekends, please call the toll-free number listed on the back of the Participant's identification card. The Participant's call will be recorded and returned the next business day. A benefits management nurse will follow up with the Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if the Participant uses an In-Network provider or In-Network specialty care provider. If the Participant elects to use Out-of-Network providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not reasonably available from In-Network providers as defined by applicable law, and the Plan authorizes the Participant's visit to an Out-of-Network provider to be covered at the In- Network Benefit level prior to the visit, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When Prior Authorization of an inpatient admission is obtained, a length of stay is assigned. The Participant's provider may seek an extension for the additional days if the Participant requires a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the Length of Stay/Service Review subsection of this Plan Document.

If the Plan determines that the Participant's treatment does not require inpatient level of care, the Participant and the Participant's provider will be notified of that decision. If the Participant proceeds with an inpatient stay without the Plan's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant, the Participant's provider, or other appropriate party, as identified above, does not request Prior Authorization, the Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

For Behavioral Health Inpatient Hospital Admissions please see Contacting Behavioral Health section below.

Prior Authorization not Required for Maternity Care Unless Extension of Minimum Length of Stay Requested

The Plan is required to provide a minimum length of stay in a Hospital facility for the following:

Maternity Care

1. 48 hours following an uncomplicated vaginal delivery; or
2. 96 hours following an uncomplicated delivery by caesarean section.

The Participant or the Participant's provider will not be required to obtain Prior Authorization from the Plan for a length of stay less than 48 hours (or 96 hours) for Maternity Care. If the Participant requires a longer stay, the Participant, the Participant's authorized representative, or the Participant's provider must seek an extension for the additional days by obtaining Prior Authorization from the Plan.

Outpatient Service Prior Authorization Review

There may be general categories of covered Outpatient services that require Prior Authorization.

To determine if a specific service or category requires Prior Authorization, visit the Claim Administrator's website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. The Participant can also call Customer Service at the number on the back of the Participant's identification card.

For Behavioral Health Outpatient Service review please see Contacting Behavioral Health section below.

Prior Authorization Duration

A Prior Authorization is valid for at least three Months from the date the Participant's provider receives approval from the Plan. Actual availability of Benefits is subject to eligibility and other terms, conditions and limitations and Exclusions of this Plan Document.

It is NOT necessary to obtain Prior Authorization for standard x-ray and lab services or Routine office visits.

If the Plan does not approve the Outpatient Service, the Participant and the Participant's provider will be notified of that decision. If the Participant proceeds with the services without the Plan's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant, the Participant's provider, or other appropriate party, as identified above, does not request Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

Response to Prior Authorization Requests Involving Non-Urgent Care

Except in the case of a Prior Authorization request involving Urgent Care (see below), the Plan will provide a written response to the Participant's Prior Authorization request no later than seven business days following the date the Plan receives the Participant's request. This period may be extended one time for up to seven additional business days, if the Plan determines that additional time is necessary due to matters beyond our control.

If the Plan determines that additional time is necessary, the Plan will notify the Participant in writing, prior to the expiration of the original seven business day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Plan expects to make the determination. If an extension of time is necessary due to the need for additional information, the Plan will notify the Participant of the specific information needed, and the Participant will have 45 days from receipt of the notice to provide the additional information.

The Plan will provide a written response to the Participant's request for Prior Authorization within seven business days following either the receipt of the additional information or, if the additional information is not received, the deadline for the receipt of the additional information. The procedure for appealing an adverse Prior Authorization determination is set forth in the section entitled Complaints and Grievances.

Response to Prior Authorization Requests Involving Urgent Care

A Prior Authorization request involving Urgent Care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or in the opinion of a Physician

with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Prior Authorization request.

In case of a Prior Authorization request involving Urgent Care, the Plan will respond to the Participant no later than 48 hours after receipt of the request, unless the Participant fails to provide sufficient information, in which case, the Participant will be notified of the missing information within 24 hours of the Plan's receipt of the Urgent Care request and will have no less than 48 hours to provide the information. A response will be given as soon as possible (taking into account medical exigencies) but no later than 48 hours after the initial request, or, in the case where further information is requested, within 24 hours after the missing information is received or of the end of the period for the Participant to provide the missing information.

NOTE: The Plan's response to the Participant's Prior Authorization request involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Prior Authorization Required for Certain Prescription Drug Products and Other Medications

Prescription Drug Products, which are self-administered, process under the Prescription Drugs section of this Plan Document. There are other medications that are administered by a Covered Provider which process under the medical Benefits.

1. **Prescription Drugs – Covered Under the Prescription Drugs Benefit**

   Certain prescription drugs, which are self-administered, require Prior Authorization. Please refer to the Prescription Drugs section for complete information about the Prescription Drug Products that are subject to Prior Authorization, step therapy, and quantity limits, the process for requesting Prior Authorization, and related information.

2. **Other Medications – Covered Under Medical Benefits**

   Medications that are administered by a Covered Provider will process under the medical Benefits of this Plan Document. Certain medications administered by a Covered Provider require Prior Authorization. The medications that require Prior Authorization are subject to change by the Plan.

   In making determinations of coverage, the Plan may rely upon Pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in Montana, Medical Necessity, and Medical Policies. The Pharmacy policies and Medical Policies are located on the Plan website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.

   To determine which medications are subject to Prior Authorization, the Participant or provider should refer to the list of medications which applies to the Participant's Plan on the Plan website at www.bcbsmt.com or call the Customer Service toll-free number identified on the Participant's identification card or the Plan website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.

General Provisions Applicable to All Required Prior Authorizations

1. **No Guarantee of Payment**

   Prior Authorization does not guarantee payment of Benefits by the Plan. Even if the service has been approved through Prior Authorization, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible for coverage as of the date of service or the Participant's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Prior Authorization process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Prior Authorization, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

3. **Failure to Obtain Prior Authorization**

   If the Participant, the Participant's provider, or other appropriate party, as identified above, does not obtain Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is

determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

Length of Stay/Service Review

Length of stay/concurrent service review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions under this Plan Document.

Upon completion of the inpatient or emergency admission review, the Claim Administrator will send a letter to the Participant, the Participant's provider, behavioral health practitioner and/or Hospital or facility with a determination on the approved length of service or length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient Care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the Appeal Procedure section of this Plan Document.

A length of stay/service review, also known as a concurrent Medical Necessity review, occurs when the Participant, the Participant's provider, or other authorized representative submits a request to the Plan for continued services. If the Participant, the Participant's provider or the Participant's authorized representative requests to extend care beyond the approved time limit and it is a request involving Urgent Care or an ongoing course of treatment, The Plan will make a determination on the request as soon as possible but no later than 48 hours after it receives an urgent request, within 48 hours after it receives requested information (if the initial request is incomplete) or within seven business days after receipt of a non-urgent Concurrent Care request.

Recommended Clinical Review

A Recommended Clinical Review is a Medical Necessity review for a covered service that occurs before services are completed and helps limit the situations where the Participant may have to pay for a non-approved service. The Plan will review a Clinical Review request to determine if it meets the approved Claim Administrator's Medical Policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, the services will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit the Claim Administrator's website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed, or call Customer Service at the number on the back of the Participant's identification card. The Participant or provider may request a Recommended Clinical Review.

Please coordinate with the provider to submit a written request for Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is not a guarantee of Benefits or payment of Benefits by the Plan. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Plan Document. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible for coverage as of the date of service or the Participant's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

Contacting Behavioral Health

The Participant, the Participant's provider, or authorized representative may contact the Plan for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of the Participant's identification card and follow the prompts to the behavioral health unit. During regular business hours (7:00 a.m. and 5:00 p.m., Mountain Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 5:00 p.m., on weekends, and on holidays, the same behavioral health line is answered by clinicians available for inpatient acute Recommended Clinical Reviews only. Requests for residential or Partial Hospitalization are reviewed during regular business hours.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Participant eligibility, availability of Benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a post-service review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Plan Document. Post-Service Medical Necessity Review does not guarantee payment of Benefits by the Plan, for instance a Participant may become ineligible for coverage as of the date of service or the Participant's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Post-Service Medical Necessity Review process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

Care Management

The goal of Care Management is to help the Participant receive the most appropriate care that is also cost effective. If the Participant has an ongoing medical condition or a catastrophic Illness, the Participant should contact the Plan. If appropriate, a care manager will be assigned to work with the Participant and the Participant's providers to facilitate a treatment plan. Care Management includes Participant education, referral coordination, utilization review and individual care planning. Involvement in Care Management does not guarantee payment by the Plan.

ELIGIBILITY AND COVERAGE

Eligibility for Participation

The following Participants are eligible for participation in the Plan:

1. Employees who have completed the Eligibility Waiting Period and who are Actively Working at least 40 hours per week for full-time Employees and 20-39 hours per week for part-time Employees in the employ of entities eligible to participate in this health plan, or

2. Employees retiring from entities eligible to participate in this health plan and are under age of 65, and within 31 days of retirement have:

   a. Elected coverage, are at least age 50 (hired prior to July 1, 2011) or at least age 55 (hired July 1, 2011 or after), or on a disability retirement and are receiving a monthly pension benefit from Montana Public Employee Retirement Board (Defined Benefit Plan or Defined Contribution Plan); and
   b. Completed and filed with Yellowstone County, the Authorization for Deduction for Health Insurance Premium form: and
   c. Retirees satisfying the above criteria on the Defined Contribution pension plan may continue coverage by submitting full payment by personal check/bank bill pay to Yellowstone County. Additionally, those retirees on the Defined Contribution plan must take monthly deductions from their pension that are equal to the monthly insurance premium amount.

3. Officials, who have been elected to office and completed at least one term of office, who are terminating employment, under age 65, and within 31 days of leaving office have:

   a. Elected coverage; and

   b. Are at least age 50 (elected prior to July 1, 2011) or at least age 55 (elected July 1, 2011 or after). Retirees satisfying the above criteria, but receiving a Defined Benefit pension payment less than the amount of the health insurance premium, may continue coverage by submitting full payment by personal check to Yellowstone County. Premiums are requested by the 20th of each month for the following month's coverage. According to the terms of this contract, if a payment is not received by the due date (the first of the month) a 15-day grace period is allowed, but if full payment is not received within the grace period, the policy will be cancelled. Check should be made payable to Yellowstone County.

      Mail payments to:

      Yellowstone County
      Human Resources
      P.O. Box 35041
      Billings, MT 59107

Declining Coverage

If an eligible person, as outlined above, declines coverage under this Plan, the eligible person must state the reason(s) for declining coverage in writing. Failure to provide these reasons in writing may result in the Plan refusing enrollment at a later date or may require that the only time in the future the eligible person may enroll is during an open enrollment period, if applicable.

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time between the date of employment, or date in which the Employee meets the eligibility criteria specified above, and the first day of the calendar month following one entire calendar month of active employment. If the Employee begins work on the first workday of a calendar month, the date of employment will be considered to be the first day of the calendar month for the purpose of determining the date of eligibility. Any leave without pay of five scheduled work days or more will not qualify as time necessary to satisfy the Eligibility Waiting Period.

Enrollment

Each Employee must fill out and sign an enrollment card.

Effective Date of Coverage

An individual's coverage will be effective as follows:

1. Employees

   If Employee coverage is noncontributory, an Employee's coverage will be effective on the day he or she becomes eligible.

If Employee coverage is contributory, each Employee who both applies for coverage on a form approved by BCBSMT and agrees in writing to pay the required contributions, will become covered as follows:

If the Employee applies within 31 days of the date he or she first becomes eligible, he or she will be covered on the later of:

a. The date he or she applies; or
b. The date he or she becomes eligible.

2. Dependents

If dependent coverage is noncontributory, a dependent's coverage will be effective on the date he or she becomes eligible. The employee must be covered in order for his or her dependents to be covered.

If the dependent coverage is contributory, the Employee who both applies for dependent coverage on a form approved by BCBSMT and agrees in writing to pay the required contributions for dependents will become covered for his or her dependents as follows:

a. The date the employee applies for dependents coverage; or
b. The date the Employee becomes covered.

3. Employees and Dependents

a. If an Employee and spouse are both Employees of the group, any children shall be considered dependents of only one of the Employees, not both.
b. If an individual is not eligible because;

1) The Employee is not actively working for the Employer; and/or
2) The depend is confined in a Hospital or Skilled Nursing Facility;

The Employee will not become covered until the day he or she returns to full-time or qualified part-time active work and the dependent will not become covered if the Employee is not covered or if the dependent is confined in a Hospital or Skilled Nursing Facility.

Special Enrollment Period

A Special Enrollment Period is allowed with substantiating documentation for eligible Employees and/or dependents who are not currently enrolled and who originally declined coverage because they had other coverage, and:

- Whose other coverage was as a COBRA covered person and that coverage was exhausted, or
- Who lost eligibility for the prior coverage, or
- Who were covered on a group plan whose employer terminated contributions to that plan, and
- Who apply for coverage and submit required documentation under the current employer's plan within 31 days of the termination of such coverage.
- Who lost eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the Employee or Family Participant becomes eligible for financial assistance for group health coverage, under either the Children's Health Insurance Program or the Medicaid Program.

A Special Enrollment Period also occurs when there is a change in family status: a birth, adoption, marriage, divorce, death or loss of eligible coverage.

***Note:** "Period" is defined as the following:
1st of the month through the 14th of the month;
15th of the month through the last day of the month

- In the event of birth or adoption, the Employee and the Employee's dependents may enroll within 31 days of the birth or adoption. The effective date of the child will be the date of birth or adoption providing the new dependent was properly enrolled. The effective date of the dependents will be the first day of the period following birth or adoption.
- In the event of a marriage, an Employee previously eligible, but not enrolled, may enroll within 31 days after the marriage. The Employee's new spouse and/or children under the age of 26 may enroll within 31 days after the marriage. The effective date will be no later than the first day of the period beginning after the date the completed request for enrollment is received by the Plan.

- In the event of losing eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the Employee must request enrollment for the Employee or Family Participant not later than 60 days after the date of termination of coverage. The effective date will be no later than the first of the period beginning after the date the completed request for enrollment is received by the Plan.

  Note: Required documentation may be, but not limited to, one or more of the following:

  a. Certified marriage certificate;
  b. Declaration of marriage without solemnization certificate;
  c. Court adoption papers;
  d. Certified birth certificate;
  e. Employment paperwork showing separation of employment (i.e., reduction in force, termination letter, etc.);
  f. Certificate of Eligible Coverage.

Use of "Look-Back" Measurement Method to Determine Eligibility for the Yellowstone County Health Plan

The Affordable Care Act (ACA) imposes new rules governing offers of group health plan coverage by employers to their full-time employees. For this purpose, Yellowstone County has chosen to determine which employees are "full-time" employees under the "look-back measurement period." These rules will be included in your Summary Plan Description (SPD) beginning July 1, 2015. The purpose of this is to describe how the "look-back" measurement method applies to both newly hired and other "variable hour" employees. These rules are important, since they determine:

- The circumstances under which employees qualify for health insurance coverage and when; and
- How long an employee may continue health insurance coverage under the "Stability Period".

For health insurance purposes, upon hire an employee will be classified as regular full-time, regular part-time, temporary, variable hour, or seasonal employees:

- A "regular full-time" employee is an employee who is expected to work on average 40 hours per week during each calendar month.
- A "regular part-time" employee is an employee who is expected to work on average 20-39 hours per week during each calendar month.
- A "temporary full-time" employee (ACA definition) is an employee that is reasonably expected at his or her start date to work 30 or more hours per work for at least three (3) consecutive months or more.
- A "variable hour" employee is an employee who we cannot determine is reasonably expected to be employed on average at least 30 hours of service per week/130 hours per month (1,560 hours) during his or her "initial measurement period" (i.e. the 12-month period commencing the first day of the month following date-of-hire) because the employee's hours are variable or otherwise uncertain.
- A "seasonal" employee is an employee who is hired into a position for which the customary annual employment is six months or less in a 12-month period.

Changes in eligibility as a result of the Affordable Care Act's "30-hour" rule:

The "30-hour rule" includes two grouping of employees: Immediately Eligible and Not Immediately Eligible.

Immediately Eligible:

Employees classified as "regular full-time", "regular part-time" or "temporary full-time employee" will be eligible to participate in the Yellowstone County Health Plan on the first day of the calendar month following their hire date and one full calendar month of employment. (i.e. The employee is hired on January 15 the health insurance would become effective on March 1.)

Not Immediately Eligible:

"Variable hour" and "seasonal" employees must first complete a 12-month initial measurement period (that starts on the first day of the month following date of hire) during which they are not eligible to participate in the Yellowstone County Health Plan. At the completion of the initial measurement period, an employee who has averaged 30 hours per week/130 hours per month (1,560 hours) in the 12-month period will be eligible for coverage. Employees who qualify for coverage under this rule will remain eligible for a 12-month period (called the "stability period") irrespective of their hours, provided they remain employed. An employee who fails to work on average at least 30 hours per

week/130 hours per month (1,560 hours) during his or her initial measurement period is not eligible for coverage during the corresponding stability period.

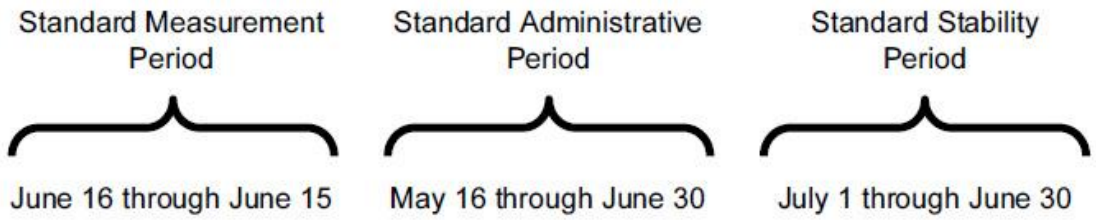
Yellowstone County has elected to use a 12-month standard measurement period. The initial measurement period will be from June 16, 2014 through June 15, 2015 and every June 16 through June 15 thereafter. Variable hour or seasonal employees meeting the required averaged 30 hours per week/130 hours per month (1,560 hours in a 12-month period) will be eligible for coverage. Those eligible variable hour and eligible seasonal employees will receive notice between May 16 and June 30, 2015 and every May 16 through June 30 thereafter (called the "administrative period") to elect or waive coverage for an effective date of July 1, 2015 and every July 1 thereafter.

In addition, where an employee experiences a break-in-service of at least 13-weeks, he or she may be treated as newly-hired upon their return. A similar result occurs under a "rule of parity" where a rehired employee may be treated as a new employee following a break of at least four (4) weeks if the employee's break in service is longer than the employee's period of service immediately preceding the break in service. (i.e. An employee worked for 6 weeks and then had a break in employment of 8 weeks, the employee will be considered a new hire.) If the break in service is less than four (4) weeks or less than the prior period of service, the employee will not be treated as a new hire and hours of service prior to and after the break will count during the measurement period.

New employees, not employed during the initial measurement period, must be evaluated on a "rolling basis". The hours of service will be tracked during both their "initial" measurement period which will begin as of the first of the month after their date of hire and the first standard measurement period that begins after their date of hire. New employees who work on average at least 30 hours per week/130 hours per month (1,560 hours in a 12-month period) will be offered health insurance coverage during the associated "stability" period.

Once an employee has worked through a full standard measurement period (June 16 – June 15), he or she is no longer classified as full-time, part-time, variable hour or seasonal. He or she would then be classified as an "on-going" employee and only tracked during the standard measurement period. An on-going employee who works on average at least 30 hours of service per week/130 hours per month (1,560 hours in 12 month period) during the annual standard measurement period will qualify for coverage during the upcoming stability period. An on-going employee who fails to work on average at least 30 hours per week/130 hours per month (1,560 hours in 12-month period) is not eligible for coverage during the corresponding stability period.

- The "standard 12-month measurement period" will be June 16 through June 15 annually.
- The "standard administrative period" will be from May 16 (corresponding year) through June 30.
- The "standard 12-month stability period" will be from July 1 through June 30 (corresponding year).



If you have questions about how these rules affect you, please contact Human Resources at 256-2705.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Participant can obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Claim Administrator.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

1. The Family and Medical Leave Act of 1993 (FMLA) requires employers, who employ at least 50 workers within a 75-mile radius of the workplace, to provide eligible employees with up to 12 weeks of leave during any 12-Month period for any of the following reasons:
   - **a.** To care for a newborn child;
   - **b.** Because a child has been placed with the employee for adoption or foster care;
   - **c.** To care for a Spouse, child, or parent of the employee;
   - **d.** The employee's own serious health condition makes the employee unable to perform his or her job.
2. Eligible employees are those who have been employed by the employer for at least 12 Months and who have worked at least 1,250 hours for that employer during the previous 12-Month period.
3. The health Benefits of an employee and Dependents, if any, will be maintained during FMLA leave on the same terms and conditions as if the employee had not taken leave.
4. The health Benefits of an employee and Dependents, if any, may lapse at the employer's discretion during FMLA leave because the employee does not pay his or her share of the premiums in a timely manner or the employee does not elect health Benefits during the FMLA leave. Upon return from leave, the employee and Dependents, if any, will be reenrolled in the health Benefit Plan as if the coverage had not lapsed.
5. The employee's reenrollment in the health Plan will be effective upon the date on which the employee returns to work.
6. An employee who takes FMLA leave and fails to pay any required premium contribution or fails to return from leave will be entitled to COBRA coverage for the maximum COBRA coverage period beginning when the FMLA coverage terminated.

TERMINATION OF COVERAGE

An individual's insurance will end automatically on the earliest of the following dates:

Note: "Period" is defined as the following: 1st of the month through 14th of the month
15th of the month through the last day of the month

1. The date this Plan ends
2. The end of the last period for which any required contribution agree to in writing has been made (1st – 14th; or 15th – last day of month);
3. The last day of the period in which he or she is no longer eligible for insurance;
4. The last day of the period in which Employee's employment with the Employer ends. Except that: The Employer may , at its option, continue insurance as shown below for individuals whose employment has ended, if it does so without individual selection between Employees and if it continues making premium payments for those individuals.

   Coverage will terminate automatically at midnight, Mountain Time, on the last day of the Month in which a child reaches age 26 years. Coverage for a Spouse will terminate at midnight, Mountain Time, on the last day of the Month in which the Spouse's marriage to the Employee is terminated.

   Insurance may be continued for all Benefits for:

   - An Employee on an approved leave of absence; or
   - An employee temporarily laid off; or
   - An Employee unable to work because of disability.

   Employee should refer to the Employee Handbook and/or Collective Bargaining Agreement for more specific information.

   The Employer may, at its option, continue Employee's insurance for up to 12 Months if the Employee's insurance would otherwise end due to his or her work schedule reducing to less than the minimum time required to qualify

for coverage, provided the Employer does so without individual selection among Employees and provided that premium payments are continued for those individuals.

No Benefits are payable for charges incurred after an individual's insurance ends.

Termination of Benefits on Termination of Coverage

When the participation of an eligible Employee and/or Family Members is terminated for any reason listed in this section or any other section of this Plan, the Benefits of this Plan will no longer be provided, and the Plan will not make payment for services provided to the Employee and/or Family Members after the date on which cancellation becomes effective.

Certificate of Creditable Coverage

Even though this health plan does not have a preexisting condition exclusion period, the Claim Administrator will issue a Certificate of Creditable Coverage to the Participant, upon request, following termination of coverage.

CONTINUATION OF COVERAGE

COBRA

Certain employers maintaining group health coverage plans (whether insured or self-insured) must provide COBRA continuation coverage for qualified beneficiaries when group health coverage is lost. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). To lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before a qualifying event. A loss of coverage need not occur immediately after a qualifying event so long as the loss of coverage occurs before the end of the maximum COBRA coverage period. A qualified beneficiary is entitled to the coverage made available to similarly situated employees.

COBRA requires qualified beneficiaries or a representative acting on behalf of a qualified beneficiary to provide certain notices to the Plan Administrator (generally the employer) and requires the Plan Administrator to provide certain notices to qualified beneficiaries. The Plan Administrator is also the COBRA Administrator unless the Plan Administrator has designated another individual or entity to administer COBRA.

1. Small Employer Exception

Small employer plans are generally exempt from the COBRA regulations. A small employer plan, for the purposes of COBRA, is defined as an employer plan that normally employed fewer than 20 employees, including part-time employees, during the preceding calendar year. A group health plan that is a multi-employer plan (as defined in Internal Revenue Code (IRC)) is a small-employer plan if each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. Whether the plan is a multi-employer plan or not, the term employer includes all members of a controlled group.

A small employer employs fewer than 20 employees during a calendar year if it had fewer than 20 employees on at least 50 percent of its typical business days during that year. Only common-law employees are counted for purposes of the small employer exception; self-employed individuals, independent contractors (and their employees and independent contractors), and corporate directors are not counted.

2. Qualified Beneficiaries

Continuation of coverage is available to qualified beneficiaries. A qualified beneficiary is:

a. Any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the Spouse of a covered employee, or the Dependent child of a covered employee; or
b. Any child born to or placed for adoption with a covered employee during a period of COBRA continuation.

Individuals added to a qualified beneficiary's COBRA coverage (e.g., a new Spouse or person added as the result of a Special Enrollment event, etc.) do not become qualified beneficiaries in their own right, with the exception of 2(b) above.

Nonresidents - An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of IRC section 911(d)(2)) that constituted income from sources within the United States (within the meaning of IRC section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

3. Qualifying Events

A qualifying event is any of a set of specified events that occur while a group health plan is subject to COBRA and which causes a qualified beneficiary to lose coverage under the plan.

a. Employee

An employee will become a qualified beneficiary if the employee loses coverage under the plan because either one of the following qualifying events happen:

1. Employee's hours of employment are reduced; or
2. Employment ends for any reason other than gross misconduct.

b. Spouse

The Spouse of an employee will become a qualified beneficiary if the Spouse loses coverage under the plan because any of the following qualifying events happen:

1. The employee dies;
2. The employee's hours of employment are reduced;
3. The employee's employment ends for any reason other than gross misconduct;
4. The employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. Divorce or legal separation from the employee.

c. Dependent Children

Dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happen:

1. The employee dies;
2. The employee's hours of employment are reduced;
3. The employee's employment ends for any reason other than gross misconduct;
4. The employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The employee becomes divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "Dependent child."

d. Retirees

If the plan provides retiree health coverage, a proceeding in bankruptcy under Title 11 of the United States Code can sometimes 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 for any retired employee covered under the plan, the covered retiree will become a qualified beneficiary with respect to the bankruptcy. The covered retiree's covered Spouse or surviving Spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

4. Period of Coverage

a. A qualified beneficiary may continue coverage for up to 18 months when the employee loses coverage under the plan due to one of the following qualifying events:

1. A reduction in work hours; or
2. Voluntary or involuntary termination of employment for reasons other than gross misconduct.

b. A qualified beneficiary may continue coverage for up to 36 months when the qualified beneficiary loses coverage under the plan due to one of the following qualifying events:

1. The employee's death;
2. Divorce or legal separation from the employee;
3. The covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or
4. A covered Dependent child ceases to be a Dependent child of the covered employee under the terms of the group health plan.

c. Bankruptcy

If the employer files Chapter 11 bankruptcy which results in loss of coverage (or substantial elimination of coverage within one year before or after bankruptcy is filed), a qualified beneficiary may continue coverage up to the following applicable periods:

1. Covered retiree: The maximum duration of the COBRA coverage is the lifetime of the retired covered employee.
2. Covered Spouse, surviving Spouse, or Dependent child of covered retiree: The maximum duration of the COBRA coverage ends the earlier of:

   a. The date of death (of the Spouse, surviving Spouse or Dependent child); or
   b. 36 months after the death of the covered retiree.

5. Providing Notice of Qualifying Events

a. Responsibilities of Qualified Beneficiaries

1. General Notice Requirements

The qualified beneficiary or a representative of the qualified beneficiary must notify the administrator of the qualifying events listed below within 60 days after the latest of (1) the qualifying event; (2) the loss of coverage, or (3) the date that the qualified beneficiary receives information concerning COBRA coverage in a General Notice.

   a. Divorce or legal separation;
   b. Covered Dependent child ceases to be a Dependent child of a covered employee under terms of the plan; or
   c. A second qualifying event. (See 5(a)(2)).

Notification of a qualifying event must be timely mailed to the Plan Administrator (generally the Participant's employer), or to the entity identified as the COBRA Administrator in the General COBRA Notice provided to the Participant upon enrollment or when the Participant's coverage is terminated. **Important Information: If notices are not received within the timeframes specified below, the qualified beneficiary will not be provided COBRA coverage.**

A single notice sent by or on behalf of the covered employee or any one of the qualified beneficiaries affected by the qualifying event satisfies the notice requirement for all qualified beneficiaries.

The following information should be included:

   a. Name of covered employee;
   b. Subscriber identification number;
   c. Employee and qualified beneficiary names, address and telephone number (also note any different addresses for other qualified beneficiaries);
   d. Employer/former employer;
   e. Whether the event is a qualifying event, disability, or second qualifying event; and
   f. Date of qualifying event.

Certain COBRA qualifying events have additional notice requirements which are explained in more detail below.

2. Second Qualifying Event

The qualified beneficiary or a representative of the qualified beneficiary must notify the administrator within 60 days of a second qualifying event. **Important Information: If notice is not received within the timeframes specified below, an extension of COBRA coverage will not be provided to the qualified beneficiary.**

The initial 18-month COBRA coverage period may be extended for an additional 18 months (for a total of 36 months) for Spouses and Dependents who initially elected COBRA coverage if:

a. The first qualifying event is the employee's termination of employment or reduction in hours;
b. The second qualifying event occurs during the initial 18-month COBRA coverage period;
c. The second qualifying event has a 36-month maximum coverage period (see Period of Coverage (4)(b)); and
d. The second qualifying event is one that would have caused loss of coverage in the absence of the first qualifying event.

If COBRA coverage was previously extended from 18 months to 29 months due to a Medicare disability determination, the maximum COBRA coverage period under a second qualifying event will be 36 months.

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the Spouse and Dependent children will end 36 months from the date the employee became entitled to Medicare as a result of turning 65 (but the covered employee's maximum coverage period will be 18 months).

3. Disability Extension

A qualified beneficiary may be entitled to a disability extension of up to 11 additional months. If a qualified beneficiary is entitled to the extension, which shall not extend the total period of continuation coverage beyond 29 months, the extension applies to each qualified beneficiary who is not disabled, as well as to the disabled beneficiary, and it applies independently with respect to each of the qualified beneficiaries.

To qualify for a disability extension, the following requirements must be met:

a. The qualifying event must be a termination or reduction of hours of a covered employee's employment; and
b. The qualified beneficiary must have been determined under Title II or XVI of the Social Security Act (SSA) to be disabled at any time during the first 60 days of the COBRA continuation coverage.

Individuals who have been determined by SSA to be disabled prior to the occurrence of a qualifying event and the disability continues to exist at the time of the qualifying event, qualified beneficiaries are considered to meet the statutory requirements of being disabled within the first 60 days of COBRA coverage.

In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption.

The qualified beneficiary must provide a disability notice before the end of the first 18 months of coverage.

The qualified beneficiary or a representative of the qualified beneficiary must also provide notice to the administrator within 30 days after the date of any final determination under the SSA that the qualified beneficiary is no longer disabled. Coverage will be terminated the later of (1) the first day of the month that is more than 30 days after a final determination by SSA that the individual is no longer disabled; or (2) the end of the COBRA period that applies without regard to the disability extension.

b. Responsibilities of Plan Administrator

The Plan Administrator must notify the party responsible for administering COBRA within 30 days of the following events.

1. The employee's death;
2. The employee's termination (other than for gross misconduct);
3. Reduction in work hours of employment;
4. A proceeding in bankruptcy with respect to an employer from whose employment a covered employee retires; and
5. The covered employee becomes entitled to Medicare.

c. Responsibilities of the COBRA Administrator

The COBRA administrator must notify qualified beneficiaries of their right to COBRA coverage within 14 days after receiving notice of a qualifying event by providing qualified beneficiaries with a COBRA Election form.

If the Plan Administrator is the COBRA administrator, the Plan Administrator must notify qualified beneficiaries of their right to COBRA coverage within 44 days after receiving notice of a qualifying event.

6. Election of COBRA Coverage - Notice Requirements

After a qualified beneficiary or COBRA administrator has provided notice of a qualifying event, the qualified beneficiary will receive a COBRA Election form.

Each qualified beneficiary has an independent right to elect COBRA coverage. The qualified beneficiary or a representative of the qualified beneficiary must return the COBRA Election form to the administrator within 60 days from the date on the COBRA Election form. **Important Information: If the COBRA Election form is not returned within the 60-day timeframe, COBRA coverage will not be provided to any qualified beneficiaries.**

7. Trade Adjustment Assistance Eligible Employees

Employees who lost coverage as the result of a termination or a reduction of hours and who qualify for “Trade Adjustment Assistance” (“TAA”) under the Trade Act of 1974, as amended, are entitled to a second opportunity to elect COBRA coverage, if such coverage was not elected within the first 60 days after coverage is lost.

The second COBRA election period provisions are effective for individuals with respect to whom petitions for certification for trade adjustment assistance are filed on or after November 4, 2002. The second election period begins on the first day the employee began receiving TAA (or would have become eligible to begin receiving TAA but for exhaustion of unemployment compensation), but only if made within months after group health coverage is lost. Notice must be provided in accordance with “Responsibility of Qualified Beneficiary” above.

This coverage may continue for 18 months from the date COBRA coverage begins. When the employee elects coverage, the election can include coverage for previously covered Dependents. Dependents are not qualified beneficiaries in their own right under this provision and therefore do not have an independent election.

8. Payment of Premium

The first premium payment must be made within 45 days of the date of the election of COBRA continuation coverage and must include payments retroactive to the date coverage would normally have terminated under this plan.

Subsequent payments must be made within 30 days after the first day of each coverage period. Payment is considered to be made on the date payment is sent to the employer or COBRA administrator. If the premium is not paid by the first day of the coverage period, a grace period of 30 days will be allowed for payment. The Participant may instead request to be billed for continuation coverage for the following coverage periods: quarterly, semi-annually or annually.

9. Termination of Continued Coverage

a. Coverage terminates the last day of the maximum required period under COBRA;
b. Any of the following events will result in termination of coverage prior to expiration of the 18-Month, 29-Month, or 36-Month period:

1. The first day on which timely payment is not made with respect to the qualified beneficiary;
2. The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

3. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes covered under any other group health plan; or
4. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

10. Questions Concerning COBRA Coverage

For any questions concerning COBRA coverage, contact the Claim Administrator at 1-855-258-3489.

11. Provide Notice of Address Changes

In order to protect all COBRA rights, Participants must notify the administrator of the COBRA coverage and the Claim Administrator of any changes to the Participant's or Family Member's addresses. A Participant should also keep a copy of any notices for personal records.

BENEFITS

The Plan will pay for the following Benefits provided by a Covered Provider based on the Allowable Fee and is subject to any Deductible, Copayment and/or Coinsurance and other provisions, as applicable.

Please note that services must be determined to be Medically Necessary by the Plan in order to be covered. Coverage of Benefits is subject to Blue Cross and Blue Shield of Montana policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, Utilization Management, and clinical payment and coding policies, which may be updated throughout the plan year. The policies and guidelines are resources utilized by Blue Cross and Blue Shield of Montana when making coverage determinations and lay out the procedure and/or criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Medical Expense or is not eligible for coverage as not Medically Necessary, Experimental/Investigational/Unproven, cosmetic, a convenience item, or a Plan Document Exclusion.

The clinical payment and coding policies are intended to ensure the creation and submission of accurate documentation of the services performed and require all providers to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Under the clinical payment and coding policies, claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Provider claims are subject to the code edit protocols for services/procedures billed as well as to other applicable claim review which may include, but is not limited to, review of any terms of Benefit coverage, provider contract language, medical and medical management policies, utilization or clinical review or Utilization Management policies, medical records, clinical payment and coding policies as well as coding software logic, including but not limited to, lab management or other coding logic or edits.

Any line on the claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included as a Covered Medical Expense and will not be eligible for payment by the Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the provider rendering the item or service or submitting the claim is In-Network or Out-of-Network. The most up-to-date medical policies and clinical procedure and coding policies are available at www.bcbsmt.com or by contacting Customer Service at the number shown on the Participant's identification card.

Accident

Services which are provided for bodily injuries resulting from an Accident.

Acupuncture

Services provided by a licensed acupuncturist to treat Illness or Injury.

Advanced Practice Registered Nurses and Physician Assistants - Certified

Services provided by an Advanced Practice Registered Nurse or a Physician Assistant-Certified who is licensed to practice medicine in the state where the services are provided and when payment would otherwise be made if the same services were provided by a Physician.

Ambulance

Licensed ground and air ambulance transport required for a Medically Necessary condition to the nearest appropriate site.

Anesthesia Services

Anesthesia services provided by a Physician (other than the attending Physician) or nurse anesthetist including the administration of spinal anesthesia and the injection or inhalation of a drug or other anesthetic agent.

The Plan will not pay for:

1. Hypnosis;
2. Local anesthesia or intravenous (IV) sedation that is considered to be an Inclusive Service/Procedure;
3. Anesthesia consultations before surgery that are considered to be Inclusive Services/Procedures because the Allowable Fee for the anesthesia performed during the surgery includes this anesthesia consultation; or
4. Anesthesia for dental services or extraction of teeth, except anesthesia provided at a Hospital in conjunction with dental treatment will be covered only when a nondental physical Illness or Injury exists which makes Hospital care Medically Necessary to safeguard the Participant's health. Dental services and treatment are not a Benefit of this Plan Document, except:
    a. As specifically included in the Dental Accident Benefit; or
    b. Anesthesia Services associated with any Medically Necessary dental procedure when provided to a Participant who is severely disabled; or who has a medical or emotional condition which requires **h**ospitalization or general anesthesia for dental care; or who, in the judgment of the treating provider, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

Approved Clinical Trials

Routine Patient Costs provided in connection with an Approved Clinical Trial.

Autism Spectrum Disorders

Diagnosis and treatment of autistic disorder, Asperger's Disorder or Pervasive Developmental Disorder.

Covered services include:

1. Habilitative Care or Rehabilitative Care, including, but not limited to, professional, counseling and guidance services and treatment programs; Applied Behavior Analysis (ABA), also known as Lovaas Therapy; discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention;
2. Medications;
3. Psychiatric or psychological care; and
4. Therapeutic care provided by a speech-language pathologist, audiologist, occupational therapist or physical therapist.

Birthing Centers

Services for the delivery of a newborn provided at a birthing center.

Blood Transfusions

Blood transfusions, including the cost of blood, blood plasma, blood plasma expanders and packed cells. Storage charges for blood are paid when a Participant has blood drawn and stored for the Participant's own use for a planned surgery.

Breast Examinations (Preventive and Medical)

Mammography examinations.

The minimum mammography examination recommendations are:

1. One baseline mammogram for women ages 35 through 39.
2. One mammogram every two years for women ages 40 through 49, or more frequently as recommended by a Physician.
3. One mammogram every year for women age 50 or older.

Chemotherapy

The use of drugs approved for use in humans by the U.S. Food and Drug Administration (FDA) and ordered by the Physician for the treatment of disease.

Chiropractic Services

Services of a licensed chiropractor.

The Schedule of Benefits describes payment limitations for these services.

Contraceptives

Services and supplies related to contraception, including but not limited to, oral contraceptives, contraceptive devices and injections, subject to the terms and limitations of the Plan Document.

Deductible and Coinsurance do not apply to contraceptives covered under the Preventive Health Care Benefit, whether provided during an office visit or through the Prescription Drugs Benefit.

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Convalescent Home Services

Services of a Convalescent Home as an alternative to Hospital Inpatient Care. The Plan will not pay for Custodial Care.

NOTE: The Plan will not pay for the services of a Convalescent Home if the Participant remains inpatient at the Convalescent Home when a skilled level of care is not Medically Necessary.

Prior Authorization is required for Convalescent Home services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

The Schedule of Benefits describes payment limitations for these services.

Dental Accident Services

Dental services provided by Physicians, dentists, oral surgeons and/or any other provider are not covered under this Plan Document except that, Medically Necessary services for the initial repair or replacement of sound natural teeth which are damaged as a result of an Accident, are covered, except that orthodontics, dentofacial orthopedics, or related appliances are not covered, even if related to the Accident.

The Plan will not pay for services for the repair or replacement of teeth which are damaged as the result of biting and chewing. Damage to teeth as a result of biting and chewing will not be considered an Accident.

Dental Services (Non-Accident)

Type 1 – Diagnostic and Preventive Services – Paid at 80%* once the deductible has been met.

1. Dental examinations.
2. Emergency treatment of dental pain (including emergency exams).
3. Bitewing x-rays (maximum of two sets per Benefit Period).
4. Complete mouth x-rays (once every three years and this will count as one of the two sets of x-rays payable during that Benefit Period).
5. Oral prophylaxis (cleaning limited to maximum of two per Benefit Period)
6. Topical application of fluoride limited to dependent children under the age of 19. Maximum of two per Benefit Period.
7. X-rays (in addition to panoramic-full mouth and bitewings). No limit on single x-rays.
8. Dental sealants are covered with no age limit and payable once per tooth per lifetime.
9. Space maintainers (not including orthodontics) Once per tooth per lifetime per tooth area. No Age max.
10. Nightguards (occlusal guards for bruxism)

Type 2 – Basic Dental Services – Paid at 80%* once the deductible has been met.

1. Oral surgery , removal of impacted teeth
2. Extractions.
3. General anesthesia when administered with oral surgery.
4. Restorations using amalgam and composite resin. No frequency limit.
5. Repair of crowns, temporary crowns, stainless steel crowns. No frequency limit.
6. Endodontics. No frequency limit.
7. Periodontics. Perio maintenance limited to four times per benefit period. Scaling/Planning, limited to one per quadrant every 24 months.
8. Repair and/or relining or rebasing of existing complete or partial dentures and bridges. No frequency limit.
9. Sterile tray for extractions and surgical procedures.
10. Crown lengthening with prior authorization. No frequency limit.

Type 3 – Major Restorative Services – Paid at 80%* once the deductible has been met.

1. Fixed bridges, removable partial dentures, removable complete dentures, limited to once every five years.
2. Restorations using gold foil, gold inlays and porcelain, limited to once every 5 years.
3. Implants, crowns (single restorations once every five years), labial veneers with prior authorization (benefits available for composite bonded veneers with used for restoration of extensive caries or fractures but not for cosmetic purposes). No frequency limit on implants/veneers.

*80% is based on the allowed charges.
No orthodontic coverage.

The Plan will not pay for:

1. Services and supplies which are excluded under the base Plan, unless the exclusion is specifically modified in this plan.
2. Any service for which Benefits were received under any other plan offered by the Employer and administered by Blue Cross and Blue Shield of Montana
3. Any service not provided or prescribed by a Dentist or Denturist.
4. Services for which there is no legal obligation to pay.
5. Any experimental procedure, services or treatments.
6. Any service not required and provided in accordance with accepted standards of dental practice.
7. Replacing any lost or stolen appliance or any appliance damaged when not in the mouth.
8. Any services provided for cosmetic purposes, including teeth bleaching.
9. Precision attachments for cosmetic purposes.
10. Characterization dentures.
11. Services, appliances or restorations used primarily to increase vertical dimensions or to restore occlusion.

12. Patient education in oral hygiene and dietary planning.
13. Interim (temporary) dentures.
14. Local anesthesia.
15. Desensitizing medications.

Out-of-Network providers may bill the Participant the difference between the Allowable Amount and the provider's charge even if Prior Authorization is obtained for the service, or if treatment is provided for Emergency Services. Any billing by the Provider is in addition to any applicable Deductible, Copayment and/or Coinsurance for which the participant is responsible.

Diabetes Treatment (Office Visit)

Services and supplies for the treatment of diabetes provided during an office visit. For additional Benefits related to the treatment of diabetes, e.g., surgical services and medical supplies, refer to that specific Benefit.

Diabetic Education

Outpatient self-management training and education services for the treatment of diabetes provided by a Covered Provider with expertise in diabetes.

NOTE: Benefits for outpatient diabetic self-management training and education are not subject to any visit limitations.

The Schedule of Benefits describes payment limitations for these services.

Diagnostic Services

Diagnostic x-ray examinations, laboratory and tissue diagnostic examinations and medical diagnostic procedures (machine tests such as EKG, EEG) are covered. Covered services include, but are not limited to, the following:

1. X-rays and Other Radiology. Some examples of other radiology include:
   a. Computerized tomography scan (CT Scan).
   b. MRIs.
   c. Nuclear medicine.
   d. Ultrasound.
2. Laboratory Tests. Some examples of laboratory tests include:
   a. Urinalysis.
   b. Blood tests.
   c. Throat cultures.
3. Diagnostic Testing. Tests to diagnose an Illness or Injury. Some examples of diagnostic testing include:
   a. Electroencephalograms (EEG).
   b. Electrocardiograms (EKG or ECG).

This Benefit does not include diagnostic services such as biopsies which are covered under the surgery Benefit.

Dialysis Treatment - Outpatient

For Outpatient Dialysis, see separate Outpatient Dialysis Plan Document.

Durable Medical Equipment

The appropriate type of equipment used for therapeutic purposes where the Participant resides. Durable medical equipment, which requires a written prescription, must also be:

1. Able to withstand repeated use (consumables are not covered);
2. Primarily used to serve a medical purpose rather than for comfort or convenience; and
3. Generally, not useful to a person who is not ill or injured.

Replacement Equipment.

1. Replacement of durable medical equipment will not be subject to any reduced replacement Coinsurance that may be applicable if the replacement is five (5) years or longer after the original purchase.
2. Durable medical equipment will not be considered a replacement if the current equipment no longer meets the medical needs of the Participant due to physical changes or a deteriorating medical condition.

The Plan will not pay for the following items:

1. Exercise equipment;
2. Car lifts or stair lifts;
3. Biofeedback equipment;
4. Self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition;
5. Air conditioners and air purifiers;
6. Whirlpool baths, hot tubs, or saunas;
7. Waterbeds;
8. Other equipment which is not always used for healing or curing;
9. Deluxe equipment. The Plan has the right to decide when deluxe equipment is required. However, upon such decision, payment for deluxe equipment will be based on the Allowable Fee for standard equipment;
10. Computer-assisted communication devices;
11. Durable medical equipment required primarily for use in athletic activities;
12. Replacement of lost or stolen durable medical equipment;
13. Repair to rental equipment; and/or
14. Duplicate equipment purchased primarily for Participant convenience when the need for duplicate equipment is not medical in nature.

Prior Authorization from the Plan is recommended for the original purchase or replacement of durable medical equipment over $2,000. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Emergency Room Care

1. Emergency room care for an accidental Injury.
2. Emergency room care for sudden and serious Illness.
3. Emergency room care for the treatment of Mental Illness and/or Substance Use Disorder.

If the Participant disagrees with the Plan's determination in processing Benefits as nonemergency services instead of Emergency Services, the Participant may call the Plan at the number on the back of the Participant’s identification card. Please see the section entitled How to File an Internal Appeal of an Adverse Benefit Determination in this document for specific information on the Participant's right to seek and obtain a full and fair review of the claim.

Foot Orthotics

Foot orthotics provided by a Covered Provider.

Hearing Aid Coverage for Adults 19+

1. Hearing aids, repair and replacement of hearing aid device;
2. Hearing aids and appliances are covered when needed for auditory deterioration.

The Schedule of Benefits describes payment limitations for these services.

Hearing Coverage for Dependent Children Under Age 19

Coverage is available for the Medically Necessary diagnosis and treatment of hearing loss for a covered Dependent under age 19, when prescribed, provided, or ordered by a licensed health care provider. One Amplification Device, with required accessories, are available for each ear, every three years, or as required by a licensed audiologist.

The Schedule of Benefits describes payment limitations for these services.

Home Health Care

The following services, when prescribed and supervised by the Participant's attending Physician provided in the Participant's home by a licensed Home Health Agency and which are part of the Participant's treatment plan:

1. Nursing services;
2. Home Health Aide services;
3. Hospice services;
4. Physical Therapy;
5. Occupational Therapy;
6. Speech Therapy;
7. Medical social worker services;
8. Medical supplies and equipment suitable for use in the home; and/or
9. Medically Necessary personal hygiene, grooming and dietary assistance.

The Plan will not pay for:

1. Maintenance or Custodial Care visits.
2. Domestic or housekeeping services.
3. "Meals-on-Wheels" or similar food arrangements.
4. Visits, services, medical equipment, or supplies not approved or included as part of the Participant's treatment plan.
5. Services for the treatment of Mental Illness.
6. Services provided in a nursing home or skilled nursing facility.

Prior Authorization is required for home health care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

The Schedule of Benefits describes payment limitations for these services.

Home Infusion Therapy Services

The preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Participant by a Home Infusion Therapy Agency, including:

1. Education for the Participant, the Participant's caregiver, or a Family Member;
2. Pharmacy;
3. Supplies;
4. Equipment; and
5. Skilled nursing services when billed by a Home Infusion Therapy Agency.

NOTE: Skilled nursing services billed by a Licensed Home Health Agency will be covered under the home health services Benefit.

Home infusion therapy services must be ordered by a Physician and provided by a licensed Home Infusion Therapy Agency. A licensed Hospital, which provides home infusion therapy services, must have a Home Infusion Therapy Agency license or an endorsement to its Hospital facility license for home infusion therapy services.

Prior Authorization is required for home infusion therapy services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Hospice Care

A coordinated program of home care and Inpatient Care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill Participant and the Participant's Immediate Family. Benefits include:

1. Inpatient and Outpatient care;

2. Home care;
3. Nursing services – skilled and non-skilled;
4. Counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally ill Participant; and
5. Instructions for care of the Participant, counseling and other support services for the Participant's Immediate Family.

The Plan will not pay for services that do not require skilled nursing care, including Custodial Care or care for the convenience of the patient or Family Member.

Prior Authorization is required for hospice care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Hospital Services - Facility and Professional

Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations
    a. Room and board, which includes special diets and nursing services.
    b. Intensive care and cardiac care units which include special equipment and concentrated nursing services provided by nurses who are Hospital employees.
2. Miscellaneous Hospital Services
    a. Laboratory procedures.
    b. Operating room, delivery room and recovery room.
    c. Anesthetic supplies.
    d. Surgical supplies.
    e. Oxygen and use of equipment for its administration.
    f. X-ray.
    g. Intravenous injections and setups for intravenous solutions.
    h. Special diets when Medically Necessary.
    i. Respiratory therapy, chemotherapy, radiation therapy and dialysis therapy.
    j. Physical Therapy, Speech Therapy and Occupational Therapy.
    k. Drugs and medicines which:
        1. Are approved for use in humans by the FDA; and
        2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
        3. Require a Physician's written prescription.

        Drugs and medicines which are used in off-label situations may be reviewed for Medical Necessity.

Inpatient Care services are subject to the following conditions:

1. Days of care
    a. The number of days of Inpatient Care provided is 365 days.
    b. In computing the number of Inpatient Care days available, days will be counted according to the standard midnight census procedure used in most Hospitals. The day a Participant is admitted to a Hospital is counted, but the day a Participant is discharged is not. If a Participant is discharged on the day of admission, one day is counted.
    c. The day a Participant enters a Hospital is the day of admission. The day a Participant leaves a Hospital is the day of discharge.
2. The Participant will be responsible to the Hospital for payment of its charges if the Participant remains as an Inpatient Participant when Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed

reserved for a Participant. No Benefits will be paid for Inpatient Care provided primarily for diagnostic or therapy services.

Prior Authorization is required for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Inpatient Care Medical Services Billed by a Professional Provider

Nonsurgical services by a Covered Provider, Concurrent Care and Consultation Services.

Medical services do not include surgical or maternity services. Inpatient Care medical services are covered only if the Participant is eligible for Benefits under the Hospital Services, Inpatient Care Services section for the admission.

Medical care visits are limited to one visit per day per Covered Provider unless a Participant's condition requires a Physician's constant attendance and treatment for a prolonged period of time.

Observation Beds/Rooms

Benefits will be made available for observation beds when Medically Necessary.

Outpatient Hospital Services

Use of the Hospital's facilities and equipment for surgery, respiratory therapy, chemotherapy, radiation therapy and dialysis therapy.

Inborn Errors of Metabolism

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

Infertility – Diagnosis and Treatment

Services and supplies provided for the diagnosis/screening of Infertility.

The Plan will pay for:

The diagnosis of Infertility.

The Plan will not pay for:

1. Prescription drugs used to treat infertility.
2. Services, supplies, drugs and devices related to in vitro fertilization.
3. Medically Necessary evaluation to determine cause of infertility.
4. Artificial insemination (AI) or intrauterine insemination (IUI).
5. Medically Necessary reproductive procedures not related to in vitro fertilization.

Infusion Therapy Services – Outpatient

Some Outpatient infusion services for Routine maintenance drugs have been identified as capable of being administered outside of an Outpatient Hospital setting. The Out of Pocket Amount expenses may be lower when services are provided by a professional provider in an Infusion Suite, a home or an office, instead of a Hospital. Non maintenance Outpatient infusion therapy services will be covered the same as any other Illness.

Maternity Services - Professional and Facility Covered Providers

1. Prenatal and postpartum care.
2. Delivery of one or more newborns.
3. Hospital Inpatient Care for conditions related directly to pregnancy. Inpatient Care following delivery will be covered for whatever length of time is Medically Necessary and will be at least 48 hours following a vaginal delivery and at least 96 hours following a delivery by cesarean section. The decision to shorten the length of stay

of Inpatient Care to less than that stated in the preceding sentence must be made by the attending health care provider and the mother.

Under federal law, Benefits may not be restricted 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, under federal law, Covered Providers may not be required to obtain Prior Authorization from the Plan for prescribing a length of stay not in excess of 48 hours or 96 hours.

4. Payment for any maternity services by the professional provider is limited to the Allowable Fee for total maternity care, which includes delivery, prenatal and postpartum care.

Please refer also to the Newborn Initial Care section.

Medical Supplies

The following supplies for use outside of a Hospital:

1. Supplies for insulin pumps, syringes and related supplies for conditions such as diabetes;
2. Injection aids, visual reading and urine test strips, glucagon emergency kits for treatment of diabetes. One insulin pump for each warranty period is covered under the Durable Medical Equipment Benefit;
3. Sterile dressings for conditions such as cancer or burns;
4. Catheters;
5. Splints;
6. Colostomy bags and related supplies; and/or
7. Supplies for renal dialysis equipment or machines.

Medical supplies are covered only when:

1. Medically Necessary to treat a condition for which Benefits are payable; and
2. Prescribed by a Covered Provider.

Mental Health

Benefits provided for mental health are for the treatment of Mental Illness as defined in the section entitled Definitions.

Benefits include but are not limited to, Inpatient Care services, Outpatient services, rehabilitation services and medication for the treatment of Mental Illness.

Payment for mental health Benefits will be made as for any other Illness.

Outpatient Services

Care and treatment of Mental Illness if the Participant is not an Inpatient Participant and is provided by:

1. A Hospital;
2. A Physician or prescribed by a Physician;
3. A Mental Health Treatment Center;
4. A Substance Use Disorder Treatment Center;
5. A licensed psychologist;
6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. A licensed psychiatrist;
10. A licensed Advanced Practice Registered Nurse with a specialty in mental health;
11. A licensed Advanced Practice Registered Nurse with prescriptive authority and specializing in mental health; or
12. Other Qualified Health Care Provider.

Outpatient Benefits are subject to the following conditions:

1. The services must be provided to diagnose and treat recognized Mental Illness; and
2. The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by Mental Illness.

The Plan will not pay for hypnotherapy or for services given by a staff member of a school or halfway house.

Inpatient Services

Care and treatment of Mental Illness, while the Participant is an Inpatient Participant, and which are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity residential services provided at a Residential Treatment Center are Benefits of this Plan Document.

Prior Authorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Partial Hospitalization

Care and treatment of Mental Illness, while the Partial Hospitalization services are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Prior Authorization is required for Partial Hospitalization. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Naturopathy

Services provided by a licensed naturopathic provider are covered if such services are a Benefit of this Plan Document.

Newborn Initial Care

1. The initial care of a newborn at birth provided by a Physician.
2. Nursery Care - Hospital nursery care of newborn infants.

Office Visits

Covered services provided in a Covered Provider's office during a Professional Call and covered services provided in the home by a Covered Provider. Visits are limited to one visit per day per provider.

Orthopedic Devices/Orthotic Devices

A supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, when Medically Necessary, Benefits will be provided for adjustments, repairs or replacement of the device because of a change in the Participant's physical condition.

Prior Authorization is recommended for the original purchase or replacement of orthopedic devices over $2,000. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Out-of-State Emergency Travel

Out of state commercial transportation must be pre-authorized. In network medical benefits apply.

Charges for transportation may be covered to the nearest city out of state with appropriate facilities. Prior authorization is required. Approved coverage includes one-way, out-of-state transportation by regularly scheduled passenger aircraft or mileage at the normal reimbursement rate for travel by personal automobile inside the United States to the nearest medical facility equipped to provide the necessary treatment not available in a Montana facility. Transportation for treatment at in-state facilities is not covered.

Transportation benefits are limited to the following circumstances:

1. Health Care Facility to Health Care Specialty Facility Transfer. A Life-endangering situation exists that requires immediate transfer to a facility that has special facilities for treatment of the condition that cannot be performed in the current facility.
2. Treatment is needed that cannot be performed in state as determined by Blue Cross and Blue Shield of Montana.

Medical review based on information provided by the Prior Authorization form. Transportation Benefits in any one benefit year shall be limited to: one visit for treatment or surgery and one preparatory or follow-up visit for a condition that cannot be treated in state. If the patient is a child under 18 years of age, the transportation charges for one parent may be allowed if the attending physician certifies the need for such attendance and attendance of one parent has been approved by Prior Authorization.

Physician Medical Services

Medical services by a Covered Provider for:

1. Inpatient Hospital Physician visits.
2. Convalescent Home facility Physician visits.
3. Surgical facility Physician services.

The Plan will not pay for pre- or postsurgical visits that are considered to be Inclusive Services/Procedures that are included in the payment for the surgery.

This Benefit does not include services provided in the home or the Covered Provider's office.

Postmastectomy Care and Reconstructive Breast Surgery

Postmastectomy Care

Medically Necessary Inpatient Care for the period of time determined by the attending Physician and the Participant, following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

Prior Authorization is required for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Reconstructive Breast Surgery

1. All stages of Reconstructive Breast Surgery after a mastectomy including, but not limited to:
    a. All stages of reconstruction of the breast on which a mastectomy has been performed.
    b. Surgery and reconstruction of the other breast to establish a symmetrical appearance.
    c. Chemotherapy.
    d. Prostheses and physical complications of all stages of a mastectomy and breast reconstruction, including lymphedemas.

    Coverage described in 1(a) through 1(d) will be provided in a manner determined in consultation with the attending Physician and the patient.
2. Breast prostheses as the result of a mastectomy.

For specific Benefits related to postmastectomy care, refer to that specific Benefit, e.g., surgical services and Hospital services.

Prescription Drugs

Refer to the Prescription Drugs section in the Schedule of Benefits for specific information on the application of any Deductible, Copayment and/or Coinsurance.

The Prescription Drugs Benefit is for Prescription Drug Products which are self-administered. This Benefit does not include medications which are administered by a Covered Provider. If a medication is administered by a Covered Provider, the claim will process under the Participant's medical Benefits. **Please refer to the Utilization Management section for complete information about the medications that are subject to the Participant's medical Benefits, the process for requesting Prior Authorization for medications subject to the Participant's medical Benefits, and related information.**

Subject to the terms, conditions, and limitations of this Plan Document, the Claim Administrator will pay for Prescription Drug Products, which:

1. Are approved for use in humans by the FDA; and
2. Require a Physician's written prescription; and
3. Are dispensed under federal or state law pursuant to a prescription order or refill.

Prescription Drug Products which are used in off-label situations may be reviewed for Medical Necessity.

Drug Lists

Drugs listed on the Drug List are selected by the Claim Administrator based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Claim Administrator. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the Drug List. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost, and how it compares with drugs currently on the Drug List.

Positive changes (e.g., adding drugs to the Drug List, drugs moving to a lower payment tier) occur quarterly after review by the Committee. Changes to the Drug List that could have an adverse financial impact to the Participant (e.g., drug Exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or Prior Authorization) occur annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the Drug List may occur more frequently.

The Drug List and any modifications will be made available to the Participant. By accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists or calling the Customer Service toll-free number on the Participant's identification card, the Participant will be able to determine the Drug List that applies to the Participant's Plan and whether a particular drug is on the Drug List.

The Participant, or the Participant's prescribing health care provider, can ask for a Drug List exception if the Participant's drug is not on the Drug List. To request this exception, the Participant or the Participant's prescriber, can call the number on the back of the Participant's identification card to ask for a review. The Claim Administrator will notify the Participant or the Participant's prescriber of its decision with respect to the request within 72 hours after the request is received.

If the Participant has a health condition that may jeopardize their life, health or keep the Participant from regaining function, or the Participant's current drug therapy uses a non-covered drug, the Participant's prescriber, may be able to ask for an expedited review process by marking the review as an urgent request. The Claim Administrator will notify the Participant or the Participant's prescriber, of the coverage decision within 24 hours after they receive the request for an expedited review. If the coverage request is denied, the Claim Administrator will let the Participant and the Participant's prescriber, know why it was denied and offer the Participant a covered alternative drug (if applicable). If the Participant's exception is denied, the Participant may appeal the decision according to the appeals process the Participant will receive with the denial determination. The Participant should call the number on the back of the Participant's identification card if the Participant has any questions.

Covered Prescription Drug Products

The following Prescription Drugs Products, obtained from a Participating Pharmacy, either retail or mail order, or a retail nonparticipating Pharmacy, are covered:

1. Legend drugs - drugs requiring written prescriptions and dispensed by a licensed pharmacist for treatment of an Illness or Injury.
2. One prescription oral agent for controlling blood sugar levels for each class of drug approved by the FDA.
3. Insulin with a prescription.
4. Disposable insulin needles/syringes.
5. Test strips.
6. Lancets.
7. Contraceptives as specified on the Drug List.
8. Smoking cessation products and over-the-counter smoking cessation aids/medications with a written prescription, as required by the Affordable Care Act. Tobacco counseling is available under the Preventive Health Care Benefit.

The Schedule of Benefits lists any Deductible, Copayment and/or Coinsurance that the Participant is responsible for and payment limitations for these Prescription Drug Products.

Non-Covered Prescription Drug Products

The Plan will not pay for:

1. Drugs/products which are not included on the Drug List, unless specifically covered elsewhere in this Plan Document and/or such coverage is required in accordance with applicable law or regulatory guidance.
2. Compounded Drugs.
3. Drugs, that the use or intended use of which would be illegal, abusive, not Medically Necessary, or otherwise improper such as anabolic steroids.
4. Any drug used for the purpose of weight loss.
5. Fluoride supplements, except as required by the Affordable Care Act for children under age 6.
6. Devices, technologies, and/or Durable Medical Equipment of any type (even though such devices may require a prescription order), such as, but not limited to, therapeutic devices, artificial appliance, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections).
7. Over-the-counter drugs that do not require a prescription, except over-the-counter smoking cessation aids with a written prescription.
8. Prescription Drug Products for which there is an exact over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined.
9. Prescription Drug Products for cosmetic purposes, including the treatment of hair loss (e.g., Minoxidil, Rogaine).
10. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those otherwise covered under this section.
11. Prescription Drug Products used for erectile dysfunction.
12. Insulin pumps and glucose meters. Insulin pumps and glucose meters are covered under the Durable Medical Equipment Benefit. Insulin pump supplies are covered under the Medical Supplies Benefit.
13. Drugs or items labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Participant is charged for the item.
14. Biological sera, blood, or blood plasma.
15. Prescription Drug Products which are to be taken by or administered to the Participant, in whole or in part, while the Participant is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility’s charge.
16. Any Prescription Drug Product refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician’s original order.
17. Replacement prescription drugs or Prescription Drug Products due to loss, theft or spoilage.

18. Prescription Drug Products obtained from a Pharmacy located outside the United States for consumption within the United States.
19. Prescription Drug Products provided by a mail-order Pharmacy that is not approved by the Plan.
20. Repackagers, Institutional Packs, Clinic Packs or other custom packaging
21. Non-sedating antihistamines.
22. Prescription Drug Products determined by the Claim Administrator to have inferior efficacy or significant safety issues.
23. Administration or injection of any drugs.
24. Non-FDA approved drugs.
25. Drugs which do not by law require a Prescription from a provider or health care practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies); and drugs or covered devices for which no valid Prescription is obtained.
26. Vitamins (except those vitamins which by law require a Prescription and for which there is no non–prescription alternative).
27. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select vaccinations administered through certain Participating Pharmacies are an exception to this Exclusion.
28. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned for in this Plan Document.

    NOTE: This exception does not apply to dietary formula necessary for the treatment of Inborn Errors of Metabolism.

29. Drugs used or intended to be used in the treatment of a condition, sickness, disease, Injury, or bodily malfunction which is not covered under the Plan Document, or for which Benefits have been exhausted.
30. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Participant's identification card.
31. Benefits will not be provided for any self-administered drugs dispensed by a Physician.
32. Experimental/Investigational/Unproven status of a drug or device is determined by the Claim Administrator taking into consideration a variety of factors, including demonstration of efficacy in peer reviewed literature. With respect to FDA approval, if FDA approval is not obtained, the drug will be considered Experimental/Investigational/Unproven, but if FDA approval is obtained, while this will be considered by the Claim Administrator in making its determination of Experimental/Investigational/Unproven status, such approval will not be determinative.
33. Pharmaceutical aids, such as excipients found in the UPS-NF (United States Pharmacopeia National Formulary) including, but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.
34. Certain drug classes where there are over-the-counter alternatives available.
35. Bulk Powders.
36. Surgical supplies (e.g. Amvisc, Cellugel, Duovisc, Hyalgan, Provisc, Supartz, Synvisc, Viscoat).
37. Prescription Drug Products used for the Treatment of Infertility.
38. Diagnostic agents (except for diabetic testing supplies or test strips).
39. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
40. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, the Claim Administrator may limit Benefits to only certain therapeutic equivalents/therapeutic alternatives. If the Participant does not choose the therapeutic equivalents/therapeutic alternatives that are covered under the Prescription Drug Program, the drug purchased will not be covered under any Benefit level; and
41. New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug..

Vaccinations Obtained Through Select Participating Pharmacies

Vaccinations are available through select Participating Pharmacies that have contracted with the Claim Administrator. To obtain a current list of Participating Pharmacies and a list of covered vaccines, the Participant can

call the Customer Service toll-free number identified on the Participant's identification card or access www.bcbsmt.com and click on "Member Services". Then click on the "Prescription Drug Plan Information" and select "Pharmacy Program." The Participant should present the Participant's identification card to the pharmacist at the time services are received. The pharmacist will inform the Participant of any applicable Copayment and/or Coinsurance.

Each select Participating Pharmacy that has contracted with the Claim Administrator to provide this service may have age, scheduling, or other requirements that will apply, so the Participant should contact the Participating Pharmacy in advance. Childhood immunizations subject to state regulations are not available under this Pharmacy Benefit but are covered under the medical Benefits of the health plan.

Controlled Substances Limitation

If it is determined that a Participant may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary or appropriate and restrictions may include but not be limited to a certain provider and/or Pharmacy and/or quantities and/or day's supply for the prescribing and dispensing of the controlled substance medication. Additional Copayments may apply.

Multi-Category Split-Fill Program

If it is the Participant's first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if the Participant has not filled a select medication within the previous 120 days, the Participant may only be eligible for a partial fill (14 - 15-day supply) of the medication for up to the first 3 Months of therapy. The partial fill is designed to determine how the medication is working therapeutically for the Participant. Any applicable [Copayment and/or]Coinsurance may be adjusted to align with the quantity of pills dispensed. If the medication is working and the Participant's provider would like to continue on this medication, the Participant may be eligible to receive up to a 30-day supply after completing up to 3 Months of the partial supply. Call the number on the back of the Participant's identification card for any questions or for a list of drugs that are included in this program or visit the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/pharmacy/pharmacy-programs.

GLP-1 New to Therapy

If it is the Participant's first time using select GLP-1 medications or if the Participant has not filled a select GLP-1 medication within the previous 120 days, the Participant may only be eligible to receive a 30-day supply of the medication for the first fill. After the first fill of select GLP-1 medications for a 30-day supply, the Participant may be eligible to fill for up to a 90-day supply, per the Plan Benefits. This 30-day supply limit may continue to apply after the first fill if you change your GLP-1 medication and/or dosing strength.

Purchase and Payment of Prescription Drug Products

Prescription Drug Products may be obtained using an Outpatient retail Pharmacy, an extended supply Pharmacy or a mail-order Pharmacy approved by the Claim Administrator. To use a mail-order Pharmacy, the Participant must send an order form with the prescription to the address listed on the mail-order service form and pay any required Deductible, Copayment and/or Coinsurance. The address of each mail order Pharmacy approved by the Plan is listed on the inside cover of this Plan Document.

Available Prescription Drug Products include Brand-Name Drugs and Generic Drugs. If a Generic equivalent of a Brand-Name Drug becomes available during the period of coverage for the Plan, it will be added to the Drug List maintained by and available to the Participant on the Blue Cross and Blue Shield of Montana website and the Pharmacy Benefit Manager's website. Refer to the inside cover of this Plan Document for information on Blue Cross and Blue Shield of Montana's Pharmacy Benefit Manager. The availability of a Generic Drug may allow the Participant to obtain a drug at a potentially lower out of pocket cost. The factors that determine the costs to a Participant include the terms of the coverage and the Drug List in effect as of the date of the prescription and the Pharmacy service date, as well as the use of a Participating Pharmacy or nonparticipating pharmacy.

If drugs or Prescription Drug Products are purchased at a Participating Pharmacy, an extended supply Pharmacy or a mail order Pharmacy approved by the Claim Administrator, and the Participant presents the Participant's identification card at the time of purchase, the Participant must pay any required Deductible, Copayment and/or Coinsurance.

If the Participant uses a Participating Pharmacy to fill a prescription, but elects to submit the claim directly to the Claim Administrator's Pharmacy Benefit Manager, instead of having the Participating Pharmacy submit the claim, the Participant will be reimbursed for the prescription drug based on the amount that would have been paid to the Participating Pharmacy, less the Participant's Deductible, Copayment and/or Coinsurance.

If drugs or Prescription Drug Products are purchased at a nonparticipating Outpatient Pharmacy, the Participant must pay for the prescription at the time of dispensing and then file a prescription drug claim form with the Claim Administrator's Pharmacy Benefit Manager for reimbursement. Please refer to Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefits section of this Plan Document for additional information.

The Participant's Employer has chosen to participate in FlexAccess™ Qualified HDHP which lowers the Participant's out of pocket costs for select drugs by obtaining drug manufacturer assistance when available. Drug manufacturers may provide financial support for some, or all, of the Participant's out of pocket costs for select drugs. Any amount paid through a drug manufacturer assistance program (e.g., manufacturer cost-share assistance, manufacturer discount plans, and/or manufacturer coupons) will not apply to the Participant's Deductible (if part of the Plan) or yearly Out of Pocket Amounts. The list of drugs covered under FlexAccess™ Qualified HDHP is subject to change. If the Participant is taking a qualifying drug, a Prime Therapeutics representative will contact the Participant to assist in applying for the manufacturer assistance program.

Prescription Drug Products Subject to Prior Authorization, Step Therapy or Dispensing Limits

1. Prescription Drug Products subject to Prior Authorization require prior approval from the Plan's Pharmacy Benefit Manager before they can qualify for coverage under the Plan. If the Participant does not obtain Prior Authorization before a Prescription Drug Product is dispensed, the Participant may pay for the prescription and then pursue authorization of the drug from the Plan's Pharmacy Benefit Manager. If the authorization is approved by the Plan's Pharmacy Benefit Manager, the Participant should then submit a claim for the prescription drug on a prescription claim form to the Plan's Pharmacy Benefit Manager for reimbursement.
2. Prior Authorization does not guarantee payment of the Prescription Drug Product by the Plan. Even if the prescription drug has been approved through Prior Authorization, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date the drug is dispensed, or the Participant's Benefits may have changed as of the date the drug is dispensed.
3. The step therapy program requires that the Participant has a prescription history for a prerequisite medication before the Plan will cover a targeted drug. If the Participant and the Participant's provider decide that a prerequisite drug is not right for the Participant or is not as good in treating Participant's condition, the provider should submit a Prior Authorization request for coverage of the second-line drug.
4. A dispensing limit is a limitation on the number or amount of a Prescription Drug Product covered within a certain time period and quantity of covered medication per prescription. Dispensing limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, appropriate utilization, and to avoid misuse/abuse of the medication. A prescription written for a quantity in excess of the established limit will require a clinical review before Benefits are available.

Certain Prescription Drug Products, such as those used to treat rheumatoid arthritis, growth hormone deficiency, or hepatitis C, may be subject to Prior Authorization, step therapy, or dispensing limits. The Prescription Drug Products included in these programs are subject to change, and medications for other conditions may be added to the program.

If the Participant's provider is prescribing a Prescription Drug Product subject to Prior Authorization, step therapy, or dispensing limits, the provider should fax the request for Prior Authorization to the Claim Administrator's Pharmacy Benefit Manager at the fax number listed on the inside cover of this Plan Document. The Participant and provider will be notified of the Claim Administrator's Pharmacy Benefit Manager's determination. If the request is denied, the decisions may be appealed according to the appeals process provided with the denial determination.

In making determinations of coverage, the Claim Administrator's Pharmacy Benefit Manager may rely upon Pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in Montana, Pharmacy Benefit Manager evaluations, Medical Necessity, and Medical Policies. The Pharmacy policies and Medical Policies are located on the Claim Administrator's website at www.bcbsmt.com.

To find out more about Prior Authorization/step therapy/dispensing limits or to determine which Prescription Drug Products are subject to Prior Authorization, step therapy or dispensing limits, the Participant or provider should refer to the Drug List which applies to the Participant's Plan at https://www.bcbsmt.com/rx-

drugs/drug-lists/drug-lists or www.myprime.com or call the Customer Service toll-free number identified on the Participant's identification card.

Specialty Medications

1. Specialty Medications are generally prescribed for individuals with complex medical conditions such as multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These medications also have one or more of the following characteristics:
   a. Injected or infused, but some may be taken by mouth.
   b. Unique storage or shipment requirements.
   c. Additional education and support required from a health care professional.
   d. Usually not stocked at retail Pharmacies.
2. For the highest level of Benefits, Specialty Medications must be acquired through the Plan's contracted Specialty Pharmacies listed on the inside cover of this Plan Document. A list of covered Specialty Medications may be found on the Plan website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. Registration and other applicable forms are also located on the website.
3. Coverage for Specialty Medications is limited to a 30-day supply. However, some Specialty Medications have FDA approved dosing regimens exceeding the 30-day supply limit and may be dispensed for more than a 30-day supply, if allowed by The Plan. Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

Preventive Health Care

Covered preventive services include, but are not limited to:

1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's (USPSTF) current recommendations (additional information is provided by accessing http://www.uspreventiveservicestaskforce.org); and
2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention (CDC); and
3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;

   In addition to the screening services recommended under the HRSA Guidelines, the following services are included:

   a. Lactation Services

      Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. In addition, Benefits are provided for the purchase of manual or electric breast pumps or the rental of Hospital-grade pumps. The purchase of an electric breast pump is limited to one electric breast pump per Benefit Period.

   b. Contraceptives

      FDA approved contraceptive methods, including certain contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity; and
4. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to or after November 2009.
5. Current recommendations of the United States Preventive Service Task Force regarding obesity screening and counseling.

The preventive services listed above may change as USPSTF, CDC and HRSA guidelines are modified and any such changes will be implemented by the Claim Administrator in the quantities and at the times required by applicable law.

Examples of Preventive Health Care services as defined under federal law include, but are not limited to, colonoscopies, immunizations and vaccinations. Examples of other Preventive Health Care services include, but are not limited to, physical examinations. Any services that are billed as a diagnostic service, will be covered under regular medical Benefits.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a nonparticipating Pharmacy, may be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximums.

A Copayment waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

High Deductible Health Plan – Health Savings Account (HDHP)-HSA Preventive Drug Program

In addition to the Preventive Health Care listed above, Benefits include coverage for certain Outpatient prescription drugs that are covered under the HSA Preventive Drug Program. Outpatient Drug Products covered under the HSA Preventive Drug Program are not subject to any applicable Deductible, Copayment and/or Coinsurance provisions of the Plan when obtained from a Participating Pharmacy or Participating Pharmacy when prescribed for preventive purposes.

Outpatient Drug Products covered under the HSA Preventive Drug Program when obtained from an Out-of-Network Pharmacy will be subject to the applicable Out-of-Network member share.

The HDHP-HSA Preventive Drug Program includes Prescription Drugs in the following drug categories:

- Anticoagulants/antiplatelets;
- Bowel preparation;
- Breast cancer primary prevention;
- Contraceptives;
- Depression (SSRI);
- Diabetes Rx – hypoglycemic agents;
- Diabetes Rx – insulin and oral;
- Diabetic supplies;
- Fluoride;
- GLP-1 Oral/Injectables;
- High blood pressure;
- High cholesterol;
- Osteoporosis;
- Respiratory;
- Smoking cessation;
- Vaccines.

These drugs could also at times be prescribed for treatment purposes. If the Participant's Qualified Health Care Provider has prescribed a listed drug for treatment purposes (and not preventive purposes) then it will be subject to any applicable Deductible, Copayment and/or Coinsurance. For additional information about specific drugs included in the HSA Preventive Drug Program, contact Customer Service toll-free at the number on the back of the Participant's identification card.

NOTE: For more information on drugs covered under the Prescription Drug Benefit refer to the Prescription Drugs section.

For more detailed information on all covered services, contact Customer Service at the number on the back of the Participant's identification card.

Prostheses

The appropriate devices used to replace a body part missing because of an Accident, Injury, or Illness.

When placement of a prosthesis is part of a surgical procedure, it will be paid under Surgical Services.

Payment for deluxe prosthetics will be based on the Allowable Fee for a standard prosthesis.

Replacement Prosthesis.

1. Replacement of a prosthesis will not be subject to any reduced replacement Coinsurance that may be applicable if the replacement is five (5) years of longer after the original purchase.
2. A prosthesis will not be considered a replacement if the original prosthesis no longer meets the medical needs of the Participant due to physical changes or a deteriorating medical condition.

The Plan will not pay for the following items:

1. Prostheses required primarily for use in athletic activities;
2. Replacement of lost or stolen prostheses;
3. Duplicate prosthetic devices purchased primarily for Participant convenience when the need is not medical in nature; or
4. Computer-assisted communication devices.

Prior Authorization is recommended for the original purchase or replacement of a prosthesis if the cost is over $2,000. Refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Radiation Therapy

The use of x-ray, radium, or radioactive isotopes ordered by the attending Physician and performed by a Covered Provider for the treatment of disease.

Rehabilitation – Facility and Professional

Rehabilitation Therapy and other covered services, as outlined in this Rehabilitation section, billed by a Rehabilitation Facility provider or a professional provider for services provided to a Participant.

The Plan will not pay when the primary reason for Rehabilitation is any one of the following:

1. Custodial Care;
2. Diagnostic admissions;
3. Maintenance, nonmedical self-help, or vocational educational therapy;
4. Social or cultural rehabilitation;
5. Learning and developmental disabilities; and
6. Visual, speech, or auditory disorders because of learning and developmental disabilities or psychoneurotic and psychotic conditions.

Benefits will not be provided under this Rehabilitation section for treatment of Substance Use Disorder or Mental Illness as defined in the Substance Use Disorder and Mental Health sections.

Benefits will be provided for services, supplies and other items that are within the scope of the rehabilitation Benefit described in this Rehabilitation section only as provided in and subject to the terms, conditions and limitations applicable to this Rehabilitation section and other applicable terms, conditions and limitations of this Plan Document. Other Benefit sections of this Plan Document, such as but not limited to Hospital Services, do not include Benefits for any services, supplies or items that are within the scope of the rehabilitation Benefit as outlined in this section.

Rehabilitation Facility Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations: Room and Board, which includes but is not limited to dietary and general, medical and rehabilitation nursing services.
2. Miscellaneous Rehabilitation Facility Services (whether or not such services are Rehabilitation Therapy or are general, medical or other services provided by the Rehabilitation Facility during the Participant's admission), including but not limited to:
    a. Rehabilitation Therapy services and supplies, including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy.
    b. Laboratory procedures.
    c. Diagnostic testing.

d. Pulmonary services and supplies, including but not limited to oxygen and use of equipment for its administration.
e. X-rays and other radiology.
f. Intravenous injections and setups for intravenous solutions.
g. Special diets when Medically Necessary.
h. Operating room, recovery room.
i. Anesthetic and surgical supplies.
j. Drugs and medicines which:

1. Are approved for use in humans by the FDA; and
2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
3. Require a Physician's written prescription.

Drugs and medicines which are used in off-label situations may be reviewed for Medical Necessity.

3. Rehabilitation Facility Inpatient Care Services do not include services, supplies or items for any period during which the Participant is absent from the Rehabilitation Facility for purposes not related to rehabilitation, including but not limited to intervening inpatient admissions to an acute care Hospital.

Prior Authorization is required for Rehabilitation Facility Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Rehabilitation Facility Inpatient Care is subject to the following conditions:

1. The Participant will be responsible to the Rehabilitation Facility for payment of the Facility's charges if the Participant remains as an Inpatient Participant when Rehabilitation Facility Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed reserved for a Participant.

2. The term Rehabilitation Facility does not include:

a. A Hospital when a Participant is admitted to a general medical, surgical or specialty floor or unit (other than a rehabilitation unit) for acute Hospital care, even though rehabilitation services are or may be provided as a part of acute care;
b. A nursing home;
c. A rest home;
d. Hospice;
e. A skilled nursing facility;
f. A Convalescent Home;
g. A place for care and treatment of Substance Use Disorder;
h. A place for treatment of Mental Illness; and/or
i. A long-term, chronic-care institution or facility providing the type of care listed above.

Rehabilitation Facility Inpatient Care Services Billed by a Professional Provider

All professional services provided by a Covered Provider who is a physiatrist or other Physician directing the Participant's Rehabilitation Therapy. Such professional services include care planning and review, patient visits and examinations, consultation with other Physicians, nurses or staff, and all other professional services provided with respect to the Participant. Professional services provided by other Covered Providers (i.e., who are not the Physician directing the Participant's Rehabilitation Therapy) are not included in the rehabilitation Benefit, but are included to the extent provided in and subject to the terms, conditions and limitations of other contract Benefits (e.g., Physician Medical Services).

Outpatient Rehabilitation

Rehabilitation Therapy provided on an Outpatient basis by a facility or professional provider.

Second Surgical Opinion

The Benefit percentage is 100 percent and there is no Deductible and Coinsurance for charges on a second surgical opinion consultation.

"Second surgical opinion" means an evaluation of the need for surgery by a second doctor (or third doctor if the opinions of the doctor recommending surgery and the second doctor are in conflict), including the doctor's exam of the patient and diagnostic testing.

Substance Use Disorder

Benefits for Substance Use Disorder will be paid as any other Illness.

Outpatient Services

Care and treatment for Substance Use Disorder when the Participant is not an Inpatient Participant and provided in or by:

1. A Hospital;
2. A Mental Health Treatment Center;
3. A Substance Use Disorder Treatment Center;
4. A Physician or prescribed by a Physician;
5. A licensed psychologist;
6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. A licensed psychiatrist; or
10. Other Qualified Health Care Provider.

Outpatient services are subject to the following conditions:

1. The services must be provided to diagnose and treat recognized Substance Use Disorder; and
2. The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Substance Use Disorder.

The Claim Administrator will not pay for hypnotherapy or for services given by a staff member of a school or halfway house.

Inpatient Care Services

Care and treatment of Substance Use Disorder, while the Participant is an Inpatient Participant, and which are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity services provided at a Residential Treatment Center are Benefits of the Plan.

Prior Authorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Partial Hospitalization

Care and treatment of Substance Use Disorder, while the Partial Hospitalization services are provided by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Prior Authorization is required for Partial Hospitalization services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Surgical Services

Surgical Services Billed by a Professional Provider

Services by a professional provider for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery. The charge for a surgical suite outside of the Hospital is included in the Allowable Fee for the surgery.

Surgical Services Billed by an Outpatient Surgical Facility or Freestanding Surgery Centers

Services of a surgical facility or a freestanding surgery center licensed, or certified for Medicare, by the state in which it is located and have an effective peer review program to ensure quality and appropriate patient care. The surgical procedure performed in a surgical facility or a freestanding surgery center is recognized as a procedure which can be safely and effectively performed in an Outpatient setting.

The Plan will allow Benefits for a Recovery Care Bed when Medically Necessary and provided for less than 24 hours. Payment will not exceed the semiprivate room rate that would be billed for an inpatient stay.

Surgical Services Billed by a Hospital (Inpatient and Outpatient)

Services of a Hospital for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery.

Telehealth

Medically Necessary Telehealth services are covered when provided by a Covered Provider.

Temporomandibular Joint Dysfunction

Surgical and non-surgical treatment services and supplies for surgical and non-surgical treatment of temporomandibular joint dysfunction.

The Schedule of Benefits describes payment limitations for these services.

Therapies - Outpatient

Services provided for Physical Therapy, Speech Therapy, cardiac therapy and Occupational Therapy, not including Rehabilitation Therapy.

Transplants

A heart, heart/lung, single lung, double lung, liver, pancreas, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplants to a Participant.

The Claim Administrator contracts with Blue Distinction Centers or Blue Distinction Centers+ for certain transplant services and highly recommends use of these centers because they have a proven record of delivering specialty care and results. Two levels of recognition allow the Participant and the Participant's Physician to pick the option that best meets their needs. Blue Distinction Centers offer quality care, treatment expertise and better overall patient results. Participants being considered for a transplant procedure are encouraged to contact the Claim Administrator's Customer Service to discuss the possible benefits of utilizing the Blue Distinction Centers or Blue Distinction Centers+.

Transplant services include:

1. Organ procurement including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ and transportation of the donor or donor organ to the location of the transplant operation.
2. Donor services including the pre-operative services, transplant related diagnostic lab and x-ray services, and the transplant surgery hospitalization. Transplant related services are covered for up to six Months after the transplant.
3. Hospital Inpatient Care services.
4. Surgical services.
5. Anesthesia.

6. Professional provider and diagnostic Outpatient services.
7. Licensed ambulance travel or commercial air travel for the Participant receiving the treatment to the nearest Hospital with appropriate facilities.

Payment by the Plan is subject to the following conditions:

1. When both the transplant recipient and donor are Participants, both will receive Benefits.
2. When the transplant recipient is a Participant and the donor is not, both will receive Benefits to the extent that benefits for the donor are not provided under other hospitalization coverage.
3. When the transplant recipient is not a Participant and the donor is, the donor will receive Benefits to the extent that benefits are not provided to the donor by hospitalization coverage of the recipient.

The Plan will not pay for:

1. Experimental/Investigational/Unproven procedures.
2. Transplants of a nonhuman organ or artificial organ implant.
3. Donor searches.

Prior Authorization is required for transplants. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Well-Child Care

Well-child care provided by a Physician or a health care professional supervised by a Physician.

Benefits shall include coverage for:

1. Histories;
2. Physical examinations;
3. Developmental assessments;
4. Anticipatory guidance;
5. Laboratory tests;
6. Preventive immunizations.

COORDINATION OF BENEFITS WITH OTHER COVERAGE

The Coordination of Benefits (COB) provision applies when a Participant has health care coverage under more than one plan. “Plan” is defined below.

The order in which each plan will make payment for Covered Medical Expenses is governed by the order of benefit determination rules. The plan that pays first is called the primary plan. The primary plan must pay Covered Medical Expenses in accordance with its plan document terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce payment for Covered Medical Expenses so that payment by all plans does not exceed 100% of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

Plan

Any of the following that provide benefits, or services, for medical or dental care or treatment include:

1. Group and nongroup health insurance contracts;
2. Health Maintenance Organization (HMO) contracts;
3. Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured);
4. Medical care components of long-term care contracts, such as skilled nursing care; and
5. Medicare or any other federal governmental plan, as permitted by law.

The term plan does not include:

1. Hospital indemnity coverage or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified Accident coverage;
4. Limited benefit health coverage or excepted benefits;
5. School Accident type coverage;
6. Benefits for non-medical components of long-term care policies;
7. Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

Each contract of coverage or group health plan is a separate coverage plan.

This Plan

“This Plan” means the Plan represented by this Plan Document.

Order of Benefit Determination Rules

The rules that determine whether a plan is a primary plan or a secondary plan, when a covered person has health care coverage under more than one plan.

1. When a plan is primary, it determines payment for covered medical expenses first before those of any other plan without considering any other plan's benefits.
2. When a plan is secondary, it determines its benefits after those of another plan. A secondary plan may reduce payment for covered medical expenses so that payment by all plans does not exceed 100% of the total allowable expense.

Allowable Expense

A Covered Medical Expense, including Deductibles, Copayment and/or Coinsurance, that is covered at least in part by any plan covering a covered person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering a covered person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an allowable expense, unless one of the plans provides coverage for private Hospital room expenses.
2. If a covered person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
3. If a covered person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
4. If a covered person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan

A plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent

The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a Participant is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan; and
2. Except as provided below, a plan that does not contain a COB provision that is consistent with applicable regulations is always primary unless the provisions of both plans state that the complying plan is primary.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits, and provides that this supplementary coverage, shall be excess to any other parts of the plan provided by the group. Examples of such situations include major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.

3. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

4. Each plan determines its order of benefits using the first of the following rules that apply:

   Non-Dependent or Dependent

   The plan that covers a person as an employee or retiree is the primary plan and the plan that covers the employee or retiree as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee or retiree is the secondary plan and the other plan is the primary plan.

   Dependent Child Covered Under More Than One Plan

   Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan, the order of benefits is determined as follows:

   1. **Dependent Child - Parents are married or are living together**

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

   2. **Dependent Child - Parents are divorced or separated or not living together**

      a. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
      b. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above shall determine the order of benefits;
      c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above shall determine the order of benefits; or
      d. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         1. The plan covering the custodial parent;
         2. The plan covering the Spouse of the custodial parent;

3. The plan covering the non-custodial parent and then;
4. The plan covering the Spouse of the non-custodial parent.

3. Dependent Child Covered Under More than One Plan of Individuals Who Are Not the Parents of the Child

The provisions of 1. or 2. above shall determine the order of benefits as if those individuals were the parents of the child.

4. Active Employee or Retired or Laid-off Employee

The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, (or a Dependent of such employee) is the primary plan. The plan covering that same person as a retired or laid-off employee (or a Dependent of such employee) is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the section entitled Non-Dependent or Dependent can determine the order of benefits.

5. COBRA or State Continuation Coverage

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee or retiree or covering the person as a Dependent of an employee or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the section entitled Non-Dependent or Dependent can determine the order of benefits.

6. Longer or Shorter Length of Coverage

The plan that covered the person as an employee or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of 'plan'. In addition, This Plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Plan and other plans. The Claim Administrator may obtain the facts and information it needs from or provide such facts and information to other organizations or persons for the purpose of applying these COB rules and determining Benefits payable under this Plan and other plans covering the Participant claiming Benefits. The Claim Administrator need not inform, or get the consent of, any person to obtain such information. Each Participant claiming Benefits under this Plan must provide the Claim Administrator any facts it needs to apply those rules and determine Benefits payable.

Facility of Payment

A payment made by another plan may include an amount that should have been paid under This Plan. In such a case, the Claim Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means the reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, the Claim Administrator may recover the excess from one or more of the Participants it has paid or for whom it has paid; or any other person or organization that may be responsible for the Benefits or services provided for the Participant. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

Coordination with Medicare

This Plan will coordinate Benefits with Medicare according to the federal Medicare secondary payor laws and regulations (“MSP rules”). This means that This Plan and/or Medicare may adjust payment so that the combined payments by This Plan and Medicare will be no more than the charge for the Benefits received by the Participant. This Plan will never pay more than it would pay if the Participant was not covered by Medicare. The general rules for coordination with Medicare are as follows:

1. For Working Aged

   Medicare pays secondary to a plan sponsored by employers with 20 or more employees, for covered persons who qualify for age-based Medicare as a result of attaining age 65 and older and who are covered by virtue of the covered person’s current employment status.

   Medicare will be the primary for a covered person that refuses coverage under the plan.

   Medicare will pay primary to the plan for the working aged individuals covered by employers with fewer than 20 employees, including a multi-employer association if the covered person is covered by an employer within the multi-employer association with fewer than 20 employees.

2. For Disabled Participants under Age 65

   Medicare pays secondary to a plan covering individuals under age 65, covered by employers with 100 or more employees, who qualify for disability-based Medicare and are covered by virtue of a covered person’s current employment status.

   Medicare pays primary to a plan for disabled individuals under age 65 covered by employers with fewer than 100 employees.

3. For End-Stage Renal Disease

   Medicare pays secondary to a plan covering individuals who qualify for Medicare as a result of end-stage renal disease (“ESRD”), regardless of employer size, for the first 30 months that a particular covered person qualifies for Medicare as a result of ESRD. After the 30-month period, Medicare will pay primary to the plan.

   Special Coordination of Benefits rules apply if a covered person is entitled to Medicare based on ESRD and Medicare based on either age or disability:

   a. If a plan is required to pay before Medicare under 1 or 2 above for an individual before the individual qualifies for Medicare based on ESRD, the plan will continue to pay primary to Medicare after the individual becomes covered under Medicare based on ESRD but only for the 30-month period above, after which Medicare will pay primary to the plan.
   b. If a plan is required to pay primary to Medicare based on ESRD and an individual that qualifies for Medicare based on ESRD above later becomes entitled to age-based or disability-based Medicare during the 30-month period, Medicare will pay secondary to the plan for the duration of the 30-month period, after which Medicare will pay primary to the plan. If the individual qualifies for age-based or disability-based Medicare after the 30-month period, Medicare will pay primary to the plan.

c. Medicare continues to be primary to a plan after an aged or disabled individual becomes eligible for Medicare based on ESRD if:

1. The individual is already entitled to Medicare on the basis of age or disability when the individual becomes eligible for Medicare based on ESRD; and
2. The employer has fewer than 20 employees in the case of age-based Medicare or fewer than 100 employees in the case of disability-based Medicare.

4. Current Employment Status

Under the MSP rules, a covered person has current employment status if the covered person is:

a. Actively working as an employee; or
b. Not actively working but is receiving disability benefits from an employer but only for a period of up to 6 months; or
c. Not actively working but retains employment rights in the industry (including but not limited to a covered person who is temporarily laid off or on sick leave, who is a teacher or other seasonal worker), has not been terminated by an employer, is not receiving disability benefits from an employer for more than 6 months, is not receiving Social Security disability benefits and has group health coverage under a plan that is not COBRA coverage.

Other Insurance

If a property or casualty insurer pays for services provided to the Participant and coordination of benefits is not applicable, This Plan will credit the Participant's Deductible, Copayment or Coinsurance, as applicable, if the Participant notifies This Plan of the payment, within 12 months of the date of service.

EXCLUSIONS AND LIMITATIONS

All Benefits provided under this Plan are subject to the Exclusions and limitations in this section and as stated under the Benefit section. **The Plan will not pay for:**

1. All services, supplies, drugs and devices which are provided to treat any Illness or Injury arising out of employment when the Participant's Employer has elected or is required by law to obtain coverage for Illness or Injury under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This Exclusion applies to all services and supplies provided to treat such Illness or Injury even though:

a. Coverage under the government legislation provides benefits for only a portion of the services incurred.
b. The Employer has failed to obtain such coverage required by law.
c. The Participant waives his or her rights to such coverage or benefits.
d. The Participant fails to file a claim within the filing period allowed by law for such benefits.
e. The Participant fails to comply with any other provision of the law to obtain such coverage or benefits.
f. The Participant was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

This Exclusion will not apply if the Participant is permitted by statute not to be covered and the Participant elects not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws.

This Exclusion will not apply if the Participant's employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws or employer's liability acts of any state, country, or the United States.

2. Services, supplies, drugs and devices which the Participant is entitled to receive or does receive from TRICARE, the Veteran's Administration (VA), but not Medicaid. This Exclusion is not intended to exclude Covered Medical Expenses from coverage if a Participant is a resident of a Montana state institution when services are provided.

NOTE: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Participant. When such a circumstance occurs, the Participant will receive an Explanation of Benefits.

3. Services, supplies, and medications provided to treat any Injury to the extent the Participant receives or would be entitled to receive where liability is reasonably clear, benefits under an automobile insurance policy. Such benefits received by the Participant shall be used first to satisfy any remaining Coinsurance, Copayment and Deductible related to the Injury for which claims are submitted to the Plan. The Injury related claims must be submitted to the Plan to apply any applicable credit to Coinsurance, Copayment and/or Deductible.

4. Services, supplies, and medications provided to treat any Injury to the extent the Participant receives or would be entitled to receive where liability is reasonably clear, benefits from a premises liability policy. Examples of such policies are a homeowners or business liability policy. Such benefits received by the Participant shall be used first to satisfy any remaining Coinsurance, Copayment and Deductible related to the Injury for which claims are submitted to the Plan. The Injury related claims must be submitted to the Plan to apply any applicable credit to Coinsurance, Copayment and/or Deductible.

5. Services, supplies, drugs and devices to treat any Injury or Illness resulting from war, declared or undeclared, insurrection, rebellion, or armed invasion.

6. Any loss for which a contributing cause was the commission of a felony or serious illegal act, or an attempt to commit a felony or an attempt to commit a serious illegal act, for which the Participant has been found guilty in a court of competent jurisdiction or to which the Participant has plead guilty or no contest. This Exclusion does not apply to the extent the Participant suffers a loss as a victim of domestic violence.

7. Services for which a Participant is not legally required to pay or charges that are made only because Benefits are available on this Plan.

8. Services, supplies, drugs and devices provided to the Participant before the Participant's Effective Date or after the Participant's coverage terminates.

9. Orthodontics.

10. All dental services, including but not limited to ridge augmentation and vestibuloplasty, whether performed by Physicians, dentists, oral surgeons and/or any other provider, except for services provided as the result of a Dental Accident; (ii) services provided as a result of or to treat either a congenital defect or a cancer; or (iii) services in connection with a transplant or as applicable if Dental Benefits (non-Accident) are included in the section entitled Benefits.

11. Vision services, including but not limited to prescription, fitting or provision of eyeglasses or contact lenses and Lasik Surgery, except that vision services may be covered for specific conditions in Medical Policy.

12. Hearing aids, except as otherwise provided under this Plan Document, and Medically Necessary cochlear implants may also be covered per Medical Policy.

13. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging, or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

14. Cosmetic services or complications resulting therefrom except when covered services are provided to correct a condition resulting from an Accident, a condition resulting from an Injury or to treat a congenital anomaly, as applicable in Medical Policy.

15. For travel by a Participant or provider, except as specifically included in this Plan Document.

16. Any related services to a non-covered service except for Routine Patient Costs for Participants in an Approved Clinical Trial. Related services are:

    a. Services in preparation for the non-covered service;
    b. Services in connection with providing the non-covered service;
    c. Hospitalization required to perform the non-covered service; or
    d. Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

17. Any service or procedure which is determined by the Claim Administrator to be an Inclusive Service/Procedure.

18. Any services, supplies, drugs and devices which are:

- **a.** Experimental/Investigational/Unproven services, except any services, supplies, drugs and devices considered to be Experimental/Investigational/Unproven and which are provided during a Phase I or II clinical trial, or the experimental or research arm of a Phase III clinical trial, except for services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial. This includes services, supplies, drugs and devices under study to determine the maximum tolerated dosage(s), toxicity, safety or efficacy as compared with standard treatment, or for the diagnosis of the condition in question. The Plan has the ultimate authority and right to determine what services are Experimental/Investigational/Unproven and are excluded from coverage.
- **b.** Not accepted standard medical practice. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice.
- **c.** Not a Covered Medical Expense.
- **d.** Not Medically Necessary.
- **e.** Not covered under applicable Medical Policy.

19. Private duty nursing except as covered under the Home Health Care and/or Hospice Benefit.

20. Transplants of a nonhuman organ or artificial organ implant.

21. Reversal of an elective sterilization.

22. Services, supplies, drugs and devices related to the treatment of infertility, including but not limited to in vitro fertilization and artificial insemination.

23. Routine foot care for Participants without co-morbidities, except Routine foot care is covered if a Participant has co-morbidities such as diabetes.

24. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

25. Services, supplies, drugs and devices related to treatment for psychological or psychogenic sexual dysfunctions.

26. Services, supplies, drugs and devices relating to any of the following treatments or related procedures:

- **a.** Homeopathy;
- **b.** Hypnotherapy;
- **c.** Rolfing;
- **d.** Holistic medicine;
- **e.** Religious counseling;
- **f.** Self-help programs.

27. Services provided by a massage therapist.

28. Sanitarium care, Custodial Care, rest cures, or convalescent care to help the Participant with daily living tasks. Examples include but are not limited to, help in:

- **a.** Walking.
- **b.** Getting in and out of bed.
- **c.** Bathing.
- **d.** Dressing.
- **e.** Feeding.
- **f.** Using the toilet.
- **g.** Preparing special diets.
- **h.** Supervision of medication which is usually self-administered and does not require the continuous attention of medical personnel.

No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, or extended care facility for the types of care outlined in this Exclusion.

29. Vitamins, except those vitamins that may be covered in Medical Policy.

30. Over-the-counter food supplements, formulas, and/or Medical Foods, regardless of how administered except when used for Inborn Errors of Metabolism.

31. Services, supplies, drugs and devices for the surgical treatment of any degree of obesity, whether provided for weight control or any medical condition.

32. Services, supplies, drugs and devices for weight reduction or weight control. This Exclusion does not include intensive behavioral dietary counseling when services are provided by a Physician, physician assistant or nurse practitioner.

33. Services, supplies, drugs and devices for obesity, weight reduction or control whether rendered for weight control or any other condition, except for if Prior Authorized as Medically Necessary and a Benefit of this Plan Document.

34. Charges associated with health clubs, weight loss clubs or clinics.

35. Services, supplies, drugs and devices for the treatment of Illness, Injury and/or complications resulting from services that are not Covered Medical Expenses, except for any services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial.

36. Tutoring services.

37. Any services, supplies, drugs and devices not provided in or by a Covered Provider.

38. Services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature.

39. Deluxe medical equipment including, but not limited to, durable medical equipment, prosthetics and communication devices except as included in the Durable Medical Equipment Benefit and the Prosthetic Benefit in the section entitled Benefits.

40. Services or supplies for:

- **a.** Intersegmental traction;
- **b.** All types of home traction devices and equipment;
- **c.** Vertebral axial decompression sessions;
- **d.** Surface Electromyography (EMG); the measurement of muscle electrical activity with electrodes placed on the skin over the muscle;
- **e.** Spinal manipulation under anesthesia;
- **f.** Muscle testing through computerized kinesiology machines;
- **g.** Balance testing through computerized dynamic posturography sensory organization test.

41. Testing of:

- **a.** Blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood;
- **b.** Urine for measurement of collagen cross links;
- **c.** Cervicovaginal fluid for amniotic fluid protein;
- **d.** Allergen specific IgG measurement

42. Applied Behavior Analysis (ABA) services, except as specifically included in this Plan Document under Autism Spectrum Disorders.

43. Professional or courtesy discounts.

44. 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.

45. Mailing or sales tax. Charges for mailing, shipping, handling, postage, conveyance and/or sales tax.

46. Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

47. Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

48. Vocational and Cognitive retraining, described as such, or otherwise named.

49. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

50. The Plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

51. Services, supplies, drugs and devices which are not listed as a Benefit as described in this Plan Document.

52. Relative giving services. Professional services performed by a person who ordinarily resides in the Participant's home or is related to the Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

CLAIMS

How to Obtain Payment for Covered Expenses for Benefits

1. If a Participant obtains services from a Participating Provider, the Participating Provider will submit claims to the Claim Administrator for the Participant. If a Participant obtains services from a nonparticipating provider, the Participant may be required to submit all claims to the Plan. All claims for services must be submitted no later than 12 Months from the date of service. All claims must provide enough information about the services for the Claim Administrator to determine whether or not they are a Covered Medical Expense. Submission of such information is required before payment will be made.

Itemized bill must contain the following information:

- Employee's name;
- Employee Plan Identification Number from the ID card;
- Name of patient;
- Patient's date of birth;
- Employee's address;
- Provider name, address, telephone number;
- Provider number;
- Type of service;
- Procedure code for each service;
- Date of each service;
- Diagnosis;
- Charge for each service.

In certain instances, the Claim Administrator may require that additional documents or information including, but not limited to, Accident reports, medical records, and information about other insurance coverage, claims, payments and settlements, be submitted within the timeframe requested for the additional documentation before payment will be made.

2. If a Participant purchases drugs or Prescription Drug Products at a Participating Pharmacy, an Extended Supply Pharmacy or a mail order Pharmacy approved by the Plan, and the Participant's identification card is presented at the time of purchase, the Participant must pay for the Prescription Drug Product and the Participating Pharmacy will submit a claim for the cost of the covered prescription drug or Prescription Drug Product to the Plan's Pharmacy Benefit Manager. The Participant's responsibility for the cost of the covered drug or Prescription Drug Product will then accumulate to the Participant's In-Network Deductible and In-Network Out of Pocket

Amount. Once the Deductible, if applicable, is met, the Participant will only be required to pay the appropriate Copayment and/or Coinsurance if the amount can be determined by the Pharmacy at the time of purchase.

If a Participant purchases drugs or Prescription Drug Products at a nonparticipating pharmacy, the Participant must pay for the prescription at the time of dispensing and then within one year of the date of purchase submit a claim for the prescription drug on a form to the Claim Administrator's Pharmacy Benefit Manager for reimbursement. The Participant's Deductible, Copayment and/or Coinsurance for the covered drug or Prescription Drug Product will then accumulate to the Out-of-Network Deductible and the Out-of Network Out of Pocket Amounts.

Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

3. Claims must be submitted to the address listed on the inside cover of this Plan Document, on the claim form. Contact the Customer Service number on the back of the Participant's identification card for information on how to submit a claim.

Out-of-State Services – Claims for Family Members Who Live Out of State and All Other Claims for Out-of-State Services

Family Members who live out-of-state or Participants who have health care services out-of-state should use Participating Blue Cross and Blue Shield Providers in that state. In most cases, providers will file claims directly with the Claim Administrator. Please refer to the BlueCard Program section. If the provider does not file the claim, the Participant should use the same procedures outlined in the section entitled Claims Information.

Self-Audit Program

You will be eligible to receive a cash reward if you find an overcharge on your covered provider's bill that has been processed incorrectly and:

1. Was not detected by the provider.
2. Was not detected by Blue Cross and Blue Shield of Montana.
3. Was part of the charges for services which are payable under this Plan.

In order to qualify, request an itemized statement from the provider. Review the bill for services not received, the appropriate number of tests, x- rays, etc. If you find an error, ask the provider to correct the error and send you a revised statement. Clearly mark both statements "Self -Audit Program" and send them to the attention of the Claims Department at:

Blue Cross and Blue Shield of Montana
P.O. Box 660255
Dallas, TX 75266-0255

Blue Cross and Blue Shield of Montana will refund to you 50 percent (50%) of the savings up to $1,000 based on an overcharge of $2,000. The minimum error eligible to qualify for this refund is $50 with a minimum payment to you of $25.

Prescription Drug Claims - Filling Prescriptions at a Retail Pharmacy

Outpatient prescription drugs are available through the Prime Therapeutics Prescription Drugs Benefit. Prime Therapeutics is the Pharmacy Benefit Manager.

1. Go to a Prime Therapeutics Participating Pharmacy that accepts Participant identification cards. To find out if a Pharmacy takes part in the program, ask the pharmacist. To find a Prime Therapeutics Participating Pharmacy nearest the Participant, check the list on the website www.bcbsmt.com or call the Pharmacy locator at the telephone number on the inside cover of this document.
2. Present the prescription and the Participant's identification card to the pharmacist.
3. Make sure that the pharmacist has complete and correct information about the Participant for whom the prescription is written, including sex and date of birth.
4. When the Participant receives a prescription, he or she should sign the Pharmacy log and pay his or her share of the cost.

5. If a Participant purchases prescription drugs from a Participating Pharmacy or mail-service Pharmacy approved by the Claim Administrator, the Participant must pay for the Prescription Drug Product and the Pharmacy will submit the prescription drug claims to the Pharmacy Benefit Manager.
6. The Plan makes use of a Drug List, which is a list of covered prescription drugs for dispensing to Participants as appropriate.
7. For prescriptions filled at a Pharmacy that is not part of the network, the Participant will need to pay the entire cost of the prescription at the time the prescription is filled and dispensed and submit a paper claim to Pharmacy Benefit Manager for reimbursement. The Participant will be reimbursed for the prescription drug at the amount that would have been paid to a Participating Pharmacy less any Deductible, Copayment and/or Coinsurance. The Participant will not receive the preferred pricing.
8. Prescriptions filled at Hospital Pharmacies are not eligible for reimbursement unless they are listed as a network Pharmacy.

Pharmacy Benefit Manager claim forms are available by calling the Claim Administrator at the telephone number on the inside cover of this document.

Mail-Service Pharmacy

The Participant may obtain maintenance prescriptions through the mail. Maintenance prescriptions are those that the Participant expects to continue using for an extended period of time and for which a prescription can be written for up to a 90-day supply. Coverage for costly prescriptions should be verified prior to ordering. Specific Benefits are outlined in the Prescription Drugs section in this document.

To obtain a mail service claim form, call the Claim Administrator at the telephone number on the inside cover of this document.

To order a prescription:

1. Complete all sections and sign the Mail-Service order form.
2. Enclose the following:
   a. The original prescription written for up to a 90-day supply;
   b. The Participant's current Pharmacy telephone number and prescription numbers to be transferred; and
   c. The Participant's telephone number.
3. Mail the form to the mail service Pharmacy at the address listed on the form.

PRIVACY OF PROTECTED HEALTH INFORMATION

Protected Health Information about a Plan Participant will not be disclosed to the Plan Sponsor by the Health Plan or any Business Associate servicing the Health Plan, unless the Plan Sponsor certifies that the Plan Documents have been amended to include this section and the Plan Sponsor agrees to abide by this section. Any disclosure to and use by the Plan Sponsor will comply with all provisions of this section.

Definitions

For the purpose of this section, the following definitions apply:

1. Business Associate.

   A person or entity who performs or assists in performing or provides a function or activity that involves the use or disclosure of Protected Health Information on behalf of the Health Plan. Such functions or activities include, but are not limited to, claims processing, claims administration, data analysis, data processing, data administration, utilization review, quality assurance, billing, benefit management, legal services, marketing services, accounting services, and administration services.

2. Federal Regulations.

   Those regulations entitled Standards for Privacy of Individually Identifiable Health Information, 45 CFR §160 and §164.

3. Health Plan or Plan.

   The Group Health Plan, provided to the Plan Participants by or through the Plan Sponsor. The Group Health Plan may be administered by a third-party health insurance carrier or other third-party administrator. The health insurance issuer or third-party administrator is the Business Associate of the Group Health Plan.

4. Plan Participant.

   A person covered under the Group Health Plan.

5. Protected Health Information (PHI).

   Individually identifiable health information transmitted, including electronic transmission, or maintained in any form or medium.

6. Plan Sponsor.

   The Employer or other entity that sponsors the Group Health Plan.

Purpose of Disclosure to Plan Sponsor

A Plan Participant's PHI will only be disclosed to the Plan Sponsor by the Health Plan, or a Business Associate servicing the Health Plan, subject to the following:

1. To permit the Plan Sponsor to carry out Plan administration functions that are in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. Disclosures to the Plan Sponsor of a Plan Participant's PHI will be explained in the Notice of Privacy Practices issued to Plan Participants by the Health Plan.
3. No Plan Participant's PHI will be disclosed to the Plan Sponsor for the purpose of employment – related actions or decisions or in connection with any other Benefit or employee benefit plan of the Plan Sponsor.

Restrictions on Plan Sponsor's Use and Disclosure of PHI

The Plan Sponsor will:

1. Not use or further disclose PHI except as permitted or required by the Plan Documents, as amended by this section, or required by law.
2. Ensure that any agent, including subcontractors, to whom it provides PHI agrees to the restrictions and provisions of the Plan Documents, including this section.
3. Not use or disclose PHI for the purpose of employment-related actions or decisions or in connection with any other Benefit or Employee Benefit plan of the Plan Sponsor.
4. Promptly report to the Health Plan any use or disclosure of PHI that does not comply with the provisions of this section upon learning of such noncompliance.
5. Make PHI, located in a Plan Participant's designated record set, available to the Plan Participant who is the subject of the information, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for their information.
6. Make PHI, located in a Plan Participant's designated record set, available for amendment, and amend PHI, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for amendment.
7. Provide an accounting of disclosure to Plan Participants in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for an accounting of disclosures.
8. Make its internal practices, books, and records, relating to its use and disclosure of PHI, available to the Health Plan and the United States Department of Health and Human Services to determine compliance with Federal Regulations.

9. If feasible, and subject to 9b below:
    a. Return or destroy all PHI, and retain no copies, when the PHI is no longer needed for the Plan administration functions for which the disclosure was made. This includes:
        1. PHI, in whatever form or medium (including any electronic medium under the Plan Sponsor's custody or control), received from the Health Plan or a Business Associate; and
        2. Any data or compilations derived from and allowing identification of any Plan Participant who is the subject of the PHI.
    b. If it is not feasible to return or destroy all PHI, the Plan Sponsor will limit the use or disclosure of any PHI that it cannot return or destroy to those purposes that make it unfeasible to return or destroy the PHI.

Adequate Separation Between the Plan Sponsor and the Plan

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to PHI received from the Health Plan or the Business Associate servicing the Plan. This includes those Employees who may receive PHI relating to payment under, health care operations of, or other matters pertaining to the Health Plan in the ordinary course of business:

LynnDee Schmidt, Benefits and Safety Manager

Access to PHI will be given to the Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, only to perform the Plan administration functions that the Plan Sponsor provides for the Health Plan.

The Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, will be subject to disciplinary action and sanctions, up to and including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of PHI in breach or violation of, or noncompliance with the provisions of this section.

The Plan Sponsor will promptly report any breach or violation of, or noncompliance as required in the section entitled "Restrictions on Plan Sponsor's use of Disclosure of PHI," Item 4 of this section. The Plan Sponsor will cooperate with the Health Plan to:

1. Correct the breach or violation of or noncompliance.
2. Impose appropriate disciplinary action or sanctions on the person(s) responsible for causing the breach or violation of or noncompliance.
3. Mitigate any detrimental effect of the breach or violation of or noncompliance on any Plan Participant who may have had the privacy of PHI compromised by the breach or violation of or noncompliance.

GENERAL PROVISIONS

Plan Administrator Powers and Duties

The Plan Administrator shall have total and exclusive responsibility to control, operate, manage, and administer the Plan in accordance with its terms. The Plan Administrator shall have all the authority that may be necessary or helpful to enable it to discharge its responsibilities with respect to the Plan. Without limiting the generality of the preceding sentence, the Plan Administrator shall have the exclusive right: to interpret the Plan; to determine eligibility for coverage under the Plan; to determine eligibility for Benefits under the Plan; to construe any ambiguous provisions of the Plan; to correct any default; to supply any omission; to reconcile any inconsistency; and to decide any and all questions arising in administration, interpretation, and application of the Plan.

The Plan Administrator shall have full discretionary authority in all matters related to the discharge of its responsibilities and the exercise of authority under the Plan, including, without limitation, the construction of the terms of the Plan, and the determination of eligibility for coverage and Benefits. The decisions of the Plan Administrator, as Plan Administrator, shall be conclusive, binding and final upon all persons having or claiming to have any right or interest in or under the Plan and no such decision shall be modified under judicial review unless such decision is proven to be arbitrary or capricious.

The Plan Administrator may delegate some or all of its authority under the Plan or revoke such delegation to any person or persons provided that any such delegation or revocation of delegation is in writing. The Plan Administrator may delegate its authority to determine eligibility for Benefits to the Claim Administrator.

Entire Plan; Changes

This Plan supersedes any previous plan. This Plan, including the amendments and attached papers, if any, constitutes the entire Plan. No change in this Plan is valid until made pursuant to the section entitled Modification of Plan.

Modification of Plan

The Plan Sponsor and Plan Administrator reserve the right to amend the Plan in whole or in part at any time, including the right to make any amendments to a contract with an insurance company, and the right to amend any rules adopted for the administration of the Plan. Expenses incurred prior to the Effective Date of any amendment are based on the provisions in effect at the time the expenses were incurred. The Employer reserves the right to change or cancel any Benefits under the Plan, at any time. Any such change in Benefits will be based solely on the decisions of the Employer and may apply to active Employees, future retirees and current retirees as either separate groups or as one group. If the Employer cancels any Benefits under the Plan, participation in the canceled Benefits terminates on the date of the cancellation, unless otherwise specified.

The Employer may terminate the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate, unless the Plan is continued by a successor to the Employer. Any such termination in Benefits will be based solely on the decision of the Employer and may apply to current Employees and their Dependents, future retirees and current retirees as either separate groups or as one group.

Notice of Change

All changes or amendments to this Plan that directly or indirectly relate to any Benefit or coverage under the Plan including any increase in contribution for coverage required from a Participant, will be reported to all eligible Participants in accordance with federal law after the date such change or amendment is adopted.

Clerical Errors

No clerical error on the part of the Claim Administrator shall operate to defeat any of the rights, privileges, or Benefits of any Participant covered under this Plan. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits will be made. Clerical errors shall not prevent administration of this Plan in strict accordance with its terms.

Notices Under Plan

Any notice required by this Plan may be given by United States mail, postage paid. Notice to the Participant will be mailed to the address appearing on the records of the Plan. Notice to the Plan should be sent to the Plan Sponsor. Any time periods included in a notice shall be measured from the date the notice was mailed.

Rescission of Plan Document

This Plan Document is subject to rescission if the Participant commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, concerning a Participant’s health, claims history, or current receipt of health care services. The Claim Administrator will provide at least 30 days advance written notice to the Participant before coverage may be rescinded.

Payment of Claims and Assignment of Benefits

Claim Payment Assignment

All payments by the Claim Administrator for the benefit of any Participant may be made directly to any Provider furnishing Covered Medical Expenses for which such payment is due, and the Claim Administrator is authorized by such Participant to make such payments directly to such providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Participant or

provider furnishing Covered Medical Expenses. All benefits payable to the Participant which remain unpaid at the time of the death of the Participant will be paid to the estate of the Participant.

Claim Dispute

Once Covered Medical Expenses are rendered by a provider, the Participant has no right to request the Claim Administrator not to pay the Claim submitted by such provider and no such request by a Participant or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Participant or any other person because of its rejection of such request.

Plan Coverage Assignment

Neither the Plan nor a Participant's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non-assignable or non-transferable and will be forfeited if a Participant attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the Claim Administrator makes payment because of a person's wrongful use of the identification card of a Participant, such payment will be considered a proper payment and the Claim Administrator will have no obligation to pursue recovery of such payment.

Validity of Plan

If any part, term, or provision of this Plan is held by the courts to be illegal or in conflict with any law of the state of Montana, the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the Plan did not contain the particular part, term, or provision held to be invalid.

Participants Rights

A Participant has no rights or privileges except as specifically provided in this Plan. Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any Participant, or as the right of any Participant to continue in the employment of the Employer or as a limitation of the right of the Employer to discharge any of its Employees with or without cause.

Alternate Care

This Plan may make payment for services that are not listed as a Benefit of this Plan. Such payment will be made only upon mutual agreement by the Participant, the Plan Administrator, and/or the Claim Administrator. Such payment does not act as a waiver of the terms of this Plan.

Benefit Maximums

If a Participant receives services payable under any section of this Plan and exhausts all Benefits available under that section, no Benefits are available under any other section for that same condition.

Pilot Programs

The Plan reserves the right to develop and enter into pilot programs to test the success of providing Benefits for care not normally covered under this Plan. The existence of a pilot program does not guarantee that all Participants are eligible for the pilot program Benefits or that such Benefits will be permanent. A pilot program is an initial small-scale implementation that is used to prove the variability of a project idea. This could involve either the exploration of a novel new approach or idea or the application of a standard approach new to the organization. It enables an organization to manage the risk of a new idea and identify any deficiencies before substantial resources are committed.

Research Fees

The Plan reserves the right to charge a reasonable fee when extensive research is necessary to reconstruct information or documents which were previously provided in writing to the Participant by the Plan. Fees may be charged for the costs of copying labor, supplies and postage. Fees will not be charged for searching for and retrieving the requested information.

Cooperation of Participant

The Participant must cooperate fully with the Plan, and any person or entity administering this Plan Document on behalf of the Plan, in providing documents and information requested to determine whether the Participant is or remains eligible for membership; to determine whether services are Covered Medical Expenses; to determine whether any term or exclusion of this Plan Document applies; and to make any other determination necessary to administer this Plan Document. Required cooperation by a Participant includes executing such consents, releases, disclosure authorizations and other documents as may be requested by the Plan in order to obtain documents or information from a third party necessary to make such determinations.

Required cooperation of a Participant includes but is not limited to providing or authorizing the provision of the following to the Plan:

1. All medical, Hospital, dental, vision and other health care records relating to the diagnosis or treatment of or services or items provided to the Participant;
2. All information and documents regarding coverage, policy limits, claim payments, demands, litigation, settlement (including disputed and undisputed liability settlements) under any applicable or potentially applicable insurance, health plan, government benefit program or other health or medical payor plan or program, including but not limited to:
    a. Workers' compensation, FELA or other similar plan or program providing benefits for Injury or Illness arising out of employment;
    b. Personal, commercial or other automobile insurance, including but not limited to no-fault medical payment, liability or other coverages; and
    c. Personal, homeowners, commercial, or other premises insurance, including but not limited to no-fault medical payment, liability or other coverages.

Statements are Representations

Any representations or statements made to a Participant by the Plan Administrator, their representatives or agent, about being covered for Benefits under the Plan, which conflict with the provisions of the Plan shall:

1. Not be considered as representations or statements made by, or on behalf of, the Plan Administrator;
2. Not bind the Plan Administrator for Benefits under the Plan.

In the absence of fraud, all statements by applicants or the Participant shall be deemed to be representations and not warranties. Any Participant who, with intent to defraud or knowing that he or she is facilitating a fraud against the Employer or the Plan, submits an application or files a claim containing a false, incomplete, or misleading statement may be found guilty of fraud. The Employer reserves the right to take appropriate action in any instance where fraud is at issue.

Overpayments

Effective on or after January 1, 2020, if the Plan or the Claim Administrator pays Benefits for Covered Medical Expenses incurred by the Participant and it is found that the payment was more than it should have been, or it was made in error ("overpayment"), the Plan or the Claim Administrator has the right to obtain a refund of the overpayment amount from: (i) the person to, or for whom, such Covered Medical Expenses were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Out-of-Network Providers.

If no refund is received, the Plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any overpayment due up to an amount equal to the overpayment, from:

1. Any future Benefit payment made to any person or entity under this Plan Document, whether for the same or a different Participant; or
2. Any future Benefit payment made to any person or entity under another Blue Cross and Blue Shield of Montana administered ASO Benefit program and/or Blue Cross and Blue Shield of Montana administered insured Benefit program or policy, if the future Benefit payment owed is to a Participating Provider; or
3. Any future Benefit payment made to any person or entity under another Blue Cross and Blue Shield of Montana insured group Benefit plan or individual policy, if the future Benefit payment owed is to a Participating Provider; or

4. Any future Benefit payment, or other payment, made to any person or entity; or
5. Any future payment owed to one or more Participating Providers.

Further, the Claim Administrator has the right to reduce the Plan's payment to a Participating Provider by the amount necessary to recover another Blue Cross and Blue Shield of Montana's Plan or policy overpayment to the same provider and to remit the recovered amount to the other Blue Cross and Blue Shield of Montana Plan or policy.

Participant/Provider Relationship

Choosing a Provider

The choice of a Provider is solely the choice of the Participant and the Claim Administrator will not interfere with the Participant's relationship with any provider.

Claim Administrator's Role

It is expressly understood that the Claim Administrator does not itself undertake to furnish Hospital, medical or dental services, but solely to make payment to a provider for the Covered Medical Expenses received by Participants. The Claim Administrator is not in any event liable for any act or omission of any provider or the agent or employee of such provider, including, but not limited to, the failure or refusal to render services to a Participant. Professional services which can only be legally performed by a provider are not provided by the Claim Administrator. Any contractual relationship between a provider and the Claim Administrator shall not be construed to mean that the Claim Administrator is providing professional services.

Intent of Terminology

The use of an adjective such as approved, administrator, participating, in-network or network in modifying a provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such provider. In addition, the omission, non-use or non-designation of approved, administrator, participating, in-network, network or any similar modifier or the use of a term such as non-approved, non-administrator, nonparticipating, out-of-network or non-network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such provider.

Provider's Role

Each provider provides Covered Medical Expenses only to covered Participants and does not deal with or provide any services to the Employer (other than as an individual Participant) of the Plan.

Recovery, Reimbursement, and Subrogation

By enrollment in this Plan, Participants agree to the provisions of this section as a condition precedent to receiving Benefits under this Plan. Failure of a Participant to comply with the requirements of this section may result in the pending of the payment of Benefits.

1. **Right to Recover Benefits Paid in Error**

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

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

   The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine. By receipt of Benefits under this Plan, each Participant authorizes the deduction of any excess payment of such Benefits or other present or future compensation payments.

The provisions of this subsection apply to any licensed health care provider who receives an assignment of Benefits or payment of Benefits under this Plan. If a licensed health care provider refuses to refund improperly paid claims, the Plan may refuse to recognize future assignments of Benefits to that provider.

2. Reimbursement

The Plan's right to reimbursement is separate from and in addition to the Plan's right of subrogation. Reimbursement means to repay a party who has paid something on another's behalf. If the Plan pays Benefits for medical expenses on a Participant's behalf, and another party was actually responsible or liable to pay those medical expenses, the Plan has the right to be reimbursed for the amounts the Plan paid.

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

3. Subrogation

The Plan's right to subrogation is separate from and in addition to the Plan's right to reimbursement. Subrogation is the right of the Plan to exercise the Participant's rights and remedies in order to recover from third parties who are legally responsible to the Participant for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Participant, with or without his or her consent, to recover the money paid under the Plan. In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to the Participant's Accident, Injury, condition, or Illness, which the Plan has paid, then the Plan is entitled to recover, by legal action or otherwise, the money paid; in effect the Plan has the right to "stand in the shoes" of the Participant for whom Benefits were paid, and to take any action the Participant could have undertaken to recover the money paid.

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

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

4. The Following Paragraphs Apply to Both Reimbursement and Subrogation:

- **a.** Under the terms of this Plan, the Plan Administrator is not required to pay any claims where there is evidence of liability of a third party. However, the Plan, in its discretion, may instruct the Claim Administrator not to withhold payment of Benefits while the liability of a party other than the Participant is being legally determined.
- **b.** If the Plan makes a payment which the Participant, or any other party of the Participant's behalf, is or may be entitled to recover against any third party responsible for an Accident, Injury, condition or Illness, the Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. The Participant receiving payment from this Plan will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the Plan's right of recovery.
- **c.** The Participant will cooperate fully with the Plan Administrator, its agents, attorneys, and assigns, regarding the recovery of any monies paid by the Plan for any party other than the Participant who is liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Plan Administrator, upon request and in a timely manner, of all material facts regarding the Accident, Injury,

condition, or Illness; all efforts by any person to recover any such monies; provide the Plan Administrator with any and all documents, papers, reports, and the like regarding demands, litigation or settlements involving recovery of monies paid by the Plan; and notifying the Plan Administrator of the amount and source of any monies received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.

d. Participants will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers, including but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Participant will notify the Plan immediately of the name and address of any attorney whom the Participant engages to pursue any personal Injury claim on his or her behalf.

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

f. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Participant pursuing a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund," or similar statute, regulation, prior court decision, or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

5. Right of Offset

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

DEFINITIONS

This section defines certain words used throughout this Plan Document. These words are capitalized whenever they are used as defined.

ACCIDENT

An unexpected traumatic incident or unusual strain which is:

1. Identified by time and place of occurrence;
2. Identifiable by part of the body affected; and
3. Caused by a specific event on a single day.

Some examples include:

1. Fracture or dislocation.
2. Sprain or strain.
3. Abrasion, laceration.
4. Contusion.
5. Embedded foreign body.
6. Burns.
7. Concussion.

ACTIVELY WORKING

The performance of an Employee's customary duties at the usual place of employment.

ADVANCED PRACTICE REGISTERED NURSE

Nurses who have additional professional education beyond the basic nursing degree required of a registered nurse and are considered Advanced Practice Registered Nurses by applicable state law. Advanced Practice Registered Nurses include nurse practitioners, nurse-midwives, nurse-anesthetists and clinical nurse specialists.

ALLOWABLE FEE

The Allowable Fee is based on, but not limited to, the following:

1. Medicare RBRVS based is a system established by Medicare to pay Physicians for a "work unit." The RBRVS value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers' billed charge; or
2. Diagnosis-related group (DRG) methodology is a system used to classify Hospital cases into one of approximately 500 to 900 groups that are expected to have similar Hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of Hospital resources for the given DRG regardless of the actual Hospital resources used. Therefore, the amount paid by the Claim Administrator to a nonparticipating provider under the DRG system can be considerably less than the nonparticipating providers' billed charge; or
3. Billed charge is the amount billed by the provider; or
4. Case rate methodology is an all-inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the case rate system can be considerably less than the nonparticipating providers' billed charge; or
5. Per diem methodology is an all-inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the per diem system can be considerably less than the nonparticipating providers' billed charge; or
6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to a nonparticipating provider under the flat fee per category of service system can be considerably less than the nonparticipating providers' billed charge; or
7. Flat fee per unit of service fixed payment amount for a unit of service. For instance, a unit of service could be the amount of "work units" customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the flat fee per unit system can be considerably less than the nonparticipating providers' billed charge; or
8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or
9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or
10. The amount negotiated with the Pharmacy Benefit Manager or manufacturer or the actual price for prescription or drugs; or
11. The American Society of Anesthesiologists' Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a "work unit." The payment value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the system can be considerably less than the nonparticipating providers' billed charge.
12. For nonparticipating providers in Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for nonparticipating providers will represent an average contract rate for Participating Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by nonparticipating providers which may also alter the Allowable Fee for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the

Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Plan within 90 days after the Effective Date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

13. For nonparticipating providers outside Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee (i) for professional providers is based on publicly available data and historic reimbursement to providers for the same or similar professional services, adjusted for geographic differences where applicable, or (ii) for Hospital or other facility providers is based on publicly available data reflecting the approximate cost that Hospitals or other facilities have incurred historically to provide the same or similar service, adjusted for geographic differences where applicable, plus a margin factor for the Hospital or facility.

14. The Allowable Fee for Outpatient Dialysis is the Usual and Reasonable Charge as described in the separately issued Outpatient Dialysis Plan Document.

In the event the nonparticipating Allowable Fee does not equate to the nonparticipating provider's billed charges, the Participant will be responsible for the difference, along with any applicable Deductible, Copayment and/or Coinsurance amount. This difference may be considerable. To find out an estimate of the Plan's nonparticipating Allowable Fee for a particular service, Participants may call the Customer Service number shown on the back of the Participant's identification card.

AMPLIFICATION DEVICE

A hearing device, hearing aid, or a wearable, non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold.

APPLIED BEHAVIOR ANALYSIS (ABA) - (ALSO KNOWN AS LOVAAS THERAPY)

Medically Necessary interactive therapies or treatment derived from evidence-based research. The goal of ABA is to improve socially significant behaviors to a meaningful degree, including:

1. Increase desired behaviors or social interaction skills;
2. Teach new functional life, communication, or social, skills;
3. Maintain desired behaviors, such as teaching self-control and self-monitoring procedures;
4. Appropriate transfer of behavior from one situation or response to another;
5. Restrict or narrow conditions under which interfering behaviors occur;
6. Reduce interfering behaviors such as self-injury.

ABA therapy and treatment includes Pivotal Response Training, Intensive Intervention Programs, and Early Intensive Behavioral Intervention, and the terms are often used interchangeably. The ABA Benefit also includes Discrete Trial Training, a single cycle of behaviorally based instruction routine that is a companion treatment with ABA.

Services must be provided by an appropriately certified provider.

APPROVED CLINICAL TRIAL

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV, clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition. The trial must be:

1. Conducted under an investigational new drug application reviewed by the FDA;
2. Exempt from an investigational new drug application; or
3. Approved or funded by:

    a. The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
    b. A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;

c. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or

d. The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and provide unbiased scientific review by individuals who have no interest in the outcome of the review.

BENEFIT

Services, supplies and medications that are provided to a Participant and covered under this Plan Document as a Covered Medical Expense.

BENEFIT PERIOD

For the Plan - is the period of time shown in the Schedule of Benefits.

For the Participant - Is the same as for the Plan except that if the Participant's Effective Date is after the Effective Date of the Plan, the Participant's Benefit Period begins on the Participant's Effective Date and ends on the same date the Plan Benefit Period ends. Thus, the Participant's Benefit Period may be less than 12 Months.

BEST EVIDENCE

Means evidence based on:

1. Randomized Clinical Trials;
2. A Cohort Study or Case-Control Study, if Randomized Clinical Trials are not available;
3. A Case Series, if Randomized Clinical Trials, Cohort Studies or Case-Control Studies are unavailable; and/or
4. An Expert Opinion, if Randomized Clinical Trials, Cohort Studies, Case-Control Studies or Case Series are unavailable.

BLUE CROSS AND BLUE SHIELD OF MONTANA

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, is the Claim Administrator for this Plan.

BLUE CROSS AND BLUE SHIELD OF MONTANA SPECIALTY NETWORK

Specialty Pharmacy providers who have entered into an agreement with the Plan or third party on behalf of the Claim Administrator to provide Specialty Medications to Participants and which have agreed to accept specified reimbursement rates.

BRAND-NAME DRUG

A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand-Name Drug. There may also be situations where a drug's classification changes from Generic Drug to Brand-Name Drug due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to payment obligations from Generic Drug to Brand-Name Drug.

CARE COORDINATION

Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Plan Participant's healthcare needs across the continuum of care.

CARE COORDINATOR

An individual within a provider organization who facilitates Care Coordination for patients.

CARE COORDINATOR FEE

A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

CARE-MANAGEMENT

A process that assesses and evaluates options and services required to meet the Participant's health care needs. Care Management may involve a team of health care professionals, including Covered Providers, the Plan and other resources to work with the Participant to promote quality, cost-effective care.

CASE-CONTROL STUDY

A retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

CASE SERIES

An evaluation of a series of patients with a particular outcome, without the use of a control group.

CLAIM ADMINISTRATOR

Claim Administrator means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Claim Administrator is Blue Cross and Blue Shield of Montana. The Claim Administrator provides ministerial duties only, exercises no discretion over Plan assets.

CLINICAL PEER

A Physician or other health care provider who:

1. Holds a nonrestricted license in a state of the United States; and
2. Is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

CODE

The Internal Revenue Code of 1986, as amended.

COHORT STUDY

A prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

COINSURANCE

The percentage of the Allowable Fee payable by the Participant for Covered Medical Expenses. The applicable Coinsurance is stated in the Schedule of Benefits.

COMPOUNDED DRUGS

Drugs or inert ingredients that have been measured and mixed by a pharmacist to produce a unique formulation because commercial products either do not exist or do not exist in the prescribed dosage, size, or form.

CONCURRENT CARE

Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or

Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Participant's condition requires the skills of separate Physicians.

CONSULTATION SERVICES

Services of a consulting Physician requested by the attending Physician. These services include discussion with the attending Physician and a written report by the consultant based on an examination of the Participant.

CONVALESCENT HOME

An institution, or distinct part thereof, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is:

1. A skilled nursing facility;
2. An extended care facility;
3. An extended care unit; or
4. A transitional care unit.

A Convalescent Home is primarily engaged in providing continuous nursing care by or under the direction and supervision of a registered nurse for sick or injured persons during the convalescent stage of their Illness or Injuries and is not, other than incidentally, a rest home or home for Custodial Care, or for the aged.

NOTE: A Convalescent Home shall not include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and treatment of Mental Illness or Substance Use Disorder.

COSMETIC

Services that are provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical function.

COVERED MEDICAL EXPENSE

Expenses incurred for Medically Necessary services, supplies and medications that are based on the Allowable Fee and:

1. Covered under the Plan;
2. In accordance with Medical Policy; and
3. Provided to the Participant by and/or ordered by a Covered Provider for the diagnosis or treatment of an active Illness or Injury or in providing maternity care.

In order to be considered a Covered Medical Expense, the Participant must be charged for such services, supplies and medications.

COVERED PROVIDER

A participating or nonparticipating provider which has been recognized by the Claim Administrator as a provider of services for Benefits described in this Plan Document. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine if a provider is covered, the Claim Administrator looks to the nature of the services rendered, the extent of licensure and is recognized by the Claim Administrator as a provider of services for Benefits described in the Plan Document.

Covered Providers include professional providers and facility providers including Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, audiologists, nurse specialists, naturopathic physicians, Advanced Practice Registered Nurses, physician assistants, Hospitals and Freestanding Surgical Facilities.

CREDITABLE COVERAGE

Coverage that the Participant had for medical Benefits under any of the following plans, programs and coverages:

1. A group health plan;
2. Health insurance coverage;
3. Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1935c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4 (Medicare);
4. Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s (Medicaid);
5. Title 10, chapter 55, United States Code (TRICARE);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A health plan offered under Title 5, chapter 89, of the United States Code (Federal Employee Health Benefits Program);
8. A public health plan;
9. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e); or
10. A high-risk pool in any state.

Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits.

CUSTODIAL CARE

Any service, primarily for personal comfort or convenience, that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the Participant's condition. Custodial Care services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable nonprofessional personnel, are to assist with Routine medical needs (e.g. simple care and dressings, administration of Routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

DEDUCTIBLE

The dollar amount each Participant must pay for Covered Medical Expenses incurred during the Benefit Period before the Plan will make payment for any Covered Medical Expense to which the Deductible applies.

Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. Thus, Copayments, and/or Coinsurance, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Participant's responsibility.

If two or more Participants covered under the same family satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Participant of the family.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, only one Deductible will be applied to that Hospital stay (facility charges only). If the Participant satisfied the Participant's Deductible prior to that Hospital stay, no Deductible will be applied to that stay.

DENTAL PROVIDER

A Dental Provider may be participating or nonparticipating. A participating Dental Provider is a provider who has a contract with the Claim Administrator. These providers agree to accept payment directly from the Claim Administrator for covered services. This payment, together with the Participant's Deductible and Coinsurance described in the Schedule of Benefits, is accepted as payment in full. The Participant may obtain a list of participating Dental Providers from the Claim Administrator upon request.

If a Participant receives services from a nonparticipating Dental Provider, the Participant is responsible for the balance of the nonparticipating provider's bill after payment by the Plan.

DEPENDENT

A Participant who has been enrolled by an enrolled Employee and who is one of the following:

1. The Employee's legal Spouse;
2. The Employee's biological child, adopted child, or child placed for adoption and who is under the age of 26 years;
3. Children for who the Employee becomes legally responsible by reason of placement for adoption, as defined in Montana law;
4. A child of the Employee and/or Spouse who is 26 years of age or older may qualify as a Family Member if the child:
    a. Has been covered under the Plan before age 26; and
    b. Cannot support himself/herself because of intellectual disability or physical handicap; and
    c. Is legally dependent on the enrolled Employee for support.

Proof of those qualifications must be supplied to the Plan within 31 days of the child's 26th birthday. Although there is no limiting age for handicapped children, the Plan reserves the right to require periodic certification from the enrolled Employee of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child's 26th birthday.

DIAGNOSTIC BREAST EXAMINATION

A Medically Necessary and clinically appropriate examination of the breast, including diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

DRUG LIST

A list of all drugs that may be covered under the Prescription Drugs section of this Plan Document. A current list is available on the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. Contact a Customer Service representative at the telephone number shown on the back of the Participant's identification card for more information.

EFFECTIVE DATE

For a Participant, the Effective Date is the date the Participant has met the requirements of the Plan and is shown on the records of the Plan to be eligible for Benefits. For the Plan, the Effective Date is the date shown on the Schedule of Benefits. However, certain provisions shall be effective as of the dates specified within those provisions. The Effective Date of any amendment to the Plan is the Effective Date set forth on such amendment.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another Hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn fetus.

EMERGENCY SERVICES

Health care items or services furnished or required to evaluate and treat an Emergency Medical Condition.

EMPLOYEE

Any person (other than a nonresident alien who receives no U.S. income from the Employer) who is employed by the Employer. Notwithstanding the foregoing, the term “Employee” shall also include any officer, or former officer of the Employer for whom the Employer is contractually bound by written agreement to provide health Benefits. Employee shall not include any person who is classified by the Employer as an independent contractor or as a leased Employee.

EMPLOYER

Yellowstone County

ESSENTIAL HEALTH BENEFITS

A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Some plans cover more services.

EVIDENCE-BASED STANDARD

The conscientious, explicit, and judicious use of the current Best Evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

EXCLUSION

A provision which states that the Plan has no obligation under this Plan Document to make payment.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device, biological product or medical treatment or procedure is Experimental, Investigational and/or Unproven if **the Plan determines** that:

1. The drug, device, biological product or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product or medical treatment or procedure is furnished; or
2. The drug, device, biological product or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials, or 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
3. The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product or 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.

Approval by a governmental or regulatory agency will be taken into consideration in assessing the Experimental/Investigational/Unproven status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative. The Plan Administrator has the discretionary authority to make determinations as which drugs, services, supplies, care and/or treatments shall be considered experimental, investigative or unproven.

EXPERT OPINION

A belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

EXPLANATION OF BENEFITS (EOB)

A notification issued to the Participant when a health care claim is processed. The EOB shows how the claim was processed.

FAMILY MEMBER

A Dependent who has been enrolled by an enrolled Employee into the Plan and has been accepted as a Participant of the Plan.

FREESTANDING INPATIENT FACILITY

For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorder in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment Center.

Services include medical evaluation and health supervision; Substance Use Disorder education; organized individual, group and family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up program after discharge.

For treatment of Mental Illness, it means a facility licensed by the state and specializing in the treatment of Mental Illness.

GENERIC DRUG

A drug that has the same active ingredient as a Brand-Name Drug and is allowed to be produced after the Brand-Name Drug's patent has expired. In determining the brand or generic classification for covered drugs, the Claim Administrator uses the generic/brand status assigned by a nationally recognized provider of drug product database information. Not all drugs identified as a "generic" by the drug product database, manufacturer, pharmacy or Physician may process as a Generic Drug. Generic Drugs are listed on the Drug List which is available on the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. The Participant may also contact Customer Service for more information.

HABILITATIVE CARE

Coverage will be provided for Habilitative Care services when the Participant requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Other services for people with disabilities.

These services may be provided in a variety of inpatient and/or Outpatient settings as prescribed by a Physician.

HIPAA

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

HOME HEALTH AGENCY

An agency licensed by the state which provides home health care to the Participant in the Participant's home.

HOME HEALTH AIDE

A nonprofessional worker who has been trained for home care of the sick and is employed by a Home Health Agency.

HOME HEALTH SERVICE

The services provided by a Home Health Agency that must be:

1. Prescribed and supervised by the Participant's attending Physician;
2. Provided through a licensed Home Health Agency; and
3. Provided to the Participant in the Participant's home.

HOME INFUSION THERAPY AGENCY

A health care provider that provides home infusion therapy services.

HOSPITAL

A facility providing, by or under the supervision of licensed Physicians, services for medical diagnoses, treatment, rehabilitation, and care of injured, disabled, or sick individuals. A Hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week and provides 24-hour nursing care by licensed registered nurses. Hospital does not include the following, even if such facilities are associated with a Hospital:

1. A nursing home;
2. A rest home;
3. A Convalescent Home; and/or
4. A long-term, chronic-care institution or facility providing the type of care listed above.

ILLNESS

An alteration in the body or any of its organs or parts which interrupts or disturbs the performance of a vital function, thereby causing or threatening pain or weakness.

IN-NETWORK

Providers who are:

1. Participating Blue Cross and Blue Shield of Montana Professional Providers;
2. Participating Blue Cross and Blue Shield of Montana Facility Providers, except for Hospitals and surgery centers;
3. PPO Hospitals and surgery centers;
4. Blue Cross and/or Blue Shield PPO providers outside of Montana; or
5. Participating Pharmacies.

INCLUSIVE SERVICES/PROCEDURES

A portion of a service or procedure which is necessary for completion of the service or procedure or a service or procedure which is already described or considered to be part of another service or procedure.

INDEPENDENT REVIEW ORGANIZATION (IRO)

An organization that offers an independent review and determination of an adverse benefit determination once a Participant has exhausted all internal appeal options available through the health care plan.

INFUSION SUITE

An alternative to Hospital and clinic-based infusion settings where Specialty Medications can be infused.

INJURY

Physical damage to an individual's body, caused directly and independent of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

INPATIENT CARE

Care provided to a Participant who has been admitted to a facility as a registered bed patient and who is receiving services, supplies and medications under the direction of a Covered Provider with staff privileges at that facility. Examples of facilities to which a Participant might be admitted include:

1. Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent Homes; or
5. Freestanding Inpatient Facilities.

INPATIENT PARTICIPANT

A Participant who has been admitted to a facility as a registered bed patient for Inpatient Care.

LEGAL SEPARATION OR LEGALLY SEPARATED

Legal Separation and/or Legally Separated shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

LIFE-THREATENING CONDITION

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MEDICAL FOODS

Nutritional substances in any form that are:

1. Formulated to be consumed or administered enterally under supervision of a Physician;
2. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;

3. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
4. Essential to optimize growth, health, and metabolic homeostasis.

MEDICAL OR SCIENTIFIC EVIDENCE

Evidence found in the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's library of medicine for indexing in Index Medicus and Excerpta Medica, published by the Reed Elsevier group;
3. Medical journals recognized by the Secretary of Health and Human Services under 42 U.S.C. 1395x(t)(2)(B) of the federal Social Security Act;
4. The following standard reference compendia:
   a. The American Hospital Formulary Service Drug Information;
   b. Drug Facts and Comparisons;
   c. The American Dental Association Guide to Dental Therapeutics; and
   d. The United States Pharmacopeia;
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
   a. The federal Agency for Healthcare Research and Quality;
   b. The National Institutes of Health;
   c. The National Cancer Institute;
   d. The National Academy of Sciences;
   e. The Centers for Medicare and Medicaid Services;
   f. The Food and Drug Administration; and
   g. Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6. Any other Medical or Scientific Evidence that is comparable to the sources listed in subsection 4 or 5.

MEDICAL POLICY

The policy of the Claim Administrator which is used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

Medical Policy is reviewed and modified periodically as is necessary.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant

medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a Covered Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Participant receives the services, supplies, or medications and a claim is submitted to the Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MEDICALLY NECESSARY (FOR AUTISM, ASPERGER'S DISORDER AND PERVASIVE DEVELOPMENTAL DISORDER)

Any care, treatment, intervention, service, or item that is prescribed, provided or ordered by a Physician or psychologist and that will or is reasonably expected to:

1. Prevent the onset of an Illness, condition, Injury, or disability;
2. Reduce or improve the physical, mental, or developmental effects of an Illness, condition, or Injury, or disability; or
3. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

MENTAL HEALTH TREATMENT CENTER

A treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider. The facility must be:

1. Licensed as a Mental Health Treatment Center by the state;
2. Funded or eligible for funding under federal or state law; or
3. Affiliated with a Hospital under a contractual agreement with an established system for patient referral.

MENTAL ILLNESS

A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

1. Present distress or a painful symptom;
2. A disability or impairment in one or more areas of functioning; or
3. A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

Mental Illness does not include:

1. Developmental disorders;
2. Speech disorders;
3. Psychoactive Substance Use Disorders;
4. Eating disorders (except for bulimia and anorexia nervosa); or
5. Impulse control disorders (except for intermittent explosive disorder and trichotillomania).

Mental Health Parity Act of 1996 (MPHA) and Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA.

"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1) The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).

2) There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such plan.
3) The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominate treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or Coverage).
4) There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

MONTH

For the purposes of this Plan Document, a Month has 30 days even if the actual calendar Month is longer or shorter.

MULTIDISCIPLINARY TEAM

A group of health service providers who are either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. Members of the Multidisciplinary Team may include, but are not limited to, a licensed psychologist, licensed speech therapist, registered physical therapist, or licensed occupational therapist.

NEGOTIATED ARRANGEMENT

An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

NON-PREFERRED BRAND-NAME DRUG

A Brand-Name Drug that is identified on the Drug List as a Non-Preferred Brand-Name Drug. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists..

NON-PREFERRED GENERIC DRUG

A Generic Drug that is identified on the Drug List as a Non-Preferred Generic Drug. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists..

NON-PREFERRED SPECIALTY MEDICATION

A Specialty Medication, which may be a Generic or Brand-Name Drug, that is identified on the Drug List as a Non-Preferred Specialty Medication. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

OCCUPATIONAL THERAPY

Therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of speech tasks or goal-directed activities designed to improve the functional performance of an individual.

OUT-OF-NETWORK

Providers who are:

1. Nonparticipating professional providers;
2. Nonparticipating facility providers;
3. Non-PPO Network Hospitals and surgery centers; or
4. Blue Cross and Blue Shield of Montana Participating Hospitals and surgery centers that are not in the PPO Network.

OUT OF POCKET AMOUNT

For the Participant:

The total amount of applicable Deductible, Copayment and/or Coinsurance a Participant must pay for Covered Medical Expenses incurred during the Benefit Period. Once the Participant has satisfied the applicable Out of Pocket Amount, the Participant will not be required to pay the Participant's applicable Deductible, Copayment and/or Coinsurance for Covered Medical Expenses for the remainder of that Benefit Period. The Out of Pocket Amount for the Participant is listed in the Schedule of Benefits.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, the applicable Deductible, Copayment and/or Coinsurance for the entire Hospital stay (facility charges only) will only apply to the applicable Out of Pocket Amount of the Benefit

Period in which the inpatient stay began. If the Participant satisfied the Out of Pocket Amount prior to that Hospital stay, no applicable Deductible, Copayment and/or Coinsurance will be applied to that stay.

Non-covered services and amounts over the allowed amount billed by a nonparticipating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

For the Family:

The total amount of applicable Deductible, Copayment and/or Coinsurance for Covered Medical Expenses a family must pay for services incurred during that Benefit Period. Once the applicable Deductible, Copayment and/or Coinsurance paid by the Participant during the Benefit Period for two or more Family Members covered under the same family total the applicable Out of Pocket Amount for the family, the Participants covered under the same family will not be required to pay the applicable Deductible, Copayment and/or Coinsurance for Covered Medical Expenses the remainder of that Benefit Period. The Out of Pocket Amount for the family is listed on the Schedule of Benefits. For family coverage when only two Participants are enrolled, the two Participants each must meet their Individual Out of Pocket Amounts.

Non-covered services and amounts over the allowed amount billed by a nonparticipating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

OUT OF POCKET AMOUNT (PRESCRIPTION DRUGS BENEFIT)

For the Participant:

The total amount of Copayments a Participant must pay for covered prescription drugs incurred during the Benefit Period. Once the Participant has satisfied the Out of Pocket Amount, the Participant will not be required to pay that Participant's Copayment for covered prescription drugs for the remainder of that Benefit Period. The Out of Pocket Amount for the Participant is listed in the Schedule of Benefits.

For the Family:

The total amount of Copayments for covered prescription drugs a family must pay during that Benefit Period. Once the Copayment paid by the Participant during the Benefit Period for two or more Family Members covered under the same family total the Out of Pocket Amount for the family, the Participants covered under the same family will not be required to pay the Copayment for covered prescription drugs for the remainder of that Benefit Period. The Out of Pocket Amount for the family is listed on the Schedule of Benefits.

OUTPATIENT

Services or supplies provided to the Participant by a Covered Provider while the Participant is not an Inpatient Participant.

PARTIAL HOSPITALIZATION

A time-limited ambulatory (Outpatient) program offering active treatment which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

A Partial Hospitalization program should offer four to eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PARTICIPANT

An eligible Employee or Eligible Family Member who has applied for participation in accordance with the section entitled Eligibility and Coverage, has been accepted as a participant of the Plan, and maintains participation in the Plan.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA FACILITY PROVIDER

A facility which has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana and may include, but is not limited to, Hospitals, Home Health Agencies, Convalescent Homes, skilled nursing facilities, Freestanding Inpatient Facilities and freestanding surgical facilities. Please read the section entitled Providers of Care for Participants.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA PROFESSIONAL PROVIDER

A provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana and may include, but is not limited to, Physicians, physician assistants, nurse specialists, dentists, podiatrists, speech

therapists, physical therapists and occupational therapists. Please read the section entitled Providers of Care for Participants.

PARTICIPATING PHARMACY

A Pharmacy which has entered into an agreement with the Claim Administrator or a third party on behalf of the Claim Administrator to provide Prescription Drug Products to Participants and has agreed to accept specified reimbursement rates.

PARTICIPATING PROVIDER

A provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana.

PHARMACY

A state and federally licensed entity that is physically separate and apart from any provider's office, and where legend drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he or she practices.

PHARMACY BENEFIT MANAGER

The company with whom the Claim Administrator has entered into an agreement for the processing of prescription drug claims.

PHYSICAL THERAPY

Treatment of a disease or Injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and pain relief.

PHYSICIAN

A person licensed to practice medicine in the state where the service is provided.

PLAN

The health benefit plan for Employees of the company, the Plan Document, or any other relevant documents pertinent to the operation and maintenance of the Plan.

PLAN ADMINISTRATOR

The company and/or its designee who is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purpose of the Employee Retirement Income Security Act of 1974, as amended, and any applicable state legislation of a similar nature, the company will be deemed to be the Plan Administrator of the Plan unless by action of the board of directors, the company designates an individual or committee to act as Plan Administrator of the Plan.

PLAN BENEFIT YEAR

The period specified as the Benefit Period in the Schedule of Benefits.

PLAN DOCUMENT

This document which sets forth and governs the rights and duties of the Plan Sponsor, Plan Administrator, Claim Administrator, and Participants under the Plan and modified by any policies, interpretations, rules, practices, and procedures made by the Sponsor.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

PPO-A PREFERRED PROVIDER ORGANIZATION

A provider or group of providers which have contracted with Blue Cross and Blue Shield of Montana to provide services to Participants covered under PPO Benefit contracts.

PPO NETWORK

A provider or group of providers which have a PPO contract with Blue Cross Blue Shield of Montana. The Participant may obtain a list of PPO providers from Blue Cross and Blue Shield of Montana upon request.

PREFERRED BRAND-NAME DRUG

A Brand-Name Drug that is identified on the Drug List as a Preferred Brand-Name Drug. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PREFERRED GENERIC DRUG

A Generic Drug that is identified on the Drug List as a Preferred Generic Drug. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PREFERRED SPECIALTY MEDICATION

A Specialty Medication, which may be a Generic or Brand-Name Drug, that is identified on the Drug List as a Preferred Specialty Medication. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PRESCRIPTION DRUG PRODUCT

A medication, product or device approved by the FDA.

PRIOR AUTHORIZATION

The process that determines in advance the Medical Necessity or Experimental/Investigational/Unproven nature of certain care and services under the Plan Document. Prior Authorization is used to inform the Participant whether or not a proposed service, medication, supply, or on-going treatment is Medically Necessary and is a Covered Medical Expense of the Plan Document.

Prior Authorization does not guarantee that the care and services a Participant receives are eligible for Benefits under the Plan Document. At the time the Participant's claims are submitted, they will be reviewed in accordance with the terms of the Plan Document.

PROFESSIONAL CALL

An interview between the Participant and the professional provider in attendance. The professional provider must examine the Participant and when appropriate provide or prescribe medical treatment. Professional Call does not include telephone calls or any other communication where the Participant is not examined by the professional provider, except as included in the Benefit[s] section entitled Telehealth.

PROOF OF LOSS

The documentation accepted by the Claim Administrator upon which payment of Benefits is made.

PROVIDER INCENTIVE

An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

QUALIFIED HEALTH CARE PROVIDER

A person licensed as a Physician, audiologist, psychologist, social worker, clinical professional counselor, marriage and family therapist, or addiction counselor or another appropriate licensed health care practitioner.

QUALIFIED INDIVIDUAL (FOR AN APPROVED CLINICAL TRIAL)

An individual with group health coverage or group or individual health insurance coverage who is eligible to participate in an Approved Clinical Trial according to the trial protocol for the treatment of cancer or other Life-Threatening Condition because:

1. The referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate; or
2. The individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

RANDOMIZED CLINICAL TRIAL

A controlled, prospective study of patients who have been assigned at random to an experimental group or a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention. The term includes a study of the groups for variables and anticipated outcomes over time.

RECOMMENDED CLINICAL REVIEW

An optional voluntary review of a provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to determine whether the procedure, treatment or test meets approved Claim Administrator Medical Policy guidelines and Medical Necessity requirements.

RECONSTRUCTIVE BREAST SURGERY

Surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

RECOVERY CARE BED

A bed occupied in an Outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATION FACILITY

A facility, or a designated unit of a facility, licensed, certified or accredited to provide Rehabilitation Therapy including:

1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or a facility associated or co-located with a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital; and/or
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Participant, regardless of the category of facility licensure.

REHABILITATION THERAPY

A specialized, intense and comprehensive program of therapies and treatment services (including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy) provided by a Multidisciplinary Team for treatment of an Injury or physical deficit. A Rehabilitation Therapy program is:

1. Provided by a Rehabilitation Facility in an Inpatient Care or Outpatient setting;
2. Provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;
3. Designed to restore the patient's maximum function and independence; and/or
4. Medically Necessary to improve or restore bodily function and the Participant must continue to show measurable progress.

REHABILITATIVE CARE

Coverage will be provided for Rehabilitative Care services when the Participant requires help to keep, recover or improve skills and functioning for daily living that have been lost or impaired because the Participant was sick, hurt or disabled. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Psychiatric rehabilitation.

These services may be provided in a variety of inpatient and/or Outpatient settings as prescribed by a Physician.

RESIDENTIAL TREATMENT CENTER

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure Medically Necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a residential treatment facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long-term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

ROUTINE

Examinations or services provided when there is no objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any Injury or Illness.

ROUTINE PATIENT COSTS

All items and services covered by a group health plan or a plan of individual or group health insurance coverage when the items or services are typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. The term does not include:

1. An investigational item, device, or service that is part of the trial;
2. An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis.

SPECIALTY MEDICATIONS

Specialty Medications are used to treat complex medical conditions and are typically given by injection, but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail Pharmacies. Some conditions such as hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with Specialty Medications.

SPECIALTY PHARMACY

A Pharmacy which has entered into an agreement with the Claim Administrator or a third party on behalf of the Claim Administrator to provide Specialty Medications to Participants and which has agreed to accept specified reimbursement rates.

SPEECH THERAPY

Speech Therapy is the treatment of communication impairment and swallowing disorders.

SPOUSE

The opposite sex or the same sex person to whom the Employee cohabitates and is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

SUBSTANCE USE DISORDER

The uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a licensed addiction counselor or other appropriate medical practitioner.

Mental Health Parity Act of 1996 (MPHA) and Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA.

"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1) The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2) There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such plan.
3) The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominate treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or Coverage).
4) There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

SUBSTANCE USE DISORDER TREATMENT CENTER

A treatment facility that provides a program for the treatment of an individual's Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider. The treatment facility must be licensed or approved as a Substance Use Disorder Treatment Center by the Department of Health and Human Services or must be licensed or approved by the state where the facility is located.

SUPPLEMENTAL BREAST EXAMINATION

A Medically Necessary and appropriate examination of the breast, including breast magnetic resonance imaging or breast ultrasound, that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person's risk of breast cancer.

TELEHEALTH

The use of audio, video, or another telecommunications technology or media, including audio-only communication that is:

1. Used by a health care provider or health care facility to deliver health care services; and
2. Delivered over a secure connection that complies with state and federal laws.

Telehealth does not include delivery of health care services by means of facsimile machine or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

TREATMENT OF INFERTILITY

The use of methods which do not correct the inability to conceive but create the conditions for conception by stimulating the natural reproductive system or by implantation.

URGENT CARE

Urgent Care services are considered treatment in any setting that, if delayed, could seriously jeopardize the Participant's life and health or ability to regain maximum function or would subject the Participant, in the opinion of a health care provider with knowledge of the Participant's medical condition, to severe pain that cannot be adequately managed without the service or treatment.

IN WITNESS WHEREOF, the Employer has caused this Plan to be duly executed, effective as of the Plan's Effective Date.

Yellowstone County

By: _____

Title: _____

Date: _____

Yellowstone County Employees Health Plan
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY YELLOWSTONE COUNTY AND OUR CLAIMS ADMINISTRATOR AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We recognize the importance of maintaining the confidentiality and security of your protected health information. Whether it is your medical information or personally or individually identifiable information (such as your name, address, telephone number, or member identification number), we maintain safeguards to protect you against unauthorized access, use, or disclosure.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. We hope that this notice will clarify our responsibilities to you and provide you with an understanding of your rights. We will abide by the terms of the notice currently in effect.

This notice is effective July 1st, 2006.

Permitted Uses and Disclosures of Your Protected Health Information without an Authorization

In administering your health benefits, we and our claims administrator use and disclose your protected health information in a number of ways. The following examples list some of the uses and disclosures we are permitted by law to make without your authorization:

Treatment. We may use or disclose your protected health information to health care providers (such as doctors, hospitals, or pharmacists) in order for them to provide treatment or services to you. We may also disclose your protected health information to health care providers in our effort to provide you with preventive health, early detection, and case management programs.

Payment. We may use or disclose your protected health information to:

- Pay claims
- Determine your eligibility for benefits
- Coordinate benefits, care, or other services
- Determine medical necessity, care appropriateness, or charge justification
- Obtain premiums
- Issue Explanations of Benefits (EOB)

Health Care Operations. We may use or disclose your protected health information in connection with our health care operations. Examples of health care operations include, but are not limited to:

- Quality assessment and improvement activities
- Case management
- Reviewing the competence or qualifications of health care providers
- Fraud and abuse detection and compliance programs
- Performance measurement and outcome assessments
- Responses to inquiries, complaints, appeals, or external reviews
- Business planning and development
- Creating de-identified protected health information or limited data sets
- Training our employees and/or our Business Associates when other methods are not available

Health-Related Services. We may provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. This may include enhancements to a health plan and health-related products or services available only to a health plan member that add value to but are not part of, a benefit plan.

Payment and Health Care Operations of Other Covered Entities. We may use or disclose your protected health information to another covered entity for its payment purposes. We may also use or disclose your protected health

information to another covered entity for purposes of its health care operations if the other covered entity has or had a relationship with you. For example, we may facilitate payment of services under another health plan.

Business Associates. We contract with individuals and other entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these services, Business Associates may receive, create, maintain, use, or disclose protected health information, but only if the Business Associate has agreed in writing to safeguard your protected health information. For example, we may disclose your protected health information to a Business Associate to provide case management or pharmacy benefits. Our Business Associates can only use or disclose your protected health information as allowed by law.

Additional Uses Or Disclosures Permitted Without an Authorization

Required by Law. We may use or disclose your protected health information as required by state or federal law, including disclosing your protected health information to you.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law such as audits, investigations, inspections, licensure, or disciplinary actions, or civil, administrative, or criminal proceedings or actions. Examples of oversight agencies include State Commissioner of Insurance, U.S. Department of Health and Human Services, the U.S. Department of Labor, and the U.S. Food and Drug Administration.

Legal Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to a court order or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process.

Public Health Activities. We may use or disclose your protected health information to an authorized authority for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

Abuse, Neglect, or Domestic Violence. We may disclose your protected health information to a government authority concerning abuse, neglect, or domestic violence.

Law Enforcement. We may disclose your protected health information to law enforcement officials for law enforcement purposes. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness, or missing person or as necessary to provide information concerning victims of crimes.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation. We may disclose your protected health information, in certain circumstances, to a coroner or medical examiner during their investigations. We may also disclose protected health information to funeral directors to carry out their duties. Further, we may disclose your protected health information to organizations that handle donations of organs, eyes, or tissue and transplantations. For example, if you are an organ donor, we can release records to an organ donation facility.

Research. We may use or disclose your protected health information for research purposes when certain established measures are taken to protect your privacy. For example, we may disclose protected health information to a teaching university to conduct medical research.

To Prevent a Serious Threat to Health or Safety. We may use or disclose your protected health information to the extent necessary to avoid a serious and imminent threat to your health or safety or to the health or safety of others. Military Activity and National Security. We may disclose your protected health information to armed forces personnel under certain circumstances (e.g., for active duty, at separation of or termination from active duty, for veterans administration, and for foreign service personnel), and to authorized federal officials for national security and intelligence activities.

Correctional Institutions. If you are an inmate, we may disclose your protected health information to your correctional facility to help provide you health care or to ensure the safety of yourself or others.

Workers' Compensation. We may use or disclose your protected health information as required by workers' compensation laws.

Newsletters/Communications. We may use protected health information for newsletters concerning topics such as wellness, and for informing you of value-added products/services or other health-related products or services.

Disclosures of Your Protected Health Information with Your Informal Permission or Authorization

Others Involved in Your Health Care. If you give us verbal permission or if your permission can be implied, for example, during an emergency and while you are unconscious, we may disclose information to a family member or others who call on your behalf. The kind of information we will disclose in such a circumstance is the status of your enrollment or of a claim, amount paid, and payment date. We will not disclose medical information such as diagnosis without a written authorization.

Authorizations. You may give us written authorization to use your protected health information or to disclose it to anyone for any other purpose. Authorizations may be valid for up to two years unless you provide a written request to revoke the authorization. You may revoke an authorization at any time, but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your protected health information for any reason except those described in this notice.

Your Rights

Right to Inspect and Copy. You have the right to look at or get copies of protected health information contained in a "designated record set" with limited exceptions. A designated record set is a group of records that are used to administer your health benefits. This includes enrollment, claims adjudication, or case, or medical management records. To exercise your right, you must submit your request in writing to the address listed at the end of this notice or you may obtain a form to complete by calling the telephone number at the end of this notice. If you prefer, we will prepare a summary of this information. We may charge you a reasonable cost-based fee for costs associated with your request.

Right to Amend. You have the right to ask us to amend any protected health information contained in a designated record set if you believe it is incorrect or incomplete. Your request must be in writing and sent to the address provided in this notice. Additionally, your request should include the reason the amendment is necessary.

We do not amend records in the following circumstances:

- We do not have the information you requested.
- We did not create the records you want amended.
- We have determined the records are accurate and correct.
- The records are covered by the Federal Clinical Laboratory Improvement Act.
- The records have been compiled in anticipation of a civil, criminal, or administrative action or proceeding.

Right to an Accounting. You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations, or disclosures which are not otherwise authorized by you. You should know that most disclosures of protected health information are for treatment, payment, or health care operations, or by your authorization. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed and the purpose of the disclosure.

Your request for an accounting must be submitted in writing to the address listed in this notice. If you request an accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for the additional requests.

The requirement that we provide you with information about the times we have disclosed your protected health information applies for six years from the date of the disclosure. This applies only to disclosures made after April 14, 2003.

Right to Request a Restriction. You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Your request for restriction must be submitted in writing to the address listed in this notice.

Right to Request Confidential Communication. You have the right to request confidential communication of your protected health information if you believe that a disclosure of all or part of your protected health information may endanger you. We will make every effort to accommodate your request if it is reasonable and you provide an alternate manner or location for receiving our communications.

Although we may agree to confidential communications, you should know that accumulated deductibles, Copayment and/or Coinsurances may appear on the Plan Document, which may contain sufficient information to reveal that you obtained health care services for which we paid.

You may exercise your right to confidential communication by contacting us. For our records, we will need your You may exercise your right to confidential communication by contacting us. For our records, we will need your request in writing.

Right to a Paper Copy of This Notice. If you view this notice on our website or receive it by e-mail, you have a right to a paper copy of this notice by contacting us at the telephone number listed in this notice.

Right to File a Complaint. You have the right to file a complaint if you think we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information. You may file a complaint by:

1. Calling: 406-256-2705
2. Filing a written complaint at:

   Yellowstone County Human Resources
   P. O. Box 35041
   Billings, MT 59107

3. Notifying the Secretary of the U.S. Department of Health and Human Services (HHS).

Please be assured that we will not take retaliatory action against you if you file a complaint about our privacy practices.

Future Changes

Although we follow the privacy practices described in this notice, you should know that we may change our privacy practices at any time. For example, if privacy laws change, we will change our practices to comply with the law. Should this occur we will send a new notice to you prior to making a significant change in our practices; and the changes will apply to all protected health information we have in our possession, including any information created or received before we changed the notice.

WRITTEN NOTICE OF THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) AS REQUIRED BY FEDERAL LAW.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined by the Plan in consultation with the attending physician and the patient, for:

1) All stages of reconstruction of the breast on which a mastectomy has been performed.
2) Surgery and reconstruction of the other breast to establish a symmetrical appearance.
3) Chemotherapy.
4) Prostheses and physical complications of all stages of a mastectomy and breast reconstruction, including lymphedemas.

These benefits will be provided subject to any deductible, Copayment and/or Coinsurance provisions of your health plan. For specific deductible, Copayment and/or Coinsurance information on your plan, please refer to your schedule of benefits.

For further information about this notice or the benefits provided under WHCRA, please contact Customer Service at 1-855-258-3489 or visit the Claim Administrator's Website http://www.bcbsmt.com.

WRITTEN NOTICE OF THE COVERAGE FOR MINIMUM HOSPITAL STAYS FOLLOWING CHILDBIRTH AS REQUIRED BY THE MONTANA INSURANCE CODE AND FEDERAL LAW.

Health insurance for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient care, following delivery by cesarean section for a mother and newborn infant in a health care facility.

Any decision to shorten the length of inpatient stay to less than that stated above must be made by the attending health care provider and the mother. A health benefit plan may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with these provisions. Under this same requirement a health plan may not require that the provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

A health benefit plan that provides coverage for post-delivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care unless the inpatient care is determined to be medically necessary by the attending health care provider.

For further information about this notice, please contact Customer Service at 1-855-258-3489 or visit the Claim Administrator's Website http://www.bcbsmt.com.

PLAN DOCUMENT
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of the Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Plan Document to which this Amendment is attached and becomes a part of the Plan Document. Unless otherwise required by Federal or Montana law, in the event of a conflict between the terms on this Amendment and the terms of the Plan Document, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to 'You' and 'Your' mean any Participant, including Subscriber and Dependents.

The Plan Document is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of an in-network Provider as defined in the Plan Document who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the in-network Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Plan Document.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section II. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Plan Document and this Amendment, those terms will apply only to their use in the Plan Document or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a

condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- covered services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSMT for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSMT for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Participant) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Participant) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or Out of Pocket Amount, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323, Menu

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)



Blue Cross and Blue Shield of Montana
3645 Alice Street, Helena, MT 59601
P.O. Box 660255
Dallas, TX 75266-0255

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

®Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

Yellowstone County Health Benefit Plan

Plan Document

Effective July 1, 2025

MEDICAL BENEFITS
FOR CUSTOMER SERVICE
Call 1-855-258-3489

FOR PRIOR AUTHORIZATION
Call 1-855-313-8914 or Fax 1-866-589-8256 for Non-Behavioral Health
Call 1-855-313-8909 or Fax 1-855-649-9681 for Behavioral Health
For Outpatient Dialysis call 1-844-242-1400

FOR INPATIENT ADMISSIONS
Call 1-855-313-8914 or Fax 1-866-589-8256 for Non-Behavioral Health
Call 1-855-313-8909 or Fax 1-855-649-9681 for Behavioral Health

DENTAL BENEFITS
FOR CUSTOMER SERVICE
Call 1-866-739-4090

www.bcbsmt.com

- BCBSMT Provider Directory
- Wellness
- Customer Service
- Other Online Services and Information

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

FOR MEDICAL APPEALS
Send via fax:
Non-Behavioral Health: 1-866-589-8256
Behavioral Health: 1-855-649-9681
or
Mail to:
Blue Cross and Blue Shield of Montana
PO Box 660255
Dallas, TX 75266-0255

FOR PRESCRIPTION DRUG BENEFITS

Pharmacy Benefit Manager (PBM)

- Prime Therapeutics 1-855-258-8471
- For Prior Authorizations, fax: 1-877-243-6930

PBM Website www.myprime.com
Claim Forms www.myprime.com
Pharmacy Locator 1-866-325-5230
Specialty Care Pharmacy (BCBSMT Specialty Network) 1-833-721-1619

- www.bcbsmt.com or www.myprime.com
- Prescriber Fax 1-888-302-1028

Mail-Order Services

- **Express Scripts** 1-833-715-0942
  PO Box 66577
  St. Louis, MO 63166-6577
- **Ridgeway Mail-Order Pharmacy** 1-800-630-3214
  2824 US Hwy 93 North
  Victor, MT 59875

Blue Cross and Blue Shield of Montana
3645 Alice Street, Helena, MT 59601
PO Box 660255
Dallas, TX 75266-0255

FOR CLAIMS
Blue Cross and Blue Shield of Montana
PO Box 660255
Dallas, TX 75266-0255

HEALTH BENEFIT PLAN FOR EMPLOYEES OF YELLOWSTONE COUNTY

PLAN OPERATION

Plan Name

Yellowstone County Employee Health Benefit Plan

Type of Plan

Yellowstone County maintains the Employee Health and Dental Benefit Plan, a separate legal entity from Yellowstone County, for the exclusive benefit of and to provide health benefits to its eligible Employees, their legal Spouses, and eligible Dependents. The Plan provides Hospital, Medical, Dental and surgical coverage for eligible Participants.

Type of Participants Covered by the Plan

Employees, their legal Spouses, and their eligible Dependent children may participate based upon the eligibility requirements set forth in the Plan.

Plan Sponsor

Yellowstone County Human Resources
217 North 27th Street Room 106
Billings, MT 59101-5041
Phone: 406-256-2705
Fax: 406-254-7908

Plan Sponsor's Identification Number

81-6001449

Plan Effective Date

July 1, 2025

Plan Benefit Year

January 1 through December 31

Plan Year

July 1 through June 30

Plan Administrator

Yellowstone County Human Resources
217 North 27th Street Room 106
Billings, MT 59101-5041
Phone: 406-256-2705
Fax: 406-254-7908

Named Fiduciary(ies)

Yellowstone County Human Resources
217 North 27th Street Room 106
Billings, MT 59101-5041
Phone: 406-256-2705
Fax: 406-254-7908

Type of Administration

The Plan is a self-funded Health and Dental Plan established to reimburse Participants for Covered Medical Expenses. The Plan Sponsor contracts with a Claim Administrator to process claims, provide claims payment and provide other claims management functions, under the direction of the Plan Administrator. The Plan reimburses the Claim Administrator after claims are paid.

Claim Administrator

Blue Cross and Blue Shield of Montana
P.O. Box 660255
Dallas, TX 75266-0255
1-855-258-3489

Claim Administrator's Disclosures

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

The Plan Sponsor, on behalf of itself and its employees, hereby expressly acknowledges its understanding that the "Agreement" constitutes an agreement solely between the Plan Sponsor and Blue Cross and Blue Shield of Montana, that Blue Cross and Blue Shield of Montana is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, which is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Health Care Service Corporation to use the Blue Cross and Blue Shield Service Marks in the state of Montana, and that Blue Cross and Blue Shield of Montana is not contracting as the agent of the Association. The Plan Sponsor further acknowledges and agrees that it has not entered into the "Agreement" based upon representations by any person other than Blue Cross and Blue Shield of Montana and that no person, entity, or organization other than Blue Cross and Blue Shield of Montana shall be held accountable or liable to the Plan Sponsor for any of the Blue Cross and Blue Shield of Montana obligations to the Plan Sponsor created under the "Agreement." This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Montana other than those obligations created under the provisions of the "Agreement" with the Plan Sponsor.

Certain Responsibilities of the Employer and the Claim Administrator

Employer responsibility

The Employer retains full and final authority and responsibility for the Plan and its operation. The Claim Administrator is empowered to act on behalf of the Employer in connection with the Plan only as expressly stated in this Plan Document or as mutually agreed to in writing by the parties hereto.

Claim Administrator responsibility

The Claim Administrator shall have no responsibility for or liability with respect to the compliance or non - compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and the Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including but not limited to local, state or federal taxes, penalties, surcharges or other fees or amounts regardless of whether payable directly by the Employer or by or through the Claim Administrator; provided, however, the Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to the Claim Administrator in connection with the performance of its obligations under this Agreement.

Relationship of Parties

The Claim Administrator is an independent contractor with respect to the Employer. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venture nor employee of the other. Further, nothing in this Plan Document shall create or be construed to create the relationship of employer and employee between the Claim Administrator and the Employer; nor shall the Employer's agents, officers or employees be considered or construed to be considered employees of the Claim Administrator for any purpose whatsoever.

Funding Mechanism

Benefits under this Plan are funded from Employee and Employer contributions up to the Benefit limits defined in the Plan Document. Payments are made from this fund to pay Benefits.

Source of Contribution

Coverage for Employees is non-contributory for full-time Employees. Benefits for part-time Employees are available on a contributory basis. Benefits for eligible retirees, COBRA participants and dependents are also available on a contributory basis.

Agent for Service of Legal Process

Yellowstone County Civil Attorney, Attn: Plan Sponsor
PO Box 35041
Billings, MT 59107-5041
Phone: 406-256-2705
Fax: 406-254-7908

Amendment, Termination, or Modification of the Plan

The Plan Administrator reserves the right to amend, modify or terminate the Plan in whole or in part at any time.

Expenses incurred prior to the effective date of any amendment are based on the provisions in effect at the time the expenses were incurred.

Plan Coverage Status

This Plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act (The Affordable Care Act).

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Certain terms in this Plan Document are defined in the Definitions section. Defined terms are capitalized.

SCHEDULE OF BENEFITS

Employee Health Benefit Plan PPO

Group Name:	**Yellowstone County**
Group Number:	**252391**
Effective Date:	**July 1, 2025**
Benefit Period:	**Calendar Year**

The Benefits are subject to the Benefit Period unless otherwise specified.

Deductible:	**Individual:**	**$500**
	Family:	**$1,500**

The Dental Services (Non-Accident) has a separate Deductible. Refer to the specific Benefits.

Deductible does not apply to the following Benefits:

- Hospice
- Preventive Services
- Second Surgical Opinion
- Tobacco Cessation Counseling*
- Obesity Intervention Counseling*
- Diabetic Education*

*See limits listed below.

Coinsurance:	**In-Network:**	**20%**
	Out-of-Network:	**30%**
Copayment:	**Varies**	

Some Benefits may have payment limitations. Refer to the specific Benefit in this Schedule of Benefits for additional information. In addition:

- For Emergency Services provided by an Out-of-Network provider, Benefits will be provided as if such services were provided by an In-Network provider. Nonemergency services for Mental Illness or Substance Use Disorder provided in an emergency setting will be paid the same as Emergency Services.
- Out-of-Network providers may bill the Participant the difference between the Allowable Fee and the provider's charge, in addition to any applicable Deductible, Copayment and/or Coinsurance, even if Prior Authorization is obtained for the service, or if treatment is provided for Emergency Services.

Out of Pocket Amount:	**Individual:**	**$2,500**
	Family:	**$7,500**

Charges in excess of the Allowable Fee do not accumulate to help meet the Out of Pocket Amount. The Prescription Drugs Benefit has a separate Out of Pocket Amount. Refer to the Prescription Drugs section.

Term of Plan Document:	**Monthly**

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Accident		
Professional Provider Services	20%	20%
Facility Services	20%	20%
Acupuncture Services	20%	30%
Ambulance	20%	20%
Autism Spectrum Disorders	20%	30%
Services, except medications/prescription drugs and Applied Behavior Analysis (ABA) services that are described in the Benefit section entitled Autism Spectrum Disorders are covered under medical Benefits.		
Medications/prescription drugs are covered under Prescription Drugs.		
Benefits for Autism Spectrum Disorders are not subject to any applicable Physical, Occupational or Speech Therapy visit maximum.		
Breast Examinations		
Preventive	Deductible and Coinsurance Do Not Apply	
Medical	20%	30%
Chiropractic Services		
*Maximum Payable by the Plan Per Visit (does not include X-rays)	$40*	$40*
X-Rays	20%	30%
*Participant pays the difference between the charge and the $40 maximum payment. Difference does not apply to Out of Pocket maximum. Deductible, Coinsurance and Out of Pocket apply to x-rays only.		
Convalescent Home Services	20%	20%
Maximum Per Benefit Period – 90 Days		
Diabetic Education Benefit		
First $250	Deductible and Coinsurance Do Not Apply	
After the first $250 in payment	20%	30%
Diagnostic Services		
Professional Provider Services	20%	30%
Facility Services	20%	30%
Dialysis Services - Outpatient		
See the separately issued Outpatient Dialysis Plan Document		
Durable Medical Equipment	20%	20%
Prior Authorization from the Plan is recommended for the original purchase or replacement of durable medical equipment over $2,000. Please refer to the Utilization Management section.		
Emergency Room Care	20%*	20%*
*****Nonemergency Mental Illness and Substance Use Disorder services provided by an In-Network provider or an Out-of-Network provider pay as Emergency Room Care.		
Emergency Room Care not related to an Emergency Medical Condition, accidental Injury, Mental Illness or Substance Use Disorder.	20%	30%
Foot Orthotics	50%	50%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Hearing Aids		
Medical Exam	$35	30%
Routine Exam	Deductible, Copayment and/or Coinsurance Do Not Apply	30%
Hearing Aid Coverage for Adults 19+	20%	30%
Maximum - $2,500 per ear every 5 years.		
Hearing Coverage for Dependent Children Under Age 19	20%	30%
Maximum one Amplification Device per ear every 3 years or as required by an audiologist.		
Home Health Care	20%	20%
Maximum Per Benefit Period – 100 Visits		
Hospice Care		
Professional Provider Services	Deductible and Coinsurance Do Not Apply	
Facility Services	Deductible and Coinsurance Do Not Apply	
Hospital		
Professional Provider Services (when the professional provider is employed by the Hospital)		
Outpatient	20%	30%
Inpatient	20%	30%
Facility Services		
Outpatient	20%	30%
Inpatient	20%	30%
Maternity Services		
Professional Provider Services		
Outpatient	20%	30%
Inpatient	20%	30%
Facility Services		
Outpatient	20%	30%
Inpatient	20%	30%
Medical Supplies	20%	30%
Mental Health		
Professional Provider Services		
Outpatient	20%	20%
Inpatient	20%	20%
Facility Services		
Outpatient	20%	20%
Inpatient	20%	20%
Newborn Initial Care		
Professional Provider Services	20%	30%
Facility Services	20%	30%
Office Visit	20%*	30%*
*Deductible and Coinsurance do not apply to the Preventive Health Care services. Refer to the section entitled Preventive Health Care.		
Orthopedic Devices/Orthotic Devices	20%	20%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Prior Authorization from the Plan is recommended for the original purchase or replacement of orthopedic devices over $2,000. Please refer to the Utilization Management section.		
Other Facility Services – Inpatient and Outpatient	20%	30%
Physician Medical Services	20%	30%
Prescription Drugs		
Refer to the last page of this Schedule of Benefits.		
Preventive Health Care		
Preventive Services	Deductible and Coinsurance Do Not Apply	
Nutritional Education Counseling		
Tobacco Cessation Counseling – Maximum 3 visits per Benefit Period		
*Obesity Intervention Counseling for Participants – Maximum 26 visits per Benefit Period		
*18 or older with minimum BMI of 30		
Prostheses Benefit	20%	20%
Prior Authorization from the Plan is recommended for the original purchase or replacement of prosthetics over $2,000. Please refer to the Utilization Management section.		
Rehabilitation Therapy		
Professional Provider Services		
Outpatient	20%	30%
Inpatient	20%	30%
Facility Services		
Outpatient	20%	30%
Inpatient	20%	30%
Second Surgical Opinion	Deductible and Coinsurance Do Not Apply	
Substance Use Disorder		
Professional Provider Services		
Outpatient	20%	20%
Inpatient	20%	20%
Facility Services		
Outpatient	20%	20%
Inpatient	20%	20%
Surgery Center Services – Outpatient		
Professional Provider Services	20%	30%
Facility Services	20%	30%
Telehealth	20%	30%
Temporomandibular Joint Dysfunction	20%	30%
Lifetime maximum of $1,000 for surgical and nonsurgical services and supplies.		
Therapies – Outpatient		
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy		
Professional Provider Services	20%	30%
Facility Services	20%	30%
Refer to the Autism Spectrum Disorders section for information on autism spectrum disorder therapies.		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Transplants		
Professional Provider Services		
Outpatient	20%	30%
Inpatient	20%	30%
Facility Services		
Outpatient	20%	30%
Inpatient	20%	30%
Maximum Benefit for Organ Procurement, Including Donor Searches Per Transplant – $25,000		
Maximum Benefit for Commercial Air Travel Per Transplant – $10,000		
Urgent Care	20%*	30%*
Urgent Care visit and any covered services provided during the urgent care visit. Deductible and Coinsurance apply to services provided during the Urgent Care visit.		
*Deductible and Coinsurance do not apply to the Preventive Health Care services. Refer to the section entitled Preventive Health Care.		
Well-Child Care Services	Deductible and Coinsurance Do Not Apply	

PRESCRIPTION DRUG INFORMATION

	DEDUCTIBLE	COPAYMENT/ COINSURANCE

Prescription Drugs
(The Prescription Drugs Benefit utilizes a Drug List.) Any Deductible, Copayment and/or Coinsurance do not apply to certain contraceptive products. Refer to the Preventive Health Care Benefit. Any Deductible and Coinsurance also do not apply to prescription smoking cessation products and over-the-counter smoking cessation aids/medications, for two 90-day treatment regimens.

Out of Pocket Amounts

Individual	$1,650
Family	$3,300

Retail Pharmacy Prescriptions
Copayments and/or Coinsurance for a 30-day supply are:

Generic Drug:	$15
*Preferred Brand-Name Drug:	$40
*Non-Preferred Brand-Name Drug:	50%

Specialty Medications purchased at participating Specialty Pharmacies in the Blue Cross and Blue Shield Specialty Network

Copayments and/or Coinsurance for a 30-day supply are:

Generic Drug:	$150
*Preferred Brand-Name Drug:	$150
*Non-Preferred Brand-Name Drug:	$150

Mail Service Maintenance Prescriptions
Copayments and/or Coinsurance for a 90-day supply are:

Generic Drug:	$30
*Preferred Brand-Name Drug:	$80
*Non-Preferred Brand-Name Drug:	50%

Extended Supply Network
Copayments and/or Coinsurance for up to a 90-day supply are:

Generic Drug:	$45
*Preferred Brand-Name Drug:	$120
*Non-Preferred Brand-Name Drug:	50%

A covered insulin drug, regardless of the amount or type that is prescribed, will not exceed a $35 Copayment for a 30-day supply.

Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

*The Participant must pay the difference between a Brand-Name Drug and the Generic Drug equivalent in addition to the Copayment and/or Coinsurance if the Participant chooses a Brand-Name Drug when a Generic Drug equivalent is available. The amount the Participant pays for the difference between a Brand-Name Drug and the Generic Drug equivalent does not apply to the Out of Pocket Amount and will continue to be imposed after the Out of Pocket Amount is met.

Please refer to Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefits section of this Plan Document for additional information.

Any Copayment and/or Coinsurance amounts paid for prescription drugs do not apply to the medical Deductible or medical Out of Pocket Amount.

SCHEDULE OF BENEFITS, continued

ADDITIONAL INFORMATION	MAXIMUM	DEDUCTIBLE	COINSURANCE
Dental Services (Non-Accident)			
Deductible:			
Individual		$25	
Type 1 – Diagnostic and Preventive Services		Applies	20%*
Type 2 – Basic Dental Services		Applies	20%*
Type 3 – Major Restorative Services		Applies	20%*
Maximum Benefit Per Benefit Period	$3,000		
*80% payment is based on allowable charges.			
Any Deductible and Coinsurance amounts do not apply to any other Deductible or Coinsurance amounts or to the Out of Pocket Amount provision.			

PROVIDERS OF CARE FOR PARTICIPANTS

The participation or nonparticipation of providers from whom a Participant receives services, supplies, and medication impacts the amount the Plan will pay and the Participant's responsibility for payment. Professional providers and facility providers are either In-Network or Out-of-Network providers. In-Network providers include Participating Providers and PPO providers. Out-of-Network providers are nonparticipating and non-PPO providers.

In-Network and Out-of-Network Professional Providers and Facility Providers

Professional providers include, but are not limited to, Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, audiologists, Advanced Practice Registered Nurses, midwives, physician assistants, naturopathic physicians, chiropractors, acupuncturists and physical therapists.

Facility providers include, but are not limited to, Hospitals, Rehabilitation Facilities, Home Health Agencies, Convalescent Homes, skilled nursing facilities, freestanding facilities for the treatment of Substance Use Disorder or Mental Illness, and free standing surgical facilities (surgery center).

The Participant may obtain a list of Participating Providers from the Claim Administrator free of charge by contacting the Plan at the number listed on the inside cover of this Plan Document.

Yellowstone County has established a separate program for the administration and payment of benefits for Outpatient Dialysis. The Outpatient Dialysis Program is described in the separately issued Outpatient Dialysis Plan Document. Please review that document for information about coverage for and administration of claims for Outpatient Dialysis.

PPO Providers

The Claim Administrator has a PPO Network of Hospitals and surgery centers in Montana that is utilized under this Benefit Plan. Outside of the state of Montana, there are also Blue Cross and/or Blue Shield PPO Hospitals and surgery centers nationwide. The Participant receives the In-Network Benefit when utilizing the PPO Network or the nationwide Blue Cross and/or Blue Shield PPO Hospitals and surgery centers. If the Participant obtains services or supplies from a non-PPO Network provider, the Out-of-Network Deductible and Coinsurance and Out of Pocket Amount will apply as indicated on the Schedule of Benefits.

The exceptions to the Benefit reduction are:

1. Emergency Services provided when a Participant cannot reasonably reach a PPO Network provider;
2. Nonemergency services for treatment of Mental Illness and/or Substance Use Disorder provided in an emergency setting; and/or
3. Services that are unavailable within the PPO Network.

If a Participant receives services from an out-of-state provider, then services must be provided by:

- Blue Cross and/or Blue Shield PPO facility providers; and/or
- Blue Cross and/or Blue Shield participating professional providers* or PPO professional providers.

*Some Blue Cross and/or Blue Shield Plans require services to be provided by a PPO professional provider for the Participant to receive the In-Network Benefits. Contact the Plan for additional information on out-of-state services. Emergency Services and services that are unavailable within the PPO Network will be covered as In-Network.

However, any nonparticipating provider or non-PPO provider can bill the Participant for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus any Deductible, Copayment and/or Coinsurance even if Prior Authorization was obtained for such services. The Participant will be responsible for the balance of the nonparticipating provider's or non-PPO provider's charges after payment by Blue Cross and Blue Shield of Montana and payment by the Participant of any Deductible, Copayment and/or Coinsurance.

Out of PPO Network Referrals

There may be circumstances under which the most appropriate treatment for the Participant's condition is not available through the PPO Network. When this occurs, it is recommended the Participant's attending Physician contact the Claim Administrator for an out of PPO Network referral. If the referral is not approved, and the Participant

chooses to obtain services from a non-PPO Network provider, the Participant will be responsible for the Out-of-Network Deductible and Coinsurance, in addition to any difference between the Blue Cross and Blue Shield of Montana Allowable Fee and the provider's billed charges.

If the Claim Administrator approves the referral, those services will process with the In-Network Deductible, Copayment and/or Coinsurance. However, any nonparticipating provider or non-PPO provider can bill the Participant for the difference between payment by the Claim Administrator and provider charges plus Deductible, Copayment and/or Coinsurance even if the Claim Administrator approves the referral.

How Providers are Paid by the Claim Administrator and Participant Responsibility

Payment by the Claim Administrator for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield of Montana provider network.

An **In-Network Provider** agrees to accept the payment of the Allowable Fee from the Claim Administrator for Covered Medical Expenses, together with any Deductible, Copayment and/or Coinsurance from the Participant, as payment in full. Generally, the Claim Administrator will pay the Allowable Fee for a Covered Medical Expense directly to Participating Provider or PPO Provider. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

Out-of-Network providers do not have to accept the Claim Administrator's payment as payment in full. Payment to a nonparticipating provider or a non-PPO provider for Covered Medical Expenses is based on the Allowable Fee. The nonparticipating provider or a non-PPO provider can bill the Participant for the difference between payment by the Claim Administrator and provider charges plus any Deductible, Copayment and/or Coinsurance. The Participant will be responsible for the balance of the nonparticipating provider's or a non-PPO provider's charges after payment by the Claim Administrator and payment of any Deductible, Copayment and/or Coinsurance.

Generally, the Claim Administrator will pay the Allowable Fee for Covered Medical Expenses directly to the Participant. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

How Providers are Paid by the Claim Administrator and Participant Responsibility Outside of Montana

Payment by the Claim Administrator for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield provider network in the state where services are provided.

An **In-Network Provider** agrees to accept payment of the Allowable Fee from the Claim Administrator for Covered Medical Expenses, together with any Deductible, Copayment and/or Coinsurance from the Participant, as payment in full. Generally, the Claim Administrator will pay the Allowable Fee for a Covered Medical Expense directly to Participating Provider or PPO Provider. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

Out-of-Network providers do not have to accept the Claim Administrator's payment as payment in full. Payment to a nonparticipating provider or a non-PPO provider for Covered Medical Expenses is based on the Allowable Fee. The nonparticipating provider or a non-PPO provider can bill the Participant for the difference between payment by the Claim Administrator and provider charges plus any Deductible, Copayment and/or Coinsurance. The Participant will be responsible for the balance of the nonparticipating provider's or a non-PPO provider's charges after payment by the Claim Administrator and payment of any Deductible, Copayment and/or Coinsurance.

For Prescription Drug Products, the Participant will be responsible for paying the specific Deductible, Copayment and/or Coinsurance as described in the Prescription Drugs section.

The Claim Administrator will not pay for any services, supplies or medications which are not a Covered Medical Expense, or for which a Benefit maximum has been met, regardless of whether provided by a Participating Provider or a nonparticipating provider. The Participant will be responsible for all charges for such services, supplies, or medications.

Claim Payment Assignment

All benefits payable to the Participant which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Participant.

Claim Dispute

Once Covered Medical Expenses are rendered by a provider, the Participant has no right to request the Claim Administrator not to pay the claim submitted by such provider and no such request by a Participant or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Participant or any other person because of its rejection of such request.

Continuity of Care and Transitional Care

Although each Participant has a Primary Care Provider, a Participant may continue to receive services from the Participant's previous provider if the Participant is a new enrollee to the Plan, if the Blue Options Provider's or Participating Provider's contract is terminated without cause, or when the Blue Options Provider or Participating Provider voluntarily terminates the contract with the Plan, and the Participant:

1. Has a life threatening, disabling, or degenerative condition, or a serious acute condition requiring complex ongoing care. Coverage by the previous provider will be allowed for 90 days beginning on the date of the Participant's enrollment or the provider's termination.
2. Has a terminal illness with life expectancy of less than 6 months. Coverage by the previous provider will be allowed for 6 months from the date of the Participant's enrollment or to the date of death, whichever occurs first. If death does not occur within the first 6 months, the situation will be evaluated to determine if transition to the selected Primary Care Provider is appropriate.
3. Is in the second or third trimester of pregnancy. Coverage by the previous provider will be allowed through the completion of the postpartum period.

The previous provider must agree to meet the contractual terms applicable to comparable Blue Options Providers or Participating Professional Providers.

OUT-OF-AREA SERVICES – THE BLUECARD PROGRAM

Out-of-Area Services

Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever a Plan Participant obtains healthcare services outside of the Blue Cross and Blue Shield of Montana service area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program. The Inter-Plan Arrangements available to Participants under this Plan Document are described generally below.

Typically, when accessing care outside the Blue Cross and Blue Shield of Montana service area, the Plan Participant will obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, the Plan Participant may obtain care from nonparticipating healthcare providers. Blue Cross and Blue Shield of Montana payment practices in both instances are described below.

1. **BlueCard® Program**

   Under the BlueCard® Program, when a Plan Participant incurs Covered Medical Expenses within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Montana will remain responsible for fulfilling Blue Cross and Blue Shield of Montana's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   For inpatient facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the provider, and the Participant will be held harmless for the provider sanction.

Whenever the Plan Participant incurs Covered Medical Expenses outside the Blue Cross and Blue Shield of Montana service area and the claim is processed through the BlueCard Program, the amount the Plan Participant pays for Covered Medical Expenses is calculated based on the lower of:

a. The billed covered charges for the Plan Participant's covered services; or

b. The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Montana.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Plan Participant's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Plan Participant's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield of Montana uses for the Plan Participant's claim because they will not be applied retroactively to claims already paid.

Federal laws or the laws in a small number of states may require the Host Blue to add a surcharge to the Plan Participant's calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Blue Cross and Blue Shield of Montana would then calculate the Plan Participant's liability for any Covered Medical Expenses according to applicable law.

2. Value-Based Programs

a. BlueCard® Program

If a Plan Participant receives Covered Medical Expenses under a Value-Based Program inside a Host Blue's service area, the Plan Participant will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Cross and Blue Shield of Montana through average pricing or fee schedule adjustments.

b. Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Blue Cross and Blue Shield of Montana has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan Participant's employer on their behalf, Blue Cross and Blue Shield of Montana will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

3. Nonparticipating Healthcare Providers Outside of the Blue Cross and Blue Shield of Montana Service Area

a. Plan Participant Liability Calculation

When the Plan Participant incurs Covered Medical Expenses outside of the Blue Cross and Blue Shield of Montana service area for services provided by nonparticipating healthcare providers, the amount the Plan Participant pays for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Plan Participant may be liable for the difference between the amount that the nonparticipating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

b. Exceptions

In certain situations, Blue Cross and Blue Shield of Montana may use other payment bases, such as (i) The provider's billed charges for Covered Medical Expenses, (ii) the payment Blue Cross and Blue Shield of Montana would make if the Covered Medical Expenses had been received within the Blue Cross and Blue Shield of Montana service area, (iii) a special negotiated payment, or (iv) the lesser of any of the foregoing payment methods or the Allowable Fee determined for nonparticipating providers outside of Montana to pay for services provided by nonparticipating providers. In these situations, the Plan Participant may be liable for

the difference between the amount that the nonparticipating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

4. Blue Cross Blue Shield Global® Core

If the Participant is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), the Participant may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists the Participant with accessing a network of inpatient, Outpatient and professional providers, the network is not served by a Host Blue. As such, when the Participant receives care from providers outside the BlueCard service area, the Participant will typically have to pay the providers and submit the claims himself/herself to obtain reimbursement for these services.

If the Participant needs medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, the Participant should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if the Participant contacts the service center for assistance, Hospitals will not require the Participant to pay for covered inpatient services, except for the cost-share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Participant's claims to the service center to begin claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to receive reimbursement for Covered Medical Expenses.

The Participant must contact Blue Cross and Blue Shield of Montana to obtain Prior Authorization to verify that inpatient services are for the treatment of an Emergency Medical Condition.

b. Outpatient Services

Outpatient Services are available for the treatment of an Emergency Medical Condition. Physicians, urgent care centers and other Outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require the participant to pay in full at the time of service. The Participant must submit a claim to obtain reimbursement for Covered Medical Expenses.

c. Submitting a Blue Cross Blue Shield Global Core Claim

When the Participant pays for Covered Medical Expenses outside the BlueCard service area, the Participant must submit a claim to obtain reimbursement. For institutional and professional claims, the Participant should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the Participant claim. The claim form is available from the Plan, service center or online at www.bcbsglobalcore.com. If the Participant needs assistance with the Participant claim submission, the Participant should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

COMPLAINTS AND GRIEVANCES

Complaints and Grievances

The Plan has established a Complaint and Grievance process. A complaint involves a communication from the Participant expressing dissatisfaction about the Plan's services or lack of action or disagreement with the Plan's response. A grievance will typically involve a complaint about a provider or a provider's office and may include complaints about a provider's lack of availability or quality of care or services received from a provider's staff.

Most problems can be handled by calling Customer Service at the number appearing on the inside cover of this Plan Document. The Participant may also file a written complaint or grievance with the Claim Administrator. The fax number, email address, and mailing address of the Claim Administrator appears on the inside cover of this Plan Document. Written complaints or grievances will be acknowledged within 10 days of receipt. The Participant will be

notified of the Claim Administrator's response within 60 days from receipt of the Participant's written complaint or grievance.

APPEALS

Claims Procedures

Types of Claims

Claims are classified by type of claim and the timeline in which a decision must be decided and a notice provided depends on the type of claim involved. The initial Benefit claim determination notice will be included in the Participant's Explanation of Benefits (EOB) or in a letter from the Claim Administrator, whether adverse or not. There are five types of claims:

1. **Pre-Service Claims**

   A pre-service claim is any claim for a Benefit that, under the terms of this Plan Document, requires authorization or approval from the Claim Administrator or the Claim Administrator's subcontracted administrator prior to receiving the Benefit.

2. **Urgent Care Claims**

   An Urgent Care claim is any pre-service claim where a delay in the review and adjudication of the claim could seriously jeopardize the Participant's life or health or ability to regain maximum function or subject the Participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

3. **Post-Service Claims**

   A post-service claim is any claim for payment filed after a Benefit has been received and any other claim that is not a pre-service claim.

4. **Rescission Claims**

   A rescission of coverage is considered a special type of claim. A rescission is defined as any cancellation or discontinuation of coverage that has a retroactive effect and is based upon the Participant's fraud or an intentional misrepresentation of a material fact. A cancellation or discontinuance of coverage that has a retroactive effect is not a rescission if and to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage or to routine changes, such as eligibility updates. A cancellation or discontinuance with a prospective effect only is not a rescission.

5. **Concurrent Care Claim**

   A Concurrent Care decision represents a decision of the Claim Administrator approving an ongoing course of medical treatment for the Participant to be provided over a period of time or for a specific number of treatments. A Concurrent Care claim is any claim that relates to the ongoing course of medical or emergency treatment (and the basis of the approved Concurrent Care decision), such as a request by the Participant for an extension of the number of treatments or the termination by the Claim Administrator of the previously approved time period for medical treatment.

Initial Claim Determination by Type of Claim

1. **Pre-Service Claim Determination and Notice**

   a. Notice of Determination

      Upon receipt of a pre-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial determination, but no later than 15 days after receiving the claim.

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

The Claim Administrator may extend the 15-day time period for an additional 15 days for reasons beyond the Claim Administrator's control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which the Claim Administrator expects to render a decision.

2. For receipt of information from the Participant to decide the claim

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the Participant will be given 45 days from receipt of the notice within which to provide the specified information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

c. Notice of Improperly Submitted Claim

If a pre-service claim request was not properly submitted, the Claim Administrator will notify the Participant of the improper submission as soon as practicable, but no later than 5 days after the Claim Administrator's receipt of the claim and will advise the Participant of the proper procedures to be followed for filing a pre-service claim.

2. Urgent Care Claim Determination and Notice

a. Designation of Claim

Upon receipt of a pre-service claim, the Claim Administrator will make a determination if the claim involves Urgent Care. If a Physician with knowledge of the Participant's medical condition determines the claim involves Urgent Care, the Claim Administrator will treat the claim as an Urgent Care claim.

b. Notice of Determination

If the claim is treated as an Urgent Care claim, the Claim Administrator will provide the Participant with notice of the determination, either verbally or in writing, as soon as possible consistent with the Participant's medical exigencies but no later than 72 hours from the Claim Administrator's receipt of the claim. If verbal notice is provided, the Claim Administrator will provide a written notice within 3 days after the date the Claim Administrator notified the Participant.

c. Notice of Incomplete or Improperly Submitted Claim

If an Urgent Care claim is incomplete or was not properly submitted, the Claim Administrator will notify the Participant about the incomplete or improper submission no later than 24 hours from the Claim Administrator's receipt of the claim. The Participant will have at least 48 hours to provide the necessary information. The Claim Administrator will notify the Participant of the initial claim determination no later than 48 hours after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

3. Post-Service Claim Determination and Notice

a. Notice of Determination

In response to a post-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial **determination, but no later than 30 days after receiving the claim.**

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

The Claim Administrator may extend the 30-day timeframe for an additional 15-day period for reasons beyond the Claim Administrator's control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which the Claim Administrator expects to render a decision in such case.

2. For receipt of information from the Participant to decide the claim

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed. The Participant will be given 45 days from receipt of the notice to provide the information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator receives the specific information requested, or the due date for the information.

4. Concurrent Care Determination and Time Frame for Decision and Notice

a. Request for Extension of Previously Approved Time Period or Number of Treatments

1. In response to the Participant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Participant's claim involves Urgent Care, the Claim Administrator will review the claim and notify the Participant of its determination no later than 24 hours from the date the Claim Administrator received the Participant's claim, provided the Participant's claim was filed at least 24 hours prior to the end of the approved time period or number of treatments.

2. If the Participant's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Participant's claim will be treated as and decided within the timeframes for an Urgent Care claim as described in the section entitled, "Initial Claim Determination by Type of Claim."

3. If the Participant's claim did not involve Urgent Care, the time periods for deciding pre-service claims or post-service claims, as applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

Other than through a Plan amendment or termination, the Claim Administrator may not subsequently reduce or terminate an ongoing course of treatment for which the Participant has received prior approval unless the Claim Administrator provides the Participant with written notice of the reduction or termination and the scheduled date of its occurrence sufficiently in advance to allow the Participant to appeal the determination and obtain a decision before the reduction or termination occurs.

5. Rescission of Coverage Determination and Notice of Intent to Rescind

If the Claim Administrator makes a decision to rescind the Participant's coverage due to a fraud or an intentional misrepresentation of a material fact, the Claim Administrator will provide the Participant with a Notice of Intent to Rescind at least thirty (30) days prior to rescinding coverage. The Notice of Intent to Rescind will include the following information:

a. The specific reason(s) for the rescission that show the fraud or intentional misrepresentation of a material fact;

b. The date when the notice period ends and the date to which coverage is to be retroactively rescinded;

c. A statement that the Participant will have the right to appeal any final decision of the Claim Administrator to rescind coverage prior to or after the thirty (30) day period, and a description of the Claim Administrator's appeal procedures;

d. A reference to the Plan provision(s) on which the rescission is based; and/or

e. A statement that the Participant is entitled to receive upon request and free of charge reasonable access to, and copies of all documents and records and other information relevant to the rescission.

Notice of an Adverse Benefit Determination

An "adverse benefit determination" is defined as a rescission or a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Benefit. If the Claim Administrator's determination constitutes an adverse benefit determination, the notice to the Participant will include:

1. Information sufficient to identify the Benefit or claim involved, including, if applicable, the date of service, the health care provider, and the claim amount;
2. The reason(s) for the adverse benefit determination. If the adverse benefit determination is a rescission, the notice will include the basis for the fraud and/or intentional misrepresentation of a material fact;
3. A reference to the applicable Plan Document provision(s), including identification of any standard relied upon in the Plan to deny the claim (such as a Medical Necessity standard), on which the adverse benefit determination is based;
4. A description of the Claim Administrator's internal appeal and external review procedures (and for Urgent Care claims only, a description of the expedited review process applicable to such claims), a description of and contact information for any consumer appeal assistance program, and if applicable, a statement of the Participant's right to file a civil action under Section 502(a) of ERISA;
5. If applicable, a description of any additional information necessary to complete the claim and why the information is necessary;
6. If applicable, a statement that any internal Medical Policy or guideline or other medical information relied upon in making the adverse benefit determination, and an explanation for the same, will be provided, upon request and free of charge;
7. If applicable, a statement that an explanation for any adverse benefit determination that is based on an experimental treatment or similar Exclusion or limitation or a Medical Necessity standard will be provided, upon request and free of charge;
8. If applicable, a statement that diagnosis and treatment codes will be provided, and their corresponding meanings, upon request and free of charge; and
9. A statement that reasonable access to and copies of all documents and records and other information relevant to the adverse benefit determination will be provided, upon request and free of charge.

How to File an Internal Appeal of an Adverse Benefit Determination

1. **Time for Filing an Internal Appeal of an Adverse Benefit Determination**

   If the Participant disagrees with an adverse benefit determination (including a rescission), the Participant may appeal the determination within 180 days from receipt of the adverse benefit determination. With the exception of Urgent Care claims, the Participant's appeal may be made verbally or in writing, should list the reasons why the Participant does not agree with the adverse benefit determination, and must be sent to the address or fax number listed for appeals on the inside cover of this Plan Document. If the Participant is appealing an Urgent Care claim, the Participant may appeal the claim verbally by calling the telephone number listed for Urgent Care appeals on the inside cover of this Plan Document.

2. **Authorized Representative**

   The Participant may name another individual to act on the Participant's behalf for purposes of an appeal or review of an adverse benefit determination, by filing a written designation with the Claim Administrator. Contact the Claim Administrator at the number listed on the inside cover of this Plan Document for information on how to designate an authorized representative.

3. **Access to Plan Documents**

   The Participant may, at any time during the filing period, receive reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination upon request and free of charge. Documents may be viewed at the Claim Administrator's office, at 3645 Alice Street, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m. Mountain Time, Monday through Friday, excluding holidays. The Participant may also request that the Claim Administrator mail copies of all documentation to the Participant free of charge.

4. **Submission of Information and Documents**

   The Participant may present written evidence and written testimony, including any new or additional records, documents or other information that are relevant to the claim for consideration by the Claim Administrator until a final determination of the Participant's appeal has been made.

5. Consideration of Comments

The review of the claim on appeal will take into account all evidence, written testimony, new and additional records, documents, or other information the Participant submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial adverse benefit determination.

If the Claim Administrator considers, relies on or generates new or additional evidence in connection with its review of the Participant's claim, the Claim Administrator will provide the Participant with the new or additional evidence free of charge as soon as possible and with sufficient time to respond before a final determination is required to be provided by the Claim Administrator. If the Claim Administrator relies on a new or additional rationale in denying the Participant's claim on review, the Claim Administrator will provide the Participant with the new or additional rationale as soon as possible and with sufficient time to respond before a final determination is required to be provided by the Claim Administrator.

6. Scope of Review

The person who reviews and decides the Participant's appeal will be a different individual than the person who decided the initial adverse benefit determination and will not be a subordinate of the person who made the initial adverse benefit determination. The review on appeal will not give deference to the initial adverse benefit determination and will be made anew. The Claim Administrator will not make any decision regarding hiring, compensation, termination, promotion or other similar matters with respect to the individual selected to conduct the review on appeal based upon how the individual will decide the appeal.

7. Consultation with Medical Professionals

If the claim is, in whole or in part, based on medical judgment, the Claim Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not have been involved in the initial adverse benefit determination (nor have been a subordinate of any person previously consulted). The Participant may request information regarding the identity of any health care professional whose advice was obtained during the review of the Participant's claim.

Time Period for Notifying Participant of Final Internal Adverse Benefit Determination

The time period for deciding an appeal of an adverse benefit determination and notifying the Participant of the final internal adverse benefit determination depends upon the type of claim. The chart below provides the time period in which the Claim Administrator will notify the Participant of its final internal adverse benefit determination for each type of claim.

Type of Claim on Appeal	Time Period for Notification of Final Internal Adverse Benefit Determination
Urgent Care Claim	No later than 72 hours from the date the Claim Administrator received the Participant's appeal, taking into account the medical exigency.
Pre-Service Claim	No later than 30 days from the date the Claim Administrator received the Participant's appeal.
Post-Service Claim	No later than 60 days from the date the Claim Administrator received the Participant's appeal.
Concurrent Care Claim	• If the Participant's claim involved Urgent Care, no later than 72 hours from the date the Claim Administrator received the Participant's appeal, taking into account the medical exigency. • If the Participant's claim did not involve Urgent Care, the time period for deciding a pre-service (non-Urgent Care) claim or a post-service claim, as applicable, will govern.
Rescission Claim	No later than 60 days from the date the Claim Administrator received the Participant's appeal.

Content of Notice of Final Internal Adverse Benefit Determination

If the decision on appeal upholds, in whole or in part, the initial adverse benefit determination, the final internal adverse benefit determination notice will include the following information:

1. Information sufficient to identify the claim involved in the appeal, including, as applicable, the date of service, the health care provider, and the claim amount;
2. The title and qualifying credentials of each health care professional participating in the appeal;
3. A statement from each health care professional participating in the appeal of their understanding of the basis for the Participant's appeal;
4. The specific reason(s) for the final internal adverse benefit determination, including a discussion of the decision. If the final internal adverse benefit determination upholds a rescission, the notice will include the basis for the fraud or intentional misrepresentation of a material fact;
5. A reference to the applicable Plan Document provision(s), including identification of any standard relied upon in the Plan Document to deny the claim (such as a Medical Necessity standard), on which the final internal adverse benefit determination is based;
6. If applicable, a statement describing the Participant's right to request an external review and the time limits for requesting an external review;
7. If applicable, a statement that any internal Medical Policy or guideline or medical information relied on in making the final internal adverse benefit determination will be provided, upon request and free of charge;
8. If applicable, an explanation of the scientific or clinical judgment for any final internal adverse benefit determination that is based on a Medical Necessity or an experimental treatment or similar Exclusion or limitation as applied to the Participant's medical circumstances;
9. If applicable, a statement that diagnosis and treatment codes will be provided, with their corresponding meanings, upon request and free of charge;
10. A description of and contact information for any consumer appeal assistance program and a statement of the Participant's right to file a civil action under Section 502(a) of ERISA; and
11. A statement that reasonable access to and copies of all documents and records and other information relevant to the final internal adverse benefit determination will be provided, upon request and free of charge.

Deemed Exhaustion of Internal Appeal Process

1. The Participant will be deemed to have exhausted the internal appeal process and may request external review or pursue any available remedies under state law or a civil action under 502(a) of ERISA, if the Claim Administrator fails to comply with its claims and appeals procedures, except that claims and appeals procedures will not be deemed exhausted based on violations that are:
    a. De minimis;
    b. Non-prejudicial to the Participant;
    c. Attributable to good cause or matters beyond the Claim Administrator's control;
    d. In the context of an ongoing, good faith exchange of information between the Participant and the Claim Administrator; and
    e. Not reflective of a pattern or practice of violations by the Claim Administrator.
2. Upon request of the Participant, the Claim Administrator will provide an explanation of a violation within 10 days. The explanation will include a description of the basis for the Claim Administrator's assertion that the violation does not result in the deemed exhaustion of the Claim Administrator's internal claims and appeals procedures.
3. If the Participant seeks external or judicial review based on deemed exhaustion of the Claim Administrator's internal claims and appeals procedures, and the external reviewer or court rejects the Participant's request, the Claim Administrator will notify the Participant within a reasonable period of time, not to exceed 10 days, of the Participant's right to resubmit the Participant's internal appeal. The timeframe for appealing the adverse benefit determination begins to run when the Participant receives the notice of the right to resubmit the Participant's internal appeal.

External Review Procedures – In General

In most cases, and except as provided in the next two sections, the Participant must follow and exhaust the internal appeals process outlined above before the Participant may submit a request for external review. In addition, external review is limited to only those adverse benefit determinations that involve:

1. Rescissions of coverage; and

2. Medical judgment, including those adverse benefit determinations that are based on requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or adverse benefit determinations that certain treatments are experimental or investigational.

External review is not available for:

1. Adverse benefit determinations that are based on contractual or legal interpretations without any use of medical judgment; and
2. Adverse benefit determinations that are based on a failure to meet requirements for eligibility under a group health plan.

Standard External Review Procedures

There are two types of external review: a standard external review and an expedited external review. An expedited external review is generally based upon the seriousness of the Participant's medical circumstances and entitles the Participant to an expedited notice and decision-making process. The procedures for requesting standard (non-expedited) external reviews are discussed in this section. The procedures for requesting expedited external reviews are discussed in the next section.

1. **Request for a Standard External Review**

   The Participant or the Participant's authorized representative (hereafter, the Participant) must submit a written request to the Claim Administrator for a standard external review within 4 Months from the date the Participant receives an adverse benefit determination or a final internal adverse benefit determination.

2. **Preliminary Review**

   The Claim Administrator must complete a preliminary review within 5 business days from receipt of the Participant's request for a standard external review to determine whether:

   a. The Participant is or was covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Participant was covered under the Plan when the health care item or service was provided;
   b. The adverse benefit determination or final internal adverse benefit determination relates to the Participant's failure to meet the Plan's eligibility requirements;
   c. The Participant has exhausted (or is not required to exhaust) the Claim Administrator's internal appeals process; and/or
   d. The Participant has provided all the information and forms required to process the external review.

   Within 1 day after completing its review, the Claim Administrator will notify the Participant in writing if the request is eligible for external review. If further information or materials are necessary to complete the review, the written notice will describe the information or materials and the Participant will be given the remainder of the 4-Month period or 48 hours after receipt of the written notice, whichever is later, to provide the necessary information or materials. If the request is not eligible for external review, the Claim Administrator will outline the reasons for ineligibility in the notice and will provide contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

3. **Assignment of an IRO**

   If the Participant's request is eligible for external review, the Claim Administrator will within 1 business day assign the request for external review to an accredited Independent Review Organization (IRO) on a random basis or using another method of assignment that ensures the independence and impartiality of the assignment process, to conduct the external review. In making the assignment, the Claim Administrator will consider whether an IRO is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination. The Claim Administrator will also take into account other circumstances, including conflict of interest concerns.

4. **Initiation of External Review and Opportunity to Submit Additional Documents**

   Within 1 business day of assigning the IRO, the Claim Administrator will notify the Participant or the Participant's authorized representative in writing that the Claim Administrator has initiated an external review and that the Participant or the Participant's authorized representative may submit additional information to the IRO within 10

business days following the date of receipt of the notice for the IRO's consideration in its external review. The IRO may accept and consider additional information submitted after the 10 business days.

5. Claim Administrator Submission of Documents to the IRO

Within 5 business days after the date the IRO is assigned, the Claim Administrator must submit the documents and any information considered in making the benefits denial to the IRO. The Claim Administrator's failure to timely provide such documents and information will not constitute cause for delaying the external review. If the Claim Administrator fails to timely provide the documents and information, the IRO may terminate the external review and reverse the adverse benefit determination or final internal adverse benefit determination. If the IRO does so, it must notify the Participant and the Claim Administrator within 1 business day after making the decision.

6. Reconsideration by Claim Administrator

On receiving any information submitted by the Participant, the IRO must forward the information to the Claim Administrator within 1 business day. The Claim Administrator may then reconsider its adverse benefit determination or final internal adverse benefit determination. If the Claim Administrator decides to reverse its adverse benefit determination or final internal adverse benefit determination, the Claim Administrator must provide written notice to the Participant and IRO within 1 business day after making the decision. On receiving the Claim Administrator's notice, the IRO must terminate its external review.

7. Standard of Review

In reaching its decision, the IRO will review the claim and will not be bound by any decisions or conclusions reached under the Claim Administrator's internal claims and appeals process. In addition to the documents and information timely received, and to the extent the information or documents are available, the IRO will consider the following in reaching a decision:

a. The Participant's medical records;
b. The Participant's treating provider(s)'s recommendations;
c. Reports from appropriate health care professionals and other documents, opinions, and recommendations submitted by the Claim Administrator and the Participant;
d. The terms and conditions of the Plan, including specific coverage provisions, to ensure that the IRO's decision is not contrary to the terms and conditions of the Plan, unless the terms and conditions do not comply with applicable law;
e. Appropriate practice guidelines, which must include applicable Evidence-Based Standards;
f. Any applicable clinical review criteria developed and used by the Claim Administrator unless the criteria are inconsistent with the terms and conditions of the Plan or do not comply with applicable law;
g. The applicable Medical Policies of the Claim Administrator; and/or
h. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider them appropriate.

8. Written Notice of the IRO's Final External Review Decision

The IRO will send written notification of its decision to the Participant and to the Claim Administrator within 45 days after the IRO's receipt of the request for external review. The notice will include:

a. A general description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;
b. The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
c. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and Evidence-Based Standards;
d. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any Evidence-Based Standards relied on in making the decision;
e. A statement that the IRO's determination is binding, unless other remedies are available to the Claim Administrator or the Participant under state or federal law; and
f. A statement that judicial review may be available, to the Participant and the Plan.

9. Compliance with IRO Decision

If the IRO reverses the Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator will immediately provide coverage or issue payment according to the written terms and Benefits of the Plan Document.

Expedited External Review Procedures

In general, the same rules that apply to standard external review apply to expedited external review, except that the timeframe for decisions and notifications is shorter.

1. Request for Expedited External Review

Under the following circumstances, the Participant may request an expedited external review:

- **a.** If the Participant received an adverse benefit determination that denied the Participant's claim and: (1) the Participant filed a request for an internal Urgent Care appeal; and (2) the delay in completing the internal appeal process would seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function; or
- **b.** Upon receipt of a final internal adverse benefit determination which involves: (1) a medical condition of the Participant for which a delay in completing the standard external review would seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function; or (2) an admission, availability of care, a continued stay, or a health care item or service for which the Participant received Emergency Services, but has not been discharged from a facility.

2. Preliminary Review

Upon receiving the Participant's request for expedited external review, the Claim Administrator will immediately determine whether the request is eligible for external review, considering the same preliminary review requirements set forth in the Preliminary Review paragraph, Standard External Review Procedures section. After the preliminary review is complete, the Claim Administrator will immediately notify the Participant or the Participant's authorized representative in writing of its eligibility determination. If the request is not eligible for external review, the Claim Administrator will outline the reasons for ineligibility in the notice and will provide contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

3. Assignment of an IRO

If a request is eligible for expedited external review, the Claim Administrator will assign an IRO pursuant to and in compliance with the independence and other selection requirements set forth in the Assignment of an IRO paragraph, Standard External Review Procedures section. The Claim Administrator will transmit all documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO in as expeditious of a manner as possible (including by phone, facsimile, or electronically).

4. Standard of Review

In reaching its decision, the IRO will review the claim and will not be bound by any decisions or conclusions reached under the Claim Administrator's internal claims and appeals process. In addition to the documents and information timely received, and to the extent the information or documents are available, the IRO will consider the same documents and information set forth in the Standard of Review paragraph, Standard External Review Procedures section.

5. Notice of Final External Review Decision

The IRO will provide the Participant and the Claim Administrator with notice of its final external review decision as expeditiously as the Participant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO must provide written confirmation of its decision to the Participant and to the Claim Administrator within 48 hours after the date the IRO verbally conveyed the decision. The written notice will include:

- **a.** A description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;
- **b.** The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

c. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and Evidence-Based Standards;
d. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any Evidence-Based Standards relied on in making the decision;
e. A statement that the IRO's determination is binding, unless other remedies are available to the Claim Administrator or the Participant under state or federal law; and
f. A statement that judicial review may be available to the Participant or the Claim Administrator.

6. Compliance with IRO Decision

If the IRO reverses the Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator will immediately approve coverage that was the subject of the adverse benefit determination or final internal adverse benefit determination according to the written terms and Benefits of the Plan Document.

7. Inapplicability of Expedited External Review

An expedited external review may not be provided for retrospective adverse benefit determinations or retrospective final internal adverse benefit determinations.

UTILIZATION MANAGEMENT

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, inpatient admission and length of stay is based on the Claim Administrator's Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services being rendered, during the course of care, or after care has been completed as a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity Review. If requested, services normally subject to a Post-Service Medical Necessity Review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Refer to the definition of Medically Necessary in the Definitions section of this Plan Document for additional information regarding any limitations and/or special conditions pertaining to the Participant's Benefits.

Prior Authorization

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services described below for which the Participant has obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

If Prior Authorization is required, the review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions of this Plan Document. The Plan recommends the Participant confirm with the provider if Prior Authorization has been obtained.

To determine if a specific service or category requires Prior Authorization, visit the Claim Administrator's website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. The Participant can also call the Claim Administrator's Customer Service at the number on the back of the Participant's identification card.

Prior Authorization Responsibility

Participating Provider (In-Network) Prior Authorization

The Participant's Participating Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held financially responsible and will not be able to bill the Participant for the services.

For additional information about Prior Authorization for services outside of the Blue Cross and Blue Shield of Montana service area, see the section entitled, Out-of-Area Services – The BlueCard Program.

NOTE: Providers that contract with other Blue Cross and Blue Shield Plans may not be familiar with the Prior Authorization requirements of the Plan. Unless a provider contracts directly with the Plan as a Participating Provider, the provider is not responsible for being aware of the Plan's Prior Authorization requirements, except as described in the section entitled Out-of-Area Services – The BlueCard® Program.

Nonparticipating Provider (Out-of-Network) Prior Authorization

If any provider outside of Montana (except for those contracting as Participating Providers directly with the Plan) or any nonparticipating provider recommends an admission or a service that requires Prior Authorization, the provider is not obligated to obtain the Prior Authorization for the Participant. In such cases, it is the Participant's responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, the Participant may be entirely responsible for the charges if the service is determined to not be Medically Necessary. If the services were determined to be Medically Necessary, Out-of-Network Benefits will apply. The provider may call on the Participant's behalf, but it is the Participant's responsibility to ensure that the Plan is called.

Inpatient Admissions

The Participant's provider will need to obtain Prior Authorization from the Plan for an inpatient admission, if inpatient admissions are identified as needing a Prior Authorization. In the case of an elective inpatient admission, if services require an authorization it is recommended that the call for Prior Authorization should be made at least two working days before the Participant is admitted. If the admission is due to an Emergency Medical Condition and obtaining Prior Authorization would delay Emergency Services, it is recommended that Prior Authorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

If Prior Authorization is not obtained for inpatient services and the services are denied as not Medically Necessary, the Participating Provider will be held financially responsible and will not be able to bill the Participant for the services.

If the provider is not a network provider then the Participant, the Participant's provider, or the Participant's authorized representative should obtain Prior Authorization by the Plan by calling the toll-free number shown on the back of the Participant's identification card. The call should be made between 8:00 a.m. and 5:00 p.m., Mountain Time, on business days. After business hours or on weekends, please call the toll-free number listed on the back of the Participant's identification card. The Participant's call will be recorded and returned the next business day. A benefits management nurse will follow up with the Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if the Participant uses an In-Network provider or In-Network specialty care provider. If the Participant elects to use Out-of-Network providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not reasonably available from In-Network providers as defined by applicable law, and the Plan authorizes the Participant's visit to an Out-of-Network provider to be covered at the In- Network Benefit level prior to the visit, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When Prior Authorization of an inpatient admission is obtained, a length of stay is assigned. The Participant's provider may seek an extension for the additional days if the Participant requires a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the Length of Stay/Service Review subsection of this Plan Document.

If the Plan determines that the Participant's treatment does not require inpatient level of care, the Participant and the Participant's provider will be notified of that decision. If the Participant proceeds with an inpatient stay without the Plan's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant, the Participant's provider, or other appropriate party, as identified above, does not request Prior Authorization, the Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

For Behavioral Health Inpatient Hospital Admissions please see Contacting Behavioral Health section below.

Prior Authorization not Required for Maternity Care Unless Extension of Minimum Length of Stay Requested

The Plan is required to provide a minimum length of stay in a Hospital facility for the following:

Maternity Care

1. 48 hours following an uncomplicated vaginal delivery; or
2. 96 hours following an uncomplicated delivery by caesarean section.

The Participant or the Participant's provider will not be required to obtain Prior Authorization from the Plan for a length of stay less than 48 hours (or 96 hours) for Maternity Care. If the Participant requires a longer stay, the Participant, the Participant's authorized representative, or the Participant's provider must seek an extension for the additional days by obtaining Prior Authorization from the Plan.

Outpatient Service Prior Authorization Review

There may be general categories of covered Outpatient services that require Prior Authorization.

To determine if a specific service or category requires Prior Authorization, visit the Claim Administrator's website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. The Participant can also call Customer Service at the number on the back of the Participant's identification card.

For Behavioral Health Outpatient Service review please see Contacting Behavioral Health section below.

Prior Authorization Duration

A Prior Authorization is valid for at least three Months from the date the Participant's provider receives approval from the Plan. Actual availability of Benefits is subject to eligibility and other terms, conditions and limitations and Exclusions of this Plan Document.

It is NOT necessary to obtain Prior Authorization for standard x-ray and lab services or Routine office visits.

If the Plan does not approve the Outpatient Service, the Participant and the Participant's provider will be notified of that decision. If the Participant proceeds with the services without the Plan's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant, the Participant's provider, or other appropriate party, as identified above, does not request Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

Response to Prior Authorization Requests Involving Non-Urgent Care

Except in the case of a Prior Authorization request involving Urgent Care (see below), the Plan will provide a written response to the Participant's Prior Authorization request no later than seven business days following the date the Plan receives the Participant's request. This period may be extended one time for up to seven additional business days, if the Plan determines that additional time is necessary due to matters beyond our control.

If the Plan determines that additional time is necessary, the Plan will notify the Participant in writing, prior to the expiration of the original seven business day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Plan expects to make the determination. If an extension of time is necessary due to the need for additional information, the Plan will notify the Participant of the specific information needed, and the Participant will have 45 days from receipt of the notice to provide the additional information.

The Plan will provide a written response to the Participant's request for Prior Authorization within seven business days following either the receipt of the additional information or, if the additional information is not received, the deadline for the receipt of the additional information. The procedure for appealing an adverse Prior Authorization determination is set forth in the section entitled Complaints and Grievances.

Response to Prior Authorization Requests Involving Urgent Care

A Prior Authorization request involving Urgent Care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or in the opinion of a Physician

with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Prior Authorization request.

In case of a Prior Authorization request involving Urgent Care, the Plan will respond to the Participant no later than 48 hours after receipt of the request, unless the Participant fails to provide sufficient information, in which case, the Participant will be notified of the missing information within 24 hours of the Plan's receipt of the Urgent Care request and will have no less than 48 hours to provide the information. A response will be given as soon as possible (taking into account medical exigencies) but no later than 48 hours after the initial request, or, in the case where further information is requested, within 24 hours after the missing information is received or of the end of the period for the Participant to provide the missing information.

NOTE: The Plan's response to the Participant's Prior Authorization request involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Prior Authorization Required for Certain Prescription Drug Products and Other Medications

Prescription Drug Products, which are self-administered, process under the Prescription Drugs section of this Plan Document. There are other medications that are administered by a Covered Provider which process under the medical Benefits.

1. **Prescription Drugs – Covered Under the Prescription Drugs Benefit**

   Certain prescription drugs, which are self-administered, require Prior Authorization. Please refer to the Prescription Drugs section for complete information about the Prescription Drug Products that are subject to Prior Authorization, step therapy, and quantity limits, the process for requesting Prior Authorization, and related information.

2. **Other Medications – Covered Under Medical Benefits**

   Medications that are administered by a Covered Provider will process under the medical Benefits of this Plan Document. Certain medications administered by a Covered Provider require Prior Authorization. The medications that require Prior Authorization are subject to change by the Plan.

   In making determinations of coverage, the Plan may rely upon Pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in Montana, Medical Necessity, and Medical Policies. The Pharmacy policies and Medical Policies are located on the Plan website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.

   To determine which medications are subject to Prior Authorization, the Participant or provider should refer to the list of medications which applies to the Participant's Plan on the Plan website at www.bcbsmt.com or call the Customer Service toll-free number identified on the Participant's identification card or the Plan website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.

General Provisions Applicable to All Required Prior Authorizations

1. **No Guarantee of Payment**

   Prior Authorization does not guarantee payment of Benefits by the Plan. Even if the service has been approved through Prior Authorization, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible for coverage as of the date of service or the Participant's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Prior Authorization process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Prior Authorization, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

3. **Failure to Obtain Prior Authorization**

   If the Participant, the Participant's provider, or other appropriate party, as identified above, does not obtain Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is

determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

Length of Stay/Service Review

Length of stay/concurrent service review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions under this Plan Document.

Upon completion of the inpatient or emergency admission review, the Claim Administrator will send a letter to the Participant, the Participant's provider, behavioral health practitioner and/or Hospital or facility with a determination on the approved length of service or length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient Care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the Appeal Procedure section of this Plan Document.

A length of stay/service review, also known as a concurrent Medical Necessity review, occurs when the Participant, the Participant's provider, or other authorized representative submits a request to the Plan for continued services. If the Participant, the Participant's provider or the Participant's authorized representative requests to extend care beyond the approved time limit and it is a request involving Urgent Care or an ongoing course of treatment, The Plan will make a determination on the request as soon as possible but no later than 48 hours after it receives an urgent request, within 48 hours after it receives requested information (if the initial request is incomplete) or within seven business days after receipt of a non-urgent Concurrent Care request.

Recommended Clinical Review

A Recommended Clinical Review is a Medical Necessity review for a covered service that occurs before services are completed and helps limit the situations where the Participant may have to pay for a non-approved service. The Plan will review a Clinical Review request to determine if it meets the approved Claim Administrator's Medical Policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, the services will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit the Claim Administrator's website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed, or call Customer Service at the number on the back of the Participant's identification card. The Participant or provider may request a Recommended Clinical Review.

Please coordinate with the provider to submit a written request for Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is not a guarantee of Benefits or payment of Benefits by the Plan. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Plan Document. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible for coverage as of the date of service or the Participant's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

Contacting Behavioral Health

The Participant, the Participant's provider, or authorized representative may contact the Plan for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of the Participant's identification card and follow the prompts to the behavioral health unit. During regular business hours (7:00 a.m. and 5:00 p.m., Mountain Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 5:00 p.m., on weekends, and on holidays, the same behavioral health line is answered by clinicians available for inpatient acute Recommended Clinical Reviews only. Requests for residential or Partial Hospitalization are reviewed during regular business hours.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Participant eligibility, availability of Benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a post-service review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Plan Document. Post-Service Medical Necessity Review does not guarantee payment of Benefits by the Plan, for instance a Participant may become ineligible for coverage as of the date of service or the Participant's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Post-Service Medical Necessity Review process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

Care Management

The goal of Care Management is to help the Participant receive the most appropriate care that is also cost effective. If the Participant has an ongoing medical condition or a catastrophic Illness, the Participant should contact the Plan. If appropriate, a care manager will be assigned to work with the Participant and the Participant's providers to facilitate a treatment plan. Care Management includes Participant education, referral coordination, utilization review and individual care planning. Involvement in Care Management does not guarantee payment by the Plan.

ELIGIBILITY AND COVERAGE

Eligibility for Participation

The following Participants are eligible for participation in the Plan:

1. Employees who have completed the Eligibility Waiting Period and who are Actively Working at least 40 hours per week for full-time Employees and 20-39 hours per week for part-time Employees in the employ of entities eligible to participate in this health plan, or

2. Employees retiring from entities eligible to participate in this health plan and are under age of 65, and within 31 days of retirement have:

   a. Elected coverage, are at least age 50 (hired prior to July 1, 2011) or at least age 55 (hired July 1, 2011 or after), or on a disability retirement and are receiving a monthly pension benefit from Montana Public Employee Retirement Board (Defined Benefit Plan or Defined Contribution Plan); and
   b. Completed and filed with Yellowstone County, the Authorization for Deduction for Health Insurance Premium form: and
   c. Retirees satisfying the above criteria on the Defined Contribution pension plan may continue coverage by submitting full payment by personal check/bank bill pay to Yellowstone County. Additionally, those retirees on the Defined Contribution plan must take monthly deductions from their pension that are equal to the monthly insurance premium amount.

3. Officials, who have been elected to office and completed at least one term of office, who are terminating employment, under age 65, and within 31 days of leaving office have:

   a. Elected coverage; and
   b. Are at least age 50 (elected prior to July 1, 2011) or at least age 55 (elected July 1, 2011 or after). Retirees satisfying the above criteria, but receiving a Defined Benefit pension payment less than the amount of the health insurance premium, may continue coverage by submitting full payment by personal check to Yellowstone County. Premiums are requested by the 20th of each month for the following month's coverage. According to the terms of this contract, if a payment is not received by the due date (the first of the month) a 15-day grace period is allowed, but if full payment is not received within the grace period, the policy will be cancelled. Check should be made payable to Yellowstone County.

      Mail payments to:

      Yellowstone County
      Human Resources
      P.O. Box 35041
      Billings, MT 59107

Declining Coverage

If an eligible person, as outlined above, declines coverage under this Plan, the eligible person must state the reason(s) for declining coverage in writing. Failure to provide these reasons in writing may result in the Plan refusing enrollment at a later date or may require that the only time in the future the eligible person may enroll is during an open enrollment period, if applicable.

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time between the date of employment, or date in which the Employee meets the eligibility criteria specified above, and the first day of the calendar month following one entire calendar month of active employment. If the Employee begins work on the first workday of a calendar month, the date of employment will be considered to be the first day of the calendar month for the purpose of determining the date of eligibility. Any leave without pay of five scheduled work days or more will not qualify as time necessary to satisfy the Eligibility Waiting Period.

Enrollment

Each Employee must fill out and sign an enrollment card.

Effective Date of Coverage

An individual's coverage will be effective as follows:

1. Employees

   If Employee coverage is noncontributory, an Employee's coverage will be effective on the day he or she becomes eligible.

If Employee coverage is contributory, each Employee who both applies for coverage on a form approved by BCBSMT and agrees in writing to pay the required contributions, will become covered as follows:

If the Employee applies within 31 days of the date he or she first becomes eligible, he or she will be covered on the later of:

a. The date he or she applies; or
b. The date he or she becomes eligible.

2. Dependents

If dependent coverage is noncontributory, a dependent's coverage will be effective on the date he or she becomes eligible. The employee must be covered in order for his or her dependents to be covered.

If the dependent coverage is contributory, the Employee who both applies for dependent coverage on a form approved by BCBSMT and agrees in writing to pay the required contributions for dependents will become covered for his or her dependents as follows:

a. The date the employee applies for dependents coverage; or
b. The date the Employee becomes covered.

3. Employees and Dependents

a. If an Employee and spouse are both Employees of the group, any children shall be considered dependents of only one of the Employees, not both.
b. If an individual is not eligible because;

1) The Employee is not actively working for the Employer; and/or
2) The depend is confined in a Hospital or Skilled Nursing Facility;

The Employee will not become covered until the day he or she returns to full-time or qualified part-time active work and the dependent will not become covered if the Employee is not covered or if the dependent is confined in a Hospital or Skilled Nursing Facility.

Special Enrollment Period

A Special Enrollment Period is allowed with substantiating documentation for eligible Employees and/or dependents who are not currently enrolled and who originally declined coverage because they had other coverage, and:

- Whose other coverage was as a COBRA covered person and that coverage was exhausted, or
- Who lost eligibility for the prior coverage, or
- Who were covered on a group plan whose employer terminated contributions to that plan, and
- Who apply for coverage and submit required documentation under the current employer's plan within 31 days of the termination of such coverage.
- Who lost eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the Employee or Family Participant becomes eligible for financial assistance for group health coverage, under either the Children's Health Insurance Program or the Medicaid Program.

A Special Enrollment Period also occurs when there is a change in family status: a birth, adoption, marriage, divorce, death or loss of eligible coverage.

***Note:** "Period" is defined as the following:
1st of the month through the 14th of the month;
15th of the month through the last day of the month

- In the event of birth or adoption, the Employee and the Employee's dependents may enroll within 31 days of the birth or adoption. The effective date of the child will be the date of birth or adoption providing the new dependent was properly enrolled. The effective date of the dependents will be the first day of the period following birth or adoption.
- In the event of a marriage, an Employee previously eligible, but not enrolled, may enroll within 31 days after the marriage. The Employee's new spouse and/or children under the age of 26 may enroll within 31 days after the marriage. The effective date will be no later than the first day of the period beginning after the date the completed request for enrollment is received by the Plan.

- In the event of losing eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the Employee must request enrollment for the Employee or Family Participant not later than 60 days after the date of termination of coverage. The effective date will be no later than the first of the period beginning after the date the completed request for enrollment is received by the Plan.

  Note: Required documentation may be, but not limited to, one or more of the following:

  a. Certified marriage certificate;
  b. Declaration of marriage without solemnization certificate;
  c. Court adoption papers;
  d. Certified birth certificate;
  e. Employment paperwork showing separation of employment (i.e., reduction in force, termination letter, etc.);
  f. Certificate of Eligible Coverage.

Use of "Look-Back" Measurement Method to Determine Eligibility for the Yellowstone County Health Plan

The Affordable Care Act (ACA) imposes new rules governing offers of group health plan coverage by employers to their full-time employees. For this purpose, Yellowstone County has chosen to determine which employees are "full-time" employees under the "look-back measurement period." These rules will be included in your Summary Plan Description (SPD) beginning July 1, 2015. The purpose of this is to describe how the "look-back" measurement method applies to both newly hired and other "variable hour" employees. These rules are important, since they determine:

- The circumstances under which employees qualify for health insurance coverage and when; and
- How long an employee may continue health insurance coverage under the "Stability Period".

For health insurance purposes, upon hire an employee will be classified as regular full-time, regular part-time, temporary, variable hour, or seasonal employees:

- A "regular full-time" employee is an employee who is expected to work on average 40 hours per week during each calendar month.
- A "regular part-time" employee is an employee who is expected to work on average 20-39 hours per week during each calendar month.
- A "temporary full-time" employee (ACA definition) is an employee that is reasonably expected at his or her start date to work 30 or more hours per work for at least three (3) consecutive months or more.
- A "variable hour" employee is an employee who we cannot determine is reasonably expected to be employed on average at least 30 hours of service per week/130 hours per month (1,560 hours) during his or her "initial measurement period" (i.e. the 12-month period commencing the first day of the month following date-of-hire) because the employee's hours are variable or otherwise uncertain.
- A "seasonal" employee is an employee who is hired into a position for which the customary annual employment is six months or less in a 12-month period.

Changes in eligibility as a result of the Affordable Care Act's "30-hour" rule:

The "30-hour rule" includes two grouping of employees: Immediately Eligible and Not Immediately Eligible.

Immediately Eligible:

Employees classified as "regular full-time", "regular part-time" or "temporary full-time employee" will be eligible to participate in the Yellowstone County Health Plan on the first day of the calendar month following their hire date and one full calendar month of employment. (i.e. The employee is hired on January 15 the health insurance would become effective on March 1.)

Not Immediately Eligible:

"Variable hour" and "seasonal" employees must first complete a 12-month initial measurement period (that starts on the first day of the month following date of hire) during which they are not eligible to participate in the Yellowstone County Health Plan. At the completion of the initial measurement period, an employee who has averaged 30 hours per week/130 hours per month (1,560 hours) in the 12-month period will be eligible for coverage. Employees who qualify for coverage under this rule will remain eligible for a 12-month period (called the "stability period") irrespective of their hours, provided they remain employed. An employee who fails to work on average at least 30 hours per

week/130 hours per month (1,560 hours) during his or her initial measurement period is not eligible for coverage during the corresponding stability period.

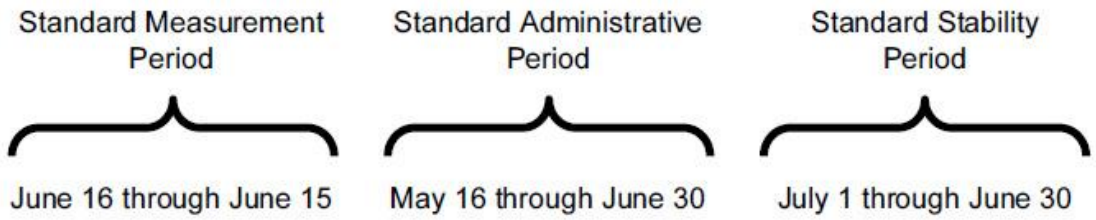
Yellowstone County has elected to use a 12-month standard measurement period. The initial measurement period will be from June 16, 2014 through June 15, 2015 and every June 16 through June 15 thereafter. Variable hour or seasonal employees meeting the required averaged 30 hours per week/130 hours per month (1,560 hours in a 12-month period) will be eligible for coverage. Those eligible variable hour and eligible seasonal employees will receive notice between May 16 and June 30, 2015 and every May 16 through June 30 thereafter (called the "administrative period") to elect or waive coverage for an effective date of July 1, 2015 and every July 1 thereafter.

In addition, where an employee experiences a break-in-service of at least 13-weeks, he or she may be treated as newly-hired upon their return. A similar result occurs under a "rule of parity" where a rehired employee may be treated as a new employee following a break of at least four (4) weeks if the employee's break in service is longer than the employee's period of service immediately preceding the break in service. (i.e. An employee worked for 6 weeks and then had a break in employment of 8 weeks, the employee will be considered a new hire.) If the break in service is less than four (4) weeks or less than the prior period of service, the employee will not be treated as a new hire and hours of service prior to and after the break will count during the measurement period.

New employees, not employed during the initial measurement period, must be evaluated on a "rolling basis". The hours of service will be tracked during both their "initial" measurement period which will begin as of the first of the month after their date of hire and the first standard measurement period that begins after their date of hire. New employees who work on average at least 30 hours per week/130 hours per month (1,560 hours in a 12-month period) will be offered health insurance coverage during the associated "stability" period.

Once an employee has worked through a full standard measurement period (June 16 – June 15), he or she is no longer classified as full-time, part-time, variable hour or seasonal. He or she would then be classified as an "on-going" employee and only tracked during the standard measurement period. An on-going employee who works on average at least 30 hours of service per week/130 hours per month (1,560 hours in 12 month period) during the annual standard measurement period will qualify for coverage during the upcoming stability period. An on-going employee who fails to work on average at least 30 hours per week/130 hours per month (1,560 hours in 12-month period) is not eligible for coverage during the corresponding stability period.

- The "standard 12-month measurement period" will be June 16 through June 15 annually.
- The "standard administrative period" will be from May 16 (corresponding year) through June 30.
- The "standard 12-month stability period" will be from July 1 through June 30 (corresponding year).



If you have questions about how these rules affect you, please contact Human Resources at 256-2705.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Participant can obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Claim Administrator.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

1. The Family and Medical Leave Act of 1993 (FMLA) requires employers, who employ at least 50 workers within a 75-mile radius of the workplace, to provide eligible employees with up to 12 weeks of leave during any 12-Month period for any of the following reasons:
   - **a.** To care for a newborn child;
   - **b.** Because a child has been placed with the employee for adoption or foster care;
   - **c.** To care for a Spouse, child, or parent of the employee;
   - **d.** The employee's own serious health condition makes the employee unable to perform his or her job.
2. Eligible employees are those who have been employed by the employer for at least 12 Months and who have worked at least 1,250 hours for that employer during the previous 12-Month period.
3. The health Benefits of an employee and Dependents, if any, will be maintained during FMLA leave on the same terms and conditions as if the employee had not taken leave.
4. The health Benefits of an employee and Dependents, if any, may lapse at the employer's discretion during FMLA leave because the employee does not pay his or her share of the premiums in a timely manner or the employee does not elect health Benefits during the FMLA leave. Upon return from leave, the employee and Dependents, if any, will be reenrolled in the health Benefit Plan as if the coverage had not lapsed.
5. The employee's reenrollment in the health Plan will be effective upon the date on which the employee returns to work.
6. An employee who takes FMLA leave and fails to pay any required premium contribution or fails to return from leave will be entitled to COBRA coverage for the maximum COBRA coverage period beginning when the FMLA coverage terminated.

TERMINATION OF COVERAGE

An individual's insurance will end automatically on the earliest of the following dates:

Note: "Period" is defined as the following: 1st of the month through 14th of the month
15th of the month through the last day of the month

1. The date this Plan ends
2. The end of the last period for which any required contribution agree to in writing has been made (1st – 14th; or 15th – last day of month);
3. The last day of the period in which he or she is no longer eligible for insurance;
4. The last day of the period in which Employee's employment with the Employer ends. Except that: The Employer may , at its option, continue insurance as shown below for individuals whose employment has ended, if it does so without individual selection between Employees and if it continues making premium payments for those individuals.

   Coverage will terminate automatically at midnight, Mountain Time, on the last day of the Month in which a child reaches age 26 years. Coverage for a Spouse will terminate at midnight, Mountain Time, on the last day of the Month in which the Spouse's marriage to the Employee is terminated.

   Insurance may be continued for all Benefits for:

   - An Employee on an approved leave of absence; or
   - An employee temporarily laid off; or
   - An Employee unable to work because of disability.

   Employee should refer to the Employee Handbook and/or Collective Bargaining Agreement for more specific information.

   The Employer may, at its option, continue Employee's insurance for up to 12 Months if the Employee's insurance would otherwise end due to his or her work schedule reducing to less than the minimum time required to qualify

for coverage, provided the Employer does so without individual selection among Employees and provided that premium payments are continued for those individuals.

No Benefits are payable for charges incurred after an individual's insurance ends.

Termination of Benefits on Termination of Coverage

When the participation of an eligible Employee and/or Family Members is terminated for any reason listed in this section or any other section of this Plan, the Benefits of this Plan will no longer be provided, and the Plan will not make payment for services provided to the Employee and/or Family Members after the date on which cancellation becomes effective.

Certificate of Creditable Coverage

Even though this health plan does not have a preexisting condition exclusion period, the Claim Administrator will issue a Certificate of Creditable Coverage to the Participant, upon request, following termination of coverage.

CONTINUATION OF COVERAGE

COBRA

Certain employers maintaining group health coverage plans (whether insured or self-insured) must provide COBRA continuation coverage for qualified beneficiaries when group health coverage is lost. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). To lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before a qualifying event. A loss of coverage need not occur immediately after a qualifying event so long as the loss of coverage occurs before the end of the maximum COBRA coverage period. A qualified beneficiary is entitled to the coverage made available to similarly situated employees.

COBRA requires qualified beneficiaries or a representative acting on behalf of a qualified beneficiary to provide certain notices to the Plan Administrator (generally the employer) and requires the Plan Administrator to provide certain notices to qualified beneficiaries. The Plan Administrator is also the COBRA Administrator unless the Plan Administrator has designated another individual or entity to administer COBRA.

1. Small Employer Exception

Small employer plans are generally exempt from the COBRA regulations. A small employer plan, for the purposes of COBRA, is defined as an employer plan that normally employed fewer than 20 employees, including part-time employees, during the preceding calendar year. A group health plan that is a multi-employer plan (as defined in Internal Revenue Code (IRC)) is a small-employer plan if each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. Whether the plan is a multi-employer plan or not, the term employer includes all members of a controlled group.

A small employer employs fewer than 20 employees during a calendar year if it had fewer than 20 employees on at least 50 percent of its typical business days during that year. Only common-law employees are counted for purposes of the small employer exception; self-employed individuals, independent contractors (and their employees and independent contractors), and corporate directors are not counted.

2. Qualified Beneficiaries

Continuation of coverage is available to qualified beneficiaries. A qualified beneficiary is:

a. Any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the Spouse of a covered employee, or the Dependent child of a covered employee; or
b. Any child born to or placed for adoption with a covered employee during a period of COBRA continuation.

Individuals added to a qualified beneficiary's COBRA coverage (e.g., a new Spouse or person added as the result of a Special Enrollment event, etc.) do not become qualified beneficiaries in their own right, with the exception of 2(b) above.

Nonresidents - An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of IRC section 911(d)(2)) that constituted income from sources within the United States (within the meaning of IRC section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

3. Qualifying Events

A qualifying event is any of a set of specified events that occur while a group health plan is subject to COBRA and which causes a qualified beneficiary to lose coverage under the plan.

a. Employee

An employee will become a qualified beneficiary if the employee loses coverage under the plan because either one of the following qualifying events happen:

1. Employee's hours of employment are reduced; or
2. Employment ends for any reason other than gross misconduct.

b. Spouse

The Spouse of an employee will become a qualified beneficiary if the Spouse loses coverage under the plan because any of the following qualifying events happen:

1. The employee dies;
2. The employee's hours of employment are reduced;
3. The employee's employment ends for any reason other than gross misconduct;
4. The employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. Divorce or legal separation from the employee.

c. Dependent Children

Dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happen:

1. The employee dies;
2. The employee's hours of employment are reduced;
3. The employee's employment ends for any reason other than gross misconduct;
4. The employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The employee becomes divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "Dependent child."

d. Retirees

If the plan provides retiree health coverage, a proceeding in bankruptcy under Title 11 of the United States Code can sometimes 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 for any retired employee covered under the plan, the covered retiree will become a qualified beneficiary with respect to the bankruptcy. The covered retiree's covered Spouse or surviving Spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

4. Period of Coverage

a. A qualified beneficiary may continue coverage for up to 18 months when the employee loses coverage under the plan due to one of the following qualifying events:

1. A reduction in work hours; or
2. Voluntary or involuntary termination of employment for reasons other than gross misconduct.

b. A qualified beneficiary may continue coverage for up to 36 months when the qualified beneficiary loses coverage under the plan due to one of the following qualifying events:

1. The employee's death;
2. Divorce or legal separation from the employee;
3. The covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or
4. A covered Dependent child ceases to be a Dependent child of the covered employee under the terms of the group health plan.

c. Bankruptcy

If the employer files Chapter 11 bankruptcy which results in loss of coverage (or substantial elimination of coverage within one year before or after bankruptcy is filed), a qualified beneficiary may continue coverage up to the following applicable periods:

1. Covered retiree: The maximum duration of the COBRA coverage is the lifetime of the retired covered employee.
2. Covered Spouse, surviving Spouse, or Dependent child of covered retiree: The maximum duration of the COBRA coverage ends the earlier of:

   a. The date of death (of the Spouse, surviving Spouse or Dependent child); or
   b. 36 months after the death of the covered retiree.

5. Providing Notice of Qualifying Events

a. Responsibilities of Qualified Beneficiaries

1. General Notice Requirements

The qualified beneficiary or a representative of the qualified beneficiary must notify the administrator of the qualifying events listed below within 60 days after the latest of (1) the qualifying event; (2) the loss of coverage, or (3) the date that the qualified beneficiary receives information concerning COBRA coverage in a General Notice.

   a. Divorce or legal separation;
   b. Covered Dependent child ceases to be a Dependent child of a covered employee under terms of the plan; or
   c. A second qualifying event. (See 5(a)(2)).

Notification of a qualifying event must be timely mailed to the Plan Administrator (generally the Participant's employer), or to the entity identified as the COBRA Administrator in the General COBRA Notice provided to the Participant upon enrollment or when the Participant's coverage is terminated. **Important Information: If notices are not received within the timeframes specified below, the qualified beneficiary will not be provided COBRA coverage.**

A single notice sent by or on behalf of the covered employee or any one of the qualified beneficiaries affected by the qualifying event satisfies the notice requirement for all qualified beneficiaries.

The following information should be included:

   a. Name of covered employee;
   b. Subscriber identification number;
   c. Employee and qualified beneficiary names, address and telephone number (also note any different addresses for other qualified beneficiaries);
   d. Employer/former employer;
   e. Whether the event is a qualifying event, disability, or second qualifying event; and
   f. Date of qualifying event.

Certain COBRA qualifying events have additional notice requirements which are explained in more detail below.

2. Second Qualifying Event

The qualified beneficiary or a representative of the qualified beneficiary must notify the administrator within 60 days of a second qualifying event. **Important Information: If notice is not received within the timeframes specified below, an extension of COBRA coverage will not be provided to the qualified beneficiary.**

The initial 18-month COBRA coverage period may be extended for an additional 18 months (for a total of 36 months) for Spouses and Dependents who initially elected COBRA coverage if:

a. The first qualifying event is the employee's termination of employment or reduction in hours;
b. The second qualifying event occurs during the initial 18-month COBRA coverage period;
c. The second qualifying event has a 36-month maximum coverage period (see Period of Coverage (4)(b)); and
d. The second qualifying event is one that would have caused loss of coverage in the absence of the first qualifying event.

If COBRA coverage was previously extended from 18 months to 29 months due to a Medicare disability determination, the maximum COBRA coverage period under a second qualifying event will be 36 months.

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the Spouse and Dependent children will end 36 months from the date the employee became entitled to Medicare as a result of turning 65 (but the covered employee's maximum coverage period will be 18 months).

3. Disability Extension

A qualified beneficiary may be entitled to a disability extension of up to 11 additional months. If a qualified beneficiary is entitled to the extension, which shall not extend the total period of continuation coverage beyond 29 months, the extension applies to each qualified beneficiary who is not disabled, as well as to the disabled beneficiary, and it applies independently with respect to each of the qualified beneficiaries.

To qualify for a disability extension, the following requirements must be met:

a. The qualifying event must be a termination or reduction of hours of a covered employee's employment; and
b. The qualified beneficiary must have been determined under Title II or XVI of the Social Security Act (SSA) to be disabled at any time during the first 60 days of the COBRA continuation coverage.

Individuals who have been determined by SSA to be disabled prior to the occurrence of a qualifying event and the disability continues to exist at the time of the qualifying event, qualified beneficiaries are considered to meet the statutory requirements of being disabled within the first 60 days of COBRA coverage.

In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption.

The qualified beneficiary must provide a disability notice before the end of the first 18 months of coverage.

The qualified beneficiary or a representative of the qualified beneficiary must also provide notice to the administrator within 30 days after the date of any final determination under the SSA that the qualified beneficiary is no longer disabled. Coverage will be terminated the later of (1) the first day of the month that is more than 30 days after a final determination by SSA that the individual is no longer disabled; or (2) the end of the COBRA period that applies without regard to the disability extension.

b. Responsibilities of Plan Administrator

The Plan Administrator must notify the party responsible for administering COBRA within 30 days of the following events.

1. The employee's death;
2. The employee's termination (other than for gross misconduct);
3. Reduction in work hours of employment;
4. A proceeding in bankruptcy with respect to an employer from whose employment a covered employee retires; and
5. The covered employee becomes entitled to Medicare.

c. Responsibilities of the COBRA Administrator

The COBRA administrator must notify qualified beneficiaries of their right to COBRA coverage within 14 days after receiving notice of a qualifying event by providing qualified beneficiaries with a COBRA Election form.

If the Plan Administrator is the COBRA administrator, the Plan Administrator must notify qualified beneficiaries of their right to COBRA coverage within 44 days after receiving notice of a qualifying event.

6. Election of COBRA Coverage - Notice Requirements

After a qualified beneficiary or COBRA administrator has provided notice of a qualifying event, the qualified beneficiary will receive a COBRA Election form.

Each qualified beneficiary has an independent right to elect COBRA coverage. The qualified beneficiary or a representative of the qualified beneficiary must return the COBRA Election form to the administrator within 60 days from the date on the COBRA Election form. **Important Information: If the COBRA Election form is not returned within the 60-day timeframe, COBRA coverage will not be provided to any qualified beneficiaries.**

7. Trade Adjustment Assistance Eligible Employees

Employees who lost coverage as the result of a termination or a reduction of hours and who qualify for “Trade Adjustment Assistance” (“TAA”) under the Trade Act of 1974, as amended, are entitled to a second opportunity to elect COBRA coverage, if such coverage was not elected within the first 60 days after coverage is lost.

The second COBRA election period provisions are effective for individuals with respect to whom petitions for certification for trade adjustment assistance are filed on or after November 4, 2002. The second election period begins on the first day the employee began receiving TAA (or would have become eligible to begin receiving TAA but for exhaustion of unemployment compensation), but only if made within months after group health coverage is lost. Notice must be provided in accordance with “Responsibility of Qualified Beneficiary” above.

This coverage may continue for 18 months from the date COBRA coverage begins. When the employee elects coverage, the election can include coverage for previously covered Dependents. Dependents are not qualified beneficiaries in their own right under this provision and therefore do not have an independent election.

8. Payment of Premium

The first premium payment must be made within 45 days of the date of the election of COBRA continuation coverage and must include payments retroactive to the date coverage would normally have terminated under this plan.

Subsequent payments must be made within 30 days after the first day of each coverage period. Payment is considered to be made on the date payment is sent to the employer or COBRA administrator. If the premium is not paid by the first day of the coverage period, a grace period of 30 days will be allowed for payment. The Participant may instead request to be billed for continuation coverage for the following coverage periods: quarterly, semi-annually or annually.

9. Termination of Continued Coverage

a. Coverage terminates the last day of the maximum required period under COBRA;
b. Any of the following events will result in termination of coverage prior to expiration of the 18-Month, 29-Month, or 36-Month period:

1. The first day on which timely payment is not made with respect to the qualified beneficiary;
2. The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

3. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes covered under any other group health plan; or
4. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

10. Questions Concerning COBRA Coverage

For any questions concerning COBRA coverage, contact the Claim Administrator at 1-855-258-3489.

11. Provide Notice of Address Changes

In order to protect all COBRA rights, Participants must notify the administrator of the COBRA coverage and the Claim Administrator of any changes to the Participant's or Family Member's addresses. A Participant should also keep a copy of any notices for personal records.

BENEFITS

The Plan will pay for the following Benefits provided by a Covered Provider based on the Allowable Fee and is subject to any Deductible, Copayment and/or Coinsurance and other provisions, as applicable.

Please note that services must be determined to be Medically Necessary by the Plan in order to be covered. Coverage of Benefits is subject to Blue Cross and Blue Shield of Montana policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, Utilization Management, and clinical payment and coding policies, which may be updated throughout the plan year. The policies and guidelines are resources utilized by Blue Cross and Blue Shield of Montana when making coverage determinations and lay out the procedure and/or criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Medical Expense or is not eligible for coverage as not Medically Necessary, Experimental/Investigational/Unproven, cosmetic, a convenience item, or a Plan Document Exclusion.

The clinical payment and coding policies are intended to ensure the creation and submission of accurate documentation of the services performed and require all providers to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Under the clinical payment and coding policies, claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Provider claims are subject to the code edit protocols for services/procedures billed as well as to other applicable claim review which may include, but is not limited to, review of any terms of Benefit coverage, provider contract language, medical and medical management policies, utilization or clinical review or Utilization Management policies, medical records, clinical payment and coding policies as well as coding software logic, including but not limited to, lab management or other coding logic or edits.

Any line on the claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included as a Covered Medical Expense and will not be eligible for payment by the Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the provider rendering the item or service or submitting the claim is In-Network or Out-of-Network. The most up-to-date medical policies and clinical procedure and coding policies are available at www.bcbsmt.com or by contacting Customer Service at the number shown on the Participant's identification card.

Accident

Services which are provided for bodily injuries resulting from an Accident.

Acupuncture

Services provided by a licensed acupuncturist to treat Illness or Injury.

Advanced Practice Registered Nurses and Physician Assistants - Certified

Services provided by an Advanced Practice Registered Nurse or a Physician Assistant-Certified who is licensed to practice medicine in the state where the services are provided and when payment would otherwise be made if the same services were provided by a Physician.

Ambulance

Licensed ground and air ambulance transport required for a Medically Necessary condition to the nearest appropriate site.

Anesthesia Services

Anesthesia services provided by a Physician (other than the attending Physician) or nurse anesthetist including the administration of spinal anesthesia and the injection or inhalation of a drug or other anesthetic agent.

The Plan will not pay for:

1. Hypnosis;
2. Local anesthesia or intravenous (IV) sedation that is considered to be an Inclusive Service/Procedure;
3. Anesthesia consultations before surgery that are considered to be Inclusive Services/Procedures because the Allowable Fee for the anesthesia performed during the surgery includes this anesthesia consultation; or
4. Anesthesia for dental services or extraction of teeth, except anesthesia provided at a Hospital in conjunction with dental treatment will be covered only when a nondental physical Illness or Injury exists which makes Hospital care Medically Necessary to safeguard the Participant's health. Dental services and treatment are not a Benefit of this Plan Document, except:
    a. As specifically included in the Dental Accident Benefit; or
    b. Anesthesia Services associated with any Medically Necessary dental procedure when provided to a Participant who is severely disabled; or who has a medical or emotional condition which requires **h**ospitalization or general anesthesia for dental care; or who, in the judgment of the treating provider, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

Approved Clinical Trials

Routine Patient Costs provided in connection with an Approved Clinical Trial.

Autism Spectrum Disorders

Diagnosis and treatment of autistic disorder, Asperger's Disorder or Pervasive Developmental Disorder.

Covered services include:

1. Habilitative Care or Rehabilitative Care, including, but not limited to, professional, counseling and guidance services and treatment programs; Applied Behavior Analysis (ABA), also known as Lovaas Therapy; discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention;
2. Medications;
3. Psychiatric or psychological care; and
4. Therapeutic care provided by a speech-language pathologist, audiologist, occupational therapist or physical therapist.

Birthing Centers

Services for the delivery of a newborn provided at a birthing center.

Blood Transfusions

Blood transfusions, including the cost of blood, blood plasma, blood plasma expanders and packed cells. Storage charges for blood are paid when a Participant has blood drawn and stored for the Participant's own use for a planned surgery.

Breast Examinations (Preventive and Medical)

Mammography examinations.

The minimum mammography examination recommendations are:

1. One baseline mammogram for women ages 35 through 39.
2. One mammogram every two years for women ages 40 through 49, or more frequently as recommended by a Physician.
3. One mammogram every year for women age 50 or older.

Chemotherapy

The use of drugs approved for use in humans by the U.S. Food and Drug Administration (FDA) and ordered by the Physician for the treatment of disease.

Chiropractic Services

Services of a licensed chiropractor.

The Schedule of Benefits describes payment limitations for these services.

Contraceptives

Services and supplies related to contraception, including but not limited to, oral contraceptives, contraceptive devices and injections, subject to the terms and limitations of the Plan Document.

Deductible and Coinsurance do not apply to contraceptives covered under the Preventive Health Care Benefit, whether provided during an office visit or through the Prescription Drugs Benefit.

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Convalescent Home Services

Services of a Convalescent Home as an alternative to Hospital Inpatient Care. The Plan will not pay for Custodial Care.

NOTE: The Plan will not pay for the services of a Convalescent Home if the Participant remains inpatient at the Convalescent Home when a skilled level of care is not Medically Necessary.

Prior Authorization is required for Convalescent Home services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

The Schedule of Benefits describes payment limitations for these services.

Dental Accident Services

Dental services provided by Physicians, dentists, oral surgeons and/or any other provider are not covered under this Plan Document except that, Medically Necessary services for the initial repair or replacement of sound natural teeth which are damaged as a result of an Accident, are covered, except that orthodontics, dentofacial orthopedics, or related appliances are not covered, even if related to the Accident.

The Plan will not pay for services for the repair or replacement of teeth which are damaged as the result of biting and chewing. Damage to teeth as a result of biting and chewing will not be considered an Accident.

Dental Services (Non-Accident)

Type 1 – Diagnostic and Preventive Services – Paid at 80%* once the deductible has been met.

1. Dental examinations.
2. Emergency treatment of dental pain (including emergency exams).
3. Bitewing x-rays (maximum of two sets per Benefit Period).
4. Complete mouth x-rays (once every three years and this will count as one of the two sets of x-rays payable during that Benefit Period).
5. Oral prophylaxis (cleaning limited to maximum of two per Benefit Period)
6. Topical application of fluoride limited to dependent children under the age of 19. Maximum of two per Benefit Period.
7. X-rays (in addition to panoramic-full mouth and bitewings). No limit on single x-rays.
8. Dental sealants are covered with no age limit and payable once per tooth per lifetime.
9. Space maintainers (not including orthodontics) Once per tooth per lifetime per tooth area. No Age max.
10. Nightguards (occlusal guards for bruxism)

Type 2 – Basic Dental Services – Paid at 80%* once the deductible has been met.

1. Oral surgery , removal of impacted teeth
2. Extractions.
3. General anesthesia when administered with oral surgery.
4. Restorations using amalgam and composite resin. No frequency limit.
5. Repair of crowns, temporary crowns, stainless steel crowns. No frequency limit.
6. Endodontics. No frequency limit.
7. Periodontics. Perio maintenance limited to four times per benefit period. Scaling/Planning, limited to one per quadrant every 24 months.
8. Repair and/or relining or rebasing of existing complete or partial dentures and bridges. No frequency limit.
9. Sterile tray for extractions and surgical procedures.
10. Crown lengthening with prior authorization. No frequency limit.

Type 3 – Major Restorative Services – Paid at 80%* once the deductible has been met.

1. Fixed bridges, removable partial dentures, removable complete dentures, limited to once every five years.
2. Restorations using gold foil, gold inlays and porcelain, limited to once every 5 years.
3. Implants, crowns (single restorations once every five years), labial veneers with prior authorization (benefits available for composite bonded veneers with used for restoration of extensive caries or fractures but not for cosmetic purposes). No frequency limit on implants/veneers.

*80% is based on the allowed charges.
No orthodontic coverage.

The Plan will not pay for:

1. Services and supplies which are excluded under the base Plan, unless the exclusion is specifically modified in this plan.
2. Any service for which Benefits were received under any other plan offered by the Employer and administered by Blue Cross and Blue Shield of Montana
3. Any service not provided or prescribed by a Dentist or Denturist.
4. Services for which there is no legal obligation to pay.
5. Any experimental procedure, services or treatments.
6. Any service not required and provided in accordance with accepted standards of dental practice.
7. Replacing any lost or stolen appliance or any appliance damaged when not in the mouth.
8. Any services provided for cosmetic purposes, including teeth bleaching.
9. Precision attachments for cosmetic purposes.
10. Characterization dentures.
11. Services, appliances or restorations used primarily to increase vertical dimensions or to restore occlusion.

12. Patient education in oral hygiene and dietary planning.
13. Interim (temporary) dentures.
14. Local anesthesia.
15. Desensitizing medications.

Out-of-Network providers may bill the Participant the difference between the Allowable Amount and the provider's charge even if Prior Authorization is obtained for the service, or if treatment is provided for Emergency Services. Any billing by the Provider is in addition to any applicable Deductible, Copayment and/or Coinsurance for which the participant is responsible.

Diabetes Treatment (Office Visit)

Services and supplies for the treatment of diabetes provided during an office visit. For additional Benefits related to the treatment of diabetes, e.g., surgical services and medical supplies, refer to that specific Benefit.

Diabetic Education

Outpatient self-management training and education services for the treatment of diabetes provided by a Covered Provider with expertise in diabetes.

NOTE: Benefits for outpatient diabetic self-management training and education are not subject to any visit limitations.

The Schedule of Benefits describes payment limitations for these services.

Diagnostic Services

Diagnostic x-ray examinations, laboratory and tissue diagnostic examinations and medical diagnostic procedures (machine tests such as EKG, EEG) are covered. Covered services include, but are not limited to, the following:

1. X-rays and Other Radiology. Some examples of other radiology include:
   a. Computerized tomography scan (CT Scan).
   b. MRIs.
   c. Nuclear medicine.
   d. Ultrasound.
2. Laboratory Tests. Some examples of laboratory tests include:
   a. Urinalysis.
   b. Blood tests.
   c. Throat cultures.
3. Diagnostic Testing. Tests to diagnose an Illness or Injury. Some examples of diagnostic testing include:
   a. Electroencephalograms (EEG).
   b. Electrocardiograms (EKG or ECG).

This Benefit does not include diagnostic services such as biopsies which are covered under the surgery Benefit.

Dialysis Treatment - Outpatient

For Outpatient Dialysis, see separate Outpatient Dialysis Plan Document.

Durable Medical Equipment

The appropriate type of equipment used for therapeutic purposes where the Participant resides. Durable medical equipment, which requires a written prescription, must also be:

1. Able to withstand repeated use (consumables are not covered);
2. Primarily used to serve a medical purpose rather than for comfort or convenience; and
3. Generally, not useful to a person who is not ill or injured.

Replacement Equipment.

1. Replacement of durable medical equipment will not be subject to any reduced replacement Coinsurance that may be applicable if the replacement is five (5) years or longer after the original purchase.
2. Durable medical equipment will not be considered a replacement if the current equipment no longer meets the medical needs of the Participant due to physical changes or a deteriorating medical condition.

The Plan will not pay for the following items:

1. Exercise equipment;
2. Car lifts or stair lifts;
3. Biofeedback equipment;
4. Self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition;
5. Air conditioners and air purifiers;
6. Whirlpool baths, hot tubs, or saunas;
7. Waterbeds;
8. Other equipment which is not always used for healing or curing;
9. Deluxe equipment. The Plan has the right to decide when deluxe equipment is required. However, upon such decision, payment for deluxe equipment will be based on the Allowable Fee for standard equipment;
10. Computer-assisted communication devices;
11. Durable medical equipment required primarily for use in athletic activities;
12. Replacement of lost or stolen durable medical equipment;
13. Repair to rental equipment; and/or
14. Duplicate equipment purchased primarily for Participant convenience when the need for duplicate equipment is not medical in nature.

Prior Authorization from the Plan is recommended for the original purchase or replacement of durable medical equipment over $2,000. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Emergency Room Care

1. Emergency room care for an accidental Injury.
2. Emergency room care for sudden and serious Illness.
3. Emergency room care for the treatment of Mental Illness and/or Substance Use Disorder.

If the Participant disagrees with the Plan's determination in processing Benefits as nonemergency services instead of Emergency Services, the Participant may call the Plan at the number on the back of the Participant’s identification card. Please see the section entitled How to File an Internal Appeal of an Adverse Benefit Determination in this document for specific information on the Participant's right to seek and obtain a full and fair review of the claim.

Foot Orthotics

Foot orthotics provided by a Covered Provider.

Hearing Aids

1. Hearing aids, repair and replacement of hearing aid device;
2. Hearing aids and appliances are covered when needed for auditory deterioration.

The Schedule of Benefits describes payment limitations for these services.

Hearing Coverage for Dependent Children Under Age 19

Coverage is available for the Medically Necessary diagnosis and treatment of hearing loss for a covered Dependent under age 19, when prescribed, provided, or ordered by a licensed health care provider. One Amplification Device, with required accessories, are available for each ear, every three years, or as required by a licensed audiologist.

The Schedule of Benefits describes payment limitations for these services.

Home Health Care

The following services, when prescribed and supervised by the Participant's attending Physician provided in the Participant's home by a licensed Home Health Agency and which are part of the Participant's treatment plan:

1. Nursing services;
2. Home Health Aide services;
3. Hospice services;
4. Physical Therapy;
5. Occupational Therapy;
6. Speech Therapy;
7. Medical social worker services;
8. Medical supplies and equipment suitable for use in the home; and/or
9. Medically Necessary personal hygiene, grooming and dietary assistance.

The Plan will not pay for:

1. Maintenance or Custodial Care visits.
2. Domestic or housekeeping services.
3. "Meals-on-Wheels" or similar food arrangements.
4. Visits, services, medical equipment, or supplies not approved or included as part of the Participant's treatment plan.
5. Services for the treatment of Mental Illness.
6. Services provided in a nursing home or skilled nursing facility.

Prior Authorization is required for home health care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

The Schedule of Benefits describes payment limitations for these services.

Home Infusion Therapy Services

The preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Participant by a Home Infusion Therapy Agency, including:

1. Education for the Participant, the Participant's caregiver, or a Family Member;
2. Pharmacy;
3. Supplies;
4. Equipment; and
5. Skilled nursing services when billed by a Home Infusion Therapy Agency.

NOTE: Skilled nursing services billed by a Licensed Home Health Agency will be covered under the home health services Benefit.

Home infusion therapy services must be ordered by a Physician and provided by a licensed Home Infusion Therapy Agency. A licensed Hospital, which provides home infusion therapy services, must have a Home Infusion Therapy Agency license or an endorsement to its Hospital facility license for home infusion therapy services.

Prior Authorization is required for home infusion therapy services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Hospice Care

A coordinated program of home care and Inpatient Care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill Participant and the Participant's Immediate Family. Benefits include:

1. Inpatient and Outpatient care;
2. Home care;

3. Nursing services – skilled and non-skilled;
4. Counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally ill Participant; and
5. Instructions for care of the Participant, counseling and other support services for the Participant's Immediate Family.

The Plan will not pay for services that do not require skilled nursing care, including Custodial Care or care for the convenience of the patient or Family Member.

Prior Authorization is required for hospice care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Hospital Services - Facility and Professional

Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations
    a. Room and board, which includes special diets and nursing services.
    b. Intensive care and cardiac care units which include special equipment and concentrated nursing services provided by nurses who are Hospital employees.
2. Miscellaneous Hospital Services
    a. Laboratory procedures.
    b. Operating room, delivery room and recovery room.
    c. Anesthetic supplies.
    d. Surgical supplies.
    e. Oxygen and use of equipment for its administration.
    f. X-ray.
    g. Intravenous injections and setups for intravenous solutions.
    h. Special diets when Medically Necessary.
    i. Respiratory therapy, chemotherapy, radiation therapy and dialysis therapy.
    j. Physical Therapy, Speech Therapy and Occupational Therapy.
    k. Drugs and medicines which:
        1. Are approved for use in humans by the FDA; and
        2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
        3. Require a Physician's written prescription.

        Drugs and medicines which are used in off-label situations may be reviewed for Medical Necessity.

Inpatient Care services are subject to the following conditions:

1. Days of care
    a. The number of days of Inpatient Care provided is 365 days.
    b. In computing the number of Inpatient Care days available, days will be counted according to the standard midnight census procedure used in most Hospitals. The day a Participant is admitted to a Hospital is counted, but the day a Participant is discharged is not. If a Participant is discharged on the day of admission, one day is counted.
    c. The day a Participant enters a Hospital is the day of admission. The day a Participant leaves a Hospital is the day of discharge.
2. The Participant will be responsible to the Hospital for payment of its charges if the Participant remains as an Inpatient Participant when Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed reserved for a Participant. No Benefits will be paid for Inpatient Care provided primarily for diagnostic or therapy services.

Prior Authorization is required for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Inpatient Care Medical Services Billed by a Professional Provider

Nonsurgical services by a Covered Provider, Concurrent Care and Consultation Services.

Medical services do not include surgical or maternity services. Inpatient Care medical services are covered only if the Participant is eligible for Benefits under the Hospital Services, Inpatient Care Services section for the admission.

Medical care visits are limited to one visit per day per Covered Provider unless a Participant's condition requires a Physician's constant attendance and treatment for a prolonged period of time.

Observation Beds/Rooms

Benefits will be made available for observation beds when Medically Necessary.

Outpatient Hospital Services

Use of the Hospital's facilities and equipment for surgery, respiratory therapy, chemotherapy, radiation therapy and dialysis therapy.

Inborn Errors of Metabolism

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

Infertility – Diagnosis and Treatment

Services and supplies provided for the diagnosis/screening of Infertility.

The Plan will pay for:

The diagnosis of Infertility.

The Plan will not pay for:

1. Prescription drugs used to treat infertility.
2. Services, supplies, drugs and devices related to in vitro fertilization.
3. Medically Necessary evaluation to determine cause of infertility.
4. Artificial insemination (AI) or intrauterine insemination (IUI).
5. Medically Necessary reproductive procedures not related to in vitro fertilization.

Infusion Therapy Services – Outpatient

Some Outpatient infusion services for Routine maintenance drugs have been identified as capable of being administered outside of an Outpatient Hospital setting. The Out of Pocket Amount expenses may be lower when services are provided by a professional provider in an Infusion Suite, a home or an office, instead of a Hospital. Non maintenance Outpatient infusion therapy services will be covered the same as any other Illness.

Maternity Services - Professional and Facility Covered Providers

1. Prenatal and postpartum care.
2. Delivery of one or more newborns.
3. Hospital Inpatient Care for conditions related directly to pregnancy. Inpatient Care following delivery will be covered for whatever length of time is Medically Necessary and will be at least 48 hours following a vaginal delivery and at least 96 hours following a delivery by cesarean section. The decision to shorten the length of stay of Inpatient Care to less than that stated in the preceding sentence must be made by the attending health care provider and the mother.

Under federal law, Benefits may not be restricted 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, under federal law, Covered Providers may not be required to obtain Prior Authorization from the Plan for prescribing a length of stay not in excess of 48 hours or 96 hours.

4. Payment for any maternity services by the professional provider is limited to the Allowable Fee for total maternity care, which includes delivery, prenatal and postpartum care.

Please refer also to the Newborn Initial Care section.

Medical Supplies

The following supplies for use outside of a Hospital:

1. Supplies for insulin pumps, syringes and related supplies for conditions such as diabetes;
2. Injection aids, visual reading and urine test strips, glucagon emergency kits for treatment of diabetes. One insulin pump for each warranty period is covered under the Durable Medical Equipment Benefit;
3. Sterile dressings for conditions such as cancer or burns;
4. Catheters;
5. Splints;
6. Colostomy bags and related supplies; and/or
7. Supplies for renal dialysis equipment or machines.

Medical supplies are covered only when:

1. Medically Necessary to treat a condition for which Benefits are payable; and
2. Prescribed by a Covered Provider.

Mental Health

Benefits provided for mental health are for the treatment of Mental Illness as defined in the section entitled Definitions.

Benefits include but are not limited to, Inpatient Care services, Outpatient services, rehabilitation services and medication for the treatment of Mental Illness.

Payment for mental health Benefits will be made as for any other Illness.

Outpatient Services

Care and treatment of Mental Illness if the Participant is not an Inpatient Participant and is provided by:

1. A Hospital;
2. A Physician or prescribed by a Physician;
3. A Mental Health Treatment Center;
4. A Substance Use Disorder Treatment Center;
5. A licensed psychologist;
6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. A licensed psychiatrist;
10. A licensed Advanced Practice Registered Nurse with a specialty in mental health;
11. A licensed Advanced Practice Registered Nurse with prescriptive authority and specializing in mental health; or
12. Other Qualified Health Care Provider.

Outpatient Benefits are subject to the following conditions:

1. The services must be provided to diagnose and treat recognized Mental Illness; and
2. The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by Mental Illness.

The Plan will not pay for hypnotherapy or for services given by a staff member of a school or halfway house.

Inpatient Services

Care and treatment of Mental Illness, while the Participant is an Inpatient Participant, and which are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity residential services provided at a Residential Treatment Center are Benefits of this Plan Document.

Prior Authorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Partial Hospitalization

Care and treatment of Mental Illness, while the Partial Hospitalization services are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Prior Authorization is required for Partial Hospitalization. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Naturopathy

Services provided by a licensed naturopathic provider are covered if such services are a Benefit of this Plan Document.

Newborn Initial Care

1. The initial care of a newborn at birth provided by a Physician.
2. Nursery Care - Hospital nursery care of newborn infants.

Office Visits

Covered services provided in a Covered Provider's office during a Professional Call and covered services provided in the home by a Covered Provider. Visits are limited to one visit per day per provider.

Orthopedic Devices/Orthotic Devices

A supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, when Medically Necessary, Benefits will be provided for adjustments, repairs or replacement of the device because of a change in the Participant's physical condition.

Prior Authorization is recommended for the original purchase or replacement of orthopedic devices over $2,000. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Out-of-State Emergency Travel

Out of state commercial transportation must be pre-authorized. In network medical benefits apply.

Charges for transportation may be covered to the nearest city out of state with appropriate facilities. Prior authorization is required. Approved coverage includes one-way, out-of-state transportation by regularly scheduled passenger aircraft or mileage at the normal reimbursement rate for travel by personal automobile inside the United States to the nearest medical facility equipped to provide the necessary treatment not available in a Montana facility. Transportation for treatment at in-state facilities is not covered.

Transportation benefits are limited to the following circumstances:

1. Health Care Facility to Health Care Specialty Facility Transfer. A Life-endangering situation exists that requires immediate transfer to a facility that has special facilities for treatment of the condition that cannot be performed in the current facility.
2. Treatment is needed that cannot be performed in state as determined by Blue Cross and Blue Shield of Montana.

Medical review based on information provided by the Prior Authorization form. Transportation Benefits in any one benefit year shall be limited to: one visit for treatment or surgery and one preparatory or follow-up visit for a condition that cannot be treated in state. If the patient is a child under 18 years of age, the transportation charges for one parent may be allowed if the attending physician certifies the need for such attendance and attendance of one parent has been approved by Prior Authorization.

Physician Medical Services

Medical services by a Covered Provider for:

1. Inpatient Hospital Physician visits.
2. Convalescent Home facility Physician visits.
3. Surgical facility Physician services.

The Plan will not pay for pre- or postsurgical visits that are considered to be Inclusive Services/Procedures that are included in the payment for the surgery.

This Benefit does not include services provided in the home or the Covered Provider's office.

Postmastectomy Care and Reconstructive Breast Surgery

Postmastectomy Care

Medically Necessary Inpatient Care for the period of time determined by the attending Physician and the Participant, following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

Prior Authorization is required for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Reconstructive Breast Surgery

1. All stages of Reconstructive Breast Surgery after a mastectomy including, but not limited to:
    a. All stages of reconstruction of the breast on which a mastectomy has been performed.
    b. Surgery and reconstruction of the other breast to establish a symmetrical appearance.
    c. Chemotherapy.
    d. Prostheses and physical complications of all stages of a mastectomy and breast reconstruction, including lymphedemas.

    Coverage described in 1(a) through 1(d) will be provided in a manner determined in consultation with the attending Physician and the patient.
2. Breast prostheses as the result of a mastectomy.

For specific Benefits related to postmastectomy care, refer to that specific Benefit, e.g., surgical services and Hospital services.

Prescription Drugs

Refer to the Prescription Drugs section in the Schedule of Benefits for specific information on the application of any Deductible, Copayment and/or Coinsurance.

The Prescription Drugs Benefit is for Prescription Drug Products which are self-administered. This Benefit does not include medications which are administered by a Covered Provider. If a medication is administered by a Covered Provider, the claim will process under the Participant's medical Benefits. **Please refer to the Utilization Management section for complete information about the medications that are subject to the Participant's medical Benefits, the process for requesting Prior Authorization for medications subject to the Participant's medical Benefits, and related information.**

Subject to the terms, conditions, and limitations of this Plan Document, the Claim Administrator will pay for Prescription Drug Products, which:

1. Are approved for use in humans by the FDA; and
2. Require a Physician's written prescription; and
3. Are dispensed under federal or state law pursuant to a prescription order or refill.

Prescription Drug Products which are used in off-label situations may be reviewed for Medical Necessity.

Drug Lists

Drugs listed on the Drug List are selected by the Claim Administrator based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Claim Administrator. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the Drug List. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost, and how it compares with drugs currently on the Drug List.

Positive changes (e.g., adding drugs to the Drug List, drugs moving to a lower payment tier) occur quarterly after review by the Committee. Changes to the Drug List that could have an adverse financial impact to the Participant (e.g., drug Exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or Prior Authorization) occur annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the Drug List may occur more frequently.

The Drug List and any modifications will be made available to the Participant. By accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists or calling the Customer Service toll-free number on the Participant's identification card, the Participant will be able to determine the Drug List that applies to the Participant's Plan and whether a particular drug is on the Drug List.

The Participant, or the Participant's prescribing health care provider, can ask for a Drug List exception if the Participant's drug is not on the Drug List. To request this exception, the Participant or the Participant's prescriber, can call the number on the back of the Participant's identification card to ask for a review. The Claim Administrator will notify the Participant or the Participant's prescriber of its decision with respect to the request within 72 hours after the request is received.

If the Participant has a health condition that may jeopardize their life, health or keep the Participant from regaining function, or the Participant's current drug therapy uses a non-covered drug, the Participant's prescriber, may be able to ask for an expedited review process by marking the review as an urgent request. The Claim Administrator will notify the Participant or the Participant's prescriber, of the coverage decision within 24 hours after they receive the request for an expedited review. If the coverage request is denied, the Claim Administrator will let the Participant and the Participant's prescriber, know why it was denied and offer the Participant a covered alternative drug (if applicable). If the Participant's exception is denied, the Participant may appeal the decision according to the appeals process the Participant will receive with the denial determination. The Participant should call the number on the back of the Participant's identification card if the Participant has any questions.

Covered Prescription Drug Products

The following Prescription Drugs Products, obtained from a Participating Pharmacy, either retail or mail order, or a retail nonparticipating Pharmacy, are covered:

1. Legend drugs - drugs requiring written prescriptions and dispensed by a licensed pharmacist for treatment of an Illness or Injury.
2. One prescription oral agent for controlling blood sugar levels for each class of drug approved by the FDA.
3. Insulin with a prescription.
4. Disposable insulin needles/syringes.
5. Test strips.
6. Lancets.
7. Contraceptives as specified on the Drug List.
8. Smoking cessation products and over-the-counter smoking cessation aids/medications with a written prescription, as required by the Affordable Care Act. Tobacco counseling is available under the Preventive Health Care Benefit.

The Schedule of Benefits lists any Deductible, Copayment and/or Coinsurance that the Participant is responsible for and payment limitations for these Prescription Drug Products.

Non-Covered Prescription Drug Products

The Plan will not pay for:

1. Drugs/products which are not included on the Drug List, unless specifically covered elsewhere in this Plan Document and/or such coverage is required in accordance with applicable law or regulatory guidance.
2. Compounded Drugs.
3. Drugs, that the use or intended use of which would be illegal, abusive, not Medically Necessary, or otherwise improper such as anabolic steroids.
4. Any drug used for the purpose of weight loss.
5. Fluoride supplements, except as required by the Affordable Care Act for children under age 6.
6. Devices, technologies, and/or Durable Medical Equipment of any type (even though such devices may require a prescription order), such as, but not limited to, therapeutic devices, artificial appliance, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections).
7. Over-the-counter drugs that do not require a prescription, except over-the-counter smoking cessation aids with a written prescription.
8. Prescription Drug Products for which there is an exact over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined.
9. Prescription Drug Products for cosmetic purposes, including the treatment of hair loss (e.g., Minoxidil, Rogaine).
10. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those otherwise covered under this section.
11. Prescription Drug Products used for erectile dysfunction.
12. Insulin pumps and glucose meters. Insulin pumps and glucose meters are covered under the Durable Medical Equipment Benefit. Insulin pump supplies are covered under the Medical Supplies Benefit.
13. Drugs or items labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Participant is charged for the item.
14. Biological sera, blood, or blood plasma.
15. Prescription Drug Products which are to be taken by or administered to the Participant, in whole or in part, while the Participant is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility's charge.
16. Any Prescription Drug Product refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
17. Replacement prescription drugs or Prescription Drug Products due to loss, theft or spoilage.

18. Prescription Drug Products obtained from a Pharmacy located outside the United States for consumption within the United States.
19. Prescription Drug Products provided by a mail-order Pharmacy that is not approved by the Plan.
20. Repackagers, Institutional Packs, Clinic Packs or other custom packaging
21. Non-sedating antihistamines.
22. Prescription Drug Products determined by the Claim Administrator to have inferior efficacy or significant safety issues.
23. Administration or injection of any drugs.
24. Non-FDA approved drugs.
25. Drugs which do not by law require a Prescription from a provider or health care practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies); and drugs or covered devices for which no valid Prescription is obtained.
26. Vitamins (except those vitamins which by law require a Prescription and for which there is no non–prescription alternative).
27. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select vaccinations administered through certain Participating Pharmacies are an exception to this Exclusion.
28. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned for in this Plan Document.

    NOTE: This exception does not apply to dietary formula necessary for the treatment of Inborn Errors of Metabolism.

29. Drugs used or intended to be used in the treatment of a condition, sickness, disease, Injury, or bodily malfunction which is not covered under the Plan Document, or for which Benefits have been exhausted.
30. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Participant's identification card.
31. Benefits will not be provided for any self-administered drugs dispensed by a Physician.
32. Experimental/Investigational/Unproven status of a drug or device is determined by the Claim Administrator taking into consideration a variety of factors, including demonstration of efficacy in peer reviewed literature. With respect to FDA approval, if FDA approval is not obtained, the drug will be considered Experimental/Investigational/Unproven, but if FDA approval is obtained, while this will be considered by the Claim Administrator in making its determination of Experimental/Investigational/Unproven status, such approval will not be determinative.
33. Pharmaceutical aids, such as excipients found in the UPS-NF (United States Pharmacopeia National Formulary) including, but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.
34. Certain drug classes where there are over-the-counter alternatives available.
35. Bulk Powders.
36. Surgical supplies (e.g. Amvisc, Cellugel, Duovisc, Hyalgan, Provisc, Supartz, Synvisc, Viscoat).
37. Prescription Drug Products used for the Treatment of Infertility.
38. Diagnostic agents (except for diabetic testing supplies or test strips).
39. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
40. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, the Claim Administrator may limit Benefits to only certain therapeutic equivalents/therapeutic alternatives. If the Participant does not choose the therapeutic equivalents/therapeutic alternatives that are covered under the Prescription Drug Program, the drug purchased will not be covered under any Benefit level; and
41. New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug..

Vaccinations Obtained Through Select Participating Pharmacies

Vaccinations are available through select Participating Pharmacies that have contracted with the Claim Administrator. To obtain a current list of Participating Pharmacies and a list of covered vaccines, the Participant can

call the Customer Service toll-free number identified on the Participant's identification card or access www.bcbsmt.com and click on "Member Services". Then click on the "Prescription Drug Plan Information" and select "Pharmacy Program." The Participant should present the Participant's identification card to the pharmacist at the time services are received. The pharmacist will inform the Participant of any applicable Copayment and/or Coinsurance.

Each select Participating Pharmacy that has contracted with the Claim Administrator to provide this service may have age, scheduling, or other requirements that will apply, so the Participant should contact the Participating Pharmacy in advance. Childhood immunizations subject to state regulations are not available under this Pharmacy Benefit but are covered under the medical Benefits of the health plan.

Controlled Substances Limitation

If it is determined that a Participant may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary or appropriate and restrictions may include but not be limited to a certain provider and/or Pharmacy and/or quantities and/or day's supply for the prescribing and dispensing of the controlled substance medication. Additional Copayments may apply.

Multi-Category Split-Fill Program

If it is the Participant's first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if the Participant has not filled a select medication within the previous 120 days, the Participant may only be eligible for a partial fill (14 - 15-day supply) of the medication for up to the first 3 Months of therapy. The partial fill is designed to determine how the medication is working therapeutically for the Participant. Any applicable [Copayment and/or]Coinsurance may be adjusted to align with the quantity of pills dispensed. If the medication is working and the Participant's provider would like to continue on this medication, the Participant may be eligible to receive up to a 30-day supply after completing up to 3 Months of the partial supply. Call the number on the back of the Participant's identification card for any questions or for a list of drugs that are included in this program, or visit the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/pharmacy/pharmacy-programs.

GLP-1 New to Therapy

If it is the Participant's first time using select GLP-1 medications or if the Participant has not filled a select GLP-1 medication within the previous 120 days, the Participant may only be eligible to receive a 30-day supply of the medication for the first fill. After the first fill of select GLP-1 medications for a 30-day supply, the Participant may be eligible to fill for up to a 90-day supply, per the Plan Benefits. This 30-day supply limit may continue to apply after the first fill if you change your GLP-1 medication and/or dosing strength.

Purchase and Payment of Prescription Drug Products

Prescription Drug Products may be obtained using an Outpatient retail Pharmacy, an extended supply Pharmacy or a mail-order Pharmacy approved by the Claim Administrator. To use a mail-order Pharmacy, the Participant must send an order form with the prescription to the address listed on the mail-order service form and pay any required Deductible, Copayment and/or Coinsurance. The address of each mail order Pharmacy approved by the Plan is listed on the inside cover of this Plan Document.

Available Prescription Drug Products include Brand-Name Drugs and Generic Drugs. If a Generic Drug equivalent of a Brand-Name Drug becomes available during the period of coverage for the Plan, it may be added to the Drug List maintained by and available to the Participant on the Claim Administrator's website and the Pharmacy Benefit Manager's website. Refer to the inside cover of this Plan Document for information on the Claim Administrator's Pharmacy Benefit Manager. The availability of a Generic Drug may allow the Participant to obtain a drug at a potentially lower out of pocket cost. The factors that determine the costs to a Participant include the terms of the coverage and the Drug List in effect as of the date of the prescription and the Pharmacy service date, as well as the use of a Participating Pharmacy or nonparticipating Pharmacy. In addition to any Deductible, Copayment and/or Coinsurance, if the Participant chooses a Brand-Name Drug for which a Generic Drug equivalent is available, the Participant is required to pay the difference between the cost of the Brand-Name Drug and the Generic Drug equivalent.

The Participant may not be required to pay the difference in cost between the Brand-Name Drug and the Generic Drug equivalent if there is a medical reason the Participant needs to take the Brand-Name Drug and certain criteria are met. The Participant's provider can submit a request to waive the difference in cost between the Brand-Name

Drug and the Generic Drug equivalent. Documentation that the Participant's provider has submitted a form to the Food and Drug Administration is required. Applicable Deductible, Copayment and/or Coinsurance amounts still apply. For additional information, contact the Customer Service number on the back of the Participant's identification card or visit www.bcbsmt.com.

Exceptions to this provision may be allowed for certain preventive medications (including prescription contraceptive medications) if the Participant's health care provider submits a request to the Plan indicating that the Generic Drug equivalent would be medically inappropriate, along with supporting documentation. If the Plan grants the exception request, any difference between the cost of the Brand-Name Drug and the Generic Drug equivalent will be waived.

The difference in the cost between a Generic Drug equivalent and a Brand-Name Drug may not be required if there is a medical reason (e.g., adverse event) the Participant would need to take the Brand-Name Drug and certain criteria are met. The Participant's provider can submit a request to waive the difference in cost between the Brand-Name Drug and the Generic Drug equivalent. In order for this request to be reviewed, the Participant's provider must send in a MedWatch form to the FDA to notify the FDA of the issues experienced by the Participant with the Generic Drug equivalent. The Participant's provider must provide a copy of this form to the Claim Administrator when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Deductible, Copayment and/or Coinsurance will still apply. For additional information, contact Customer Service at the number on the back of the Participant's identification card or visit the Claim Administrator's website at www.bcbsmt.com.

If drugs or Prescription Drug Products are purchased at a Participating Pharmacy, an extended supply Pharmacy or a mail order Pharmacy approved by the Claim Administrator, and the Participant presents the Participant's identification card at the time of purchase, the Participant must pay any required Deductible, Copayment and/or Coinsurance. In addition to any Deductible, Copayment and/or Coinsurance, if the Participant chooses a Brand-Name Drug for which a Generic Drug equivalent is available, the Participant is required to pay the difference between the cost of the Brand-Name Drug and the Generic Drug equivalent. The Participant will only be required to pay the appropriate Deductible, Copayment and/or Coinsurance and the difference between the cost of the Brand-Name Drug and the Generic Drug equivalent if the amount can be determined by the Pharmacy at the time of purchase. Exceptions to this provision may be allowed for certain preventive medications (including prescription contraceptive medications) if the Participant's health care Provider submits a request to the Claim Administrator, along with supporting documentation, indicating that the Generic Drug would be medically inappropriate. If the Claim Administrator grants the exception request, any difference between the cost of the Brand-Name Drug and the Generic Drug equivalent will be waived.

If the Participant uses a Participating Pharmacy to fill a prescription, but elects to submit the claim directly to the Claim Administrator's Pharmacy Benefit Manager, instead of having the Participating Pharmacy submit the claim, the Participant will be reimbursed for the prescription drug based on the amount that would have been paid to the Participating Pharmacy, less the Participant's Deductible, Copayment and/or Coinsurance.

If drugs or Prescription Drug Products are purchased at a nonparticipating Outpatient Pharmacy, the Participant must pay for the prescription at the time of dispensing and then file a prescription drug claim form with the Claim Administrator's Pharmacy Benefit Manager for reimbursement. Please refer to Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefits section of this Plan Document for additional information.

The Participant's Employer has chosen to participate in FlexAccess™ (FlexAccess) which lowers your out of pocket costs for select drugs by obtaining drug manufacturer assistance when available. Under this program, out of pocket costs for select drugs may be set to the maximum amount of the current design or be based on any available manufacturer-funded assistance. Drug manufacturers may provide financial support for some, or all, of your out of pocket costs for select drugs. The Participant may be required to pay an amount typically $0 - $35.00 for select drugs. Any amount paid through a drug manufacturer assistance program (e.g., manufacturer cost-share assistance, manufacturer discount plans, and/or manufacturer coupons) will not apply to the Participant's Deductible (if part of the Plan) or yearly Out of Pocket Amounts. The list of drugs covered under FlexAccess is subject to change. Please call the toll-free telephone number on the back of your Identification Card, or FlexAccess at 1-888-302-3618 to determine whether the Participant's drug is covered under this FlexAccess program. If the Participant is taking a qualifying drug, a FlexAccess representative will contact the Participant to participate in the FlexAccess program. The Participant is not required to participate in this FlexAccess program; however, if the Participant chooses to opt-out of the FlexAccess program, or if the Participant does not affirmatively enroll in any manufacturer's assistance, the Particpant will be responsible for up to 100% of the cost of the drug. Please note there is a difference between opting out of the FlexAccess program and being ineligible for the Flex Access program. Ineligibility may be due to a drug's

exclusion from a drug manufacturer's assistance program, or if the Participant switches to a drug that has no assistance program available, or the Participant is taking a drug that is not on the FlexAccess Drug list. In the event the Participant is ineligible for the FlexAccess program, the Participant's cost for a select drug will be equal to the amount specified under this health care Plan.

Prescription Drug Products Subject to Prior Authorization, Step Therapy or Dispensing Limits

1. Prescription Drug Products subject to Prior Authorization require prior approval from the Plan's Pharmacy Benefit Manager before they can qualify for coverage under the Plan. If the Participant does not obtain Prior Authorization before a Prescription Drug Product is dispensed, the Participant may pay for the prescription and then pursue authorization of the drug from the Plan's Pharmacy Benefit Manager. If the authorization is approved by the Plan's Pharmacy Benefit Manager, the Participant should then submit a claim for the prescription drug on a prescription claim form to the Plan's Pharmacy Benefit Manager for reimbursement.
2. Prior Authorization does not guarantee payment of the Prescription Drug Product by the Plan. Even if the prescription drug has been approved through Prior Authorization, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date the drug is dispensed, or the Participant's Benefits may have changed as of the date the drug is dispensed.
3. The step therapy program requires that the Participant has a prescription history for a prerequisite medication before the Plan will cover a targeted drug. If the Participant and the Participant's provider decide that a prerequisite drug is not right for the Participant or is not as good in treating Participant's condition, the provider should submit a Prior Authorization request for coverage of the second-line drug.
4. A dispensing limit is a limitation on the number or amount of a Prescription Drug Product covered within a certain time period and quantity of covered medication per prescription. Dispensing limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, appropriate utilization, and to avoid misuse/abuse of the medication. A prescription written for a quantity in excess of the established limit will require a clinical review before Benefits are available.

Certain Prescription Drug Products, such as those used to treat rheumatoid arthritis, growth hormone deficiency, or hepatitis C, may be subject to Prior Authorization, step therapy, or dispensing limits. The Prescription Drug Products included in these programs are subject to change, and medications for other conditions may be added to the program.

If the Participant's provider is prescribing a Prescription Drug Product subject to Prior Authorization, step therapy, or dispensing limits, the provider should fax the request for Prior Authorization to the Claim Administrator's Pharmacy Benefit Manager at the fax number listed on the inside cover of this Plan Document. The Participant and provider will be notified of the Claim Administrator's Pharmacy Benefit Manager's determination. If the request is denied, the decisions may be appealed according to the appeals process provided with the denial determination.

In making determinations of coverage, the Claim Administrator's Pharmacy Benefit Manager may rely upon Pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in Montana, Pharmacy Benefit Manager evaluations, Medical Necessity, and Medical Policies. The Pharmacy policies and Medical Policies are located on the Claim Administrator's website at www.bcbsmt.com.

To find out more about Prior Authorization/step therapy/dispensing limits or to determine which Prescription Drug Products are subject to Prior Authorization, step therapy or dispensing limits, the Participant or provider should refer to the Drug List which applies to the Participant's Plan at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists or www.myprime.com or call the Customer Service toll-free number identified on the Participant's identification card.

Specialty Medications

1. Specialty Medications are generally prescribed for individuals with complex medical conditions such as multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These medications also have one or more of the following characteristics:
    a. Injected or infused, but some may be taken by mouth.
    b. Unique storage or shipment requirements.
    c. Additional education and support required from a health care professional.
    d. Usually not stocked at retail Pharmacies.

2. For the highest level of Benefits, Specialty Medications must be acquired through the Plan's contracted Specialty Pharmacies listed on the inside cover of this Plan Document. A list of covered Specialty Medications may be found on the Plan website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. Registration and other applicable forms are also located on the website.
3. Coverage for Specialty Medications is limited to a 30-day supply. However, some Specialty Medications have FDA approved dosing regimens exceeding the 30-day supply limit and may be dispensed for more than a 30-day supply, if allowed by The Plan. Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

Preventive Health Care

Covered preventive services include, but are not limited to:

1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's (USPSTF) current recommendations (additional information is provided by accessing http://www.uspreventiveservicestaskforce.org); and
2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention (CDC); and
3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;

   In addition to the screening services recommended under the HRSA Guidelines, the following services are included:

   a. Lactation Services

      Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. In addition, Benefits are provided for the purchase of manual or electric breast pumps or the rental of Hospital-grade pumps. The purchase of an electric breast pump is limited to one electric breast pump per Benefit Period.

   b. Contraceptives

      FDA approved contraceptive methods, including certain contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity; and
4. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to or after November 2009.
5. Current recommendations of the United States Preventive Service Task Force regarding obesity screening and counseling.

The preventive services listed above may change as USPSTF, CDC and HRSA guidelines are modified and any such changes will be implemented by the Claim Administrator in the quantities and at the times required by applicable law.

Examples of Preventive Health Care services as defined under federal law include, but are not limited to, colonoscopies, immunizations and vaccinations. Examples of other Preventive Health Care services include, but are not limited to, physical examinations. Any services that are billed as a diagnostic service, will be covered under regular medical Benefits.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a nonparticipating Pharmacy, may be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximums.

A Copayment waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

For more detailed information on all covered services, contact Customer Service at the number on the back of the Participant's identification card.

Prostheses

The appropriate devices used to replace a body part missing because of an Accident, Injury, or Illness.

When placement of a prosthesis is part of a surgical procedure, it will be paid under Surgical Services.

Payment for deluxe prosthetics will be based on the Allowable Fee for a standard prosthesis.

Replacement Prosthesis.

1. Replacement of a prosthesis will not be subject to any reduced replacement Coinsurance that may be applicable if the replacement is five (5) years of longer after the original purchase.
2. A prosthesis will not be considered a replacement if the original prosthesis no longer meets the medical needs of the Participant due to physical changes or a deteriorating medical condition.

The Plan will not pay for the following items:

1. Prostheses required primarily for use in athletic activities;
2. Replacement of lost or stolen prostheses;
3. Duplicate prosthetic devices purchased primarily for Participant convenience when the need is not medical in nature; or
4. Computer-assisted communication devices.

Prior Authorization is recommended for the original purchase or replacement of a prosthesis if the cost is over $2,000. Refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Radiation Therapy

The use of x-ray, radium, or radioactive isotopes ordered by the attending Physician and performed by a Covered Provider for the treatment of disease.

Rehabilitation – Facility and Professional

Rehabilitation Therapy and other covered services, as outlined in this Rehabilitation section, billed by a Rehabilitation Facility provider or a professional provider for services provided to a Participant.

The Plan will not pay when the primary reason for Rehabilitation is any one of the following:

1. Custodial Care;
2. Diagnostic admissions;
3. Maintenance, nonmedical self-help, or vocational educational therapy;
4. Social or cultural rehabilitation;
5. Learning and developmental disabilities; and
6. Visual, speech, or auditory disorders because of learning and developmental disabilities or psychoneurotic and psychotic conditions.

Benefits will not be provided under this Rehabilitation section for treatment of Substance Use Disorder or Mental Illness as defined in the Substance Use Disorder and Mental Health sections.

Benefits will be provided for services, supplies and other items that are within the scope of the rehabilitation Benefit described in this Rehabilitation section only as provided in and subject to the terms, conditions and limitations applicable to this Rehabilitation section and other applicable terms, conditions and limitations of this Plan Document. Other Benefit sections of this Plan Document, such as but not limited to Hospital Services, do not include Benefits for any services, supplies or items that are within the scope of the rehabilitation Benefit as outlined in this section.

Rehabilitation Facility Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations: Room and Board, which includes but is not limited to dietary and general, medical and rehabilitation nursing services.

2. Miscellaneous Rehabilitation Facility Services (whether or not such services are Rehabilitation Therapy or are general, medical or other services provided by the Rehabilitation Facility during the Participant's admission), including but not limited to:

   a. Rehabilitation Therapy services and supplies, including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy.
   b. Laboratory procedures.
   c. Diagnostic testing.
   d. Pulmonary services and supplies, including but not limited to oxygen and use of equipment for its administration.
   e. X-rays and other radiology.
   f. Intravenous injections and setups for intravenous solutions.
   g. Special diets when Medically Necessary.
   h. Operating room, recovery room.
   i. Anesthetic and surgical supplies.
   j. Drugs and medicines which:

      1. Are approved for use in humans by the FDA; and
      2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
      3. Require a Physician's written prescription.

      Drugs and medicines which are used in off-label situations may be reviewed for Medical Necessity.

3. Rehabilitation Facility Inpatient Care Services do not include services, supplies or items for any period during which the Participant is absent from the Rehabilitation Facility for purposes not related to rehabilitation, including but not limited to intervening inpatient admissions to an acute care Hospital.

Prior Authorization is required for Rehabilitation Facility Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Rehabilitation Facility Inpatient Care is subject to the following conditions:

1. The Participant will be responsible to the Rehabilitation Facility for payment of the Facility's charges if the Participant remains as an Inpatient Participant when Rehabilitation Facility Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed reserved for a Participant.

2. The term Rehabilitation Facility does not include:

   a. A Hospital when a Participant is admitted to a general medical, surgical or specialty floor or unit (other than a rehabilitation unit) for acute Hospital care, even though rehabilitation services are or may be provided as a part of acute care;
   b. A nursing home;
   c. A rest home;
   d. Hospice;
   e. A skilled nursing facility;
   f. A Convalescent Home;
   g. A place for care and treatment of Substance Use Disorder;
   h. A place for treatment of Mental Illness; and/or
   i. A long-term, chronic-care institution or facility providing the type of care listed above.

Rehabilitation Facility Inpatient Care Services Billed by a Professional Provider

All professional services provided by a Covered Provider who is a physiatrist or other Physician directing the Participant's Rehabilitation Therapy. Such professional services include care planning and review, patient visits and

examinations, consultation with other Physicians, nurses or staff, and all other professional services provided with respect to the Participant. Professional services provided by other Covered Providers (i.e., who are not the Physician directing the Participant's Rehabilitation Therapy) are not included in the rehabilitation Benefit, but are included to the extent provided in and subject to the terms, conditions and limitations of other contract Benefits (e.g., Physician Medical Services).

Outpatient Rehabilitation

Rehabilitation Therapy provided on an Outpatient basis by a facility or professional provider.

Second Surgical Opinion

The Benefit percentage is 100 percent and there is no Deductible and Coinsurance for charges on a second surgical opinion consultation.

"Second surgical opinion" means an evaluation of the need for surgery by a second doctor (or third doctor if the opinions of the doctor recommending surgery and the second doctor are in conflict), including the doctor's exam of the patient and diagnostic testing.

Substance Use Disorder

Benefits for Substance Use Disorder will be paid as any other Illness.

Outpatient Services

Care and treatment for Substance Use Disorder when the Participant is not an Inpatient Participant and provided in or by:

1. A Hospital;
2. A Mental Health Treatment Center;
3. A Substance Use Disorder Treatment Center;
4. A Physician or prescribed by a Physician;
5. A licensed psychologist;
6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. A licensed psychiatrist; or
10. Other Qualified Health Care Provider.

Outpatient services are subject to the following conditions:

1. The services must be provided to diagnose and treat recognized Substance Use Disorder; and
2. The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Substance Use Disorder.

The Claim Administrator will not pay for hypnotherapy or for services given by a staff member of a school or halfway house.

Inpatient Care Services

Care and treatment of Substance Use Disorder, while the Participant is an Inpatient Participant, and which are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity services provided at a Residential Treatment Center are Benefits of the Plan.

Prior Authorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Partial Hospitalization

Care and treatment of Substance Use Disorder, while the Partial Hospitalization services are provided by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Prior Authorization is required for Partial Hospitalization services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Surgical Services

Surgical Services Billed by a Professional Provider

Services by a professional provider for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery. The charge for a surgical suite outside of the Hospital is included in the Allowable Fee for the surgery.

Surgical Services Billed by an Outpatient Surgical Facility or Freestanding Surgery Centers

Services of a surgical facility or a freestanding surgery center licensed, or certified for Medicare, by the state in which it is located and have an effective peer review program to ensure quality and appropriate patient care. The surgical procedure performed in a surgical facility or a freestanding surgery center is recognized as a procedure which can be safely and effectively performed in an Outpatient setting.

The Plan will allow Benefits for a Recovery Care Bed when Medically Necessary and provided for less than 24 hours. Payment will not exceed the semiprivate room rate that would be billed for an inpatient stay.

Surgical Services Billed by a Hospital (Inpatient and Outpatient)

Services of a Hospital for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery.

Telehealth

Medically Necessary Telehealth services are covered when provided by a Covered Provider.

Temporomandibular Joint Dysfunction

Surgical and non-surgical treatment services and supplies for surgical and non-surgical treatment of temporomandibular joint dysfunction.

The Schedule of Benefits describes payment limitations for these services.

Therapies - Outpatient

Services provided for Physical Therapy, Speech Therapy, cardiac therapy and Occupational Therapy, not including Rehabilitation Therapy.

Transplants

A heart, heart/lung, single lung, double lung, liver, pancreas, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplants to a Participant.

The Claim Administrator contracts with Blue Distinction Centers or Blue Distinction Centers+ for certain transplant services and highly recommends use of these centers because they have a proven record of delivering specialty care and results. Two levels of recognition allow the Participant and the Participant's Physician to pick the option that best meets their needs. Blue Distinction Centers offer quality care, treatment expertise and better overall patient results. Participants being considered for a transplant procedure are encouraged to contact the Claim Administrator's Customer Service to discuss the possible benefits of utilizing the Blue Distinction Centers or Blue Distinction Centers+.

Transplant services include:

1. Organ procurement including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ and transportation of the donor or donor organ to the location of the transplant operation.
2. Donor services including the pre-operative services, transplant related diagnostic lab and x-ray services, and the transplant surgery hospitalization. Transplant related services are covered for up to six Months after the transplant.
3. Hospital Inpatient Care services.
4. Surgical services.
5. Anesthesia.
6. Professional provider and diagnostic Outpatient services.
7. Licensed ambulance travel or commercial air travel for the Participant receiving the treatment to the nearest Hospital with appropriate facilities.

Payment by the Plan is subject to the following conditions:

1. When both the transplant recipient and donor are Participants, both will receive Benefits.
2. When the transplant recipient is a Participant and the donor is not, both will receive Benefits to the extent that benefits for the donor are not provided under other hospitalization coverage.
3. When the transplant recipient is not a Participant and the donor is, the donor will receive Benefits to the extent that benefits are not provided to the donor by hospitalization coverage of the recipient.

The Plan will not pay for:

1. Experimental/Investigational/Unproven procedures.
2. Transplants of a nonhuman organ or artificial organ implant.
3. Donor searches.

Prior Authorization is required for transplants. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Well-Child Care

Well-child care provided by a Physician or a health care professional supervised by a Physician.

Benefits shall include coverage for:

1. Histories;
2. Physical examinations;
3. Developmental assessments;
4. Anticipatory guidance;
5. Laboratory tests;
6. Preventive immunizations.

COORDINATION OF BENEFITS WITH OTHER COVERAGE

The Coordination of Benefits (COB) provision applies when a Participant has health care coverage under more than one plan. “Plan” is defined below.

The order in which each plan will make payment for Covered Medical Expenses is governed by the order of benefit determination rules. The plan that pays first is called the primary plan. The primary plan must pay Covered Medical Expenses in accordance with its plan document terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce payment for Covered Medical Expenses so that payment by all plans does not exceed 100% of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

Plan

Any of the following that provide benefits, or services, for medical or dental care or treatment include:

1. Group and nongroup health insurance contracts;
2. Health Maintenance Organization (HMO) contracts;
3. Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured);
4. Medical care components of long-term care contracts, such as skilled nursing care; and
5. Medicare or any other federal governmental plan, as permitted by law.

The term plan does not include:

1. Hospital indemnity coverage or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified Accident coverage;
4. Limited benefit health coverage or excepted benefits;
5. School Accident type coverage;
6. Benefits for non-medical components of long-term care policies;
7. Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

Each contract of coverage or group health plan is a separate coverage plan.

This Plan

“This Plan” means the Plan represented by this Plan Document.

Order of Benefit Determination Rules

The rules that determine whether a plan is a primary plan or a secondary plan, when a covered person has health care coverage under more than one plan.

1. When a plan is primary, it determines payment for covered medical expenses first before those of any other plan without considering any other plan's benefits.
2. When a plan is secondary, it determines its benefits after those of another plan. A secondary plan may reduce payment for covered medical expenses so that payment by all plans does not exceed 100% of the total allowable expense.

Allowable Expense

A Covered Medical Expense, including Deductibles, Copayment and/or Coinsurance, that is covered at least in part by any plan covering a covered person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering a covered person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an allowable expense, unless one of the plans provides coverage for private Hospital room expenses.
2. If a covered person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
3. If a covered person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
4. If a covered person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary

plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan

A plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent

The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a Participant is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan; and
2. Except as provided below, a plan that does not contain a COB provision that is consistent with applicable regulations is always primary unless the provisions of both plans state that the complying plan is primary.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits, and provides that this supplementary coverage, shall be excess to any other parts of the plan provided by the group. Examples of such situations include major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.

3. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

4. Each plan determines its order of benefits using the first of the following rules that apply:

   Non-Dependent or Dependent

   The plan that covers a person as an employee or retiree is the primary plan and the plan that covers the employee or retiree as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee or retiree is the secondary plan and the other plan is the primary plan.

   Dependent Child Covered Under More Than One Plan

   Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan, the order of benefits is determined as follows:

   1. **Dependent Child - Parents are married or are living together**

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

   2. **Dependent Child - Parents are divorced or separated or not living together**

      a. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that

plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

b. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above shall determine the order of benefits;

c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above shall determine the order of benefits; or

d. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The plan covering the custodial parent;
2. The plan covering the Spouse of the custodial parent;
3. The plan covering the non-custodial parent and then;
4. The plan covering the Spouse of the non-custodial parent.

3. Dependent Child Covered Under More than One Plan of Individuals Who Are Not the Parents of the Child

The provisions of 1. or 2. above shall determine the order of benefits as if those individuals were the parents of the child.

4. Active Employee or Retired or Laid-off Employee

The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, (or a Dependent of such employee) is the primary plan. The plan covering that same person as a retired or laid-off employee (or a Dependent of such employee) is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the section entitled Non-Dependent or Dependent can determine the order of benefits.

5. COBRA or State Continuation Coverage

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee or retiree or covering the person as a Dependent of an employee or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the section entitled Non-Dependent or Dependent can determine the order of benefits.

6. Longer or Shorter Length of Coverage

The plan that covered the person as an employee or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of ‘plan’. In addition, This Plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Plan and other plans. The Claim Administrator may obtain the facts and information it needs from or provide such facts and information to other organizations or persons for the purpose of applying these COB rules and determining Benefits payable under this Plan and other plans covering the Participant claiming Benefits. The Claim Administrator need not inform, or get the consent of, any person to obtain such information. Each Participant claiming Benefits under this Plan must provide the Claim Administrator any facts it needs to apply those rules and determine Benefits payable.

Facility of Payment

A payment made by another plan may include an amount that should have been paid under This Plan. In such a case, the Claim Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means the reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, the Claim Administrator may recover the excess from one or more of the Participants it has paid or for whom it has paid; or any other person or organization that may be responsible for the Benefits or services provided for the Participant. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

Coordination with Medicare

This Plan will coordinate Benefits with Medicare according to the federal Medicare secondary payor laws and regulations (“MSP rules”). This means that This Plan and/or Medicare may adjust payment so that the combined payments by This Plan and Medicare will be no more than the charge for the Benefits received by the Participant. This Plan will never pay more than it would pay if the Participant was not covered by Medicare. The general rules for coordination with Medicare are as follows:

1. For Working Aged

   Medicare pays secondary to a plan sponsored by employers with 20 or more employees, for covered persons who qualify for age-based Medicare as a result of attaining age 65 and older and who are covered by virtue of the covered person’s current employment status.

   Medicare will be the primary for a covered person that refuses coverage under the plan.

   Medicare will pay primary to the plan for the working aged individuals covered by employers with fewer than 20 employees, including a multi-employer association if the covered person is covered by an employer within the multi-employer association with fewer than 20 employees.

2. For Disabled Participants under Age 65

   Medicare pays secondary to a plan covering individuals under age 65, covered by employers with 100 or more employees, who qualify for disability-based Medicare and are covered by virtue of a covered person’s current employment status.

   Medicare pays primary to a plan for disabled individuals under age 65 covered by employers with fewer than 100 employees.

3. For End-Stage Renal Disease

   Medicare pays secondary to a plan covering individuals who qualify for Medicare as a result of end-stage renal disease (“ESRD”), regardless of employer size, for the first 30 months that a particular covered person qualifies for Medicare as a result of ESRD. After the 30-month period, Medicare will pay primary to the plan.

   Special Coordination of Benefits rules apply if a covered person is entitled to Medicare based on ESRD and Medicare based on either age or disability:

a. If a plan is required to pay before Medicare under 1 or 2 above for an individual before the individual qualifies for Medicare based on ESRD, the plan will continue to pay primary to Medicare after the individual becomes covered under Medicare based on ESRD but only for the 30-month period above, after which Medicare will pay primary to the plan.

b. If a plan is required to pay primary to Medicare based on ESRD and an individual that qualifies for Medicare based on ESRD above later becomes entitled to age-based or disability-based Medicare during the 30-month period, Medicare will pay secondary to the plan for the duration of the 30-month period, after which Medicare will pay primary to the plan. If the individual qualifies for age-based or disability-based Medicare after the 30-month period, Medicare will pay primary to the plan.

c. Medicare continues to be primary to a plan after an aged or disabled individual becomes eligible for Medicare based on ESRD if:

1. The individual is already entitled to Medicare on the basis of age or disability when the individual becomes eligible for Medicare based on ESRD; and

2. The employer has fewer than 20 employees in the case of age-based Medicare or fewer than 100 employees in the case of disability-based Medicare.

4. Current Employment Status

Under the MSP rules, a covered person has current employment status if the covered person is:

a. Actively working as an employee; or

b. Not actively working but is receiving disability benefits from an employer but only for a period of up to 6 months; or

c. Not actively working but retains employment rights in the industry (including but not limited to a covered person who is temporarily laid off or on sick leave, who is a teacher or other seasonal worker), has not been terminated by an employer, is not receiving disability benefits from an employer for more than 6 months, is not receiving Social Security disability benefits and has group health coverage under a plan that is not COBRA coverage.

Other Insurance

If a property or casualty insurer pays for services provided to the Participant and coordination of benefits is not applicable, This Plan will credit the Participant's Deductible, Copayment or Coinsurance, as applicable, if the Participant notifies This Plan of the payment, within 12 months of the date of service.

EXCLUSIONS AND LIMITATIONS

All Benefits provided under this Plan are subject to the Exclusions and limitations in this section and as stated under the Benefit section. **The Plan will not pay for:**

1. All services, supplies, drugs and devices which are provided to treat any Illness or Injury arising out of employment when the Participant's Employer has elected or is required by law to obtain coverage for Illness or Injury under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This Exclusion applies to all services and supplies provided to treat such Illness or Injury even though:

a. Coverage under the government legislation provides benefits for only a portion of the services incurred.

b. The Employer has failed to obtain such coverage required by law.

c. The Participant waives his or her rights to such coverage or benefits.

d. The Participant fails to file a claim within the filing period allowed by law for such benefits.

e. The Participant fails to comply with any other provision of the law to obtain such coverage or benefits.

f. The Participant was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

This Exclusion will not apply if the Participant is permitted by statute not to be covered and the Participant elects not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws.

This Exclusion will not apply if the Participant's employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws or employer's liability acts of any state, country, or the United States.

2. Services, supplies, drugs and devices which the Participant is entitled to receive or does receive from TRICARE, the Veteran's Administration (VA), but not Medicaid. This Exclusion is not intended to exclude Covered Medical Expenses from coverage if a Participant is a resident of a Montana state institution when services are provided.

   NOTE: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Participant. When such a circumstance occurs, the Participant will receive an Explanation of Benefits.

3. Services, supplies, and medications provided to treat any Injury to the extent the Participant receives or would be entitled to receive where liability is reasonably clear, benefits under an automobile insurance policy. Such benefits received by the Participant shall be used first to satisfy any remaining Coinsurance, Copayment and Deductible related to the Injury for which claims are submitted to the Plan. The Injury related claims must be submitted to the Plan to apply any applicable credit to Coinsurance, Copayment and/or Deductible.

4. Services, supplies, and medications provided to treat any Injury to the extent the Participant receives or would be entitled to receive where liability is reasonably clear, benefits from a premises liability policy. Examples of such policies are a homeowners or business liability policy. Such benefits received by the Participant shall be used first to satisfy any remaining Coinsurance, Copayment and Deductible related to the Injury for which claims are submitted to the Plan. The Injury related claims must be submitted to the Plan to apply any applicable credit to Coinsurance, Copayment and/or Deductible.

5. Services, supplies, drugs and devices to treat any Injury or Illness resulting from war, declared or undeclared, insurrection, rebellion, or armed invasion.

6. Any loss for which a contributing cause was the commission of a felony or serious illegal act, or an attempt to commit a felony or an attempt to commit a serious illegal act, for which the Participant has been found guilty in a court of competent jurisdiction or to which the Participant has plead guilty or no contest. This Exclusion does not apply to the extent the Participant suffers a loss as a victim of domestic violence.

7. Services for which a Participant is not legally required to pay or charges that are made only because Benefits are available on this Plan.

8. Services, supplies, drugs and devices provided to the Participant before the Participant's Effective Date or after the Participant's coverage terminates.

9. Orthodontics.

10. All dental services, including but not limited to ridge augmentation and vestibuloplasty, whether performed by Physicians, dentists, oral surgeons and/or any other provider, except for services provided as the result of a Dental Accident; (ii) services provided as a result of or to treat either a congenital defect or a cancer; or (iii) services in connection with a transplant or as applicable if Dental Benefits (non-Accident) are included in the section entitled Benefits.

11. Vision services, including but not limited to prescription, fitting or provision of eyeglasses or contact lenses and Lasik Surgery, except that vision services may be covered for specific conditions in Medical Policy.

12. Hearing aids, except as otherwise provided under this Plan Document, and Medically Necessary cochlear implants may also be covered per Medical Policy.

13. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging, or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

14. Cosmetic services or complications resulting therefrom except when covered services are provided to correct a condition resulting from an Accident, a condition resulting from an Injury or to treat a congenital anomaly, as applicable in Medical Policy.

15. For travel by a Participant or provider, except as specifically included in this Plan Document.

16. Any related services to a non-covered service except for Routine Patient Costs for Participants in an Approved Clinical Trial. Related services are:
    a. Services in preparation for the non-covered service;
    b. Services in connection with providing the non-covered service;
    c. Hospitalization required to perform the non-covered service; or
    d. Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
17. Any service or procedure which is determined by the Claim Administrator to be an Inclusive Service/Procedure.
18. Any services, supplies, drugs and devices which are:
    a. Experimental/Investigational/Unproven services, except any services, supplies, drugs and devices considered to be Experimental/Investigational/Unproven and which are provided during a Phase I or II clinical trial, or the experimental or research arm of a Phase III clinical trial, except for services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial. This includes services, supplies, drugs and devices under study to determine the maximum tolerated dosage(s), toxicity, safety or efficacy as compared with standard treatment, or for the diagnosis of the condition in question. The Plan has the ultimate authority and right to determine what services are Experimental/Investigational/Unproven and are excluded from coverage.
    b. Not accepted standard medical practice. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice.
    c. Not a Covered Medical Expense.
    d. Not Medically Necessary.
    e. Not covered under applicable Medical Policy.
19. Private duty nursing except as covered under the Home Health Care and/or Hospice Benefit.
20. Transplants of a nonhuman organ or artificial organ implant.
21. Reversal of an elective sterilization.
22. Services, supplies, drugs and devices related to the treatment of infertility, including but not limited to in vitro fertilization and artificial insemination.
23. Routine foot care for Participants without co-morbidities, except Routine foot care is covered if a Participant has co-morbidities such as diabetes.
24. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
25. Services, supplies, drugs and devices related to treatment for psychological or psychogenic sexual dysfunctions.
26. Services, supplies, drugs and devices relating to any of the following treatments or related procedures:
    a. Homeopathy;
    b. Hypnotherapy;
    c. Rolfing;
    d. Holistic medicine;
    e. Religious counseling;
    f. Self-help programs.
27. Services provided by a massage therapist.
28. Sanitarium care, Custodial Care, rest cures, or convalescent care to help the Participant with daily living tasks. Examples include but are not limited to, help in:
    a. Walking.
    b. Getting in and out of bed.
    c. Bathing.

d. Dressing.
e. Feeding.
f. Using the toilet.
g. Preparing special diets.
h. Supervision of medication which is usually self-administered and does not require the continuous attention of medical personnel.

No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, or extended care facility for the types of care outlined in this Exclusion.

29. Vitamins, except those vitamins that may be covered in Medical Policy.

30. Over-the-counter food supplements, formulas, and/or Medical Foods, regardless of how administered except when used for Inborn Errors of Metabolism.

31. Services, supplies, drugs and devices for the surgical treatment of any degree of obesity, whether provided for weight control or any medical condition.

32. Services, supplies, drugs and devices for weight reduction or weight control. This Exclusion does not include intensive behavioral dietary counseling when services are provided by a Physician, physician assistant or nurse practitioner.

33. Services, supplies, drugs and devices for obesity, weight reduction or control whether rendered for weight control or any other condition, except for if Prior Authorized as Medically Necessary and a Benefit of this Plan Document.

34. Charges associated with health clubs, weight loss clubs or clinics.

35. Services, supplies, drugs and devices for the treatment of Illness, Injury and/or complications resulting from services that are not Covered Medical Expenses, except for any services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial.

36. Tutoring services.

37. Any services, supplies, drugs and devices not provided in or by a Covered Provider.

38. Services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature.

39. Deluxe medical equipment including, but not limited to, durable medical equipment, prosthetics and communication devices except as included in the Durable Medical Equipment Benefit and the Prosthetic Benefit in the section entitled Benefits.

40. Services or supplies for:

a. Intersegmental traction;
b. All types of home traction devices and equipment;
c. Vertebral axial decompression sessions;
d. Surface Electromyography (EMG); the measurement of muscle electrical activity with electrodes placed on the skin over the muscle;
e. Spinal manipulation under anesthesia;
f. Muscle testing through computerized kinesiology machines;
g. Balance testing through computerized dynamic posturography sensory organization test.

41. Testing of:

a. Blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood;
b. Urine for measurement of collagen cross links;
c. Cervicovaginal fluid for amniotic fluid protein;

d. Allergen specific IgG measurement

42. Applied Behavior Analysis (ABA) services, except as specifically included in this Plan Document under Autism Spectrum Disorders.

43. Professional or courtesy discounts.

44. 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.

45. Mailing or sales tax. Charges for mailing, shipping, handling, postage, conveyance and/or sales tax.

46. Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

47. Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

48. Vocational and Cognitive retraining, described as such, or otherwise named.

49. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

50. The Plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

51. Services, supplies, drugs and devices which are not listed as a Benefit as described in this Plan Document.

52. Relative giving services. Professional services performed by a person who ordinarily resides in the Participant's home or is related to the Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

CLAIMS

How to Obtain Payment for Covered Expenses for Benefits

1. If a Participant obtains services from a Participating Provider, the Participating Provider will submit claims to the Claim Administrator for the Participant. If a Participant obtains services from a nonparticipating provider, the Participant may be required to submit all claims to the Plan. All claims for services must be submitted no later than 12 Months from the date of service. All claims must provide enough information about the services for the Claim Administrator to determine whether or not they are a Covered Medical Expense. Submission of such information is required before payment will be made.

Itemized bill must contain the following information:

- Employee's name;
- Employee Plan Identification Number from the ID card;
- Name of patient;
- Patient's date of birth;
- Employee's address;
- Provider name, address, telephone number;
- Provider number;
- Type of service;
- Procedure code for each service;
- Date of each service;
- Diagnosis;
- Charge for each service.

In certain instances, the Claim Administrator may require that additional documents or information including, but not limited to, Accident reports, medical records, and information about other insurance coverage, claims, payments and settlements, be submitted within the timeframe requested for the additional documentation before payment will be made.

2. If a Participant purchases drugs or Prescription Drug Products at a Participating Pharmacy, an Extended Supply Pharmacy or a mail order Pharmacy approved by the Plan, and the Participant's identification card is presented at the time of purchase, the Participant must pay for the Prescription Drug Product and the Participating Pharmacy will submit a claim for the cost of the covered prescription drug or Prescription Drug Product to the Plan's Pharmacy Benefit Manager. The Participant's responsibility for the cost of the covered drug or Prescription Drug Product will then accumulate to the Participant's Deductible and Out of Pocket Amount. Once the Deductible, if applicable, is met, the Participant will only be required to pay the appropriate Copayment and/or Coinsurance if the amount can be determined by the Pharmacy at the time of purchase.

   If a Participant purchases drugs or Prescription Drug Products at a nonparticipating pharmacy, the Participant must pay for the prescription at the time of dispensing and then within one year of the date of purchase submit a claim for the prescription drug on a form to the Claim Administrator's Pharmacy Benefit Manager for reimbursement. The Participant's Copayment and/or Coinsurance for the covered drug or Prescription Drug Product will then accumulate to the Prescription Drug Out of Pocket Amounts.

   Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

3. Claims must be submitted to the address listed on the inside cover of this Plan Document, on the claim form. Contact the Customer Service number on the back of the Participant's identification card for information on how to submit a claim.

Out-of-State Services – Claims for Family Members Who Live Out of State and All Other Claims for Out-of-State Services

Family Members who live out-of-state or Participants who have health care services out-of-state should use Participating Blue Cross and Blue Shield Providers in that state. In most cases, providers will file claims directly with the Claim Administrator. Please refer to the BlueCard Program section. If the provider does not file the claim, the Participant should use the same procedures outlined in the section entitled Claims Information.

Self-Audit Program

You will be eligible to receive a cash reward if you find an overcharge on your covered provider's bill that has been processed incorrectly and:

1. Was not detected by the provider.
2. Was not detected by Blue Cross and Blue Shield of Montana.
3. Was part of the charges for services which are payable under this Plan.

In order to qualify, request an itemized statement from the provider. Review the bill for services not received, the appropriate number of tests, x- rays, etc. If you find an error, ask the provider to correct the error and send you a revised statement. Clearly mark both statements "Self -Audit Program" and send them to the attention of the Claims Department at:

Blue Cross and Blue Shield of Montana
P.O. Box 660255
Dallas, TX 75266-0255

Blue Cross and Blue Shield of Montana will refund to you 50 percent (50%) of the savings up to $1,000 based on an overcharge of $2,000. The minimum error eligible to qualify for this refund is $50 with a minimum payment to you of $25.

Prescription Drug Claims - Filling Prescriptions at a Retail Pharmacy

Outpatient prescription drugs are available through the Prime Therapeutics Prescription Drugs Benefit. Prime Therapeutics is the Pharmacy Benefit Manager.

1. Go to a Prime Therapeutics Participating Pharmacy that accepts Participant identification cards. To find out if a Pharmacy takes part in the program, ask the pharmacist. To find a Prime Therapeutics Participating Pharmacy nearest the Participant, check the list on the website www.bcbsmt.com or call the Pharmacy locator at the telephone number on the inside cover of this document.
2. Present the prescription and the Participant's identification card to the pharmacist.
3. Make sure that the pharmacist has complete and correct information about the Participant for whom the prescription is written, including sex and date of birth.
4. When the Participant receives a prescription, he or she should sign the Pharmacy log and pay his or her share of the cost.
5. If a Participant purchases prescription drugs from a Participating Pharmacy or mail-service Pharmacy approved by the Claim Administrator, the Participant must pay for the Prescription Drug Product and the Pharmacy will submit the prescription drug claims to the Pharmacy Benefit Manager.
6. The Participant must pay the difference between a Brand-Name Drug and the Generic Drug equivalent if the Participant purchases a Brand-Name Drug when a Generic Drug equivalent is available.
7. The Plan makes use of a Drug List, which is a list of covered prescription drugs for dispensing to Participants as appropriate.
8. For prescriptions filled at a Pharmacy that is not part of the network, the Participant will need to pay the entire cost of the prescription at the time the prescription is filled and dispensed and submit a paper claim to Pharmacy Benefit Manager for reimbursement. The Participant will be reimbursed for the prescription drug at the amount that would have been paid to a Participating Pharmacy less any Deductible, Copayment and/or Coinsurance. The Participant will not receive the preferred pricing.
9. Prescriptions filled at Hospital Pharmacies are not eligible for reimbursement unless they are listed as a network Pharmacy.

Pharmacy Benefit Manager claim forms are available by calling the Claim Administrator at the telephone number on the inside cover of this document.

Mail-Service Pharmacy

The Participant may obtain maintenance prescriptions through the mail. Maintenance prescriptions are those that the Participant expects to continue using for an extended period of time and for which a prescription can be written for up to a 90-day supply. Coverage for costly prescriptions should be verified prior to ordering. Specific Benefits are outlined in the Prescription Drugs section in this document.

To obtain a mail service claim form, call the Claim Administrator at the telephone number on the inside cover of this document.

To order a prescription:

1. Complete all sections and sign the Mail-Service order form.
2. Enclose the following:
   a. The original prescription written for up to a 90-day supply;
   b. The Participant's current Pharmacy telephone number and prescription numbers to be transferred; and
   c. The Participant's telephone number.
3. Mail the form to the mail service Pharmacy at the address listed on the form.

PRIVACY OF PROTECTED HEALTH INFORMATION

Protected Health Information about a Plan Participant will not be disclosed to the Plan Sponsor by the Health Plan or any Business Associate servicing the Health Plan, unless the Plan Sponsor certifies that the Plan Documents have been amended to include this section and the Plan Sponsor agrees to abide by this section. Any disclosure to and use by the Plan Sponsor will comply with all provisions of this section.

Definitions

For the purpose of this section, the following definitions apply:

1. Business Associate.

   A person or entity who performs or assists in performing or provides a function or activity that involves the use or disclosure of Protected Health Information on behalf of the Health Plan. Such functions or activities include, but are not limited to, claims processing, claims administration, data analysis, data processing, data administration, utilization review, quality assurance, billing, benefit management, legal services, marketing services, accounting services, and administration services.

2. Federal Regulations.

   Those regulations entitled Standards for Privacy of Individually Identifiable Health Information, 45 CFR §160 and §164.

3. Health Plan or Plan.

   The Group Health Plan, provided to the Plan Participants by or through the Plan Sponsor. The Group Health Plan may be administered by a third-party health insurance carrier or other third-party administrator. The health insurance issuer or third-party administrator is the Business Associate of the Group Health Plan.

4. Plan Participant.

   A person covered under the Group Health Plan.

5. Protected Health Information (PHI).

   Individually identifiable health information transmitted, including electronic transmission, or maintained in any form or medium.

6. Plan Sponsor.

   The Employer or other entity that sponsors the Group Health Plan.

Purpose of Disclosure to Plan Sponsor

A Plan Participant's PHI will only be disclosed to the Plan Sponsor by the Health Plan, or a Business Associate servicing the Health Plan, subject to the following:

1. To permit the Plan Sponsor to carry out Plan administration functions that are in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. Disclosures to the Plan Sponsor of a Plan Participant's PHI will be explained in the Notice of Privacy Practices issued to Plan Participants by the Health Plan.
3. No Plan Participant's PHI will be disclosed to the Plan Sponsor for the purpose of employment – related actions or decisions or in connection with any other Benefit or employee benefit plan of the Plan Sponsor.

Restrictions on Plan Sponsor's Use and Disclosure of PHI

The Plan Sponsor will:

1. Not use or further disclose PHI except as permitted or required by the Plan Documents, as amended by this section, or required by law.
2. Ensure that any agent, including subcontractors, to whom it provides PHI agrees to the restrictions and provisions of the Plan Documents, including this section.
3. Not use or disclose PHI for the purpose of employment-related actions or decisions or in connection with any other Benefit or Employee Benefit plan of the Plan Sponsor.
4. Promptly report to the Health Plan any use or disclosure of PHI that does not comply with the provisions of this section upon learning of such noncompliance.
5. Make PHI, located in a Plan Participant's designated record set, available to the Plan Participant who is the subject of the information, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for their information.

6. Make PHI, located in a Plan Participant's designated record set, available for amendment, and amend PHI, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for amendment.
7. Provide an accounting of disclosure to Plan Participants in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for an accounting of disclosures.
8. Make its internal practices, books, and records, relating to its use and disclosure of PHI, available to the Health Plan and the United States Department of Health and Human Services to determine compliance with Federal Regulations.
9. If feasible, and subject to 9b below:
    a. Return or destroy all PHI, and retain no copies, when the PHI is no longer needed for the Plan administration functions for which the disclosure was made. This includes:
        1. PHI, in whatever form or medium (including any electronic medium under the Plan Sponsor's custody or control), received from the Health Plan or a Business Associate; and
        2. Any data or compilations derived from and allowing identification of any Plan Participant who is the subject of the PHI.
    b. If it is not feasible to return or destroy all PHI, the Plan Sponsor will limit the use or disclosure of any PHI that it cannot return or destroy to those purposes that make it unfeasible to return or destroy the PHI.

Adequate Separation Between the Plan Sponsor and the Plan

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to PHI received from the Health Plan or the Business Associate servicing the Plan. This includes those Employees who may receive PHI relating to payment under, health care operations of, or other matters pertaining to the Health Plan in the ordinary course of business:

LynnDee Schmidt, Benefits and Safety Manager

Access to PHI will be given to the Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, only to perform the Plan administration functions that the Plan Sponsor provides for the Health Plan.

The Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, will be subject to disciplinary action and sanctions, up to and including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of PHI in breach or violation of, or noncompliance with the provisions of this section.

The Plan Sponsor will promptly report any breach or violation of, or noncompliance as required in the section entitled "Restrictions on Plan Sponsor's use of Disclosure of PHI," Item 4 of this section. The Plan Sponsor will cooperate with the Health Plan to:

1. Correct the breach or violation of or noncompliance.
2. Impose appropriate disciplinary action or sanctions on the person(s) responsible for causing the breach or violation of or noncompliance.
3. Mitigate any detrimental effect of the breach or violation of or noncompliance on any Plan Participant who may have had the privacy of PHI compromised by the breach or violation of or noncompliance.

GENERAL PROVISIONS

Plan Administrator Powers and Duties

The Plan Administrator shall have total and exclusive responsibility to control, operate, manage, and administer the Plan in accordance with its terms. The Plan Administrator shall have all the authority that may be necessary or helpful to enable it to discharge its responsibilities with respect to the Plan. Without limiting the generality of the preceding sentence, the Plan Administrator shall have the exclusive right: to interpret the Plan; to determine eligibility for coverage under the Plan; to determine eligibility for Benefits under the Plan; to construe any ambiguous

provisions of the Plan; to correct any default; to supply any omission; to reconcile any inconsistency; and to decide any and all questions arising in administration, interpretation, and application of the Plan.

The Plan Administrator shall have full discretionary authority in all matters related to the discharge of its responsibilities and the exercise of authority under the Plan, including, without limitation, the construction of the terms of the Plan, and the determination of eligibility for coverage and Benefits. The decisions of the Plan Administrator, as Plan Administrator, shall be conclusive, binding and final upon all persons having or claiming to have any right or interest in or under the Plan and no such decision shall be modified under judicial review unless such decision is proven to be arbitrary or capricious.

The Plan Administrator may delegate some or all of its authority under the Plan or revoke such delegation to any person or persons provided that any such delegation or revocation of delegation is in writing. The Plan Administrator may delegate its authority to determine eligibility for Benefits to the Claim Administrator.

Entire Plan; Changes

This Plan supersedes any previous plan. This Plan, including the amendments and attached papers, if any, constitutes the entire Plan. No change in this Plan is valid until made pursuant to the section entitled Modification of Plan.

Modification of Plan

The Plan Sponsor and Plan Administrator reserve the right to amend the Plan in whole or in part at any time, including the right to make any amendments to a contract with an insurance company, and the right to amend any rules adopted for the administration of the Plan. Expenses incurred prior to the Effective Date of any amendment are based on the provisions in effect at the time the expenses were incurred. The Employer reserves the right to change or cancel any Benefits under the Plan, at any time. Any such change in Benefits will be based solely on the decisions of the Employer and may apply to active Employees, future retirees and current retirees as either separate groups or as one group. If the Employer cancels any Benefits under the Plan, participation in the canceled Benefits terminates on the date of the cancellation, unless otherwise specified.

The Employer may terminate the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate, unless the Plan is continued by a successor to the Employer. Any such termination in Benefits will be based solely on the decision of the Employer and may apply to current Employees and their Dependents, future retirees and current retirees as either separate groups or as one group.

Notice of Change

All changes or amendments to this Plan that directly or indirectly relate to any Benefit or coverage under the Plan including any increase in contribution for coverage required from a Participant, will be reported to all eligible Participants in accordance with federal law after the date such change or amendment is adopted.

Clerical Errors

No clerical error on the part of the Claim Administrator shall operate to defeat any of the rights, privileges, or Benefits of any Participant covered under this Plan. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits will be made. Clerical errors shall not prevent administration of this Plan in strict accordance with its terms.

Notices Under Plan

Any notice required by this Plan may be given by United States mail, postage paid. Notice to the Participant will be mailed to the address appearing on the records of the Plan. Notice to the Plan should be sent to the Plan Sponsor. Any time periods included in a notice shall be measured from the date the notice was mailed.

Rescission of Plan Document

This Plan Document is subject to rescission if the Participant commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, concerning a Participant’s health, claims history,

or current receipt of health care services. The Claim Administrator will provide at least 30 days advance written notice to the Participant before coverage may be rescinded.

Payment of Claims and Assignment of Benefits

Claim Payment Assignment

All payments by the Claim Administrator for the benefit of any Participant may be made directly to any Provider furnishing Covered Medical Expenses for which such payment is due, and the Claim Administrator is authorized by such Participant to make such payments directly to such providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Participant or provider furnishing Covered Medical Expenses. All benefits payable to the Participant which remain unpaid at the time of the death of the Participant will be paid to the estate of the Participant.

Claim Dispute

Once Covered Medical Expenses are rendered by a provider, the Participant has no right to request the Claim Administrator not to pay the Claim submitted by such provider and no such request by a Participant or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Participant or any other person because of its rejection of such request.

Plan Coverage Assignment

Neither the Plan nor a Participant's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non-assignable or non-transferable and will be forfeited if a Participant attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the Claim Administrator makes payment because of a person's wrongful use of the identification card of a Participant, such payment will be considered a proper payment and the Claim Administrator will have no obligation to pursue recovery of such payment.

Validity of Plan

If any part, term, or provision of this Plan is held by the courts to be illegal or in conflict with any law of the state of Montana, the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the Plan did not contain the particular part, term, or provision held to be invalid.

Participants Rights

A Participant has no rights or privileges except as specifically provided in this Plan. Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any Participant, or as the right of any Participant to continue in the employment of the Employer or as a limitation of the right of the Employer to discharge any of its Employees with or without cause.

Alternate Care

This Plan may make payment for services that are not listed as a Benefit of this Plan. Such payment will be made only upon mutual agreement by the Participant, the Plan Administrator, and/or the Claim Administrator. Such payment does not act as a waiver of the terms of this Plan.

Benefit Maximums

If a Participant receives services payable under any section of this Plan and exhausts all Benefits available under that section, no Benefits are available under any other section for that same condition.

Pilot Programs

The Plan reserves the right to develop and enter into pilot programs to test the success of providing Benefits for care not normally covered under this Plan. The existence of a pilot program does not guarantee that all Participants are eligible for the pilot program Benefits or that such Benefits will be permanent. A pilot program is an initial small-scale implementation that is used to prove the variability of a project idea. This could involve either the exploration of a novel new approach or idea or the application of a standard approach new to the organization. It enables an

organization to manage the risk of a new idea and identify any deficiencies before substantial resources are committed.

Research Fees

The Plan reserves the right to charge a reasonable fee when extensive research is necessary to reconstruct information or documents which were previously provided in writing to the Participant by the Plan. Fees may be charged for the costs of copying labor, supplies and postage. Fees will not be charged for searching for and retrieving the requested information.

Cooperation of Participant

The Participant must cooperate fully with the Plan, and any person or entity administering this Plan Document on behalf of the Plan, in providing documents and information requested to determine whether the Participant is or remains eligible for membership; to determine whether services are Covered Medical Expenses; to determine whether any term or exclusion of this Plan Document applies; and to make any other determination necessary to administer this Plan Document. Required cooperation by a Participant includes executing such consents, releases, disclosure authorizations and other documents as may be requested by the Plan in order to obtain documents or information from a third party necessary to make such determinations.

Required cooperation of a Participant includes but is not limited to providing or authorizing the provision of the following to the Plan:

1. All medical, Hospital, dental, vision and other health care records relating to the diagnosis or treatment of or services or items provided to the Participant;
2. All information and documents regarding coverage, policy limits, claim payments, demands, litigation, settlement (including disputed and undisputed liability settlements) under any applicable or potentially applicable insurance, health plan, government benefit program or other health or medical payor plan or program, including but not limited to:
    a. Workers' compensation, FELA or other similar plan or program providing benefits for Injury or Illness arising out of employment;
    b. Personal, commercial or other automobile insurance, including but not limited to no-fault medical payment, liability or other coverages; and
    c. Personal, homeowners, commercial, or other premises insurance, including but not limited to no-fault medical payment, liability or other coverages.

Statements are Representations

Any representations or statements made to a Participant by the Plan Administrator, their representatives or agent, about being covered for Benefits under the Plan, which conflict with the provisions of the Plan shall:

1. Not be considered as representations or statements made by, or on behalf of, the Plan Administrator;
2. Not bind the Plan Administrator for Benefits under the Plan.

In the absence of fraud, all statements by applicants or the Participant shall be deemed to be representations and not warranties. Any Participant who, with intent to defraud or knowing that he or she is facilitating a fraud against the Employer or the Plan, submits an application or files a claim containing a false, incomplete, or misleading statement may be found guilty of fraud. The Employer reserves the right to take appropriate action in any instance where fraud is at issue.

Overpayments

Effective on or after January 1, 2020, if the Plan or the Claim Administrator pays Benefits for Covered Medical Expenses incurred by the Participant and it is found that the payment was more than it should have been, or it was made in error ("overpayment"), the Plan or the Claim Administrator has the right to obtain a refund of the overpayment amount from: (i) the person to, or for whom, such Covered Medical Expenses were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Out-of-Network Providers.

If no refund is received, the Plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any overpayment due up to an amount equal to the overpayment, from:

1. Any future Benefit payment made to any person or entity under this Plan Document, whether for the same or a different Participant; or
2. Any future Benefit payment made to any person or entity under another Blue Cross and Blue Shield of Montana administered ASO Benefit program and/or Blue Cross and Blue Shield of Montana administered insured Benefit program or policy, if the future Benefit payment owed is to a Participating Provider; or
3. Any future Benefit payment made to any person or entity under another Blue Cross and Blue Shield of Montana insured group Benefit plan or individual policy, if the future Benefit payment owed is to a Participating Provider; or
4. Any future Benefit payment, or other payment, made to any person or entity; or
5. Any future payment owed to one or more Participating Providers.

Further, the Claim Administrator has the right to reduce the Plan's payment to a Participating Provider by the amount necessary to recover another Blue Cross and Blue Shield of Montana's Plan or policy overpayment to the same provider and to remit the recovered amount to the other Blue Cross and Blue Shield of Montana Plan or policy.

Participant/Provider Relationship

Choosing a Provider

The choice of a Provider is solely the choice of the Participant and the Claim Administrator will not interfere with the Participant's relationship with any provider.

Claim Administrator's Role

It is expressly understood that the Claim Administrator does not itself undertake to furnish Hospital, medical or dental services, but solely to make payment to a provider for the Covered Medical Expenses received by Participants. The Claim Administrator is not in any event liable for any act or omission of any provider or the agent or employee of such provider, including, but not limited to, the failure or refusal to render services to a Participant. Professional services which can only be legally performed by a provider are not provided by the Claim Administrator. Any contractual relationship between a provider and the Claim Administrator shall not be construed to mean that the Claim Administrator is providing professional services.

Intent of Terminology

The use of an adjective such as approved, administrator, participating, in-network or network in modifying a provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such provider. In addition, the omission, non-use or non-designation of approved, administrator, participating, in-network, network or any similar modifier or the use of a term such as non-approved, non-administrator, nonparticipating, out-of-network or non-network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such provider.

Provider's Role

Each provider provides Covered Medical Expenses only to covered Participants and does not deal with or provide any services to the Employer (other than as an individual Participant) of the Plan.

Recovery, Reimbursement, and Subrogation

By enrollment in this Plan, Participants agree to the provisions of this section as a condition precedent to receiving Benefits under this Plan. Failure of a Participant to comply with the requirements of this section may result in the pending of the payment of Benefits.

1. Right to Recover Benefits Paid in Error

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

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

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine. By receipt of Benefits under this Plan, each Participant authorizes the deduction of any excess payment of such Benefits or other present or future compensation payments.

The provisions of this subsection apply to any licensed health care provider who receives an assignment of Benefits or payment of Benefits under this Plan. If a licensed health care provider refuses to refund improperly paid claims, the Plan may refuse to recognize future assignments of Benefits to that provider.

2. Reimbursement

The Plan's right to reimbursement is separate from and in addition to the Plan's right of subrogation. Reimbursement means to repay a party who has paid something on another's behalf. If the Plan pays Benefits for medical expenses on a Participant's behalf, and another party was actually responsible or liable to pay those medical expenses, the Plan has the right to be reimbursed for the amounts the Plan paid.

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

3. Subrogation

The Plan's right to subrogation is separate from and in addition to the Plan's right to reimbursement. Subrogation is the right of the Plan to exercise the Participant's rights and remedies in order to recover from third parties who are legally responsible to the Participant for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Participant, with or without his or her consent, to recover the money paid under the Plan. In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to the Participant's Accident, Injury, condition, or Illness, which the Plan has paid, then the Plan is entitled to recover, by legal action or otherwise, the money paid; in effect the Plan has the right to "stand in the shoes" of the Participant for whom Benefits were paid, and to take any action the Participant could have undertaken to recover the money paid.

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

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

4. The Following Paragraphs Apply to Both Reimbursement and Subrogation:

a. Under the terms of this Plan, the Plan Administrator is not required to pay any claims where there is evidence of liability of a third party. However, the Plan, in its discretion, may instruct the Claim Administrator not to withhold payment of Benefits while the liability of a party other than the Participant is being legally determined.

b. If the Plan makes a payment which the Participant, or any other party of the Participant's behalf, is or may be entitled to recover against any third party responsible for an Accident, Injury, condition or Illness, the Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. The Participant receiving payment from this Plan will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the Plan's right of recovery.

c. The Participant will cooperate fully with the Plan Administrator, its agents, attorneys, and assigns, regarding the recovery of any monies paid by the Plan for any party other than the Participant who is liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Plan Administrator, upon request and in a timely manner, of all material facts regarding the Accident, Injury, condition, or Illness; all efforts by any person to recover any such monies; provide the Plan Administrator with any and all documents, papers, reports, and the like regarding demands, litigation or settlements involving recovery of monies paid by the Plan; and notifying the Plan Administrator of the amount and source of any monies received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.

d. Participants will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers, including but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Participant will notify the Plan immediately of the name and address of any attorney whom the Participant engages to pursue any personal Injury claim on his or her behalf.

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

f. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Participant pursuing a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund," or similar statute, regulation, prior court decision, or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

5. Right of Offset

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

DEFINITIONS

This section defines certain words used throughout this Plan Document. These words are capitalized whenever they are used as defined.

ACCIDENT

An unexpected traumatic incident or unusual strain which is:

1. Identified by time and place of occurrence;
2. Identifiable by part of the body affected; and
3. Caused by a specific event on a single day.

Some examples include:

1. Fracture or dislocation.
2. Sprain or strain.
3. Abrasion, laceration.
4. Contusion.
5. Embedded foreign body.

6. Burns.
7. Concussion.

ACTIVELY WORKING

The performance of an Employee's customary duties at the usual place of employment.

ADVANCED PRACTICE REGISTERED NURSE

Nurses who have additional professional education beyond the basic nursing degree required of a registered nurse and are considered Advanced Practice Registered Nurses by applicable state law. Advanced Practice Registered Nurses include nurse practitioners, nurse-midwives, nurse-anesthetists and clinical nurse specialists.

ALLOWABLE FEE

The Allowable Fee is based on, but not limited to, the following:

1. Medicare RBRVS based is a system established by Medicare to pay Physicians for a "work unit." The RBRVS value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers' billed charge; or
2. Diagnosis-related group (DRG) methodology is a system used to classify Hospital cases into one of approximately 500 to 900 groups that are expected to have similar Hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of Hospital resources for the given DRG regardless of the actual Hospital resources used. Therefore, the amount paid by the Claim Administrator to a nonparticipating provider under the DRG system can be considerably less than the nonparticipating providers' billed charge; or
3. Billed charge is the amount billed by the provider; or
4. Case rate methodology is an all-inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the case rate system can be considerably less than the nonparticipating providers' billed charge; or
5. Per diem methodology is an all-inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the per diem system can be considerably less than the nonparticipating providers' billed charge; or
6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to a nonparticipating provider under the flat fee per category of service system can be considerably less than the nonparticipating providers' billed charge; or
7. Flat fee per unit of service fixed payment amount for a unit of service. For instance, a unit of service could be the amount of "work units" customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the flat fee per unit system can be considerably less than the nonparticipating providers' billed charge; or
8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or
9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or
10. The amount negotiated with the Pharmacy Benefit Manager or manufacturer or the actual price for prescription or drugs; or
11. The American Society of Anesthesiologists' Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a "work unit." The payment value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by the Claim Administrator to nonparticipating providers under the system can be considerably less than the nonparticipating providers' billed charge.
12. For nonparticipating providers in Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee is developed from base Medicare reimbursements,

excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for nonparticipating providers will represent an average contract rate for Participating Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by nonparticipating providers which may also alter the Allowable Fee for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Plan within 90 days after the Effective Date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

13. For nonparticipating providers outside Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee (i) for professional providers is based on publicly available data and historic reimbursement to providers for the same or similar professional services, adjusted for geographic differences where applicable, or (ii) for Hospital or other facility providers is based on publicly available data reflecting the approximate cost that Hospitals or other facilities have incurred historically to provide the same or similar service, adjusted for geographic differences where applicable, plus a margin factor for the Hospital or facility.

14. The Allowable Fee for Outpatient Dialysis is the Usual and Reasonable Charge as described in the separately issued Outpatient Dialysis Plan Document.

In the event the nonparticipating Allowable Fee does not equate to the nonparticipating provider's billed charges, the Participant will be responsible for the difference, along with any applicable Deductible, Copayment and/or Coinsurance amount. This difference may be considerable. To find out an estimate of the Plan's nonparticipating Allowable Fee for a particular service, Participants may call the Customer Service number shown on the back of the Participant's identification card.

AMPLIFICATION DEVICE

A hearing device, hearing aid, or a wearable, non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold.

APPLIED BEHAVIOR ANALYSIS (ABA) - (ALSO KNOWN AS LOVAAS THERAPY)

Medically Necessary interactive therapies or treatment derived from evidence-based research. The goal of ABA is to improve socially significant behaviors to a meaningful degree, including:

1. Increase desired behaviors or social interaction skills;
2. Teach new functional life, communication, or social, skills;
3. Maintain desired behaviors, such as teaching self-control and self-monitoring procedures;
4. Appropriate transfer of behavior from one situation or response to another;
5. Restrict or narrow conditions under which interfering behaviors occur;
6. Reduce interfering behaviors such as self-injury.

ABA therapy and treatment includes Pivotal Response Training, Intensive Intervention Programs, and Early Intensive Behavioral Intervention, and the terms are often used interchangeably. The ABA Benefit also includes Discrete Trial Training, a single cycle of behaviorally based instruction routine that is a companion treatment with ABA.

Services must be provided by an appropriately certified provider.

APPROVED CLINICAL TRIAL

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV, clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition. The trial must be:

1. Conducted under an investigational new drug application reviewed by the FDA;
2. Exempt from an investigational new drug application; or
3. Approved or funded by:

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

BENEFIT

Services, supplies and medications that are provided to a Participant and covered under this Plan Document as a Covered Medical Expense.

BENEFIT PERIOD

For the Plan - is the period of time shown in the Schedule of Benefits.

For the Participant - Is the same as for the Plan except that if the Participant's Effective Date is after the Effective Date of the Plan, the Participant's Benefit Period begins on the Participant's Effective Date and ends on the same date the Plan Benefit Period ends. Thus, the Participant's Benefit Period may be less than 12 Months.

BEST EVIDENCE

Means evidence based on:

1. Randomized Clinical Trials;
2. A Cohort Study or Case-Control Study, if Randomized Clinical Trials are not available;
3. A Case Series, if Randomized Clinical Trials, Cohort Studies or Case-Control Studies are unavailable; and/or
4. An Expert Opinion, if Randomized Clinical Trials, Cohort Studies, Case-Control Studies or Case Series are unavailable.

BLUE CROSS AND BLUE SHIELD OF MONTANA

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, is the Claim Administrator for this Plan.

BLUE CROSS AND BLUE SHIELD OF MONTANA SPECIALTY NETWORK

Specialty Pharmacy providers who have entered into an agreement with the Plan or third party on behalf of the Claim Administrator to provide Specialty Medications to Participants and which have agreed to accept specified reimbursement rates.

BRAND-NAME DRUG

A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand-Name Drug. There may also be situations where a drug's classification changes from Generic Drug to Brand-Name Drug due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to payment obligations from Generic Drug to Brand-Name Drug.

CARE COORDINATION

Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Plan Participant's healthcare needs across the continuum of care.

CARE COORDINATOR
An individual within a provider organization who facilitates Care Coordination for patients.

CARE COORDINATOR FEE
A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

CARE-MANAGEMENT
A process that assesses and evaluates options and services required to meet the Participant's health care needs. Care Management may involve a team of health care professionals, including Covered Providers, the Plan and other resources to work with the Participant to promote quality, cost-effective care.

CASE-CONTROL STUDY
A retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

CASE SERIES
An evaluation of a series of patients with a particular outcome, without the use of a control group.

CLAIM ADMINISTRATOR
Claim Administrator means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Claim Administrator is Blue Cross and Blue Shield of Montana. The Claim Administrator provides ministerial duties only, exercises no discretion over Plan assets.

CLINICAL PEER
A Physician or other health care provider who:

1. Holds a nonrestricted license in a state of the United States; and
2. Is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

CODE
The Internal Revenue Code of 1986, as amended.

COHORT STUDY
A prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

COINSURANCE
The percentage of the Allowable Fee payable by the Participant for Covered Medical Expenses. The applicable Coinsurance is stated in the Schedule of Benefits.

COMPOUNDED DRUGS
Drugs or inert ingredients that have been measured and mixed by a pharmacist to produce a unique formulation because commercial products either do not exist or do not exist in the prescribed dosage, size, or form.

CONCURRENT CARE
Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or

Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Participant's condition requires the skills of separate Physicians.

CONSULTATION SERVICES
Services of a consulting Physician requested by the attending Physician. These services include discussion with the attending Physician and a written report by the consultant based on an examination of the Participant.

CONVALESCENT HOME
An institution, or distinct part thereof, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is:

1. A skilled nursing facility;
2. An extended care facility;

3. An extended care unit; or
4. A transitional care unit.

A Convalescent Home is primarily engaged in providing continuous nursing care by or under the direction and supervision of a registered nurse for sick or injured persons during the convalescent stage of their Illness or Injuries and is not, other than incidentally, a rest home or home for Custodial Care, or for the aged.

NOTE: A Convalescent Home shall not include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and treatment of Mental Illness or Substance Use Disorder.

COPAYMENT

The specific dollar amount payable by the Participant for Covered Medical Expenses. The applicable Copayments are stated in the Schedule of Benefits.

COSMETIC

Services that are provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical function.

COVERED MEDICAL EXPENSE

Expenses incurred for Medically Necessary services, supplies and medications that are based on the Allowable Fee and:

1. Covered under the Plan;
2. In accordance with Medical Policy; and
3. Provided to the Participant by and/or ordered by a Covered Provider for the diagnosis or treatment of an active Illness or Injury or in providing maternity care.

In order to be considered a Covered Medical Expense, the Participant must be charged for such services, supplies and medications.

COVERED PROVIDER

A participating or nonparticipating provider which has been recognized by the Claim Administrator as a provider of services for Benefits described in this Plan Document. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine if a provider is covered, the Claim Administrator looks to the nature of the services rendered, the extent of licensure and is recognized by the Claim Administrator as a provider of services for Benefits described in the Plan Document.

Covered Providers include professional providers and facility providers including Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, audiologists, nurse specialists, naturopathic physicians, Advanced Practice Registered Nurses, physician assistants, Hospitals and Freestanding Surgical Facilities.

CREDITABLE COVERAGE

Coverage that the Participant had for medical Benefits under any of the following plans, programs and coverages:

1. A group health plan;
2. Health insurance coverage;
3. Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1935c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4 (Medicare);
4. Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s (Medicaid);
5. Title 10, chapter 55, United States Code (TRICARE);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A health plan offered under Title 5, chapter 89, of the United States Code (Federal Employee Health Benefits Program);
8. A public health plan;
9. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e); or
10. A high-risk pool in any state.

Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits.

CUSTODIAL CARE

Any service, primarily for personal comfort or convenience, that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the Participant's condition. Custodial Care services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable nonprofessional personnel, are to assist with Routine medical needs (e.g. simple care and dressings, administration of Routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

DEDUCTIBLE

The dollar amount each Participant must pay for Covered Medical Expenses incurred during the Benefit Period before the Plan will make payment for any Covered Medical Expense to which the Deductible applies.

Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. Thus, Copayments, and/or Coinsurance, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Participant's responsibility.

If three or more Participants covered under the same family satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Participant of the family.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, only one Deductible will be applied to that Hospital stay (facility charges only). If the Participant satisfied the Participant's Deductible prior to that Hospital stay, no Deductible will be applied to that stay.

DENTAL PROVIDER

A Dental Provider may be participating or nonparticipating. A participating Dental Provider is a provider who has a contract with the Claim Administrator. These providers agree to accept payment directly from the Claim Administrator for covered services. This payment, together with the Participant's Deductible and Coinsurance described in the Schedule of Benefits, is accepted as payment in full. The Participant may obtain a list of participating Dental Providers from the Claim Administrator upon request.

If a Participant receives services from a nonparticipating Dental Provider, the Participant is responsible for the balance of the nonparticipating provider's bill after payment by the Plan.

DEPENDENT

A Participant who has been enrolled by an enrolled Employee and who is one of the following:

1. The Employee's legal Spouse;
2. The Employee's biological child, adopted child, or child placed for adoption and who is under the age of 26 years;
3. Children for who the Employee becomes legally responsible by reason of placement for adoption, as defined in Montana law;
4. A child of the Employee and/or Spouse who is 26 years of age or older may qualify as a Family Member if the child:
    a. Has been covered under the Plan before age 26; and
    b. Cannot support himself/herself because of intellectual disability or physical handicap; and
    c. Is legally dependent on the enrolled Employee for support.

Proof of those qualifications must be supplied to the Plan within 31 days of the child's 26th birthday. Although there is no limiting age for handicapped children, the Plan reserves the right to require periodic certification from the enrolled Employee of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child's 26th birthday.

DIAGNOSTIC BREAST EXAMINATION

A Medically Necessary and clinically appropriate examination of the breast, including diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

DRUG LIST

A list of all drugs that may be covered under the Prescription Drugs section of this Plan Document. A current list is available on the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. Contact a Customer Service representative at the telephone number shown on the back of the Participant's identification card for more information.

EFFECTIVE DATE

For a Participant, the Effective Date is the date the Participant has met the requirements of the Plan and is shown on the records of the Plan to be eligible for Benefits. For the Plan, the Effective Date is the date shown on the Schedule of Benefits. However, certain provisions shall be effective as of the dates specified within those provisions. The Effective Date of any amendment to the Plan is the Effective Date set forth on such amendment.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another Hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn fetus.

EMERGENCY SERVICES

Health care items or services furnished or required to evaluate and treat an Emergency Medical Condition.

EMPLOYEE

Any person (other than a nonresident alien who receives no U.S. income from the Employer) who is employed by the Employer. Notwithstanding the foregoing, the term "Employee" shall also include any officer, or former officer of the Employer for whom the Employer is contractually bound by written agreement to provide health Benefits. Employee shall not include any person who is classified by the Employer as an independent contractor or as a leased Employee.

EMPLOYER

Yellowstone County

ESSENTIAL HEALTH BENEFITS

A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Some plans cover more services.

EVIDENCE-BASED STANDARD

The conscientious, explicit, and judicious use of the current Best Evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

EXCLUSION

A provision which states that the Plan has no obligation under this Plan Document to make payment.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device, biological product or medical treatment or procedure is Experimental, Investigational and/or Unproven if **the Plan determines** that:

1. The drug, device, biological product or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product or medical treatment or procedure is furnished; or
2. The drug, device, biological product or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials, or 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
3. The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product or 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.

Approval by a governmental or regulatory agency will be taken into consideration in assessing the Experimental/Investigational/Unproven status of a drug, device, biological product, supply and equipment for

medical treatment or procedure but will not be determinative. The Plan Administrator has the discretionary authority to make determinations as which drugs, services, supplies, care and/or treatments shall be considered experimental, investigative or unproven.

EXPERT OPINION

A belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

EXPLANATION OF BENEFITS (EOB)

A notification issued to the Participant when a health care claim is processed. The EOB shows how the claim was processed.

FAMILY MEMBER

A Dependent who has been enrolled by an enrolled Employee into the Plan and has been accepted as a Participant of the Plan.

FREESTANDING INPATIENT FACILITY

For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorder in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment Center.

Services include medical evaluation and health supervision; Substance Use Disorder education; organized individual, group and family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up program after discharge.

For treatment of Mental Illness, it means a facility licensed by the state and specializing in the treatment of Mental Illness.

GENERIC DRUG

A drug that has the same active ingredient as a Brand-Name Drug and is allowed to be produced after the Brand-Name Drug's patent has expired. In determining the brand or generic classification for covered drugs, the Claim Administrator uses the generic/brand status assigned by a nationally recognized provider of drug product database information. Not all drugs identified as a "generic" by the drug product database, manufacturer, pharmacy or Physician may process as a Generic Drug. Generic Drugs are listed on the Drug List which is available on the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. The Participant may also contact Customer Service for more information.

HABILITATIVE CARE

Coverage will be provided for Habilitative Care services when the Participant requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Other services for people with disabilities.

These services may be provided in a variety of inpatient and/or Outpatient settings as prescribed by a Physician.

HIPAA

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

HOME HEALTH AGENCY

An agency licensed by the state which provides home health care to the Participant in the Participant's home.

HOME HEALTH AIDE

A nonprofessional worker who has been trained for home care of the sick and is employed by a Home Health Agency.

HOME HEALTH SERVICE

The services provided by a Home Health Agency that must be:

1. Prescribed and supervised by the Participant's attending Physician;
2. Provided through a licensed Home Health Agency; and
3. Provided to the Participant in the Participant's home.

HOME INFUSION THERAPY AGENCY

A health care provider that provides home infusion therapy services.

HOSPITAL

A facility providing, by or under the supervision of licensed Physicians, services for medical diagnoses, treatment, rehabilitation, and care of injured, disabled, or sick individuals. A Hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week and provides 24-hour nursing care by licensed registered nurses. Hospital does not include the following, even if such facilities are associated with a Hospital:

1. A nursing home;
2. A rest home;
3. A Convalescent Home; and/or
4. A long-term, chronic-care institution or facility providing the type of care listed above.

ILLNESS

An alteration in the body or any of its organs or parts which interrupts or disturbs the performance of a vital function, thereby causing or threatening pain or weakness.

IN-NETWORK

Providers who are:

1. Participating Blue Cross and Blue Shield of Montana Professional Providers;
2. Participating Blue Cross and Blue Shield of Montana Facility Providers, except for Hospitals and surgery centers;
3. PPO Hospitals and surgery centers;
4. Blue Cross and/or Blue Shield PPO providers outside of Montana; or
5. Participating Pharmacies.

INCLUSIVE SERVICES/PROCEDURES

A portion of a service or procedure which is necessary for completion of the service or procedure or a service or procedure which is already described or considered to be part of another service or procedure.

INDEPENDENT REVIEW ORGANIZATION (IRO)

An organization that offers an independent review and determination of an adverse benefit determination once a Participant has exhausted all internal appeal options available through the health care plan.

INFUSION SUITE

An alternative to Hospital and clinic-based infusion settings where Specialty Medications can be infused.

INJURY

Physical damage to an individual's body, caused directly and independent of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

INPATIENT CARE

Care provided to a Participant who has been admitted to a facility as a registered bed patient and who is receiving services, supplies and medications under the direction of a Covered Provider with staff privileges at that facility. Examples of facilities to which a Participant might be admitted include:

1. Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent Homes; or
5. Freestanding Inpatient Facilities.

INPATIENT PARTICIPANT

A Participant who has been admitted to a facility as a registered bed patient for Inpatient Care.

LEGAL SEPARATION OR LEGALLY SEPARATED

Legal Separation and/or Legally Separated shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

LIFE-THREATENING CONDITION

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MEDICAL FOODS

Nutritional substances in any form that are:

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

MEDICAL OR SCIENTIFIC EVIDENCE

Evidence found in the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's library of medicine for indexing in Index Medicus and Excerpta Medica, published by the Reed Elsevier group;
3. Medical journals recognized by the Secretary of Health and Human Services under 42 U.S.C. 1395x(t)(2)(B) of the federal Social Security Act;
4. The following standard reference compendia:
   a. The American Hospital Formulary Service Drug Information;
   b. Drug Facts and Comparisons;
   c. The American Dental Association Guide to Dental Therapeutics; and
   d. The United States Pharmacopeia;
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
   a. The federal Agency for Healthcare Research and Quality;
   b. The National Institutes of Health;
   c. The National Cancer Institute;
   d. The National Academy of Sciences;
   e. The Centers for Medicare and Medicaid Services;
   f. The Food and Drug Administration; and
   g. Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6. Any other Medical or Scientific Evidence that is comparable to the sources listed in subsection 4 or 5.

MEDICAL POLICY

The policy of the Claim Administrator which is used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

Medical Policy is reviewed and modified periodically as is necessary.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a Covered Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Participant receives the services, supplies, or medications and a claim is submitted to the Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MEDICALLY NECESSARY (FOR AUTISM, ASPERGER'S DISORDER AND PERVASIVE DEVELOPMENTAL DISORDER)

Any care, treatment, intervention, service, or item that is prescribed, provided or ordered by a Physician or psychologist and that will or is reasonably expected to:

1. Prevent the onset of an Illness, condition, Injury, or disability;
2. Reduce or improve the physical, mental, or developmental effects of an Illness, condition, or Injury, or disability; or
3. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

MENTAL HEALTH TREATMENT CENTER

A treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider. The facility must be:

1. Licensed as a Mental Health Treatment Center by the state;
2. Funded or eligible for funding under federal or state law; or
3. Affiliated with a Hospital under a contractual agreement with an established system for patient referral.

MENTAL ILLNESS

A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

1. Present distress or a painful symptom;
2. A disability or impairment in one or more areas of functioning; or
3. A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

Mental Illness does not include:

1. Developmental disorders;
2. Speech disorders;
3. Psychoactive Substance Use Disorders;
4. Eating disorders (except for bulimia and anorexia nervosa); or
5. Impulse control disorders (except for intermittent explosive disorder and trichotillomania).

Mental Health Parity Act of 1996 (MPHA) and Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA.

"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1) The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2) There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such plan.
3) The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominate treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or Coverage).
4) There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

MONTH

For the purposes of this Plan Document, a Month has 30 days even if the actual calendar Month is longer or shorter.

MULTIDISCIPLINARY TEAM

A group of health service providers who are either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. Members of the Multidisciplinary Team may include, but are not limited to, a licensed psychologist, licensed speech therapist, registered physical therapist, or licensed occupational therapist.

NEGOTIATED ARRANGEMENT

An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

NON-PREFERRED BRAND-NAME DRUG

A Brand-Name Drug that is identified on the Drug List as a Non-Preferred Brand-Name Drug. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists..

NON-PREFERRED GENERIC DRUG

A Generic Drug that is identified on the Drug List as a Non-Preferred Generic Drug. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists..

NON-PREFERRED SPECIALTY MEDICATION

A Specialty Medication, which may be a Generic or Brand-Name Drug, that is identified on the Drug List as a Non-Preferred Specialty Medication. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

OCCUPATIONAL THERAPY

Therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of speech tasks or goal-directed activities designed to improve the functional performance of an individual.

OUT-OF-NETWORK

Providers who are:

1. Nonparticipating professional providers;
2. Nonparticipating facility providers;
3. Non-PPO Network Hospitals and surgery centers; or
4. Blue Cross and Blue Shield of Montana Participating Hospitals and surgery centers that are not in the PPO Network.

OUT OF POCKET AMOUNT

For the Participant:

The total amount of applicable Deductible, Copayment and/or Coinsurance a Participant must pay for Covered Medical Expenses incurred during the Benefit Period. Once the Participant has satisfied the applicable Out of Pocket Amount, the Participant will not be required to pay the Participant's applicable Deductible, Copayment and/or Coinsurance for Covered Medical Expenses for the remainder of that Benefit Period. The Out of Pocket Amount for the Participant is listed in the Schedule of Benefits.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, the applicable Deductible, Copayment and/or Coinsurance for the entire Hospital stay (facility charges only) will only apply to the applicable Out of Pocket Amount of the Benefit Period in which the inpatient stay began. If the Participant satisfied the Out of Pocket Amount prior to that Hospital stay, no applicable Deductible, Copayment and/or Coinsurance will be applied to that stay.

Non-covered services, the amount the Participant pays for the difference between a Brand-Name Drug and the Generic Drug equivalent and amounts over the allowed amount billed by a nonparticipating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

For the Family:

The total amount of applicable Deductible, Copayment and/or Coinsurance for Covered Medical Expenses a family must pay for services incurred during that Benefit Period. Once the applicable Deductible, Copayment and/or Coinsurance paid by the Participant during the Benefit Period for two or more Family Members covered under the same family total the applicable Out of Pocket Amount for the family, the Participants covered under the same family will not be required to pay the applicable Deductible, Copayment and/or Coinsurance for Covered Medical Expenses the remainder of that Benefit Period. The Out of Pocket Amount for the family is listed on the Schedule of Benefits. For family coverage when only two Participants are enrolled, the two Participants each must meet their Individual Out of Pocket Amounts.

Non-covered services, the amount the Participant pays for the difference between a Brand-Name Drug and the Generic Drug equivalent and amounts over the allowed amount billed by a nonparticipating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

OUT OF POCKET AMOUNT (PRESCRIPTION DRUGS BENEFIT)

For the Participant:

The total amount of Copayments and Coinsurance a Participant must pay for covered prescription drugs incurred during the Benefit Period. Once the Participant has satisfied the Out of Pocket Amount, the Participant will not be required to pay that Participant's Copayment for covered prescription drugs for the remainder of that Benefit Period. The Out of Pocket Amount for the Participant is listed in the Schedule of Benefits.

For the Family:

The total amount of Copayments and Coinsurance for covered prescription drugs a family must pay during that Benefit Period. Once the Copayment paid by the Participant during the Benefit Period for two or more Family Members covered under the same family total the Out of Pocket Amount for the family, the Participants covered under the same family will not be required to pay the Copayment for covered prescription drugs for the remainder of that Benefit Period. The Out of Pocket Amount for the family is listed on the Schedule of Benefits.

OUTPATIENT

Services or supplies provided to the Participant by a Covered Provider while the Participant is not an Inpatient Participant.

PARTIAL HOSPITALIZATION

A time-limited ambulatory (Outpatient) program offering active treatment which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

A Partial Hospitalization program should offer four to eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PARTICIPANT

An eligible Employee or Eligible Family Member who has applied for participation in accordance with the section entitled Eligibility and Coverage, has been accepted as a participant of the Plan, and maintains participation in the Plan.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA FACILITY PROVIDER

A facility which has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana and may include, but is not limited to, Hospitals, Home Health Agencies, Convalescent Homes, skilled nursing facilities, Freestanding Inpatient Facilities and freestanding surgical facilities. Please read the section entitled Providers of Care for Participants.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA PROFESSIONAL PROVIDER

A provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana and may include, but is not limited to, Physicians, physician assistants, nurse specialists, dentists, podiatrists, speech therapists, physical therapists and occupational therapists. Please read the section entitled Providers of Care for Participants.

PARTICIPATING PHARMACY

A Pharmacy which has entered into an agreement with the Claim Administrator or a third party on behalf of the Claim Administrator to provide Prescription Drug Products to Participants and has agreed to accept specified reimbursement rates.

PARTICIPATING PROVIDER

A provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana.

PHARMACY

A state and federally licensed entity that is physically separate and apart from any provider's office, and where legend drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he or she practices.

PHARMACY BENEFIT MANAGER

The company with whom the Claim Administrator has entered into an agreement for the processing of prescription drug claims.

PHYSICAL THERAPY

Treatment of a disease or Injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and pain relief.

PHYSICIAN

A person licensed to practice medicine in the state where the service is provided.

PLAN

The health benefit plan for Employees of the company, the Plan Document, or any other relevant documents pertinent to the operation and maintenance of the Plan.

PLAN ADMINISTRATOR

The company and/or its designee who is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purpose of the Employee Retirement Income Security Act of 1974, as amended, and any applicable state legislation of a similar nature, the company will be deemed to be the Plan Administrator of the Plan unless by action of the board of directors, the company designates an individual or committee to act as Plan Administrator of the Plan.

PLAN BENEFIT YEAR

The period specified as the Benefit Period in the Schedule of Benefits.

PLAN DOCUMENT

This document which sets forth and governs the rights and duties of the Plan Sponsor, Plan Administrator, Claim Administrator, and Participants under the Plan and modified by any policies, interpretations, rules, practices, and procedures made by the Sponsor.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

PPO-A PREFERRED PROVIDER ORGANIZATION

A provider or group of providers which have contracted with Blue Cross and Blue Shield of Montana to provide services to Participants covered under PPO Benefit contracts.

PPO NETWORK

A provider or group of providers which have a PPO contract with Blue Cross Blue Shield of Montana. The Participant may obtain a list of PPO providers from Blue Cross and Blue Shield of Montana upon request.

PREFERRED BRAND-NAME DRUG

A Brand-Name Drug that is identified on the Drug List as a Preferred Brand-Name Drug. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PREFERRED GENERIC DRUG

A Generic Drug that is identified on the Drug List as a Preferred Generic Drug. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PREFERRED SPECIALTY MEDICATION

A Specialty Medication, which may be a Generic or Brand-Name Drug, that is identified on the Drug List as a Preferred Specialty Medication. The Drug List is available by accessing the Claim Administrator's website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PRESCRIPTION DRUG PRODUCT

A medication, product or device approved by the FDA.

PRIOR AUTHORIZATION

The process that determines in advance the Medical Necessity or Experimental/Investigational/Unproven nature of certain care and services under the Plan Document. Prior Authorization is used to inform the Participant whether or not a proposed service, medication, supply, or on-going treatment is Medically Necessary and is a Covered Medical Expense of the Plan Document.

Prior Authorization does not guarantee that the care and services a Participant receives are eligible for Benefits under the Plan Document. At the time the Participant's claims are submitted, they will be reviewed in accordance with the terms of the Plan Document.

PROFESSIONAL CALL

An interview between the Participant and the professional provider in attendance. The professional provider must examine the Participant and when appropriate provide or prescribe medical treatment. Professional Call does not include telephone calls or any other communication where the Participant is not examined by the professional provider, except as included in the Benefit[s] section entitled Telehealth.

PROOF OF LOSS

The documentation accepted by the Claim Administrator upon which payment of Benefits is made.

PROVIDER INCENTIVE

An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

QUALIFIED HEALTH CARE PROVIDER

A person licensed as a Physician, audiologist, psychologist, social worker, clinical professional counselor, marriage and family therapist, or addiction counselor or another appropriate licensed health care practitioner.

QUALIFIED INDIVIDUAL (FOR AN APPROVED CLINICAL TRIAL)

An individual with group health coverage or group or individual health insurance coverage who is eligible to participate in an Approved Clinical Trial according to the trial protocol for the treatment of cancer or other Life-Threatening Condition because:

1. The referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate; or
2. The individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

RANDOMIZED CLINICAL TRIAL

A controlled, prospective study of patients who have been assigned at random to an experimental group or a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention. The term includes a study of the groups for variables and anticipated outcomes over time.

RECOMMENDED CLINICAL REVIEW

An optional voluntary review of a provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to determine whether the procedure, treatment or test meets approved Claim Administrator Medical Policy guidelines and Medical Necessity requirements.

RECONSTRUCTIVE BREAST SURGERY

Surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

RECOVERY CARE BED

A bed occupied in an Outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATION FACILITY

A facility, or a designated unit of a facility, licensed, certified or accredited to provide Rehabilitation Therapy including:

1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or a facility associated or co-located with a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital; and/or
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Participant, regardless of the category of facility licensure.

REHABILITATION THERAPY

A specialized, intense and comprehensive program of therapies and treatment services (including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy) provided by a Multidisciplinary Team for treatment of an Injury or physical deficit. A Rehabilitation Therapy program is:

1. Provided by a Rehabilitation Facility in an Inpatient Care or Outpatient setting;
2. Provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;
3. Designed to restore the patient's maximum function and independence; and/or
4. Medically Necessary to improve or restore bodily function and the Participant must continue to show measurable progress.

REHABILITATIVE CARE

Coverage will be provided for Rehabilitative Care services when the Participant requires help to keep, recover or improve skills and functioning for daily living that have been lost or impaired because the Participant was sick, hurt or disabled. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Psychiatric rehabilitation.

These services may be provided in a variety of inpatient and/or Outpatient settings as prescribed by a Physician.

RESIDENTIAL TREATMENT CENTER

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure Medically Necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a residential treatment facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long-term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

ROUTINE

Examinations or services provided when there is no objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any Injury or Illness.

ROUTINE PATIENT COSTS

All items and services covered by a group health plan or a plan of individual or group health insurance coverage when the items or services are typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. The term does not include:

1. An investigational item, device, or service that is part of the trial;
2. An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis.

SPECIALTY MEDICATIONS

Specialty Medications are used to treat complex medical conditions and are typically given by injection, but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail Pharmacies. Some conditions such as hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with Specialty Medications.

SPECIALTY PHARMACY

A Pharmacy which has entered into an agreement with the Claim Administrator or a third party on behalf of the Claim Administrator to provide Specialty Medications to Participants and which has agreed to accept specified reimbursement rates.

SPEECH THERAPY

Speech Therapy is the treatment of communication impairment and swallowing disorders.

SPOUSE

The opposite sex or the same sex person to whom the Employee cohabitates and is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

SUBSTANCE USE DISORDER

The uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a licensed addiction counselor or other appropriate medical practitioner.

Mental Health Parity Act of 1996 (MPHA) and Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA.

"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1) The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2) There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such plan.
3) The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominate treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or Coverage).
4) There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

SUBSTANCE USE DISORDER TREATMENT CENTER

A treatment facility that provides a program for the treatment of an individual's Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider. The treatment facility must be licensed or approved as a Substance Use Disorder Treatment Center by the Department of Health and Human Services or must be licensed or approved by the state where the facility is located.

SUPPLEMENTAL BREAST EXAMINATION

A Medically Necessary and appropriate examination of the breast, including breast magnetic resonance imaging or breast ultrasound, that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person's risk of breast cancer.

TELEHEALTH

The use of audio, video, or another telecommunications technology or media, including audio-only communication that is:

1. Used by a health care provider or health care facility to deliver health care services; and
2. Delivered over a secure connection that complies with state and federal laws.

Telehealth does not include delivery of health care services by means of facsimile machine or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

TREATMENT OF INFERTILITY

The use of methods which do not correct the inability to conceive but create the conditions for conception by stimulating the natural reproductive system or by implantation.

URGENT CARE

Urgent Care services are considered treatment in any setting that, if delayed, could seriously jeopardize the Participant's life and health or ability to regain maximum function or would subject the Participant, in the opinion of a health care provider with knowledge of the Participant's medical condition, to severe pain that cannot be adequately managed without the service or treatment.

IN WITNESS WHEREOF, the Employer has caused this Plan to be duly executed, effective as of the Plan's Effective Date.

Yellowstone County

By: _____

Title: _____

Date: _____

Yellowstone County Employees Health Plan
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY YELLOWSTONE COUNTY AND OUR CLAIMS ADMINISTRATOR AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We recognize the importance of maintaining the confidentiality and security of your protected health information. Whether it is your medical information or personally or individually identifiable information (such as your name, address, telephone number, or member identification number), we maintain safeguards to protect you against unauthorized access, use, or disclosure.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. We hope that this notice will clarify our responsibilities to you and provide you with an understanding of your rights. We will abide by the terms of the notice currently in effect.

This notice is effective July 1st, 2006.

Permitted Uses and Disclosures of Your Protected Health Information without an Authorization

In administering your health benefits, we and our claims administrator use and disclose your protected health information in a number of ways. The following examples list some of the uses and disclosures we are permitted by law to make without your authorization:

Treatment. We may use or disclose your protected health information to health care providers (such as doctors, hospitals, or pharmacists) in order for them to provide treatment or services to you. We may also disclose your protected health information to health care providers in our effort to provide you with preventive health, early detection, and case management programs.

Payment. We may use or disclose your protected health information to:

- Pay claims
- Determine your eligibility for benefits
- Coordinate benefits, care, or other services
- Determine medical necessity, care appropriateness, or charge justification
- Obtain premiums
- Issue Explanations of Benefits (EOB)

Health Care Operations. We may use or disclose your protected health information in connection with our health care operations. Examples of health care operations include, but are not limited to:

- Quality assessment and improvement activities
- Case management
- Reviewing the competence or qualifications of health care providers
- Fraud and abuse detection and compliance programs
- Performance measurement and outcome assessments
- Responses to inquiries, complaints, appeals, or external reviews
- Business planning and development
- Creating de-identified protected health information or limited data sets
- Training our employees and/or our Business Associates when other methods are not available

Health-Related Services. We may provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. This may include enhancements to a health plan and health-related products or services available only to a health plan member that add value to but are not part of, a benefit plan.

Payment and Health Care Operations of Other Covered Entities. We may use or disclose your protected health information to another covered entity for its payment purposes. We may also use or disclose your protected health

information to another covered entity for purposes of its health care operations if the other covered entity has or had a relationship with you. For example, we may facilitate payment of services under another health plan.

Business Associates. We contract with individuals and other entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these services, Business Associates may receive, create, maintain, use, or disclose protected health information, but only if the Business Associate has agreed in writing to safeguard your protected health information. For example, we may disclose your protected health information to a Business Associate to provide case management or pharmacy benefits. Our Business Associates can only use or disclose your protected health information as allowed by law.

Additional Uses Or Disclosures Permitted Without an Authorization

Required by Law. We may use or disclose your protected health information as required by state or federal law, including disclosing your protected health information to you.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law such as audits, investigations, inspections, licensure, or disciplinary actions, or civil, administrative, or criminal proceedings or actions. Examples of oversight agencies include State Commissioner of Insurance, U.S. Department of Health and Human Services, the U.S. Department of Labor, and the U.S. Food and Drug Administration.

Legal Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to a court order or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process.

Public Health Activities. We may use or disclose your protected health information to an authorized authority for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

Abuse, Neglect, or Domestic Violence. We may disclose your protected health information to a government authority concerning abuse, neglect, or domestic violence.

Law Enforcement. We may disclose your protected health information to law enforcement officials for law enforcement purposes. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness, or missing person or as necessary to provide information concerning victims of crimes.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation. We may disclose your protected health information, in certain circumstances, to a coroner or medical examiner during their investigations. We may also disclose protected health information to funeral directors to carry out their duties. Further, we may disclose your protected health information to organizations that handle donations of organs, eyes, or tissue and transplantations. For example, if you are an organ donor, we can release records to an organ donation facility.

Research. We may use or disclose your protected health information for research purposes when certain established measures are taken to protect your privacy. For example, we may disclose protected health information to a teaching university to conduct medical research.

To Prevent a Serious Threat to Health or Safety. We may use or disclose your protected health information to the extent necessary to avoid a serious and imminent threat to your health or safety or to the health or safety of others. Military Activity and National Security. We may disclose your protected health information to armed forces personnel under certain circumstances (e.g., for active duty, at separation of or termination from active duty, for veterans administration, and for foreign service personnel), and to authorized federal officials for national security and intelligence activities.

Correctional Institutions. If you are an inmate, we may disclose your protected health information to your correctional facility to help provide you health care or to ensure the safety of yourself or others.

Workers' Compensation. We may use or disclose your protected health information as required by workers' compensation laws.

Newsletters/Communications. We may use protected health information for newsletters concerning topics such as wellness, and for informing you of value-added products/services or other health-related products or services.

Disclosures of Your Protected Health Information with Your Informal Permission or Authorization

Others Involved in Your Health Care. If you give us verbal permission or if your permission can be implied, for example, during an emergency and while you are unconscious, we may disclose information to a family member or others who call on your behalf. The kind of information we will disclose in such a circumstance is the status of your enrollment or of a claim, amount paid, and payment date. We will not disclose medical information such as diagnosis without a written authorization.

Authorizations. You may give us written authorization to use your protected health information or to disclose it to anyone for any other purpose. Authorizations may be valid for up to two years unless you provide a written request to revoke the authorization. You may revoke an authorization at any time, but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your protected health information for any reason except those described in this notice.

Your Rights

Right to Inspect and Copy. You have the right to look at or get copies of protected health information contained in a "designated record set" with limited exceptions. A designated record set is a group of records that are used to administer your health benefits. This includes enrollment, claims adjudication, or case, or medical management records. To exercise your right, you must submit your request in writing to the address listed at the end of this notice or you may obtain a form to complete by calling the telephone number at the end of this notice. If you prefer, we will prepare a summary of this information. We may charge you a reasonable cost-based fee for costs associated with your request.

Right to Amend. You have the right to ask us to amend any protected health information contained in a designated record set if you believe it is incorrect or incomplete. Your request must be in writing and sent to the address provided in this notice. Additionally, your request should include the reason the amendment is necessary.

We do not amend records in the following circumstances:

- We do not have the information you requested.
- We did not create the records you want amended.
- We have determined the records are accurate and correct.
- The records are covered by the Federal Clinical Laboratory Improvement Act.
- The records have been compiled in anticipation of a civil, criminal, or administrative action or proceeding.

Right to an Accounting. You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations, or disclosures which are not otherwise authorized by you. You should know that most disclosures of protected health information are for treatment, payment, or health care operations, or by your authorization. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed and the purpose of the disclosure.

Your request for an accounting must be submitted in writing to the address listed in this notice. If you request an accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for the additional requests.

The requirement that we provide you with information about the times we have disclosed your protected health information applies for six years from the date of the disclosure. This applies only to disclosures made after April 14, 2003.

Right to Request a Restriction. You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Your request for restriction must be submitted in writing to the address listed in this notice.

Right to Request Confidential Communication. You have the right to request confidential communication of your protected health information if you believe that a disclosure of all or part of your protected health information may endanger you. We will make every effort to accommodate your request if it is reasonable and you provide an alternate manner or location for receiving our communications.

Although we may agree to confidential communications, you should know that accumulated deductibles, Copayment and/or Coinsurances may appear on the Plan Document, which may contain sufficient information to reveal that you obtained health care services for which we paid.

You may exercise your right to confidential communication by contacting us. For our records, we will need your You may exercise your right to confidential communication by contacting us. For our records, we will need your request in writing.

Right to a Paper Copy of This Notice. If you view this notice on our website or receive it by e-mail, you have a right to a paper copy of this notice by contacting us at the telephone number listed in this notice.

Right to File a Complaint. You have the right to file a complaint if you think we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information. You may file a complaint by:

1. Calling: 406-256-2705
2. Filing a written complaint at:

   Yellowstone County Human Resources
   P. O. Box 35041
   Billings, MT 59107

3. Notifying the Secretary of the U.S. Department of Health and Human Services (HHS).

Please be assured that we will not take retaliatory action against you if you file a complaint about our privacy practices.

Future Changes

Although we follow the privacy practices described in this notice, you should know that we may change our privacy practices at any time. For example, if privacy laws change, we will change our practices to comply with the law. Should this occur we will send a new notice to you prior to making a significant change in our practices; and the changes will apply to all protected health information we have in our possession, including any information created or received before we changed the notice.

WRITTEN NOTICE OF THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) AS REQUIRED BY FEDERAL LAW.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined by the Plan in consultation with the attending physician and the patient, for:

1) All stages of reconstruction of the breast on which a mastectomy has been performed.
2) Surgery and reconstruction of the other breast to establish a symmetrical appearance.
3) Chemotherapy.
4) Prostheses and physical complications of all stages of a mastectomy and breast reconstruction, including lymphedemas.

These benefits will be provided subject to any deductible, Copayment and/or Coinsurance provisions of your health plan. For specific deductible, Copayment and/or Coinsurance information on your plan, please refer to your schedule of benefits.

For further information about this notice or the benefits provided under WHCRA, please contact Customer Service at 1-855-258-3489 or visit the Claim Administrator's Website http://www.bcbsmt.com.

WRITTEN NOTICE OF THE COVERAGE FOR MINIMUM HOSPITAL STAYS FOLLOWING CHILDBIRTH AS REQUIRED BY THE MONTANA INSURANCE CODE AND FEDERAL LAW.

Health insurance for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient care, following delivery by cesarean section for a mother and newborn infant in a health care facility.

Any decision to shorten the length of inpatient stay to less than that stated above must be made by the attending health care provider and the mother. A health benefit plan may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with these provisions. Under this same requirement a health plan may not require that the provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

A health benefit plan that provides coverage for post-delivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care unless the inpatient care is determined to be medically necessary by the attending health care provider.

For further information about this notice, please contact Customer Service at 1-855-258-3489 or visit the Claim Administrator's Website http://www.bcbsmt.com.

PLAN DOCUMENT
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of the Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Plan Document to which this Amendment is attached and becomes a part of the Plan Document. Unless otherwise required by Federal or Montana law, in the event of a conflict between the terms on this Amendment and the terms of the Plan Document, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to 'You' and 'Your' mean any Participant, including Subscriber and Dependents.

The Plan Document is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of an in-network Provider as defined in the Plan Document who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the in-network Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Plan Document.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section II. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Plan Document and this Amendment, those terms will apply only to their use in the Plan Document or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a

condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- covered services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSMT for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSMT for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Participant) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Participant) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. <u>Federal No Surprises Act Surprise Billing Protections</u>

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or Out of Pocket Amount, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323, Menu

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)



Blue Cross and Blue Shield of Montana
3645 Alice Street, Helena, MT 59601
P.O. Box 660255
Dallas, TX 75266-0255

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

®Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

B.O.C.C. Regular **4. b.**

Meeting Date: 10/21/2025

Title: PAR

Submitted By: Teri Reitz, Board Clerk

TOPIC:

PERSONNEL ACTION REPORT - Detention Facility - 1 Appointment

BACKGROUND:

See attached.

RECOMMENDED ACTION:

Approve.

Attachments

PAR

Yellowstone County Commissioners
RECEIVED

OCT 16 2025

Employer logo

Hire/Personnel Action Form

Employee Information

Employee
Elijah Daniels

Hire Information

Position Details Detention Officer (D) (5090)	Hire Req# 202500314	Job Type Full-Time Regular
Person ID 64385903	Job Class Detention Officer (D)	Pay Rate $24.67
Department Sheriff's Office	Job Class# 5090	HireDate 10/27/25
Division Detention Facility		

Comments

Funding: 2300.136.420200.111 @ 100%
replaces: Rios

Approvals

HUMAN RESOURCES	Kevin Gillen	10/16/25 7:14 AM
FINANCE	JENNIFER JONES	10/16/25 7:15 AM

Commissioners Action

	Approve	Disapprove
Chair	MH	____
Member	MSW	____
Member	____	____

B.O.C.C. Regular
Meeting Date: 10/21/2025
Title: Checks and Disbursements for September 2025
Submitted By: Teri Reitz, Board Clerk

TOPIC:
Checks and Disbursements for September 2025

BACKGROUND:
See attached.

RECOMMENDED ACTION:
Place to file.

Attachments

Checks and Disbursements for September 2025

Yellowstone County Commissioners
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OCT 09 2025

13th Judicial District Court, Yellowstone County
Report of Jury Service Costs and Monthly Reimbursement Summary for September-25

Total Transactions (See Attached Transaction Report):	**$6,063.15**
Less Voided Items	$0.00
	$0.00
	$0.00
	$6,063.15

Adjustments to Total Transactions:

Jury Meals:

9/30/2025

Total paid to Jimmy John's	$	131.58
Reduced for Juror Tip/Bailiff Meals	$	(37.56)
Amount over allowable total to be reimbursed	$	94.02

Subtotal **$ 94.02**

Postage Reimbursements (Witness & Juror Summons/Payments):

DC 23-1537	**9/1/2025**	State of Montana vs	Justin Wade Cary	$127.60
DC 24-863	**9/29/2025**	State of Montana vs	April Dawn Sheehan	$216.04
		State of Montana vs		
		State of Montana vs		
		State of Montana vs		
		State of Montana vs		
		State of Montana vs		
		Subtotal		**$343.64**

Supplies Reimbursements (Mailing Supplies):

DC 23-1537	**9/1/2025**	**0**	State of Montana vs	Justin Wade Cary	$43.32
DC 24-863	**9/29/2025**	**0**	State of Montana vs	April Dawn Sheehan	$59.54
		0	State of Montana vs	0	
		0	State of Montana vs	0	
		0	State of Montana vs	0	
		0	State of Montana vs	0	
		0	State of Montana vs	0	
			Subtotal		**$102.86**

Total Adjustments: **$540.52**

Total Reimbursement Requested for: **September-25** **$6,603.67**

Review by: _____
Clerk of District Court

Prepared by: VMILLER

YELLOWSTONE COUNTY DISTRICT COURT
Transaction Listing
From 09/01/2025 to 09/30/2025
General Ledger Accounts 200-1300 through 200-1365
Totals Only

Date		Account		Debit Amount	Credit Amount
Posted on	**9/12/2025**	200-1300- Jury Fees/Mileage		$ 2,675.20	
		200-1325- Jury Meals		$ -	
		200-1350- Jury Accomodations		$ -	
	(July)	200-1355- Jury Parking		$ 442.50	
		200-1360-Jury Transportation		$ -	
		200-13650 Jury Supplies		$ -	
		Total For	**9/12/2025**	**$ 3,117.70**	$ -
Posted on	**8/30/2025**	200-1300- Jury Fees/Mileage		$ -	
		200-1325- Jury Meals		$ -	
		200-1350- Jury Accomodations		$ -	
	(August)	200-1355- Jury Parking		$ 421.25	
		200-1360-Jury Transportation		$ -	
		200-13650 Jury Supplies		$ -	
		Total For	**8/30/2025**	**$ 421.25**	$ -
Posted on	**9/29/2025**	200-1300- Jury Fees/Mileage		$ 2,524.20	
		200-1325- Jury Meals		$ -	
		200-1350- Jury Accomodations		$ -	
		200-1355- Jury Parking		$ -	
		200-1360-Jury Transportation		$ -	
		200-13650 Jury Supplies		$ -	
		Total For	**9/29/2025**	**$ 2,524.20**	$ -
		Total Transactions		**$ 6,063.15**	$ -

Check Register Number Range

For Bank Account: Jury Funds - 9705883054925
FROM: 932129 TO: 932196

Check Number	Check Date	Payee	Amount	Status	Cleared Date
932129	09/22/2025	ANDERSON JANEIL EVA	$34.40	Outstanding	
932130	09/22/2025	ANDERSON MIRANDA JO	$13.40	Outstanding	
932131	09/22/2025	BAILEY TRAVIS RAY	$38.60	Outstanding	
932132	09/22/2025	BENTLEY RANDY W	$20.40	Outstanding	
932133	09/22/2025	BRADLEY CODY JOE	$21.80	Outstanding	
932134	09/22/2025	BRADY KORTNEY LOUISE	$19.00	Outstanding	
932135	09/22/2025	BREWINGTON GRACE YVONNE	$26.00	Outstanding	
932136	09/22/2025	BUSHMAN JANIS MARIE	$17.60	Outstanding	
932137	09/22/2025	BUTT TAD	$26.00	Outstanding	
932138	09/22/2025	CHANDLER SHERI LYNN	$17.60	Outstanding	
932139	09/22/2025	CHRISTMAN DEREK JOSEPH	$17.60	Outstanding	
932140	09/22/2025	CROWDER SHAYN	$17.60	Outstanding	
932141	09/22/2025	DANIELSON BAILEY	$20.40	Outstanding	
932142	09/22/2025	DOLAN STEVEN MICHAEL	$13.40	Outstanding	
932143	09/22/2025	EATON KRISTIN ALYSS	$17.60	Outstanding	
932144	09/22/2025	ELLIOTT ABBY PATRICE	$17.60	Outstanding	
932145	09/22/2025	FEUERSTEIN RHONDA D	$121.20	Outstanding	
932146	09/22/2025	FRAKER JOHN W	$17.60	Outstanding	
932147	09/22/2025	FRANK SCOTT HENRY	$34.40	Outstanding	
932148	09/22/2025	FRANK SYDNEY MORGAN	$20.40	Outstanding	
932149	09/22/2025	FUST ARTHUR NORMAN	$91.80	Outstanding	
932150	09/22/2025	GREEN SHERIDAN JAY	$24.60	Outstanding	
932151	09/22/2025	GREGOR LORRI	$21.80	Outstanding	
932152	09/22/2025	HALLETT ROBIN JACOB	$17.60	Outstanding	
932153	09/22/2025	HANEBURY BRIDGET SOPHIA	$87.60	Outstanding	
932154	09/22/2025	HECK SHAWN MICHAEL	$35.80	Outstanding	
932155	09/22/2025	IRWIN SUSAN M	$16.20	Outstanding	
932156	09/22/2025	JACKSON JOHN J	$21.80	Outstanding	
932157	09/22/2025	KELLER LAURENA	$100.20	Outstanding	
932158	09/22/2025	KUNTZ JASON GEORGE	$14.80	Outstanding	
932159	09/22/2025	LABORDA PASCUAL R	$16.20	Outstanding	
932160	09/22/2025	LUOMA KENNETH A	$16.20	Outstanding	
932161	09/22/2025	MARTINSKLANKE LISA	$14.80	Outstanding	
932162	09/22/2025	MCDONALD TARA COLLEEN	$20.40	Outstanding	
932163	09/22/2025	MEIER AMY LYNN	$133.80	Outstanding	
932164	09/22/2025	MERRITT MICHAELA LEEANN	$33.00	Outstanding	
932165	09/22/2025	MILLER WESLEY GENE	$17.60	Outstanding	
932166	09/22/2025	MOORE JENNIFER	$19.00	Outstanding	
932167	09/22/2025	NELSON COLBY S	$21.80	Outstanding	
932168	09/22/2025	ODONNELL ALLISON	$13.40	Outstanding	
932169	09/22/2025	OLSEN DONALD JAMES	$17.60	Outstanding	
932170	09/22/2025	OPHEIM JENNIFER JO	$87.60	Outstanding	
932171	09/22/2025	OWENS ASHTON ANTHONY	$23.20	Outstanding	

Check Register Number Range

For Bank Account: Jury Funds - 9705883054925
FROM: 932129 TO: 932196

Check Number	Check Date	Payee	Amount	Status	Cleared Date
932172	09/22/2025	PALMER STEVEN JAMES	$87.60	Outstanding	
932173	09/22/2025	RACHAC GREGORY EDWARD	$17.60	Outstanding	
932174	09/22/2025	REESE TERRY ALAN	$14.80	Outstanding	
932175	09/22/2025	REICHENBACH HALEY ELIZABETH	$16.20	Outstanding	
932176	09/22/2025	REIF SHAY N	$42.80	Outstanding	
932177	09/22/2025	ROLLER GARY LEE	$104.40	Outstanding	
932178	09/22/2025	RUBIN SAMUEL SCOTT	$125.40	Outstanding	
932179	09/22/2025	SALA SHERI L	$13.40	Outstanding	
932180	09/22/2025	SCALA TRISTAN GIOVANNI	$20.40	Outstanding	
932181	09/22/2025	SCANLAN JESSICA J	$34.40	Outstanding	
932182	09/22/2025	SCHAAK CHANDLER JEFFREY	$17.60	Outstanding	
932183	09/22/2025	SCHMITZ JESSICA	$100.20	Outstanding	
932184	09/22/2025	SCOTT LYNETTE ELOISE	$27.40	Outstanding	
932185	09/22/2025	SEIDL SUSAN M	$87.60	Outstanding	
932186	09/22/2025	SELLE JUDY	$42.80	Outstanding	
932187	09/22/2025	SHUCK KYLE MATHEW	$27.40	Outstanding	
932188	09/22/2025	STENE WILLIAM SCOTT	$26.00	Outstanding	
932189	09/22/2025	TELFORD MICHAEL KEITH	$23.20	Outstanding	
932190	09/22/2025	THOMASMILLHOUSE JERI LYNN	$100.20	Outstanding	
932191	09/22/2025	TOWNSEND NICHOLAS K	$23.20	Outstanding	
932192	09/22/2025	TRAUTMANN SARA ELIZABETH	$121.20	Outstanding	
932193	09/22/2025	TROST CALEB MICHAEL	$21.80	Outstanding	
932194	09/22/2025	TROWBRIDGE MARCY K	$23.20	Outstanding	
932195	09/22/2025	TWICHEL KENNETH K	$138.00	Outstanding	
932196	09/22/2025	URQUIDI RAYCHAELANNE JOY	$19.00	Outstanding	
Totals	**Number of Checks: 68**		**Total:** **$2,675.20**		

Check Register Number Range

For Bank Account: Jury Funds - 9705883054925
FROM: 932197 TO: 932197

Check Number	Check Date	Payee		Amount	Status	Cleared Date
932197	09/23/2025	CITY OF BILLINGS		$863.75	Outstanding	
Totals	**Number of Checks: 1**		**Total:**	**$863.75**		

B.O.C.C. Regular
Meeting Date: 10/21/2025
Title: Board Minutes
Submitted By: Erika Guy

TOPIC:
Board Minutes - Tax Appeal Board 10/14/25

BACKGROUND:
See Attached

RECOMMENDED ACTION:
File

Attachments

Minutes
Org Meeting

Yellowstone County Tax Appeal Board

Physical Address:
316 N 26th Street Rm 3101
Billings, MT 59101

Mailing Address:
PO Box 35000
Billings, MT 59107-5000

Yellowstone County Tax Appeal Board

MINUTES

COUNTY: Yellowstone County
PLACE: BOCC Board Room

DATE: October 14th, 2025
TIME: 1:00pm-1:48pm
*SHOW RECESS AND RECONVENTION

BOARD MEMBERS PRESENT:
J.R. Reger
Hanna Wagner
Dan Cohn

SECRETARY:
Erika Guy

HEARINGS HELD:

1:00pm	Docket #A-04-24 A-05-25 A-06-25	Ewalt

DECISIONS MADE:

Docket #A-04-25/C01246	Ewalt	Adjusted
Docket #A-05-25/C01245	Ewalt	Adjusted
Docket #A-06-25/C01244	Ewalt	Adjusted

Docket #A-04-25, A-05-25 & A-06-25:
Motion made by Hanna Wagner to adjust tax code C01246 from $27,763 to $20,000, C01245 from $27,026 to $20,000 & C01244 from $27,000 to $20,000. Seconded by J.R. Reger. Motion passed unanimously.

SIGNED:

J.R. Reger, Chair

2131 Willet
1 of 3 lots appeal

Yellowstone County Commissioners
RECEIVED
AUG 18 2025

C01246

APPEAL TO THE COUNTY APPEAL TAX BOARD

MTAB-401

Complete this document to appeal a property tax classification or assessment set by the Montana Department of Revenue (DOR). This appeal must be filed with the County Clerk and Recorder of the county where the property is located. This appeal will be heard by that county's Tax Appeal Board (CTAB). The County Tax Appeal Board is not part of the Department of Revenue.

FOR COUNTY APPEAL TAX BOARD USE

Docket Number: A-04-25
Date Filed: 8/18/25
Received by: Erika G.

Only one appeal may be made in each two-year appraisal cycle. The date your appeal is due depends on whether you went through the AB-26 informal review process with DOR.

If you did NOT file an AB-26.	OR	If you went through the AB-26 process.
The county Clerk and Recorder must **receive** your appeal within 30 days from the **date on the DOR's notice of tax classification or assessment.**		The county Clerk and Recorder must **receive** your appeal within 30 days from the **date on the final AB-26 decision sent by Montana Dept. of Revenue.**

If your appeal is received late it will not be considered. If your property taxes are due before the appeal is resolved, you must pay them under protest if you want them refunded to you.

If you refuse to allow DOR to inspect your property for appraisal you must submit an appraisal conducted by a licensed appraiser who is in good standing and certified in Montana. If you do not, the county and state tax appeal boards cannot revise your valuation.

Name	Francis A Ewalt, trustee & Laure F Ewalt, trustee			
Taxpayer Name	Francis Ewalt			
Property County	Yellowstone			
Address	2131 Phoebe DR			
City	Billings	**State**	MT	**Zip** 59105
Email	ltiewired@gmail.com	**Phone**	406-861-8964	

Was an AB-26 Form filed with the Dept. of Revenue?

Select One: ○ No ● Yes Decision Date: August 8, 2025

APPEAL TO THE COUNTY APPEAL TAX BOARD

MTAB-401

Legal Description of Property:

Street Address	2131 Willet	**No. of Acres**	.25
Lot(s)	Lot 11	**Section**	S15
Block(s)	1	**Township**	T01N
Addition / Subdiv.	Meadowlark Sub.	**Range**	R26
City / Town	Billings	**GEOCode**	03-1033-15-2-20-11-0000

	Dept. of Revenue Valuation	Taxpayer Requested Valuation	CTAB Valuation *For CTAB use only.*
Land	$27,763	$20,000	
Buildings & Improvements	—	—	

This section is your opportunity to describe what you think was incorrect about DOR's classification and assessment and to describe what the Board should do to correct it.

What was incorrect about DOR's classification or assessment?
(Ex: A similar house in my neighborhood sold for less.)

Lot with no water or street would not sell for price valuation. Previous assessed value was $13,929. (prior cycle)

What are you asking for to correct the problem?
(Ex: My home should be valued at $75,000.)

Suggested value @ $20,000. We had it advertised at this amount and no takers. No water or street to lot.

August / 14 / 2025 Date	Francis A. Ewalt Taxpayer Signature

APPEAL TO THE COUNTY APPEAL TAX BOARD

MTAB-401

Optional: 3rd Party Representation: List below.			
I hereby authorize		to represent me in this appeal.	
Address			
Email		**Phone**	
/ / **Date**		**Taxpayer Signature**	

Finally, make two copies of this document and:

- **Send the original AND one copy to the County Clerk and Recorder.**
- **Keep one copy for your records.**

What Happens Next?

The County Tax Appeal Board will contact you to arrange a hearing with you and the Department of Revenue. After the hearing, the County Tax Appeal Board will provide you with a decision by mail within 3 days.

The following section is for the County Tax Appeal Board to write its decision.

The above application is: *Granted* / *Denied* / *Granted in Part*

For the following reasons: The YCTAB does not believe the DOR's appraisal is an appropriate market value for this property. The value is adjusted to $420,000.00.

Date: 10.14.25 Chair Signature & County: [signature] Yellowstone

You may appeal this County Tax Appeal Board decision to the Montana Tax Appeal Board. To do so, complete and submit an Appeal to the Montana Tax Appeal Board (form MTAB-801), available at www.mtab.mt.gov.

The Montana Tax Appeal Board must receive your appeal within 30 days from when you received the County Tax Appeal Board decision or your appeal will not be accepted.

2139 Willet
2 of 3 lots appeal

C01245

Yellowstone County Commissioners
RECEIVED
AUG 18 2025

APPEAL TO THE COUNTY APPEAL TAX BOARD

MTAB-401

Complete this document to appeal a property tax classification or assessment set by the Montana Department of Revenue (DOR). This appeal must be filed with the County Clerk and Recorder of the county where the property is located. This appeal will be heard by that county's Tax Appeal Board (CTAB). The County Tax Appeal Board is not part of the Department of Revenue.

FOR COUNTY APPEAL TAX BOARD USE

Docket Number: A-05-25
Date Filed: 8/18/25
Received by: Erika G.

Only one appeal may be made in each two-year appraisal cycle. The date your appeal is due depends on whether you went through the AB-26 informal review process with DOR.

If you did NOT file an AB-26.	OR	If you went through the AB-26 process.
The county Clerk and Recorder must **receive** your appeal within 30 days from the **date on the DOR's notice of tax classification or assessment.**		The county Clerk and Recorder must **receive** your appeal within 30 days from the **date on the final AB-26 decision sent by Montana Dept. of Revenue.**

If your appeal is received late it will not be considered. If your property taxes are due before the appeal is resolved, you must pay them under protest if you want them refunded to you.

If you refuse to allow DOR to inspect your property for appraisal you must submit an appraisal conducted by a licensed appraiser who is in good standing and certified in Montana. If you do not, the county and state tax appeal boards cannot revise your valuation.

Name	Francis A Ewalt, trustee & Laurie F Ewalt, trustee			
Taxpayer Name	Francis Ewalt			
Property County	Yellowstone			
Address	2131 Phoebe Dr.			
City	Billings	**State**	MT	**Zip** 59105
Email	Ithewired@gmail.com	**Phone**	406-861-8963	

Was an AB-26 Form filed with the Dept. of Revenue?

Select One: ○ No ● Yes Decision Date: August 8, 2025

APPEAL TO THE COUNTY APPEAL TAX BOARD

MTAB-401

Legal Description of Property:

Street Address	2139 Willet DR	No. of Acres	.23
Lot(s)	Lot 10 + vacated alley	Section	S15
Block(s)	1	Township	T01N
Addition / Subdiv.	Meadowlark Sub	Range	R26
City / Town	Billings	GEOCode	03-1033-15-2-20-10-0000

	Dept. of Revenue Valuation	Taxpayer Requested Valuation	CTAB Valuation *For CTAB use only.*
Land	$27,026	$20,000	
Buildings & Improvements			

This section is your opportunity to describe what you think was incorrect about DOR's classification and assessment and to describe what the Board should do to correct it.

What was incorrect about DOR's classification or assessment?
(Ex: A similar house in my neighborhood sold for less.)

Lot with no water and no street would not sell for price suggested. Previous assessed value was $13,620 (prior cycle).

What are you asking for to correct the problem?
(Ex: My home should be valued at $75,000.)

Suggested value of $20,000. We had it advertised at that price. No takers as no water and no finished street

Date	Taxpayer Signature
August 14 2025	Francis A. Ewalt

APPEAL TO THE COUNTY APPEAL TAX BOARD

MTAB-401

Optional: 3rd Party Representation: List below.			
I hereby authorize		to represent me in this appeal.	
Address			
Email		**Phone**	
/ / **Date**		**Taxpayer Signature**	

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What Happens Next?

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The following section is for the County Tax Appeal Board to write its decision.

The above application is: *Granted* / *Denied* / *Granted in Part*

For the following reasons: The YLTAB does not believe the DOR's appraisal is an appropriate market value for His property. The value is adjusted to $20,000.00

Date: 10.14.25 Chair Signature & County: J. R. [illegible] Yellowstone

You may appeal this County Tax Appeal Board decision to the Montana Tax Appeal Board. To do so, complete and submit an Appeal to the Montana Tax Appeal Board (form MTAB-801), available at www.mtab.mt.gov.

The Montana Tax Appeal Board must receive your appeal within 30 days from when you received the County Tax Appeal Board decision or your appeal will not be accepted.

2147 Will't
3 of 3 lots appeal

C01244

Yellowstone County Commissioners
RECEIVED
AUG 18 2025

APPEAL TO THE COUNTY APPEAL TAX BOARD

MTAB-401

Complete this document to appeal a property tax classification or assessment set by the Montana Department of Revenue (DOR). This appeal must be filed with the County Clerk and Recorder of the county where the property is located. This appeal will be heard by that county's Tax Appeal Board (CTAB). The County Tax Appeal Board is not part of the Department of Revenue.

FOR COUNTY APPEAL TAX BOARD USE

Docket Number: A-06-25

Date Filed: 8/18/25

Received by: Erika G.

Only one appeal may be made in each two-year appraisal cycle. The date your appeal is due depends on whether you went through the AB-26 informal review process with DOR.

If you did NOT file an AB-26.	OR	If you went through the AB-26 process.
The county Clerk and Recorder must **receive** your appeal within 30 days from the **date on the DOR's notice of tax classification or assessment.**		The county Clerk and Recorder must **receive** your appeal within 30 days from the **date on the final AB-26 decision sent by Montana Dept. of Revenue.**

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Name	Francis A Ewalt, trustee & Laurie F Ewalt, trustee			
Taxpayer Name	Francis A. Ewalt			
Property County	Yellowstone			
Address	2131 Phoebe Dr			
City	Billings	**State**	MT	**Zip** 59105
Email	Itewired@gmail.com	**Phone**	406-861-8964	

Was an AB-26 Form filed with the Dept. of Revenue?

Select One: ○ No ✓ Yes Decision Date: August 8, 2025

APPEAL TO THE COUNTY APPEAL TAX BOARD

MTAB-401

Legal Description of Property:

Street Address	2147 Willet Dr.	No. of Acres	.23
Lot(s)	Lot 9 + vacated alley	Section	S15
Block(s)	1	Township	T01 N
Addition / Subdiv.	Meadowlark Sub	Range	R26E
City / Town	Billings	GEOCode	03-1033-15-2-20-09-0000

	Dept. of Revenue Valuation	Taxpayer Requested Valuation	CTAB Valuation *For CTAB use only.*
Land	$27,000	$20,000	
Buildings & Improvements			

This section is your opportunity to describe what you think was incorrect about DOR's classification and assessment and to describe what the Board should do to correct it.

What was incorrect about DOR's classification or assessment?
(Ex: A similar house in my neighborhood sold for less.)

Lot with no water or street would not sell for price valuation. Previous assessed value was $13,609 (prior cycle).

What are you asking for to correct the problem?
(Ex: My home should be valued at $75,000.)

Suggested value @ $20,000. We had advertised for that amount and had no takers. There is no water or street to property.

August 14 2025 Date	Francis A. Ewalt Taxpayer Signature

APPEAL TO THE COUNTY APPEAL TAX BOARD

MTAB-401

Optional: 3rd Party Representation: List below.			
I hereby authorize			to represent me in this appeal.
Address			
Email		**Phone**	
/ / **Date**		**Taxpayer Signature**	

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What Happens Next?

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The following section is for the County Tax Appeal Board to write its decision.

The above application is: *Granted* / *Denied* / *Granted in Part*

For the following reasons: The YCTAB does not believe the DOR's appraisal is an appropriate market value for this property. The value is adjusted to $70,000.00

Date: 10.14.25 Chair Signature & County: Yellowstone

You may appeal this County Tax Appeal Board decision to the Montana Tax Appeal Board. To do so, complete and submit an Appeal to the Montana Tax Appeal Board (form MTAB-801), available at www.mtab.mt.gov.

The Montana Tax Appeal Board must receive your appeal within 30 days from when you received the County Tax Appeal Board decision or your appeal will not be accepted.

Yellowstone County Tax Appeal Board

Physical Address:
316 N 26th Street Rm 3101
Billings, MT 59101

Mailing Address:
PO Box 35000
Billings, MT 59107-5000

Yellowstone County Tax Appeal Board

MINUTES

COUNTY: Yellowstone County
PLACE: BOCC Board Room

DATE: October 14th, 2025
TIME: 12:30pm
*SHOW RECESS AND RECONVENTION

Organizational Meeting Board Members Present:
Oscar Heinrich Jr.
Ted Cross
Dan Cohn
Hanna Wagner
Laura Myers
J.R. Reger

Secretary:
Erika Guy

Board Members Absent:
Jeff Weldon

The Board held its business organizational meeting at 12:30pm. Laura gave an update on remaining open appeals with DOR.

The board then discussed the schedule of appeals right now.

The board then talked about the last legislative session. The fees for CTAB's work were raised. Travis with MTAB is active in legislative session.

Laura advised the board members of some issues the secretary was experiencing with the DOR. Going forward any appeals filed with the CTAB secretary will be scheduled right away. The local DOR was asking the secretary not to schedule appeals so they could reach out to the taxpayer to see if they would instead file an AB26. Laura's objection with this process is once a taxpayer files with the county that starts the appeal. The board has no issue with the DOR reaching out to the taxpayers, however, the taxpayer is under no obligation to do so. There was also a disagreement over dismissing appeals. The DOR was instructing taxpayers to file a withdrawal of their appeal before their final determination on an AB26. Laura believes there is only one right to appeal on a determination, this could affect their appeal going forward. The board asked follow-up questions regarding this issue and discussed possibly changing the language on the tax appeal ad that is posted in May to say the taxpayer does not have to file with the DOR before filing with the CTAB.

Oscar Heinrich Jr. moved to nominate Laura Myers for Chairman and Ted Cross seconded. Motion carried.

Oscar Heinrich Jr. moved to nominate J.R. Reger as Vice-Chair. Ted Cross seconded. Motion carried.

Yellowstone County Tax Appeal Board

Physical Address:
316 N 26th Street Rm 3101
Billings, MT 59101

Mailing Address:
PO Box 35000
Billings, MT 59107-5000

The board discussed some issues with industrial appeals.

Meeting was adjourned at 12:54pm.

Signed,

Laura Myers

_____

Laura Myers, Chair

B.O.C.C. Regular
Meeting Date: 10/21/2025
Title: Memo Regarding the Transition Plan with Stonerock Business Solutions
Submitted By: Teri Reitz, Board Clerk

TOPIC:
Memo Regarding the Transition Plan with Stonerock Business Solutions

BACKGROUND:
See attached.

RECOMMENDED ACTION:
Place to file.

Attachments
Memo Regarding the Transition Plan with Stonerock Business Solutions

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MEMO

Date: July 29, 2025

To: Board of County Commissioners

From: Melissa Williams, Chief Civil Attorney
Amanda Stonerock, CEO, Stonerock Business Solutions

Re: Transition Plan

To support the transition, I have been actively assisting the team with the following:

- Providing training on reporting requirements and quality assurance controls
- Connecting them with all program partners
- Training on applicable state requirements
- Preparing the executive team for upcoming updates at the state level
- Continuing to act as a liaison until further direction is provided by the state
- Once more details are available, developing a reporting calendar
- Training on reporting processes, billing, and ongoing communication
- Supporting coordination with the state on new contracts, expectations, and procedures
- Updating all contact information
- Creating training guides and materials for Ivy staff
- Helping Ivy identify what they need internally to continue program.
- Establishing reporting needs and processes for getting the county reimbursed for medications.

Melissa Williams, Chief Civil Attorney — 10/15/25 Date

Amanda Stonerock, CEO Stonerock Business Solutions — 7/19/2025 Date