PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

MONTANA MUNICIPAL INTERLOCAL AUTHORITY

EMPLOYEE BENEFITS PROGRAM

CITY OF KALISPELL PLAN

PLAN DOCUMENT EFFECTIVE DATE:
July 1, 2026

PLAN SPONSOR'S IDENTIFICATION NUMBER:
81-0436312

GROUP NUMBER
8001036

COVER/SIGNATURE PAGE

Effective July 1, 2026, Montana Municipal Interlocal Authority (MMIA) restates its self-funded Health Care Plan for the benefit of eligible Employees of MMIA Member Entities and their eligible Dependents entitled, CITY OF KALISPELL PLAN (the Plan).

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

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

MONTANA MUNICIPAL INTERLOCAL AUTHORITY

BY: _____

TITLE: _____

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INTRODUCTION

Effective July 1, 2026, Montana Municipal Interlocal Authority (MMIA), restates the benefits, rights and privileges which will pertain to Employees of participating MMIA Member Entities, referred to as Participants, and the eligible Dependents of such Participants, as defined, and which benefits are provided through a fund established by MMIA and referred to as the Plan. This booklet describes the Plan in effect as of July 1, 2026.

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

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

Allegiance Benefit Plan Management, Inc.
PO Box 21074
Eagan, Minnesota 55121

Please read this booklet carefully before incurring any medical expenses. For specific questions regarding coverage or benefits, please refer to the Plan Document/Summary Plan Description which is available for review in the Personnel Office, at the office of the Plan Supervisor, or call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions concerning the Plan.

This Plan is not intended to, and cannot be used as workers' compensation coverage for any Employee or any covered Dependent of an Employee. See General Plan Exclusions and Limitations for specific information.

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

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

SCHEDULE OF MEDICAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

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

THE BENEFIT PERIOD IS A CALENDAR YEAR

MEDICAL BENEFIT COST SHARING PROVISIONS	
DEDUCTIBLE (Embedded) Per Covered Person per Benefit Period Per Family per Benefit Period	 $1,000 $2,000
Deductible, whether for Participating Provider or Non-Participating Provider, applies to all benefits unless specifically indicated as waived	
COPAYMENT Copayments apply as specifically stated in this Schedule of Medical Benefits and are payable by the Covered Person. Copayment applies only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other Outpatient setting). Additional charges for services that are performed at the time of the visit, e.g. diagnostic lab, office surgery, diagnostic miscellaneous testing, allergy injections, are payable at 100%, Deductible Waived. Copayments do not apply towards the Deductible but do apply towards the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments no longer apply for the remainder of the Benefit Period.	
BENEFIT PERCENTAGE ALL MONTANA PROVIDERS AND NON-MONTANA PARTICIPATING PROVIDERS Before satisfaction of Out-of-Pocket Maximum After satisfaction of Out-of-Pocket Maximum	 70% 100%
BENEFIT PERCENTAGE NON-MONTANA NON-PARTICIPATING PROVIDERS Before satisfaction of Out-of-Pocket Maximum After satisfaction of Out-of-Pocket Maximum	 50% 100%
Benefit Percentage for all Montana Providers and Non-Montana Participating Providers applies to all benefits unless specifically stated otherwise. Benefit Percentage for Non-Montana Non-Participating Provider applies to all benefits.	

MEDICAL BENEFIT COST SHARING PROVISIONS	
OUT-OF-POCKET MAXIMUM (Embedded) Per Covered Person per Benefit Period Per Family per Benefit Period	 $3,000 $6,000

Out-of-Pocket Maximum, whether for Participating Provider or Non-Participating Provider, applies to all benefits unless specifically stated otherwise and subject to all Plan provisions, limitations and exceptions based upon the Plan Document/Summary Plan Description.

Out-of-Pocket Maximum includes the Deductible, Medical Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not apply toward the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments do apply toward the applicable Pharmacy Benefit Deductible and Out-of-Pocket Maximum.

Charges for Montana and Non-Montana Participating Providers services will cross accumulate between the Montana and Non-Montana Participating Providers and Non-Montana Non-Participating Providers Out-of-Pocket Maximums.

MAXIMUM BENEFIT FOR ALL CAUSES	Not Applicable

PRE-CERTIFICATION/PRE-TREATMENT REVIEW

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

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	**BENEFIT PERCENTAGE** ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND PBME (REFERENCE BASED PRICING) (ELIGIBLE EXPENSES)	
ADVANCED RADIOLOGY IMAGING - OUTPATIENT (MRI, MRA, CT, PET Imaging)	
Facility Provider Expenses	70% after Deductible
Professional Provider Expenses	100%, Deductible Waived
ALTERNATIVE MEDICINE BENEFIT	
	100% after $25 Copayment, Deductible Waived
Benefit Limits: $500 Treatments/Office Visit Maximum per Benefit Period. Treatment includes all services provided during a calendar day. Benefit limits are for services received from all providers. Benefits are limited to acupuncture, neuro-feedback and bio-feedback services provided by a Physician, Naturopath Provider or Licensed Health Care Provider. Over-the-counter remedies are not covered.	
AMBULANCE SERVICE	
Air Ambulance	70% after Deductible
Ground Ambulance	70% after Deductible
Ambulance Service is payable as stated regardless of Participating Provider status.	
ANESTHESIA SERVICES	
	100%, Deductible Waived
AUTISM SERVICES	
Professional Provider Expenses	100%, Deductible Waived
Includes certain treatments associated with Autism Spectrum Disorder (ASD), pursuant to 33-22-515, MCA.	
BARIATRIC SURGERY BENEFIT (Surgical and Non-Surgical)	
	70% after Deductible
Benefit Limits: $30,000 Combined Surgical and Non-Surgical Maximum Lifetime Benefit; One (1) procedure Maximum Lifetime Benefit. Benefit limits are for services received from all providers. Non-surgical expenses related to obesity or bariatric surgery are payable the same as any other medical condition based on place of service.	
COLONOSCOPY	
	100%, Deductible Waived
Charges for the first Colonoscopy during a Benefit Period regardless of diagnosis or for any routine colonoscopy are payable at 100%. Subsequent Colonoscopies when performed for diagnostic purposes are payable subject to the Medical Deductible and Benefit Percentage.	

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DENTAL ACCIDENT SERVICES	
Facility Provider Expenses	70% after Deductible
Inpatient Professional Provider Expenses	100%, Deductible Waived
Office Visit Services	100% after $25 Copayment, Deductible Waived
DIABETIC EDUCATION/TRAINING AND EQUIPMENT/SUPPLIES BENEFIT	
Diabetic Education/Training	100%, Deductible Waived
Diabetic Equipment/Supplies	70%, Deductible Waived
Benefit Limits: 20 Visits Maximum Benefit per Benefit Period. Benefit limits are for services received from all providers. For purposes of this benefit, the term “Visit” refers to all services provided during the same day. Coverage for Diabetic Equipment and Supplies may also be available through the Pharmacy Benefit as stated in the Pharmacy Benefit section of the Plan.	
DIAGNOSTIC SERVICES - INPATIENT AND OUTPATIENT	
Facility Provider Expenses	70% after Deductible
Professional Provider Expenses	100%, Deductible Waived
DIALYSIS TREATMENTS - OUTPATIENT	
	70% after Deductible
Benefit Limits: $550 Maximum Benefit per dialysis session* or PBME (Referenced Based Pricing) as applicable**. Benefit limits are for services received from all providers. *Dialysis session includes charges for the dialysis, use of facility, professional fees and any and all drugs provided during the administration of a single course of dialysis. **PBME (Referenced Based Pricing) applies if the $550 benefit payment will result in a balance due to the Covered Person except for Deductible and Out-of-Pocket expenses provided the Covered Person has taken all actions available to prevent a balance due.	

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	**BENEFIT PERCENTAGE** ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND PBME (REFERENCE BASED PRICING) (ELIGIBLE EXPENSES)	
EMERGENCY ROOM CARE	
Facility Provider Expenses for Emergency	100% after $100 Copayment/visit, Deductible Waived
Professional Provider Expenses for Emergency	100%, Deductible Waived
Facility Expenses for non-emergency	No Benefit
Professional Provider Expenses for non-emergency	100%, Deductible Waived
Emergency Room Care is payable as stated regardless of Participating Provider status. As with all benefits, the PBME (Referenced Based Pricing) still applies. If admission occurs as a result of the condition requiring Emergency services, the emergency room Copayment will be waived and payment will be made according to the Hospital Inpatient Care Services benefit. "Emergency" means acute symptoms that a prudent layperson with average knowledge of health and medicine would expect that the absence of medical attention would place the individual's health in serious jeopardy, or seriously impair body functions, organs or parts.	
INFERTILITY	
Services to determine Infertility (treat underlying cause)	70% after Deductible
Infertility Treatment	No Benefit
Medically Induced Infertility/Fertility Preservation Services	70% after Deductible
See Medical Benefits for further details.	
HEARING AIDS (Including Exam and Fitting)	
	70% after Deductible
Benefit Limits: Hearing Aids limited to Dependent child up to age eighteen (18). Benefit limits are for services received from all providers.	
HOME HEALTH CARE	
	70%, Deductible Waived
HOSPICE CARE	
	100%, Deductible Waived

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	**BENEFIT PERCENTAGE** ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
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HOSPITAL SERVICES	
Inpatient Facility Provider Expenses	70% after Deductible
Inpatient Professional Provider Expenses	100%, Deductible Waived
Outpatient Facility Provider Expenses	70% after Deductible
Outpatient Professional Provider Expenses	100% after $25 Copayment, Deductible Waived
INFUSION SERVICES - HOME AND OUTPATIENT	
	100%, Deductible Waived
MAMMOGRAMS	
Routine Mammograms and other breast cancer screenings (See Preventive Care)	100%, Deductible Waived
Diagnostic Mammograms	100%, Deductible Waived
MEDICAL EQUIPMENT/SUPPLIES	
Rental (up to purchase price) or purchase	70%, Deductible Waived
Repair and Replacement	70%, Deductible Waived
Medical Supplies (For use outside of a Hospital and not provided in an office)	70% after Deductible
Orthopedic Devices	100% after $25 Copayment, Deductible Waived
Orthotics	70% after Deductible
Includes Durable Medical Equipment, Prosthetic, Orthotic, Orthoses or Orthopedic Devices **Benefit Limits:** Orthotics limited to $500 Maximum Benefit per Benefit Period. Benefit limits are for services received from all providers. Orthotics Benefit limited to custom made rigid inserts for shoes, with a medical diagnosis and prescribed by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning.	

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	BENEFIT PERCENTAGE ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND PBME (REFERENCE BASED PRICING) (ELIGIBLE EXPENSES)	
MENTAL HEALTH AND SUBSTANCE USE DISORDER	
Inpatient Facility Provider Expenses	70% after Deductible
Inpatient Professional Provider Expenses	100%, Deductible Waived
Outpatient Facility Provider Expenses	70% after Deductible
Outpatient Professional Provider Expenses including office visit services	100% after $25 Copayment, Deductible Waived
NON-AMBULANCE TRAVEL BENEFIT FOR ORGAN AND TISSUE TRANSPLANT	
	70% after Deductible
Benefit Limits: $5,000 Maximum Lifetime Benefit, limited to the following: Coach airfare. The current IRS medical travel reimbursement mileage rate for automobile travel. Meals limited to a maximum of $50 per day per person. Overnight accommodations, not to exceed $125 per night. For the Participant and one (1) companion, limited to travel to a Cigna LifeSOURCE Facility.	
NUTRITIONAL ASSESSMENT/COUNSELING BENEFIT (Not otherwise covered under Preventive Care)	
	100% after $25 Copayment, Deductible Waived
Benefit Limits: 10 Treatments/Office Visit Maximum per Benefit Period. Benefit limits are for services received from all providers. Coverage includes charges rendered by a registered dietician or other Licensed Health Care Provider for nutritional assessment/counseling. Services are not eligible for the purposes of specialty diets for athletic training or other non-medical purposes.	
OFFICE VISITS	
	100% after $25 Copayment, Deductible Waived
Copayment applies only to those charges billed for the provider's office visit services , including Advanced Practice Registered Nurses and Certified Physician Assistants, for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other Outpatient setting). Additional charges for services that are performed at the time of the visit, e.g. diagnostic lab, office surgery, diagnostic miscellaneous testing, allergy injections, are payable at 100%, Deductible Waived.	

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	**BENEFIT PERCENTAGE** ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
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ORGAN AND TISSUE TRANSPLANT SERVICES

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

Benefit Limits: $10,000 Maximum Benefit for Ground Ambulance Travel per Transplant.

For Air Ambulance and travel services obtained from Non-Participating Providers, as with all benefits, the PBME (Referenced Based Pricing) applies.

Transplants limited to Cigna LifeSOURCE Facility. Provider other than Cigna LifeSOURCE Facility is not covered.

PREGNANCY/MATERNITY SERVICES

Inpatient Facility Provider Expenses	70%, Deductible Waived
Inpatient Professional Provider Expenses	100%, Deductible Waived
Outpatient Facility Provider Expenses	70%, Deductible Waived
Outpatient Professional Provider Services (if billed as global fee)	100% after $25 Copayment, Deductible Waived
Office Visit (if not part of a global fee)	100% after $25 Copayment, Deductible Waived

See Preventive Care Benefit for well-women prenatal visits.

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

	100%, Deductible Waived

Covered Services:

- Well-Child Care
- Physical examinations
- Pelvic examination and pap smear
- Laboratory and testing
- Hearing and vision screening
- Mammograms. If additional imaging (e.g., Magnetic Resonance Imaging (MRI), Ultrasound or other mammogram) and pathology evaluation are indicated, these services are also recommended to complete the screening process for malignancies after initial mammogram
- Individualized patient navigation services for breast and cervical cancer screening and follow-up
- Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE)
- Cardiovascular screening blood tests
- Colorectal cancer screening tests
- Vaccinations and Immunizations recommended by Physician
- BRCA1 and BRCA2 when medically indicated
- Nutritional counseling
- Well Women Preventive Care subject to Plan limitations on sterilization procedures
- Screening for adolescent and adult women for intimate partner and domestic violence, at least annually and, when needed, providing or referring to intervention services

If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services. Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

PROPHYLACTIC MASTECTOMY/OOPHORECTOMY

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

ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE

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

SKILLED NURSING FACILITY

	70% after Deductible

SPECIAL BENEFITS / LIMITATIONS BENEFIT LIMITS ARE FOR SERVICES RECEIVED FROM PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS	BENEFIT PERCENTAGE ALL MONTANA, and NON-MONTANA PARTICIPATING PROVIDERS
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SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES	
	70% after Deductible
Benefit Limits: Maximum Benefit per Implant for the following: Orthopedic Implants . . . . . $40,000 Cardiac Implants (except for LVAD and RVAD) . . . . . $60,000 Cochlear Implants . . . . . $85,000 LVAD / RVAD Implants . . . . . $200,000 Maximums apply to any implantable device and all supplies associated with that implantable service. Benefit limits apply to Non-Participating Provider services only. For Participating Providers, payment will be made pursuant to the provider contract. As with all benefits, the PBME (Referenced Based Pricing) still applies.	
SURGERY - OUTPATIENT	
Hospital Facility Services	70% after Deductible
Ambulatory Surgical Center	70% after Deductible
Professional Provider Expenses	100%, Deductible Waived
TELEMEDICINE	
	100% after $25 Copayment, Deductible Waived
THERAPIES - OUTPATIENT	
Facility Provider Expenses	70% after Deductible
Professional Provider Expenses including Office Visit Services	100% after $25 Copayment, Deductible Waived
Outpatient Expenses include Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehabilitation Therapy.	
TOBACCO CESSATION BENEFIT (Not otherwise covered under Preventive Care Benefit)	
	100% after $25 Copayment, Deductible Waived
Services must be provided by a Physician or Licensed Health Care Provider.	
URGENT CARE SERVICES	
	100% after $50 Copayment/visit, Deductible Waived
Copayment applies to all charges billed by an urgent care facility when treatment has been rendered.	

PHARMACY BENEFIT

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

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

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

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

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

COST SHARING PROVISIONS

Pharmacy Deductible per Benefit Period

Per Covered Person $300

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

Pharmacy Out-of-Pocket Maximum per Benefit Period

Per Covered Person $3,600
Per Family $7,200

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

Copayment per Prescription after Deductible is met		
Drug Type	**Retail PBM Network** 1-34 day supply	**Mail Order** up to 90-day supply
Generic	$10	$20
Brand-Name(Formulary)	$20	$40
Brand-Name (Non-Formulary)	$40	$80
Specialty Drug	See ProActPLUS Prescription Drug Program	Not Applicable

Copayment per Prescription after Deductible is met
The following are payable at 100% and are not subject to any Deductible or Copayment: 1. Prescribed generic contraceptives or brand if generic is unavailable; 2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; 3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act; 4. Breast cancer preventive treatment(s) prescribed by a Physician or Licensed Health Care Provider; and 5. Colonoscopy bowel preparation products prescribed by a Physician or Licensed Health Care Provider. Preventive Service covered under the Affordable Care Act can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. Please refer to the Plan's formulary at https://secure.proactrx.com/resource-pages/drug-lists for the full list of products payable at 100%, as not all drugs and supplies are covered at 100%.

PROACT DIABETIC MANAGEMENT PROGRAM

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

PROACTPLUS PRESCRIPTION DRUG PROGRAM

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

DISPENSING LIMITATIONS

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

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

BENEFITS

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

1. It is Medically Necessary;

2. It is obtained through a Participating Pharmacy, either retail or mail order, or a retail nonparticipating pharmacy; and

3. It is provided while the person is a Participant;

4. Are approved for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed;

5. Are listed in the American Medical Association Drug Evaluation, Physicians Desk Reference, or Drug Facts and Comparisons;

6. Require a Physician's written prescription;

7. It is considered an eligible Prescription Drug Product.

8. Any drugs listed as an A or B recommendation as a Preventive service covered under the Affordable Care Act which can be viewed at https://www.healthcare.gov/coverage/preventive-care-benefits/.

Certain Prescription Drug Products require Prior Authorization.

If primary coverage is under another plan, charges for prescription drugs must be submitted to the primary carrier first. In order to receive reimbursement, the drug receipt must be submitted to the Pharmacy Benefit Manager. For all purposes, this Plan will be primary to Medicare Part D.

COVERED PRESCRIPTION DRUGS

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

1. Legend drugs: Drugs and medications requiring written prescriptions and dispensed by a licensed pharmacist for treatment of an Illness or Injury.

2. Compounded medication of which at least one ingredient is a legend drug. The national drug code (NDC) number must be provided for reimbursement.

3. Specialty Pharmaceuticals are a benefit only when obtained through a Specialty Care Pharmacy.

4. Diabetic medications, supplies and equipment. Diabetic drugs and supplies are covered only when obtained through the ProAct Diabetic Management Program, except for the first fill at a retail pharmacy.

5. Tretinoin, all dosage forms (e.g., Retin-A, Renova), for individuals through age 25.

6. Self-administered contraceptives, injectable contraceptives and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider. Female contraceptives and contraceptive management are also covered under the Preventive Care Benefit.

7. Any other drug which, under the applicable state law, may only be dispensed upon the written prescription of a Physician or other lawful prescriber and is a covered medical expense.

8. Smoking deterrents prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

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

10. Breast cancer preventive treatment(s) prescribed by a Physician or Licensed Health Care Provider.

11. Colonoscopy bowel preparation products prescribed by a Physician or Licensed Health Care Provider.

COPAYMENT

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

PRIOR AUTHORIZATION

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

EXCLUDED PRESCRIPTION DRUGS

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

1. Non-legend drugs other than insulin, except as covered.

2. Anabolic Steroids.

3. Any drug used for the purpose of weight loss.

4. Fluoride supplements.

5. Minerals. Certain minerals, requiring a prescription may be covered, if Medically Necessary and the Participant receives Prior Authorization.

6. Prescription drugs for which a therapeutic equivalent is available as an over-the-counter drug. Certain prescription drugs, for which a therapeutic equivalent is available as an over-the-counter drug may be covered, if Medically Necessary and the Participant receives Prior Authorization.

7. Drugs for Cosmetic purposes, including the treatment of alopecia (hair loss) (e.g., Minoxidil, Rogaine).

8. Vitamins, singly or in combination. Certain vitamins, requiring a prescription may be covered, if Medically Necessary and the Participant receives Prior Authorization.

9. Drugs used for erectile dysfunction. Certain drugs used for erectile dysfunction may be covered, if Medically Necessary and the Participant receives Prior Authorization.

10. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those otherwise covered under this section.

11. Diabetic infusion sets, which include a cassette, needle and tubing, and one insulin pump during the warranty period. Diabetic infusion sets and accessories for insulin pumps are covered under the medical supply benefit. Insulin pumps are covered under the Durable Medical Equipment benefit.

12. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Participant is charged for the drug.

13. Immunization agents, biological sera, blood, or blood plasma.

14. Medication which is to be taken by or administered to the Participant, in whole or in part, while the Participant is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility's charge.

15. Outpatient prescription drugs dispensed from a pharmacy within a Hospital or other facility.

16. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.

17. Smoking deterrent medications or aids, except as covered.

18. Replacement prescriptions due to loss, theft or spoilage.

19. Prescription that a Participant is entitled to receive without charge from any Workers' Compensation laws, or any municipal state, or federal program.

20. Non-sedating antihistamines.

NON-FORMULARY EXCLUSION

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

PHARMACY APPEALS

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

PROVIDERS OF CARE

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

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

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

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

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

NON-PARTICIPATING PROVIDER BENEFIT EXCEPTION

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

1. Charges for an Emergency, as defined by this Plan, limited to only those emergency medical procedures necessary to treat and stabilize an eligible Injury or Illness.

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

3. Charges for Emergency use of an Air Ambulance.

TRANSITION OF CARE AND CONTINUITY OF CARE

To ensure uninterrupted access to Medically Necessary services during changes in provider networks, the Plan offers both Transition of Care and Continuity of Care provisions. These provisions allow Covered Persons to continue receiving care at the Network benefit level under specific circumstances, as outlined below.

Transition of Care applies when a Covered Person is actively receiving treatment from a Physician who was part of the Plan's previous Network but is not included in the current Network. In such cases, certain Eligible Expenses may be covered at the Network benefit level for up to ninety (90) days from the effective date of the new Network, provided the treatment meets transitional care criteria.

Conditions eligible for Transition of Care include:

1. Active cancer treatment (e.g., chemotherapy or radiation therapy).

2. Organ transplant patients under active management or on a transplant waiting list.

3. Inpatient hospitalization that began prior to the effective date of the new Network.

4. Post-acute Injury or surgery within the past three (3) months.

5. Pregnancy in the second or third trimester, and up to eight (8) weeks postpartum.

6. Ongoing behavioral health treatment.

7. End-stage renal disease or dialysis.

8. Terminal illness with a life expectancy of six (6) months or less.

Routine procedures, treatment for stable chronic conditions, minor illnesses, and elective surgical procedures are not eligible for Transition of Care benefits.

To request Transition of Care, the Covered Person must contact the customer service number listed on their identification card.

CONTINUITY OF CARE

Continuity of Care applies when a Covered Person is receiving ongoing treatment from a provider who terminates their Network affiliation. In such cases, the Plan may continue to reimburse services at the Network benefit level and allowable amount for up to ninety (90) days following the provider's termination date, provided the treatment meets continuity of care criteria.

1. Pregnancy in the second or third trimester or postpartum care;

2. Continuation of treatment for a chronic or acute medical condition;

3. Active care at an Inpatient facility;

4. A disabling, degenerative, congenital or life threatening Illness;

5. Ongoing treatment of a terminal illness or serious medical condition; or

6. A Mental Health or Substance Use Disorder condition.

To request Continuity of Care, the Covered Person must contact the customer service number listed on their identification card.

MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

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

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider; and

2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary; and

3. Charges do not exceed the Eligible Expense of the Plan; and

4. They are not excluded under any provision or section of this Plan.

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

DEDUCTIBLE

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

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

DEDUCTIBLE CARRYOVER PROVISION

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

BENEFIT PERCENTAGE

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

OUT-OF-POCKET MAXIMUM

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

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

An individual Covered Person cannot receive credit toward the Family Out-of-Pocket Maximum for more than the Individual Out-of-Pocket Maximum as stated in the Schedule of Medical Benefits.

COPAYMENT

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

MAXIMUM BENEFIT

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

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

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

CHANGES IN COVERAGE CLASSIFICATION

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

NEW YORK STATE EXPENSES

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

MEDICAL BENEFITS

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

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

Advanced Radiology Imaging: Coverage includes charges for Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT) and Computed Tomography (CT) imaging or other similar advanced radiology imaging tests.

Alternative Medicine Benefit: Coverage under this benefit is limited to charges for services of an acupuncturist, neuro-feedback and bio-feedback services provided by a Physician, Naturopath Provider or Licensed Health Care Provider. Over-the-counter remedies are not covered. Benefit limits apply as stated in the Schedule of Medical Benefits.

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

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

Anesthetic/Anesthesia: Charges for the cost and administration of an anesthetic.

Bariatric Surgery: Coverage under this benefit includes charges for bariatric surgery based on Medical Policy. Benefit limits apply as stated in the Schedule of Medical Benefits.

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

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

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

Clinical Trials - Routine Patient Costs: Coverage under this benefit includes charges for routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and either of the following conditions must be met:

1. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or

2. The individual provides medical and scientific information establishing that the individual's participation in the qualified trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered:

1. The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets any of the following criteria:

2. It is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    A. National Institutes of Health (NIH).

    B. Centers for Disease Control and Prevention (CDC).

    C. Agency for Health Care Research and Quality (AHRQ).

    D. Centers for Medicare and Medicaid Services (CMS).

    E. A cooperative group or center of any of the entities described above or the Department of Defense (DOD).

    F. The Department of Veterans Affairs (VA).

    G. A qualified non-governmental research entity identified in NIH guidelines for center support grants.

    H. Any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if both of the following conditions are met:

        1) The study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
        2) The study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

    I. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).

    J. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The Plan does not cover any of the following services associated with a clinical trial or any services that are not considered routine patient care costs and services, including the following:

1. The Experimental/Investigational/Unproven drug, device, item, or service that is provided solely to satisfy data collection and analysis needs.

2. An item or service that is not used in the direct clinical management of the individual.

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

4. An item or service provided by the research sponsors free of charge for any person enrolled in the trial.

5. Travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:

   A. Fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train.
   B. Mileage reimbursement for driving a personal vehicle.
   C. Lodging.
   D. Meals.

6. Intravenous therapy.

7. Anesthesia services.

8. Physician services.

9. Office services.

10. Hospital services.

11. Room and Board, and medical supplies that typically would be covered under the Plan for an individual who is not enrolled in a clinical trial.

12. Routine patient costs obtained from Non-Participating Providers when non-network benefits do not exist under the Plan. Examples of routine patient care costs and services include: radiological services; and laboratory services.

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

Dental Services - Accidental Injury: Charges for dental services provided by Physicians, dentists, oral surgeons and/or any other provider are excluded under this Plan; however, benefits will be payable for Medically Necessary services required because of Accidental Injury to natural teeth.

Such Expenses must be Incurred within one (1) year from the date of the accident except in the event that it is medically impossible for service to be completed within that time frame because of the age of the Covered Person or because of the healing process of the Injury. Dental implants provided as the result of an accident will be covered within one (1) year from the date of accident, subject to Medical Necessity. This benefit will not in any event be deemed to include charges for orthodontics, dentofacial orthopedics or related appliances, or treatment for the repair or replacement of a denture.

For any charges covered under this Plan and that may also be covered under a separate dental plan, this Plan will be primary.

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

Diagnostic Tests: Charges for electrocardiograms (EKG), electroencephalograms (EEG), pneumoencephalograms (PEG), basal metabolism tests, or similar well-established diagnostic tests. This benefit does not include biopsies which are covered under the surgery benefit.

Dialysis Treatments - Outpatient: Coverage under this benefit includes charges for services and supplies related to renal dialysis done on an Outpatient basis. Benefit limits apply as stated in the Schedule of Medical Benefits.

In order to avoid or reduce liability for amounts not covered by the Plan, a Covered Person who is diagnosed with End Stage Renal Disease (ESRD) should immediately follow these steps:

1. Notify Plan Administrator when diagnosed with ESRD by the attending Physician.

2. Notify Plan Administrator if or when beginning to receive dialysis treatments.

3. Enroll in Medicare Parts A and B and use a provider that accepts Medicare patients to prevent the Covered Person from being billed for amounts in excess of the benefit amounts stated above.

4. Failure to use a provider that accepts Medicare patients may result in significant costs to the Covered Person for fees that will not be covered by the Plan.

Gender Dysphoria Services: Coverage includes charges for gender dysphoria based on Medical Policy. However, gender dysphoria services in any jurisdiction where the service is illegal by the law of that jurisdiction are excluded regardless.

Hearing Aids and Examination: Coverage includes charges for hearing aid and associated exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHA). A hearing aid is any device that amplifies sound. Services must be rendered by a licensed audiologist. Charges for repairs and batteries are not covered. Benefit limits apply as stated in the Schedule of Medical Benefits.

Hearing Services: Coverage includes charges for the following hearing services:

1. Hearing exam for medical purposes.

2. Routine hearing screening covered under Preventive Care.

3. Hearing screening not otherwise covered under Preventive Care. This benefit does not apply to hearing services for an Illness or Injury.

Home Birth: Charges for home birth by a Certified Nurse Midwife.

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

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

2. Home health aides.

3. Licensed Social Workers (LSW).

Home Health Care specifically excludes the following:

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

2. Services of a person who ordinarily resides in the home of the Covered Person, or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

3. Transportation services.

4. Domestic or housekeeping services.

5. Custodial Care.

6. “Meals-on-Wheels” or similar food arrangements.

Hospice Care Services: Coverage includes charges made by a Hospice within any one Hospice Benefit Period for:

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services.

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

3. Physical Therapy and Speech Therapy, when rendered by a licensed therapist.

4. Medical supplies, including drugs and biologicals and the use of medical appliances.

5. Physician's services.

6. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

7. Counseling and other support services, including bereavement counseling, provided to meet the physical, psychological, spiritual, and social needs of the terminally ill patient.

8. Instructions for care of the Participant, counseling and other support services for the Participant’s immediate family.

Hospital Services: Coverage includes charges for Hospital services. Hospital services include all Medically Necessary services and supplies provided by a licensed Hospital facility. These services may be provided on an Inpatient or Outpatient basis.

Hysterectomies: Charges for hysterectomies.

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

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

Medical Equipment/Supplies: Coverage includes charges for Durable Medical Equipment, Orthotic, Orthosis or Orthopedic Devices, Prosthetic Appliances and other medical equipment as follows:

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

2. Purchase of Orthosis or Orthopedic Devices or Prosthetic Appliances including, but not limited to, artificial limbs, eyes, larynx, or replacement or repair of Prosthetic Appliances.

3. Replacement or repair of Durable Medical Equipment, Orthosis or Orthopedic Devices, Prosthetic Appliances.

4. Charges for Orthotics that are custom made or custom fitted and made of rigid or semi-rigid material. Charges for corrective shoes are excluded.

5. Medical supplies such as dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies.

6. Diabetic insulin pump and supplies. See Pharmacy Benefit additional coverage.

7. Orthopedic Devices, limited to braces, corsets and trusses.

8. Orthotics that are custom made rigid inserts for shoes, with a medical diagnosis and prescribed by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning. Benefit limits apply as stated in the Schedule of Medical Benefits.

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

Medically Induced Infertility/Fertility Preservation Services: Coverage includes charges for medically induced infertility. Medically induced infertility refers to a condition in which an individual faces a high risk of permanent infertility as a result of medical treatment or underlying disease. Charges to treat medically induced infertility are subject to Medical Necessity based on current Medical Policy criteria.

Mental Health Conditions and Substance Use Disorders: Coverage under this benefit includes Medically Necessary services for the diagnosis and treatment of Mental Health Conditions and Substance Use Disorders (MH/SUD), consistent with the standards set forth by the Mental Health Parity and Addiction Equity Act (MHPAEA) and applicable federal regulations.

Covered services include, but are not limited to:

1. Professional Services: Charges by Physicians or Licensed Health Care Providers for the evaluation, diagnosis, and treatment of MH/SUD conditions, including individual, group, and family therapy.

2. Diagnostic Testing: Psychological and neuropsychological testing using well-established, evidence-based methods recognized by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD).

3. Inpatient and Partial Hospitalization Services: Facility charges for Medically Necessary Inpatient care or Partial Hospitalization at licensed facilities, including psychiatric hospitals and behavioral health units, for the same scope of services covered for physical Illness or Injury under this Plan.

4. Outpatient Services: Outpatient treatment, including intensive outpatient programs (IOP), medication management, and psychotherapy.

5. Substance Use Disorder Treatment: Detoxification, rehabilitation, and counseling services for alcohol and/or chemical dependency, provided in licensed facilities or by credentialed providers.

6. Emergency Services: Emergency care for acute MH/SUD episodes, including crisis stabilization services.

7. Family counseling/family psychotherapy, with or without the Covered Person present.

All MH/SUD benefits are subject to the same financial requirements and treatment limitations (e.g., Copayments, Deductibles, prior authorization, and Network access) as those applied to medical/surgical benefits, in accordance with MHPAEA regulations.

Naturopath Provider: Charges for services of a Naturopath Provider (ND) practicing within the scope of their license. This does not include acupuncture, services of an acupuncturist, neuro-feedback or bio-feedback services provided by a Naturopath Provider which are specifically covered under the Alternative Medicine Benefit. Benefit limits apply as stated in the Schedule of Medical Benefits.

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

Nutritional Assessment/Counseling (Not otherwise covered under Preventive Care): Charges rendered by a registered dietician or other Licensed Health Care Provider for nutritional assessment/counseling for individuals with medical conditions or Mental Health that require a special diet or counseling. Such conditions include, but may not be limited to: diabetes mellitus, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, hyperlipidemias and Mental Health (e.g., anorexia, bulimia nervosa). Benefit limits apply as stated in the Schedule of Medical Benefits.

Services are not eligible for the purposes of specialty diets for athletic training or other non-medical purposes.

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

1. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

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

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

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

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

Transplants are limited to Cigna LifeSOURCE Facility

Outpatient Prescription Drugs: Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury Charges are eligible for drugs intended for use in a Physicians’ office or settings other than home use that are billed during the course of an evaluation or management encounter. Conditions of coverage for Outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Pharmacy Benefit section of the Plan.

Outpatient Therapies: Charges for the following Outpatient therapies:

1. Occupational Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Occupational Therapy must be rendered by a Licensed Health Care Provider.

2. Physical Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Physical Therapy must be rendered by a Licensed Health Care Provider.

3. Speech Therapy provided by a Licensed Health Care Provider for diagnosis and treatment of speech and language disorders.

4. Respiratory therapy or pulmonary therapy.

5. Cardiac rehabilitation services rendered by a Licensed Health Care Provider.

Oxygen and Other Gases: Charges for oxygen and other gases and their administration.

Physician or Licensed Health Care Provider: Charges for the services of a licensed Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.

Pregnancy or Maternity: Charges for Pregnancy or maternity, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy.

Preventive Care Services: Charges are payable as specifically stated in the Schedule of Medical Benefits for Preventive Care.

Preventive Care services are covered when provided by a provider and delivered in accordance with nationally recognized Preventive Care guidelines. These guidelines include recommendations issued by the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP) and the Health Resources and Services Administration (HRSA) Supported Women's Preventive Services Guidelines.

The complete list of recommendations and guidelines can be viewed at:
https://www.healthcare.gov/coverage/preventive-care-benefits/.

Preventive Care services are covered regardless of Medical Necessity when provided for Preventive Care purposes and in accordance with applicable federal requirements.

Covered Preventive Care services include, but are not limited to, the following when recommended based on age, gender and risk factors:

1. Contraceptive management services. These services include counseling and office visits related to contraception; prescribing and obtaining a prescription for contraceptives; purchase of prescription contraceptive methods; and fitting, injection, insertion, implantation, placement and removal of contraceptive devices.

2. Cancer screenings as recommended by the USPSTF, including, but not limited to:

    A. Breast cancer screening;
    B. Cervical cancer screening; and
    C. Colorectal cancer screening;

3. Diabetes screening and prevention:

   A. Screening for prediabetes and type 2 diabetes for adults who meet USPSTF risk-based criteria, including age and body mass index guidelines.

   B. Diabetes Prevention Program (DPP) for Covered Persons identified with prediabetes, includes referral to and participation in a Diabetes Prevention Program (DPP). A DPP is a structured, evidence-based lifestyle intervention designed to support healthy eating, physical activity, and weight loss to reduce the risk of developing type 2 diabetes.

   C. Gestational diabetes for asymptomatic pregnant Covered Persons at twenty-four (24) weeks of gestation or after.

4. Behavioral counseling interventions, such as nutritional counseling and physical activity counseling for Covered Persons who are overweight or obese or who have other cardiovascular or metabolic risk factors, as recommended by the USPSTF.

5. Immunizations recommended by (ACIP), including vaccines appropriate for adults and children based on age, health status and risk factors.

6. Screening for anxiety, counseling for sexually transmitted infections (STI) and other Preventive Care under the HRSA Supported Preventive Services Guidelines.

Important Notes:

1. Preventive Care services are covered only when provided for Preventive Care purposes.

2. Coverage is subject to Plan eligibility, provider network requirements and applicable federal law.

3. Services that are diagnostic or therapeutic in nature may be subject to cost-sharing under other Plan benefits.

Prophylactic Mastectomy or Oophorectomy: Coverage includes charges for a prophylactic mastectomy or oophorectomy for treatment of individuals at high risk of developing breast or ovarian cancer based on applicable Medical Policy.

Radiation Therapy and Chemotherapy: Charges for radiation therapy and chemotherapy.

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

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

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

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

4. Intradermal tattooing to correct color defects or provide a symmetrical appearance of the areola and nipple.

Specifically excluded from this benefit are expenses for the following:

1. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;

2. Breast augmentation procedures unrelated to producing a symmetrical appearance;

3. Implants for the non-affected breast unrelated to producing a symmetrical appearance;

4. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

Residential Treatment Facility: Coverage includes charges made by a Residential Treatment Facility for treatment of Mental Health or for treatment of Substance Use Disorder, provided the facility and program meet ASAM clinical guidelines. Residential care Room and Board charges are covered in lieu of Inpatient Room and Board charges provided the patient would meet criteria for an Inpatient admission.

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

Routine Newborn Inpatient Nursery/Physician Care: Coverage under this benefit includes charges for the following services:

1. Routine Nursery Care includes room, board and Hospital services for a Newborn Dependent child, including circumcision.

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

Coverage also includes charges for circumcision performed on an Outpatient basis within six (6) months following birth.

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

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services.

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

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

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

1. Spine surgery in the absence of one the following conditions or diagnoses shall be subject to, and require proof of a minimum of three (3) consecutive months of unsuccessful conservative therapy within the six (6) months immediately prior to the scheduled date of surgery:

    A. Acute trauma;

    B. Tumor;

    C. Infection;

    D. Cauda equina syndrome;

    E. Severe disease and rapidly progressing neurologic deficit;

F. Situation where the patient risks permanent neurological or functional deficit if not operated on urgently.

2. Conservative therapies are non-operative treatments such as Physical Therapy, epidural injections, non-steroidal anti-inflammatory medications and other recommended regimens by a Physician.

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

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

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

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

Surgical Implant and/or Devices and Related Supplies: Charges for surgical implants and/or devices and related supplies are payable as specifically outlined in the Schedule of Medical Benefits, subject to all terms and conditions of this Plan. Coverage under this benefit includes charges for implants, devices and related supplies, including fastenings, screws and all other hardware related to the device or implant. Benefit limits apply as stated in the Schedule of Medical Benefits.

Surgical Procedures: Charges for Surgical Procedures.

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

For non-Participating Providers, when two or more Surgical Procedures occur during the same operative session, charges will be considered as follows:

A. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, 100% of the Eligible Expense will be considered for the Major Procedure; and 50% of the Eligible Expense will be considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services will be reimbursed at the contracted or negotiated rate.

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

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

Telemedicine: Charges for services that are related to or as a result of Telemedicine, limited to: the delivery of real-time medical and health-related services, consultations and remote monitoring as medically appropriate through audio, interactive video conferencing and secure internet-based technologies for diagnostic and therapeutic purposes in an interactive encounter between the Covered Person and their Physician or Licensed Health Care Provider practicing within the scope of their license.

Therapies for Down Syndrome: Coverage under this benefit includes charges for diagnosis and treatment of Down Syndrome for a covered Dependent eighteen (18) years of age or younger pursuant to 33-22-129 MCA. Coverage must include:

1. Habilitative or rehabilitative care that is prescribed, provided, or ordered by a Physician, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child; and

2. Medically Necessary therapeutic care that is provided as follows:

    A. Speech Therapy up to one hundred four (104) sessions per Benefit Period;

    B. Physical Therapy up to fifty-two (52) sessions per Benefit Period; and

    C. Occupational Therapy up to fifty-two (52) sessions per Benefit Period.

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

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

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

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

1. Reduce or improve the physical, mental, or developmental effects of Down Syndrome; or

2. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

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

Travel Expenses: Charges for travel Expenses Incurred by any person for any reason, except as specifically covered under the Non-Ambulance Travel Benefit for Organ and Tissue Transplant services. Coverage includes charges for the Participant and one (1) companion. Benefit is limited to travel to a Cigna LifeSOURCE Facility. Benefit limits apply as stated in the Schedule of Medical Benefits.

Urgent Care Services: Charges made by an urgent care facility when treatment has been rendered. Urgent care facility is a free-standing facility which is engaged primarily in diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention.

Vasectomy: Charges for voluntary vasectomy, including all office charges related to the vasectomy for Participants and Dependent spouse only.

EXPERIMENTAL COVERAGE

Special provisions apply to the Internal Medical Review (IMR) process for coverage decisions related to Experimental or Investigational therapies. If Allegiance denies the request because the requested service or treatment is Experimental or Investigational, the Covered Person has the option to appeal the Experimental/Investigational/Unproven denial following the standard appeal process with the exception that the appeal should include:

1. A Physician statement which certifies that the Covered Person has a life-threatening or seriously debilitating condition; the Covered Person's Physician's certification must also indicate that standard therapies have not been effective in treating the Covered Person's condition or the requested therapy is likely to be more beneficial than any standard therapy as documented in two separate sources of medical or scientific evidence.

   A "life-threatening" condition means either or both of the following:

   A. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

   B. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

   C. A "seriously debilitating" condition means diseases or conditions that cause major irreversible morbidity.

   "Medical and scientific evidence" means any of the following:

   A. 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.

   B. Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR).

   C. Medical journals recognized by the Secretary of Health and Human Services, under section 1861(t)(2) of the Social Security Act.

   D. Either of the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.

   E. Any of the following reference compendia if recognized by the Federal Center for Medicare and Medicaid Services as part of an anti-cancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, The National Comprehensive Cancer Network Drug and Biologics Compendium, The Thomson Micromedex DrugDex.

   F. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

G. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

The IMR will be conducted by three (3) Independent Medical Review Providers, who are qualified to review issues related to Experimental and Investigational therapies. If the Covered Person's Physician determines that the proposed therapy which is the subject of the IMR would be significantly less effective if not initiated promptly, an expedited IMR is available. The IMR's decision must state the reason that the therapy should or should not be covered, citing the Covered Person's specific medical condition, the relevant documents, and the relevant medical and scientific evidence. Three (3) independent reviews are conducted separately to ensure a well-rounded panel assessment of the treatment. The final determination will be based on the majority consensus among the completed IMR reviews. Allegiance will cover the services subject to the Plan terms and conditions generally applicable to other benefits.

PROVIDER SELF-AUDIT INCENTIVE PROGRAM

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

This payment error must meet the following criteria:

1. Not detected by the provider of services; and

2. Not detected by the Plan; and

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

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

Allegiance Benefit Plan Management, Inc.
Attention: Claims Department
Self-Audit Incentive Program
PO Box 21074
Eagan, Minnesota 55121

The Plan will refund 50% of the total amount of the overcharge, up to a maximum $1,000 refund based on an overcharge of $2,000. The minimum overcharge eligible to qualify is $50 which would result in a $25 refund.

HOSPITAL ADMISSION CERTIFICATION

To identify Network Providers, please visit https://www.askallegiance.com/providersearch or contact a customer service representative using the number on the back of the Participant's identification card.

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

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

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

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

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

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

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

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

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

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

CONTINUED STAY CERTIFICATION

If a Covered Person needs to stay in the Hospital longer than the days already approved by the utilization management company, those extra days must meet all the Plan's terms, conditions, and exclusions. The Plan's utilization management company will review requests for subsequent Inpatient days.

To get approval for additional days, follow the same process used for the original pre-admission certification.

MATERNITY NOTIFICATION

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

PRE-TREATMENT REVIEW

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

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

Provider requests for Pre-Treatment Review must be submitted to the CPT procedures codes database. To determine if a service requires Pre-treatment Review under this Plan, please consult the CPT (Current Procedural Terminology) procedure codes database at: https://www.askallegiance.com/CPTCode/Search.

For Participant requests for Pre-treatment Review, please call the utilization management company at the number listed on the Participant's identification card. Participants may also utilize the CPT procedure codes database above.

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

Please be aware that a Medical Necessity review is not a guarantee of payment. The Plan Supervisor will complete a final determination upon receipt of claim and review of the necessary medical records and other information. Payment is conditional and subject to all provisions and limitations of this Plan. Covered Persons should review the Schedule of Benefits within this Plan Document/Summary Plan Description for information about potential limits. For questions regarding benefit limits or the level of benefits remaining for the current Plan Year, please contact the customer service using the number listed on the Participant's identification card.

For Covered Persons to receive the highest level of benefits, services should be performed by Network Providers. To review Network Providers, please visit https://www.askallegiance.com/providersearch or call the customer service number listed on the Participant's identification card.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

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

Abortion Services: Charges for elective abortions. However, subject to applicable law, abortion services in any jurisdiction where the service is illegal by the applicable law of that jurisdiction are excluded regardless.

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

Alternative Care: Charges for services or supplies related to any of the following treatments or related procedures:

A. Acupressure.
B. Hypnotherapy.
C. Holistic medicine.
D. Religious counseling, recreational counseling.
E. Self-help programs.
F. Stress management.
G. Wilderness/camp programs, including non-hospital based, non-medical counseling/and or ancillary services for residential/behavioral health/substance abuse treatment/camp that do not fit into medical benefit categories.

Artificial Organ Implant: Charges for nonhuman organ or artificial organ implant procedures.

Benefits not Specifically Listed: Charges for services or supplies that are not specifically listed as a covered benefit of this Plan.

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

Care in the Physical Presence of a Physician or Licensed Health Care Provider: Charges for Physicians' or Licensed Health Care Providers' fees for any treatment which is not rendered by or in the physical presence of a Physician or Licensed Health Care Provider, except as may be covered by Medical Policy covered under this Plan or as specifically covered for Telemedicine.

Care while Incarcerated: Charges for care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Chiropractic Care: Charges for chiropractic treatment.

Close Relative: Charges for services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person, or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services.

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

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

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

Custodial Care: Charges related to Custodial Care.

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

Dental Treatment: Charges for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes, and dental braces, except as specifically covered.

Detoxification or Court-Ordered Services: Charges for detoxification services or Outpatient therapy under court order or as condition of parole, except when Medically Necessary and as ordered by a Physician.

Direct-Entry Midwife or Lay Midwife: Charges for services of a direct-entry midwife or lay midwife or the practice of direct-entry midwifery. A Direct-entry midwife is one practicing midwifery and licensed pursuant to 37-27-101 et seq, MCA.

“Direct-entry midwife” means a person who advises, attends, or assists a woman during Pregnancy, labor, natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.

Doula: Charges for services of a Doula. Doula services are non-clinical prenatal, labor and postpartum support services provided by a licensed Doula.

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

Equipment - Specialized: Charges for specialized computer equipment or aids or devices that assist with non-verbal communications including, but not limited to: Braille keyboards; voice recognition software; communication boards; pre-recorded speech devices; laptop computers; desktop computers; Personal Digital Assistants (PDAs), unless determined to be Medically Necessary by medical review, and not primarily for personal convenience.

Examinations for Employment and other Non-Medically Necessary Care: Charges for any services or supplies not necessary for treatment of an actual Illness or Injury including, but not limited to: annual physical examinations; insurance, premarital, athletic, and employment physicals; FAA and DOT physicals; licensing, school, camp, sports or adoption purposes; or routine examinations and routine immunizations, except as specifically covered otherwise.

Examinations for Firefighters: Charges for all medical examinations for firefighters in the state of Montana pursuant to 39-71-101, MCA et. seq.

Excess of the Eligible Expense: Charges in excess of the Eligible Expense.

Excluded from Coverage: Charges for the following treatments, services or supplies:

1. Charges related to or connected with treatments, services or supplies that are excluded under this Plan.

2. Except as provided by applicable law, charges that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan.

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

Governmental Agency: Charges for services or supplies which the Covered Person is entitled to receive or does receive from the United States or any city, county, state, or country. This exclusion applies to any programs of any agency or department of any government. This exclusion is not intended to exclude from coverage if a Covered Person is a resident of a Montana state institution when services are provided.

Note: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Covered Person from the Plan. When such a circumstance occurs, the Covered Person will receive an explanation of benefits.

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

Massage Therapist: Charges for services of a massage therapist.

Medical Research: Charges for expenses for examinations and treatment conducted for the purpose of medical research.

Never Events: Charges for Never Events. Never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.

Examples of “Never Events” include (not fully inclusive):

A. Surgery on the wrong body part
B. Foreign body left in a patient after surgery
C. Mismatched blood transfusion
D. Major medication error
E. Severe “pressure ulcer” acquired in the hospital
F. Hospital acquired injuries such as fractures, dislocations, intracranial injuries, crushing injuries and burns
G. Preventable post-operative deaths

Non-Legal Services: Charges for services, treatment or supplies not considered legal in the United States.

Non-Medical Expenses: Charges for non-medical expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician, except as specifically covered.

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

Non-Prescription Medications: Charges for non-prescription supplies, except as specifically covered under the Preventive Care Benefit.

Not Rendered or Received: Charges for treatment, services or supplies not actually rendered to or received and used by the Covered Person.

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

Other than the Covered Person: Expenses Incurred by persons other than the Covered Person receiving treatment.

Over-the-Counter Supplies: Charges for over-the-counter (OTC) supplies or common first-aid supplies such as, but not limited to: adhesive tape, bandages, antiseptics, analgesics, etc., except as specifically listed as a covered benefit. This exclusion does not apply to ostomy supplies and urinary catheters.

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

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

Reports: Charges for preparation of reports or itemized bills in connection with claims.

Routine Foot Care: Charges for routine foot care (in absence of disease) including treatment of cutting, clipping or trimming of corns, calluses, toenails and corrective shoes.

Sexual Dysfunction: Charges for prescription drug products used for the treatment of male or female sexual dysfunction including, but not limited to, erectile dysfunction, delayed ejaculation, anorgasmy, hypoactive sexual desire disorder and decreased libido, except as specifically stated in the Pharmacy Benefit.. Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants-unless Medically Necessary), anorgasmy, and premature ejaculation.

Special Duty Nursing: Charges for special duty nursing services are excluded:

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

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

Sterilization Reversal Procedures: Charges resulting from or in connection with the reversal of a sterilization procedure.

TMJ/Jaw Disorders: Coverage includes charges in connection with any operation or treatment for temporomandibular joint (TMJ) dysfunction or jaw disorders based on Medical Policy.

Travel Expenses: Charges for travel Expenses Incurred by any person for any reason, except as specifically covered under the Non-Ambulance Travel Benefit.

Vitamins or Supplements: Charges for vitamins or food nutritional supplements, whether or not prescribed by a Physician, except as specifically covered under the Preventive Care Benefit.

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

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

Worker's Compensation: Charges by the Covered Person for all services and supplies which are provided to treat any Illness or Injury arising out of employment or in the course of an occupation. However, this exclusion does not apply to charges for services and supplies as the result of an Illness or Injury which occurs in the course of employment if the Participant is a corporate officer, sole proprietor, working partner of a partnership or working member of a member-managed limited liability company who is not required to have Workers' Compensation coverage and either the Participant or their employer has not elected to obtain Workers' Compensation coverage pursuant to the provisions of Title 39, Chapter 71, MCA. This exclusion will not apply to employment, that is fully exempt from Workers' Compensation under applicable law, making it legally impossible to obtain Workers' Compensation for a specific Illness or Injury.

COORDINATION OF BENEFITS

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

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

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

DEFINITIONS

"Allowable Expense" as used herein means:

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

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

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

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

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

   A. Hospital indemnity benefits; and

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION

1. Non-Dependent/Dependent:

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

2. Dependent Child Covered Under More Than One Plan:

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

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

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

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

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

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

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

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

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

3. Active Employee or Retired or Laid-Off Employee

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

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

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

4. COBRA or State Continuation Coverage:

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

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

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

5. Longer or Shorter Length of Coverage

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

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

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

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

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

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

COORDINATION WITH MEDICARE

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

For all purposes, this Plan will be primary to Medicare Part D.

1. For Working Aged

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

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

2. For Retired Persons

   Medicare is primary and the Plan will be secondary for the covered Retiree if they are an individual who is enrolled in Medicare Part A or Part B as a result of age or disability and retired.

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

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

3. For Covered Persons who are Disabled

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

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

4. For Covered Persons with End Stage Renal Disease

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

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

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

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

COORDINATION WITH MEDICAID

If a Covered Person is also entitled to and covered by Medicaid, the Plan will always be primary and Medicaid will always be secondary coverage.

COORDINATION WITH TRICARE/CHAMPVA

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

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

PROCEDURES FOR CLAIMING BENEFITS

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

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

When completed, the claim must be sent to the Plan Supervisor at Allegiance Benefit Plan Management, Inc.; PO Box 21074; Eagan, Minnesota 55121, (406) 721-2222 or (800) 877-1122 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

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

Upon termination of the MMIA Member Entity's participation in the Plan or termination of the Plan, final claims must be received within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

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

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

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

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

"Authorized Representative" means a representative authorized by the claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization. A claimant's assignment of benefits to a health care provider or other assignee does not cause them to be a claimant's Authorized Representative.

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

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

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

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

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

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

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

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

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

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

APPEALING AN UN-REIMBURSED PHARMACY CLAIM

A Covered Person or their authorized representative has the right to appeal an Adverse Benefit Determination within one hundred eighty (180) days after an Adverse Benefit Determination decision is made. Appeals for Adverse Benefit Determination for Pharmacy Benefits claims will be processed by the Pharmacy Benefit Manager and are decided in accordance with the terms of the Plan Document/Summary Plan Description. Requests for pharmacy appeals and supporting documentation must be sent to:

ProAct Inc.
C/O Clinical Appeals Department
1230 US Highway 11
Gouverneur, New York 13642

INDEPENDENT PHARMACY CLAIM EXTERNAL REVIEW

If a Covered Person is not satisfied with an appeal Adverse Benefit Determination decision, they or their authorized representative may request an independent external review, performed by an external review group not associated with Pharmacy Benefit Manager 's internal review board. Request for an independent external review must be submitted in writing within one hundred twenty (120) days after an appeal Adverse Benefit Determination decision is made.

A request for an independent external review will not affect other benefits available under a Covered Person's Plan benefits. Requests for an independent external review must be submitted in writing to:

ProAct Inc.
C/O External Appeal Review
1230 US Highway 11
Gouverneur, New York 13642

Request should include:
- A specific request for an independent external review
- Covered Person's name, address, and insurance ID number
- Covered Person's authorized representative's name and address, if applicable
- The name of the medication that was not covered
- Any new or related information that was not provided during the appeal

The independent external review group will issue a final decision within forty-five (45) days after receipt of all necessary information. Urgent requests for independent external review will issue a final decision within seventy-two (72) hours after receipt of all necessary information. The decision of the independent external review group will be final and binding except that the Covered Person shall have an additional right to appeal the adverse determination to a court with jurisdiction.

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

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

1. The reason the claim was denied;

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

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

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

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

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

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

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

1. First Level of Benefit Determination Review

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

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

2. Second Level of Benefit Determination Review

   A sub-committee consisting of any three (3) of the fifteen (15) active members of the MMIA Board of Directors (Pre-service Appeals Sub-Committee) will review the claim in question along with the additional information submitted by the Covered Person.

   The Plan will conduct a full and fair review of the claim by the Pre-Service Appeals Sub-Committee who is neither the original decisionmaker nor the decisionmaker's subordinate. The Pre-Service Appeals Sub-Committee cannot give deference to the initial benefit determination. The Pre-Service Appeals Sub-Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the Pre-Service Appeals Sub-Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination nor their subordinate.

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

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

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

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

INDEPENDENT EXTERNAL REVIEW FOR A PRE-SERVICE CLAIM

After exhaustion of all appeal rights stated above, a Covered Person or their Authorized Representative may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, other issue requiring medical expertise for resolution, whether the Plan complied with the surprise billing and cost sharing protections of the No Surprises Act, a rescission of coverage matter, or when an Adverse Benefit Determination is made on a Mental Health or Substance Use Disorder claim based on an non-quantitative treatment limitation.

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

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

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

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

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

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

1. The reason the claim was denied;

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

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

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

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

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

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

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

1. First Level of Benefit Determination Review

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

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

2. Second Level of Benefit Determination Review

   The Executive Committee of MMIA Board of Directors will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Executive Committee of MMIA Board of Directors who is neither the original decisionmaker nor the decisionmaker's subordinate. The Executive Committee of MMIA Board of Directors cannot give deference to the initial benefit determination. The Executive Committee of MMIA Board of Directors may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the Executive Committee of MMIA Board of Directors will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or their subordinate.

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

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

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

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

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

INDEPENDENT EXTERNAL REVIEW FOR A POST-SERVICE CLAIM

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

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

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

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

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

ELIGIBILITY PROVISIONS

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

EMPLOYEE ELIGIBILITY

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

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

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

ELECTED OFFICIAL ELIGIBILITY

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

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

WAITING PERIOD

With respect to an eligible Employee, coverage under the Plan will not start until the Employee completes the applicable Waiting Period (applicable probationary period). The Waiting Period is the period of time as defined by the applicable MMIA Member Entity.

The Waiting Period commences with the Enrollment Date (eligibility date) and ends with a period of time, as designated by the Eligible Employer in the MMIA Member Entity's written personnel policy and in the eligibility statement provided by the MMIA Member Entity to the MMIA, starting from the Enrollment Date or the end of the Measurement Period whichever is applicable as defined in the MMIA Member Entity's written personnel policy and in the eligibility statement provided by the MMIA Member Entity to the MMIA.

If elected, coverage under this section shall continue for a period of time equal to the Measurement Period, provided the Participant remains employed by the Employer, but regardless of the number of hours worked during that time period. This period of time is the Coverage Period.

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

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

CONTRACTED MUNICIPAL GOVERNMENT PUBLIC OFFICER ELIGIBILITY

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

RETIREE ELIGIBILITY

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

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

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

DEPENDENT ELIGIBILITY

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

1. The Participant's or Retiree's legal spouse according to the marriage laws of the state where the marriage was first solemnized or established. Proof of legal marriage must be furnished to the Plan Administrator upon request.

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

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

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

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

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

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

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

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

   A. Neither partner is or has been for the past six (6) months, married, legally separated, a cohabiter or a domestic partner to another;

   B. The partners have cohabitated for at least six (6) months and continue to cohabitate;

   C. The partners are at least eighteen (18) years of age and mentally competent to consent to contract and mentally competent to execute the required Affidavit of Domestic Partnership;

   D. The partners are not related by blood to a degree that would bar marriage in the State of Montana;

   E. The partners are each other's sole domestic partner and intend to remain so indefinitely; and

   F. The partners are responsible for each other's common welfare and have a financial interdependent relationship evidenced by any of the following:

      1) Mutually granted financial or health care powers of attorney;
      2) Designation of each other as primary beneficiary in wills, life insurance policies or retirement plans;
      3) Executed a joint least, mortgage or deed; or
      4) Have joint ownership of a banking account.

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

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

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

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

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

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

EFFECTIVE DATE OF COVERAGE

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

PARTICIPANT COVERAGE

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

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

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

"Coverage Period" is the maximum period of time variable hour Employees can be covered under the Plan as active Employees after completion of a Measurement Period as defined in the Eligibility Provisions under the Employee Eligibility subsection.

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

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

DEPENDENT COVERAGE

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

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

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

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will be May 15 through June 15 of each year, during which an Employee and the Employee's eligible Dependents who are not covered under this Plan may request Participant or Dependent coverage. Coverage or changes requested during any Open Enrollment Period will begin on July 1 following the Open Enrollment Period. Coverage must be requested on a form approved by the Plan.

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

SPECIAL ENROLLMENT PERIOD

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

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

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

    A. Marriage to the Employee; or

    B. Birth of the Employee's child; or

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

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

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

    A. Marriage to the Participant; or

    B. Birth of the Participant's child; or

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

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

3. The spouse of a Participant (Covered Employee), or the spouse of a Retiree who is covered at the time of the Special Enrollment event, may enroll and will become covered on the date of the following specific events:

    A. Marriage to the Participant or Retiree; or

    B. Birth of the Participant's or Retiree's child; or

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

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

4. A Retiree who is covered at the time of a special enrollment event may enroll his/her eligible Dependents, including step children who are acquired under the circumstances below:

   A. Marriage to the Retiree; or

   B. Birth of the Retiree's child; or

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

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

5. The following individuals may enroll and become covered when coverage under another health care plan or health insurance terminates:

   A. If the eligible Employee's coverage terminates, the eligible Employee who lost coverage may enroll and become covered.

   B. If an eligible Dependent's coverage terminates, the eligible Dependent who lost coverage may enroll and become covered.

   C. If an eligible Dependent of a Retiree's coverage terminates, the eligible Dependent who lost coverage may enroll and become covered.

6. Individuals may enroll and become covered when coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 is terminated due to loss of eligibility, subject to the following:

   A. A request for enrollment must be made either verbally or in writing within sixty (60) days after this special enrollment event, and written application for such coverage must be made within ninety (90) days after such event.

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

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

   D. If an eligible Dependent of a Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.

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

For any Special Enrollment event, the Participant may also elect to change health plans to any plan offered by the MMIA Member Entity. The health plan for the Dependent must be the same as the Participant.

CHANGE IN STATUS

If a Covered Dependent under this Plan becomes an eligible Employee of an MMIA Member Entity, they may continue his/her coverage as a Dependent or elect to be covered as a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of an MMIA Member Entity, but is eligible to be covered as a Dependent under another Employee/Participant, they may elect to continue his/her coverage as a Dependent of such Employee/Participant.

Application for coverage due to a Change in Status must be made on the Plan's enrollment form, within thirty-one (31) days immediately following the date the Employee becomes or ceases to be an eligible Employee. A Change in Status will not be deemed to be a break or termination of coverage and will not cause a reduction or increase of any coverage or accumulations toward satisfaction of the deductible and Out-of-Pocket Maximum to which the Covered Person was entitled prior to the Change in Status.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan allows additional changes to enrollment due to change in status events under the Employer's Section 125 Cafeteria Plan only if that change is consistent with the status event. Refer to the Employer's Section 125 Cafeteria Plan for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

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

DEFINITIONS

For QMCSO requirements, the following definitions apply:

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

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

   A. Provides for child support for a child of a Participant under this Plan; or

   B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and

   C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

3. "Plan" means the MMIA Employee Health Benefit Plan, including all supplements and amendments in effect.

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

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

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

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

3. Specify each period to which such order applies.

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

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

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

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

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

NATIONAL MEDICAL SUPPORT NOTICE

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

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

EMPLOYERS SUBJECT TO FMLA

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

ELIGIBLE EMPLOYEES

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

REASONS FOR TAKING LEAVE

FMLA leave must be granted (1) to care for the Employee's newborn child; (2) to care for a child placed with the Employee for adoption or foster care; (3) to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; (4) because the Employee's own serious health condition prevents the Employee from performing their job; or (5) because of a qualifying exigency, as determined by the Secretary of Labor, arising out of the fact that a spouse, son, daughter or parent of the Employee is on active duty or has been called to active duty in the Armed Forces in support of a contingency operation (e.g., a war or national emergency declared by the President or Congress).

ADVANCE NOTICE AND MEDICAL CERTIFICATION

Ordinarily, an Employee must provide thirty (30) days advance notice when the requested leave is "foreseeable." If the leave is not foreseeable, the Employee must notify the Employer as soon as is practicable, generally within one to two working days. An employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee's serious health condition, the Employer may require second or third opinions, at the Employer's expense, and a certification of fitness to return to work prior to allowing the Employee to return to work.

PROTECTION OF JOB BENEFITS

For the duration of FMLA leave, the Employer must maintain the Employee's health coverage under any "group health plan" such as the Plan on the same conditions as coverage would have been provided if the Employee had been in Active Service during FMLA leave period. Also, the Employee and/or their authorized representative must provide acceptable medical documentation as required by the Plan Administrator. If an Employee returns to work after an FMLA leave, coverage will continue under the Plan. Taking FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave, unless the loss would have occurred even if the Employee had been in Active Service.

PAYMENT OF PLAN PREMIUMS

If applicable, arrangements will need to be made for the Employee to pay their share of Plan's premiums while on a FMLA leave. In some instances, the Employer may recover premiums it paid to maintain Plan coverage for an Employee who fails to return to work from a FMLA leave.

UNLAWFUL ACTS BY EMPLOYERS

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

ENFORCEMENT

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

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

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

1. For Member Entities:

   A. On the last day of the month in which the Participant's employment terminates if termination occurred between the 1st and the 15th of the month; or

   B. On the last day of the month following the month in which the Participant's employment terminates if termination occurred any day beyond the 15th day of the month; or

2. On the last day of the month in which the Participant or Elected Official ceases to be eligible for coverage; or

3. The date the Participant or Elected Official fails to make any required contribution for coverage; or

4. The date the Plan is terminated; or

5. The date the MMIA Member Entity terminates the Participant's or Elected Official's coverage; or

6. The date the Participant or Elected Official dies; or

7. The date the Participant or Elected Official enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days; or

8. On the last day of the month in which the Plan receives the Participant's or Elected Official's appropriate waiver of Plan Coverage; or

9. For variable hour Employees, on the last day of the Coverage Period, unless at the expiration of the Coverage Period, the Participant is otherwise eligible as the result of a subsequent Measurement Period or as a result of being reclassified as a full-time Employee.

A Participant or Elected Official whose Active Service ceases because of Illness or Injury or as a result of any other approved leave of absence may remain covered as an Employee in Active Service for a period of twelve (12) weeks, or such other length of time that is consistent with and stated in the MMIA Member Entity's written personnel policy or pursuant to the Family and Medical Leave Act. Coverage under this provision will be subject to all the provisions of FMLA if the leave is classified as FMLA leave.

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

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

RETIREE TERMINATION

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

1. The date the Retiree or their Dependents are no longer eligible to receive benefits in accordance with the applicable MMIA Member Entity's written personnel policy; or

2. The date the Retiree fails to make any required contribution for coverage; or

3. The date the Plan is terminated; or

4. The date the MMIA Member Entity terminates the Retiree's coverage; or

5. The date the Retiree dies; or

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

7. The date the Retiree is eligible for Medicare; or

8. The date the Retiree attains age sixty-five (65) years of age.

REINSTATEMENT OF COVERAGE

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

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

2. All prior accumulations toward annual or lifetime benefit maximums will apply.

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

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

DEPENDENT TERMINATION

Each Covered Person, whether Participant or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of Dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage After Termination.

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

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

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

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

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

5. The date the Plan is terminated; or

6. The date the MMIA Member Entity terminates the Dependent's coverage; or

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

8. On the last day of the month in which the Plan receives the Participant’s appropriate waiver of Plan Coverage for the Dependent; or

9. The date the Dependent of a Retiree is eligible for Medicare; or

10. The date the Dependent of a Retiree attains age sixty-five (65) years of age.

HEALTH PLAN OPTIONS

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

RESCISSION OF COVERAGE

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

CONTINUATION COVERAGE AFTER TERMINATION

Under the Public Health Service Act, as amended, Employees and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more employees.

A Participant's Domestic Partner is not eligible for COBRA Continuation Coverage.

The Plan Administrator is Montana Municipal Interlocal Authority (MMIA); 3115 McHugh Lane; Helena, MT 59602; (406) 443-0907. COBRA Continuation Coverage for the Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097, Missoula, MT 59806, (406) 721-2222; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com.

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

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

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

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

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

   A. Death of the Participant or Retiree.

   B. Termination of the Participant's employment.

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

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

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

NOTIFICATION RESPONSIBILITIES

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

1. The divorce or legal separation of the Participant or Retiree from their spouse.

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

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

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

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

3. Death of the Participant or Retiree.

4. The Participant becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

ELECTION OF COVERAGE

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

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

MONTHLY PREMIUM PAYMENTS

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

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

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

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

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and Dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and Dependent children if the former Employee dies or becomes divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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

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

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

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

WHEN COBRA CONTINUATION COVERAGE ENDS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

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

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

1. The month after employment ends; or

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

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

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

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

QUESTIONS

Questions concerning the Plan or a Covered Person's COBRA Continuation Coverage rights should be addressed to the COBRA Administrator or the Plan Administrator, as applicable. For more information about a Covered Person's COBRA Continuation Coverage rights under the Public Health Service Act, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the U.S. Department of Health and Human Services at (888) 393-2789. For more information about the Marketplace, visit www.HealthCare.gov.

INFORM THE PLAN OF ADDRESS CHANGES

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

COVERAGE FOR A MILITARY RESERVIST

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

1. If a Participant is absent from employment with Employer by reason of service in the uniformed services, or by reason for service as a reservist in the Federal Emergency Management Agency (FEMA) who is deployed for disaster response, the Participant may elect to continue coverage under this Plan for themself and their eligible Dependents as provided in this subsection if the absence is for thirty-one (31) days or more. The maximum period of coverage under such an election will be the lesser of:

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

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

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

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

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

COVERAGE FOR A MONTANA NATIONAL GUARD MEMBER

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

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

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

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

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

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

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

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

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

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

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

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

FRAUD AND ABUSE

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

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

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

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

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

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

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

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

MISSTATEMENT OF AGE

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

MISREPRESENTATION OF ELIGIBILITY

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

MISUSE OF IDENTIFICATION CARD

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

REIMBURSEMENT TO PLAN

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

RESCISSION OF COVERAGE

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

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

PAYMENT CONDITION

By enrolling in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits or requesting refunds for payments already made.

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available including, but not limited to, crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Covered Person(s), their attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s), or anyone on their behalf, settles, recovers, or is reimbursed money by any Coverage, person, corporation or entity, the Covered Person(s) agrees to reimburse the Plan, in first priority, for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for Expenses Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. Reimbursement to the Plan will be paid first, in its entirety, even if the Covered Person(s) is not paid for all of their claim for damages and regardless of whether the settlement, judgment or payment Covered Person(s) receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for Expenses Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

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

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

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine. By receipt of benefits under this Plan, each Covered Person authorizes the deduction of any excess payment from such benefits or other present or future compensation payments. The provisions of this subsection apply to any Physician or Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Physician or Licensed Health Care Provider refuses to refund improperly paid claims, the Plan may refuse to recognize future assignments of benefits to that provider.

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:

    A. Crime victim restitution funds
    B. Civil restitution funds

C. No-fault restitution funds such as vaccine injury compensation funds
D. Any medical, applicable disability or other benefit payments
E. School insurance coverage

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by their recovery from all sources, except as limited by 2-18-901 and 902, MCA, as amended. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan, except as limited by 2-18-901 and 902, MCA, as amended. Additionally, the Covered Person shall indemnify the Plan against any of the Covered Person's attorney's fees, costs, or other expenses related to the Covered Person's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights, except as limited by 2-18-901 and 902, MCA, as amended.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law, except as limited by 2-18-901 and 902, MCA, as amended. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, or disability.

COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accidental Injury. By virtue of this status, the Covered Person understands that they are required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

2. Instruct their attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

3. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which they exercise control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

RELEASE OF LIABILITY

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) ("Incurred") prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Covered Person(s) dies as a result of their Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

OBLIGATIONS

It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.

3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

9. To instruct their attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

10. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or their attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

RIGHT OF OFFSET

If timely repayment is not made, or the Covered Person and/or their attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

MINOR STATUS

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and their estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

PLAN ADMINISTRATION

PURPOSE

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

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

EFFECTIVE DATE

The effective date of the Plan is July 1, 2006, as restated July 1, 2026.

BENEFIT PERIOD

The Benefit Period is a Calendar Year.

PLAN YEAR

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

PLAN SPONSOR

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

PLAN SUPERVISOR

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

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is Montana Municipal Interlocal Authority (MMIA), an entity organized and existing under an interlocal governmental agreement, which has the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

PLAN INTERPRETATION

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

CONTRIBUTIONS TO THE PLAN

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

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

PLAN AMENDMENTS/MODIFICATION/TERMINATION

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

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

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

TERMINATION OF PLAN

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

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

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

GENERAL PROVISIONS

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined, at the expense of the Plan, whenever Injury or Illness is the basis of a claim when and so often as it may reasonably require to adjudicate the claim. The Plan will also have the right to have an autopsy performed in case of death to the extent permitted by law.

PAYMENT OF CLAIMS

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

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

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

LEGAL PROCEEDINGS

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

NO WAIVER OR ESTOPPEL

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

VERBAL STATEMENTS

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

FREE CHOICE OF PHYSICIAN

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

WORKERS' COMPENSATION NOT AFFECTED

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

CONFORMITY WITH LAW

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

MISCELLANEOUS

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

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

FACILITY OF PAYMENT

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

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

PROTECTION AGAINST CREDITORS

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

PLAN IS NOT A CONTRACT

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

GENERAL DEFINITIONS

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

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

ACCIDENTAL INJURY

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

ACTIVE SERVICE

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

ADVANCED PRACTICE REGISTERED NURSE

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

ADVERSE BENEFIT DETERMINATION

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

AMBULATORY SURGICAL CENTER

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

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

AMBULANCE SERVICE

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

AUTISM SPECTRUM DISORDER

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

BENEFIT PERCENTAGE

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

BENEFIT PERIOD

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

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

2. The date the Plan terminates.

BIRTHING CENTER

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

CALENDAR YEAR

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

CARDIAC REHABILITATION THERAPY

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

CIGNA LIFESOURCE FACILITY

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

CLOSE RELATIVE

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

COBRA

"COBRA" means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. § 300bb-1 through § 300bb-8], which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

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

CONVALESCENT NURSING FACILITY

See "Skilled Nursing Facility".

COPAYMENT

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

COSMETIC

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

COVERED PERSON

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

CUSTODIAL CARE

"Custodial Care" means any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the Covered Person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health.

These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for themselves. Custodial services include but are not limited to:

1. Services related to watching or protecting a person;

2. Services related to performing or assisting a Cover Person in preforming any activities of daily living, such as; walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and

3. Services not required to be preformed by a trained or skilled medical or paramedical personnel.

DEDUCTIBLE

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

DEPENDENT

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

DEPENDENT COVERAGE

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

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment which is:

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

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

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

ELECTED OFFICIAL

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

ELIGIBLE EXPENSES

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

EMERGENCY

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

EMPLOYEE

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

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

EMPLOYER

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

ENROLLMENT DATE

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

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

"Experimental/Investigational/Unproven" means medical, surgical, diagnostic, Psychiatric, Substance Use Disorder or other health care technologies, supplies, treatments, procedures, drug or biologic therapies or devices that are determined by the utilization review Physician to be:

1. Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;

2. Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Illness for which its use is proposed;

3. The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this Plan; or

4. The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in "Clinical Trials" of this Plan.

In determining whether any such technologies, supplies, treatments, drug or biologic therapies, or devices are Experimental, Investigational, and/or Unproven, the utilization review Physician may rely on Medical Policy. Medical Policy may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

FAMILY

"Family" means a Participant and their eligible Dependents as defined herein.

FMLA

"FMLA" means Family and Medical Leave Act.

HIPAA

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

HOME HEALTH CARE AGENCY

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

HOME HEALTH CARE PLAN

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

HOSPICE

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

HOSPICE BENEFIT PERIOD

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

HOSPITAL

"Hospital" means:

1. An institution licensed as a Hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Nurses;

2. An institution which qualifies as a Hospital, a Psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; or

3. An institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related Illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital does not include an institution which primarily a place for rest, a place for the aged or a nursing home.

ILLNESS

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

INCURRED EXPENSES OR EXPENSES INCURRED

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

INITIAL ENROLLMENT PERIOD

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

INJURY

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

INPATIENT

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

INTENSIVE CARE UNIT

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

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

2. It has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

3. It provides constant observation and treatment by Registered Nurses (RN) or other highly-trained Hospital personnel.

LICENSED HEALTH CARE PROVIDER

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

LICENSED PRACTICAL NURSE

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

LICENSED PROFESSIONAL COUNSELOR

"Licensed Professional Counselor" means a person currently licensed in the state in which services are rendered to perform mental health counseling in a clinical setting, for Mental Health conditions.

LICENSED SOCIAL WORKER

"Licensed Social Worker" (LSW) means a person holding a Master's Degree in social work and who is currently licensed as a social worker in the state in which services are rendered, and who provides counseling and treatment in a clinical setting for Mental Health conditions.

LICENSED VOCATIONAL NURSE

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

MAXIMUM LIFETIME BENEFIT

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

MEDICAID

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

MEDICALLY NECESSARY/MEDICAL NECESSITY

Except for Autism and Down syndrome, "Medically Necessary" or "Medical Necessity" means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose an Illness or Injury; and

2. Are ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and

3. Are not primarily for the convenience of the Covered Person, Physician or other Licensed Health Care Provider; and

4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person and are in accordance with the Plan's Medical Policy; and

5. Are not of an Experimental/Investigational/Unproven or solely educational nature; and

6. Are not provided primarily for medical or other research; and

7. Do not involve excessive, unnecessary or repeated tests; and

8. Are commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and

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

10. Are clinically appropriate, in terms of type, effectiveness, affordability, frequency, level and extent for the Covered Person's Illness or Injury; and

11. When multiple sites of care are clinically appropriate for the same service, the service rendered in the lowest level of care that is clinically appropriate for the Covered Person's condition.

For Autism, "Medically Necessary" or "Medical Necessity" means any care, treatment, intervention, service or item that is prescribed, provided or ordered by a Physician or Psychologist and will or is reasonable expected to:

1. Prevent the onset of an Illness, condition, Injury or disability;

2. Reduce or improve the physical, mental or developmental effects of an Illness, condition, Injury or disability; or

3. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

For Down syndrome, “Medically Necessary” or “Medical Necessity” means any care, treatment, intervention, service, or item that is prescribed, provided or order by a Physician licensed in the state of Montana, and that will or is reasonably expected to:

1. Reduce or improve the physical, mental or developmental effects of Down syndrome; or

2. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

MEDICAL POLICY

“Medical Policy” means a policy adopted by the Plan which is created and updated by Physicians and other medical providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;

2. Scientific studies showing conclusive evidence of improved net health outcome; and

3. In accordance with any established standards of good medical practice.

MEDICARE

“Medicare” means the programs established under the “Health Insurance for the Aged Act,” Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those who are eligible for Medicare Part A, Part B or Part D as a result of age, those with end-stage renal disease, or with disabilities.

MENTAL HEALTH

“Mental Health” means a medically recognized psychological, physiological, nervous or behavioral condition, affecting the brain, which can be diagnosed and treated by medically recognized and accepted methods, but will not include Substance Use Disorder or other addictive behavior. Conditions recognized by the Diagnostic Statistical Manual (the most current edition) will be included in this definition.

MMSERA

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

MMIA MEMBER ENTITY

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

NAMED FIDUCIARY

“Named Fiduciary” means the Plan Administrator which has the authority to control and manage the operation and administration of the Plan.

NEWBORN

“Newborn” refers to an infant from the date of his/her birth until the initial Hospital discharge or forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean section, whichever occurs first.

OCCUPATIONAL THERAPY

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

ORTHOPEDIC DEVICE

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

OUT-OF-POCKET MAXIMUM

"Out-of-Pocket Maximum" means the maximum dollar amount, as stated in the Schedule of Medical Benefits, that any Covered Person or Family will pay in any Benefit Period for covered services, treatments or supplies.

OUTPATIENT

"Outpatient" means a Covered Person who is receiving medical care, treatment, services or supplies at a clinic, a Physician's office, a Licensed Health Care Provider's office or at a Hospital if not a registered bed-patient at that Hospital, Psychiatric Facility or Substance Use Disorder Treatment Facility.

PARTIAL HOSPITALIZATION

"Partial Hospitalization" means care in a day care or night care facility for a minimum of twenty (20) hours per week, during which therapeutic clinical treatment is provided.

PARTICIPANT

"Participant" means an Employee of an MMIA Member Entity who is eligible and enrolled for coverage under this Plan. "Participant" may also mean a Contracted Municipal Government Public Officer as specifically described in the Eligibility Provisions section of this Plan.

PHYSICAL THERAPY

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

PHYSICIAN

"Physician" means a person holding the degree of Doctor of Medicine, Dentistry or Osteopathy, or Optometry who is legally licensed as such.

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

PLACEMENT OR PLACED FOR ADOPTION

"Placement" or "Placed for Adoption" means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

PLAN

"Plan" means the Health Benefit Plan for Employees of the MMIA Member Entities, the Plan Document/Summary Plan Description and any other relevant documents pertinent to its operation and maintenance of the Plan.

PLAN ADMINISTRATOR

"Plan Administrator" means MMIA and/or its designee which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purposes of the Public Health Service Act, Section 1310, as amended, and any applicable state legislation of a similar nature, the MMIA will be deemed to be the Plan Administrator of the Plan unless by action of the board of directors, the MMIA designates an individual or committee to act as the Plan Administrator of the Plan.

PLAN SUPERVISOR

"Plan Supervisor" means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Plan Supervisor is Allegiance Benefit Plan Management, Inc. The Plan Supervisor provides ministerial duties only, exercises no discretion over Plan assets and will not be considered a fiduciary as defined by the Public Health Service Act, Section 1310, or any other State or Federal law or regulation.

PREGNANCY

"Pregnancy" means a physical condition commencing with conception, and ending with miscarriage or birth.

PREVENTIVE CARE

"Preventive Care" means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, and which is not provided as a result of any Injury or Illness.

PROCEDURE BASED MAXIMUM EXPENSE or PBME (REFERENCED BASED PRICING)

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

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

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

For non-contracted providers for emergency services, air ambulance and non-participating providers providing services in a contracted facility, the PBME (Referenced Based Pricing) is equal to and used as the Qualified Payment Amount for No Surprises Billing Act purposes.

PROSTHETIC APPLIANCE

"Prosthetic Appliance" means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance.

PSYCHIATRIC CARE

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

PSYCHIATRIC FACILITY

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

PSYCHOLOGIST

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

QMCSO

"QMCSO" means Qualified Medical Child Support Order as defined by applicable law.

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means an Employee, former Employee or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA.

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

REGISTERED NURSE

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

RESIDENTIAL TREATMENT FACILITY

"Residential Treatment Facility" means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a Covered Person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

RETIREE

For Montana governmental entities: "Retiree" means an Employee who retires under a retirement program authorized by law and eligible to continue coverage with the Employer pursuant to the terms of 2-18-704 MCA as amended from time to time.

ROOM AND BOARD

"Room and Board" refers to all charges which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SKILLED NURSING FACILITY

"Skilled Nursing Facility" means a licensed institution (other than a Hospital, as defined) which specializes in:

1. Physical rehabilitation on an Inpatient basis; or

2. Skilled nursing and medical care on an Inpatient basis; but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Registered Nurses' services.

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

SPECIAL ENROLLMENT PERIOD

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

SPEECH THERAPY

"Speech Therapy" means a course of treatment to treat speech deficiencies or impediments.

SUBSTANCE USE DISORDER

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

SUBSTANCE USE DISORDER TREATMENT FACILITY

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

TELEMEDICINE

"Telemedicine" means the use of electronic information and communications technologies to provide and support health care when distance separates the Covered Person and their Physician or Licensed Health Care Provider.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act, as amended.

NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT: Group health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable.

IDENTIFICATION OF FUNDING: Benefits under this Plan will be paid from Employee or Employer contributions up to the limits defined in the Plan Document/Summary Plan Description (SPD). Benefits in excess of the amount stated in the stop loss policy are reimbursable to the Employer by stop loss insurance, pursuant to the stop loss insurance contract or policy, subject, however, to the terms of this Plan and the stop loss insurance contract.

WOMEN'S HEALTH AND CANCER RIGHTS ACT: This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Plan Administrator for more information.

RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When a Covered Person receives Emergency care or are treated by a Non-Network Provider at a Network Hospital or Ambulatory Surgical Center, the Covered Person is protected from balance billing. In these situations, the Covered Person should not be charged more than their Plan's Copayments, coinsurance, and/or Deductible, as applicable.

What is "balance billing" (sometimes called "surprise billing")?

When a Covered Person sees a Physician or other Licensed Health Care Provider, they may owe certain out-of-pocket costs, such as a Copayment, coinsurance, and/or Deductible, as applicable. The Covered Person may have additional costs or have to pay the entire bill if they see a Physician or other Licensed Health Care Provider or visits a health care facility that is not in the Plan's Network.

Non-Network Providers may be allowed to bill the Covered Person for the difference between what the Covered Person's Plan pays and the full amount charged for a service. This is called "balance billing". This amount is likely more than Network costs for the same service and might not count toward the Covered Person's Plan's Deductible or annual Out-of-Pocket Maximum.

"Surprise billing" is an unexpected balance bill. This can happen when the Covered Person cannot control who is involved in their care – such as when the Covered Person has an Emergency or when the Covered Person schedules a visit at Network facility but are unexpectedly treated by a Non-Network Provider.

A Covered Person is protected from balance billing for:

- **Emergency services** – If a Covered Person has an Emergency medical condition and receives Emergency services from a Non-Network Provider or facility, the most they can bill the Covered Person is the Covered Person's Plan's Network cost-sharing amount (such as Copayments, coinsurance, and Deductibles). The Covered Person cannot be balanced billed for these Emergency services. This includes services the Covered Person may receive after the Covered Person is in stable condition, unless the Covered Person gives written consent and gives up their protections not to be balanced billed for these post-stabilization services.

- **Certain non-emergency services at a Network Hospital or Ambulatory Surgical Center** – When the Covered Person receives services from a Network Hospital or Ambulatory Surgical Center, certain providers there may be Non-Network. In these cases, the most those providers can bill the Covered Person is their Plan's Network cost sharing amount. This applies to Emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill the Covered Person and may not ask the Covered Person to give up their protections not to be balanced billed.

If the Covered Person receives other types of services at these Network facilities, Non-Network Providers cannot balance bill the Covered Person, unless the Covered Person gives written consent and gives up their protections.

A Covered Person is never required to give up their protections from balance billing. A Covered Person is also not required to receive Non-Network care. The Covered Person can choose a provider or facility in their Plan's Network.

When balance billing is not allowed, a Covered Person has these protections:

- The Covered Person is only responsible for paying their share of the cost (such as Copayments, coinsurance, and Deductibles that they would pay if the provider were in-network). Their Plan will pay any additional costs to Non-Network Providers and facilities directly.

- Generally, the Plan must:

    1. Cover Emergency services without requiring the Covered Person to obtain approval in advance for services (also known as prior authorization).

    2. Cover Emergency services provided by Non-Network Providers.

    3. Base what the Covered Person owes the provider or facility (cost sharing) on what it would pay a Network Provider or facility and show that amount in the Covered Person's Explanation of Benefits (EOB).

    4. Count any amount the Covered Person pays for Emergency services or Non-Network services toward the Covered Person's Network Deductible and Out-of-Pocket Maximum.

If a Covered Person thinks they have been wrongly billed, call the phone number on their Plan's ID card. The Covered Person can also contact No Surprises Help Desk at (800) 985-3059 or www.cms.gov/nosurprises for more information about their rights under federal law.

HIPAA PRIVACY AND SECURITY STANDARDS

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

"Protected Health Information" (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to the physical or mental health of an individual, health care that individual has received, or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an Rmployer.

"Summary Health Information" means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the ZIP Code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or Plan Participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Document/Summary Plan Descriptions have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Document/Summary Plan Descriptions or as required by law. Such uses or disclosures may be for the purposes of Plan administration including, but not limited to, the following:

    A. Operational activities such as quality assurance and utilization management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.

    B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for Medical Necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.

    C. For purposes of this certification, Plan administration does not include disclosing Summary Health Information to help the Plan Sponsor obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a Participant in; is an enrollee of or has disenrolled from the group health plan.

2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. Make available PHI as required to allow the Covered Person a right of access to their PHI as required and permitted by the regulations;

6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;

7. Make available the PHI required to provide an accounting of disclosures as required by the regulations;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document/Summary Plan Description or Employees designated by the Plan Administrator(s) who need to know that information to perform Plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any Employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

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

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan Document/Summary Plan Descriptions have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.

2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.

3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.

4. Report to the Plan Administrator or the Named Fiduciary of the Plan any attempted breach, or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

PLAN SUMMARY

The following information, together with the information contained in this booklet, form the Plan Document/Summary Plan Description.

1. PLAN NAME

   The name of the Plan is the CITY OF KALISPELL PLAN, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

   This Plan provides benefits for covered Expenses Incurred by eligible Participants for: Hospital, Surgical, Medical, Maternity, other eligible medically related, necessary expenses.

3. PLAN EFFECTIVE DATE

   This Plan was established effective July 1, 2006, and restated July 1, 2026.

4. PLAN SPONSOR

   Name: Montana Municipal Interlocal Authority (MMIA)
   Phone (406) 443-0907
   Address: 3115 McHugh Lane
   Helena, MT 59602

5. PLAN ADMINISTRATOR

   Name: Montana Municipal Interlocal Authority (MMIA)
   Phone (406) 443-0907
   Address: 3115 McHugh Lane
   Helena, MT 59602

6. NAMED FIDUCIARY

   Name: Montana Municipal Interlocal Authority (MMIA)
   Phone (406) 443-0907
   Address: 3115 McHugh Lane
   Helena, MT 59602

7. PLAN FISCAL YEAR

   The Plan fiscal year ends June 30.

8. PLAN YEAR

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

9. BENEFIT PERIOD

   The Benefit Period is a Calendar Year.

10. PLAN TERMINATION

The right is reserved by the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

11. IDENTIFICATION NUMBER

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

12. PLAN SUPERVISOR

Name:	Allegiance Benefit Plan Management, Inc.
Address:	PO Box 21074 Eagan, Minnesota 55121

13. ELIGIBILITY

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

14. PLAN FUNDING

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

15. AGENT FOR SERVICE OF LEGAL PROCESS

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

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