

Plan Document and Summary Plan Description for



STILLWATER MINING COMPANY Bargaining Unit Health Plan

EFFECTIVE: JANUARY 1, 1993
RESTATED: JANUARY 1, 2014

Administered by:



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INTRODUCTION

This document is a description of the Stillwater Mining Company Bargaining Unit Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Participants against certain catastrophic health expenses.

Coverage under the Plan is available to Employees and their designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

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

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

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

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

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

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

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

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

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

Preferred Provider Networks. Explains how to select providers who provide greater discounts and greater benefits.

Covered Charges and Plan Exclusions. Explains when the benefit applies and the types of charges that are covered, as well as those that are not covered.

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

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

Claims Processing. Explains the rules for filing claims and the claims appeal process, as well as:

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

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

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

Rights, Responsibilities and Standards. Explains responsibilities of the Plan Administrator, HIPAA Privacy Standards, HIPAA Security Standards, and Participants rights under ERISA.

General Plan Information. Provides general information regarding the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees. All Employees represented by, or upon completion of applicable probationary hours will be represented by the **USW International Union, Local 11-0001** (or its successors and assigns), who have satisfied eligibility requirements shall be eligible **except:**

- (1) Non-Resident aliens; and
- (2) Any individual who is classified as an agent, consultant, independent contractor or self-employed individual, regardless of whether such person has or is later determined to have an employer-employee relationship with the Employer and regardless of any classification as a common law employee by the Internal Revenue Service or any other governmental agency, or any court of competent jurisdiction.

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

- (1) Is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work; and
- (2) Is in a class eligible for coverage.

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

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

The term 'Spouse' is the subscriber's spouse under a legally valid marriage. The Plan Administrator may require documentation proving a legal marital relationship, such as a marriage certificate or the Stillwater Affidavit of Marriage by Common Law.

The term "children" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children may also be included as long as a natural parent remains married to the Employee and the natural parent also resides in the Employee's household.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

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

Any child of a Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

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

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, is incapable of self-sustaining employment by reason of mental or physical handicap and is primarily dependent upon the covered Employee for support and maintenance and is unmarried. The covered Employee must submit proof of the Dependent child's incapacity and dependency within 31 days of the date the Dependent's coverage would otherwise terminate upon reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

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

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; or the legally separated or divorced former Spouse of the Employee.

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both. If both husband and wife are Employees, they cannot be a dependent of one another. Married children who have a parent and a spouse who are Employees cannot have duplicate coverage under both the parent and the spouse.

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

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

FUNDING

Cost of the Plan. Stillwater Mining Company shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The Plan is self-funded, which means benefits provided under the Plan are not guaranteed under a contract or policy of insurance and are paid out of the general assets of the Employer. The enrollment application for coverage will include a payroll deduction authorization.

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

ENROLLMENT

Enrollment Requirements.

An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If Dependent coverage is desired, Employee coverage is required. In order for an Employee to add a Dependent pursuant to a Qualified Medical Child Support Order (QMCSO), the Employee must also enroll.

Enrollment upon Change in Employment Status.

In the event an Employee becomes a member of the classes of Employees eligible for participation in this Plan, immediately after the Employee ceases to be in an Eligible Class of Employees for the Stillwater Mining Company Bargaining Unit Health Plan, provided that the Employee and his/her Dependents were enrolled in the Stillwater Mining Company Bargaining Unit Health Plan at the time of the status change, the Employee and his/her Dependents will become automatically enrolled in this Plan the first day of the calendar month following the employment status change. Credit will be given for any payments applied to deductible amounts, out-of-pocket maximums and any specified Plan benefit maximums met under the Stillwater Mining Company Bargaining Unit Health Plan during the Calendar Year in which the employment status change occurs.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee is automatically enrolled in this Plan for the first 31 days after birth only. To continue coverage beyond the first 31 days, the covered Employee must enroll the newborn child for Dependent coverage. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, the enrollment will be considered a Late Enrollment, there will be no payment from the Plan and **the parents will be responsible for all costs after the 31st day after the child's birth.**

TIMELY OR LATE ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

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

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

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

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

OPEN ENROLLMENT

Every year the Plan Administrator will designate an annual open enrollment period in order for Employees and their Dependents, who are Late Enrollees, to enroll in the Plan or to change coverage elections.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1st, following the open enrollment period.

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

SPECIAL ENROLLMENT RIGHTS

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

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request written for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

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

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:
 - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.
 - (d)** The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (e)** For purposes of these rules, a loss of eligibility occurs if:
 - (i)** The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a Lifetime limit on all benefits (if applicable).
 - (ii)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time employees).
 - (iii)** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be

eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

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

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

(2) Dependent beneficiaries. If:

- (a) The Employee is a Participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must complete a written request for enrollment during this 31-day period.

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

- (a) In the case of marriage, the first day of the first month beginning after the date of the completed written request for enrollment is received;
- (b) In the case of a Dependent's birth, as of the date of birth; or
- (c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

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

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

- (1) The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- (2) The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

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

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

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

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

EFFECTIVE DATE OF COVERAGE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirements.
- (2) The Active Employee Requirement(s).
- (3) The Enrollment Requirements of the Plan.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the first day of calendar month following the date that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met, or as otherwise specified under this Plan.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. **Please contact the Plan Administrator for a copy of these procedures and further details.**

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

(A "rescission" means a cancellation or discontinuance of coverage that has a retroactive effect. A "rescission" does not include the cancellation or discontinuance of coverage retroactively to the extent the cancellation or discontinuance of coverage is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage after required notice from the Plan Administrator. In the event the Plan Administrator seeks to rescind coverage, it must provide 30 days advance written notice to each Participant affected.)

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

- (1) The date the Plan is terminated;
- (2) The last day of the calendar month in which the covered Employee ceases to be eligible for coverage under the Plan. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods;
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;
- (4) If an Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage; or
- (5) As otherwise specified in the Eligibility section of this Plan.

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

Continuation During Periods of an Approved Employer-Sponsored Disability Leave of Absence. Beginning on the date in which the covered Employee last worked as an Active Employee, he or she may remain eligible for a limited period of time, not to exceed two (2) years, if Active, Full-Time work ceases due to an approved Employer sponsored disability leave of absence. Please contact the Plan Administrator for further information.

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

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that was in force when that coverage terminated. For example, waiting periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

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

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

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage. Please contact the Plan Administrator for further information.
- (3) An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

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

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

- (1) The period of coverage of a person under such an election shall be the period of time beginning on the date on which the person's absence for State active duty begins, and ending:
 - (a) The next regularly scheduled day of employment following travel time plus 8 hours, if State active duty is 30 days or less; or
 - (b) The next regularly scheduled day of employment following 14 days after termination of State active duty, if State active duty is not more than 180 days; or
 - (c) The next regularly scheduled day of employment following 90 days after termination of State active duty, if State active duty is more than 180 days.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except that a person on State active duty for less than 180 days may not be required to pay more than the regular Participant's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State active duty.

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

- (1) The date the Plan or Dependent coverage under the Plan is terminated;
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.)

- (3) On the last day of the calendar month in which a covered Spouse loses coverage due to loss of dependency status. (See the section entitled COBRA Continuation Coverage.);
- (4) On the last day of the calendar month in which a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled COBRA Continuation Coverage.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;
- (6) If a Dependent commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage; or
- (7) As otherwise specified in the Eligibility section of this Plan.

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

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the determination that: care and treatment are Medically Necessary; that payment is based on the Allowable Fee; that services, supplies and care are not Investigational and/or Experimental. The meanings of these capitalized terms are in the Defined Terms section of this document.

The Claims Administrator has entered into agreements with certain Hospitals (facilities), Physicians, and other healthcare providers. Herein, these certain Hospitals (facilities) and surgery centers shall be referred to as “**PPO Facility Providers**” and certain Home Health Agencies, Convalescent Home, Skilled Nursing Facilities and facilities for Chemical Dependency or Mental Illness shall be referred to as “**Participating Facility Providers**”, while these certain Physicians and other healthcare providers will be referred to as “**Preferred Professional Providers**” (together they shall be referred to as “Preferred Providers”). Please refer to the Preferred Provider Networks listed below.

When a Participant uses a Preferred Facility and/or Professional Provider, that Participant may receive a greater benefit from the Plan than when a Non-Preferred Facility and/or Professional Provider is used.

Should a Participant choose to use a Non-Preferred Provider (Facility or Professional), the Participant may be required to pay the total cost of the service at the point of service, submit his or her own Claim for services rendered to the Claims Administrator for processing, and may also be responsible for any amounts exceeding the Allowable Fee for that service. It is the Participant's choice as to which facility provider or professional provider to use.

The Plan will utilize the following Preferred Facility Provider and Preferred Professional Provider Networks:

In Montana:

- Blue Cross and Blue Shield of Montana PPO Facility Network;
- Blue Cross and Blue Shield of Montana Participating Facility Network;
- Blue Cross and Blue Shield of Montana Participating Professional Provider Network;

Outside of Montana:

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

*Some Blue Cross and/or Blue Shield Plans require services to be provided by a PPO professional provider for the Participant to receive the highest level of benefit. Contact the Claims Administrator for additional information on out of state services.

For the Organ Transplant benefit:

- A Centers of Excellence facility

To access a list of Blue Cross and Blue Shield Providers, please refer to the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com and/or call the toll free number listed on the back of the **Blue Cross and Blue Shield of Montana / Stillwater Mining Company identification card**. Prior to receiving medical care services, the Participant should confirm with the provider that they are a Preferred Provider.

It should be noted that this directory is to be used as a reference only, as network affiliations have a tendency to change periodically. Prior to receiving medical care services, the Participant should confirm with the provider that the provider is a participant in one of the above referenced networks. Contact information for Preferred Provider Networks may be obtained from either the Plan Administrator or the Claims Administrator.

Deductibles payable by Participants

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

A deductible is an amount of money that is paid once a Calendar Year per Participant. Typically, there is one deductible amount per Participant and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

In rare instances, an inpatient Hospital stay (reimbursed on a Diagnostic Related Group (DRG) or per diem PPO rate) can be repriced to exceed the billed amount. The Plan will be responsible for this overage.

Under the following circumstances, the higher Participating Provider payment will be made for certain Non-Participating Provider services:

- Ancillary services, including radiology, pathology, or anesthesiology when provided by a Non Network Provider at an In Network facility.

MEDICAL BENEFITS SCHEDULE

Important Note: Refer to the separate Medical Benefits section and Medical Plan Exclusions section for additional information, limitations and clarifications on the benefits described in the Schedule of Benefits below:

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$200	
Per Family Unit	\$400	
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	\$1,200	\$1,450
Per Family Unit	\$2,400	\$2,900
<i>The Preferred Provider and Non-Preferred Provider Maximum Out-Of-Pocket Amounts will apply toward each other.</i>		
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
<u>Prescription Drug copayments do not apply toward the Medical out-of-pocket maximum and are never paid at 100%</u>		
COVERED CHARGES		
Note: The maximums listed below are the total for Preferred and Non-Preferred expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Preferred and Non-Preferred providers.		
Supplementary Accident Charge Benefit	100% of the first \$500, no deductible applies – within 1 st 90 days of accident; thereafter, 80% after deductible	80% of the first \$500, no deductible applies – within 1 st 90 days of accident; thereafter, 60% after deductible
Hospital Services		
Room and Board	80% after deductible	60% after deductible
Intensive Care Unit	80% after deductible	60% after deductible
Outpatient Surgery and Hospital services	80% after deductible	60% after deductible
Emergency room services	80% after deductible	80% after deductible
Skilled Nursing Facility	80% after deductible 100 days Calendar Year maximum	60% after deductible 100 days Calendar Year maximum
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
Office visits	80% after deductible	60% after deductible
Allergy testing, serum and injections	80% after deductible	60% after deductible
Ambulance Service	80% after deductible	
Applied Behavioral Analysis (ABA) (for covered Dependent children birth to age 18 years)	80% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible
Chiropractic Care	80% after deductible 35 visits per Calendar Year	60% after deductible 35 visits per Calendar Year
Diagnostic Testing (X-ray & Lab)	80% after deductible	60% after deductible

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Durable Medical Equipment and Prosthetics (Excluding Orthotics)	80% after deductible	60% after deductible
Hearing Aids Benefit Maximum:	80% after deductible Once every two years. No coverage for repair breakage or batteries.	
Home Health Care	80% after deductible 180 visits per Calendar Year maximum	60% after deductible 180 visits per Calendar Year maximum
Hospice Care	80% after deductible	60% after deductible
Home Infusion Therapy	80% after deductible	60% after deductible
Mental Health and Substance Abuse Treatment		
Inpatient and Outpatient services	80% after deductible	60% after deductible
Orthotic Devices Foot Orthotics	80% after deductible 1 per foot per Calendar Year	80% after deductible 1 per foot per Calendar Year
Outpatient Therapies (Physical, Occupational and Speech Therapy)	80% after deductible 25 visits per Calendar Year per therapy	60% after deductible 25 visits per Calendar Year per therapy
Rehabilitation Therapy (Inpatient)	80% after deductible	60% after deductible

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Preventive Care		
Routine Well Care (Ages Birth through Adult)	100% No deductible applies	80% No deductible applies
Includes the following routine services: Office visits, routine physical examinations, well-child visits, routine x-rays and laboratory tests, routine vision and hearing screenings, and all other screenings and preventive services which are recommended and graded A or B by the United States Preventive Services Task Force.		
Breast Cancer Screening, Testing and Counseling	100% No deductible applies	80% No deductible applies
Cervical Cancer Screenings	100% No deductible applies	80% No deductible applies
Routine Colonoscopy / Flexible Sigmoidoscopy	100% No deductible applies	80% No deductible applies
Diabetes Screening	100% No deductible applies	80% No deductible applies
Dietary/Nutrition Education (including but not limited to diabetic education)	100% No deductible applies	80% No deductible applies
Hypertension Screening and Counseling	100% No deductible applies	80% No deductible applies
Hyperlipidemia Screening and Counseling	100% No deductible applies	80% No deductible applies
Immunizations and Vaccines (as adopted by the Director of Centers for Disease Control and Prevention)	100% No deductible applies	80% No deductible applies
Prostate Specific Antigen (PSA) Test	100% No deductible applies	80% No deductible applies
Tobacco Cessation benefit (including screening, counseling and treatment)	100% No deductible applies	80% No deductible applies
Obesity screening, counseling and treatment (excluding surgery)	Office Visit and Laboratory Services 100% No deductible applies	Office Visit and Laboratory Services 80% No deductible applies
	All other nonsurgical services 80% after deductible	All other nonsurgical services 60% after deductible
Pregnancy	80% after deductible	60% after deductible
Routine Well Newborn Nursery Care	80% after deductible	60% after deductible
Organ Transplants *	80% after deductible <u>Donor Procurement / Travel / Lodging benefit maximum:</u> \$500,000 Lifetime Maximum	Not Covered
*Note: This benefit will be applicable only when utilizing a Centers of Excellence (COE) transplant facility. For more information regarding this benefit, please refer to the Organ Transplant benefit listed in the Covered Charges section under this Plan.		
All Other Eligible Charges	80% after deductible	60% after deductible

PRESCRIPTION DRUG BENEFIT

Pharmacy Option – Limited to a 34-day supply.

Copayments

Generic drugs	\$5.00
Formulary Brand Name drugs	\$20.00
Non-Formulary Brand Name drugs	\$30.00

Pharmacy Option – Maintenance Rx – 90-day supply.

Available only at select participating pharmacies. Please ask your pharmacy if they are a 90-Day Retail Network Provider for Express Scripts.

Copayments

Generic drugs	\$10.00
Formulary Brand Name drugs	\$40.00
Non-Formulary Brand Name drugs	\$60.00

Mail Order Option – Maintenance Rx -90-day supply.

Copayments

Generic drugs	\$10.00
Formulary Brand Name drugs	\$40.00
Non Formulary Brand Name drugs	\$60.00

For additional information regarding this benefit contact Express Scripts at (877)583-9057.

Note: Brand Name drugs are re-evaluated from time to time, and as such the Formulary and Non-Formulary lists may change. Participants may access the following website www.express-scripts.com in order to determine which Prescription Drugs are considered Formulary.

PREFERRED PROVIDER NETWORKS

The participation or nonparticipation of providers from whom a Participant receives services, supplies, and medication impacts the amount the Plan will pay and the Participant's responsibility for payment.

Professional Providers and Facility Providers

Professional providers and facility providers are either Preferred Providers or non-preferred providers.

Preferred Professional Providers are professional health care providers who have a contract with the Claims Administrator, Blue Cross and Blue Shield of Montana. Preferred Professional Providers include, but are not limited to, Physicians, Physician assistants, nurse specialists, doctors of osteopathy, dentists, optometrists, podiatrists, acupuncturists, advanced practice registered nurses, naturopathic physicians, home infusion therapy agencies, speech therapists, occupational therapists and physical therapists.

Preferred Facility Providers are facilities that have a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana. Preferred Facility Providers include, but are not limited to, Hospitals, Home Health Care Agencies, convalescent homes, skilled nursing facilities and freestanding facilities for the treatment of chemical dependency or mental illness and freestanding surgical facilities. Also included in the Preferred Facility Provider are HealthLink PPO Providers which are Hospitals and Surgery Centers.

Centers of Excellence are transplant facilities that are recommended because of the quality of the outcomes at these facilities.

The Participant may obtain a list of Preferred Providers from Blue Cross and Blue Shield of Montana free of charge by contacting the Claims Administrator at the number listed on the inside cover of this document.

How Providers are Paid by the Plan and Participant Responsibility

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

A **Preferred Provider** agrees to accept payment of the Allowable Fee from Blue Cross and Blue Shield of Montana for Covered Charges, together with any deductible and coinsurance from the Participant, as payment in full. Generally, payment will be made directly to the Preferred Provider. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

Non-preferred providers do not have to accept Blue Cross and Blue Shield of Montana payment as payment in full. Blue Cross and Blue Shield of Montana reimburses a non-preferred provider for Covered Charges according to the Allowable Fee. The nonparticipating provider can bill the Participant for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus deductible and coinsurance. The Participant will be responsible for the balance of the non-preferred provider's charges after payment by Blue Cross and Blue Shield of Montana and payment of any deductible and coinsurance.

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

Out-of-Area Services – The BlueCard Program

Out-of-Area Services

Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Participant obtains healthcare services outside

of the Blue Cross and Blue Shield of Montana service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

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

1. BlueCard® Program

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

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

- The billed covered charges for the Participant’s covered services; or
- The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Montana.

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

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

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

2. Non-Participating Healthcare Providers Outside of the Blue Cross and Blue Shield of Montana Service Area

a. Participant Liability Calculation

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

b. Exceptions

In certain situations, Blue Cross and Blue Shield of Montana may use other payment bases, such as billed covered charges, the payment Blue Cross and Blue Shield of Montana would make if the healthcare services had been obtained within the Blue Cross and Blue Shield of Montana service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Blue Cross and Blue Shield of Montana will pay for services rendered by non-participating healthcare providers. In these situations, the Participant may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

MEDICAL BENEFITS

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

DEDUCTIBLE

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

Deductible For A Common Accident. This provision applies when two or more Participants in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Participant that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Participant will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

COVERED CHARGES

Covered Charges are the charges that are incurred for the following items of service and supply. Payment will be based on the Allowable Fee. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Acupuncture.** Services provided by an acupuncturist are covered for services performed within the scope of their licensure. Acupuncture services are not covered for smoking cessation and weight management.
- (2) **Ambulance.** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (3) **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included when performed by a Physician or Certified Registered Nurse Anesthetist (CRNA), other than the attending Physician, in connection with treatment of any condition for which medical-surgical benefits are payable, when anesthesia is Medically Necessary.

Hypnosis, local anesthesia, and anesthesia consultations before surgery, and anesthesia for dental services or extraction of teeth (except as stated as a benefit under this Plan) are not considered Covered Charges under this Plan.

- (4) **Applied Behavioral Analysis (ABA)** or other similar services, including Habilitative and Rehabilitative

Care when provided by an individual licensed by the behavioral analyst certification board or certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement. **Note:** Benefits are limited to treatment that is prescribed by a Physician and documented by a written Plan of Care provided by the treating Physician. The Claim Administrator may request periodic documentation of continued progress to goals identified in the Plan of Care.

Benefits will be payable only for covered Dependent child(ren) from birth through age 18 years and will be payable up to the limits as stated in the Schedule of Benefits.

- (5) **Approved Clinical Trials.** Routine Patient Costs provided in connection with Approved Clinical Trials.
- (6) **Blood transfusion services.** Blood bank service charge and administration charges. Blood transfusions, including cost of blood, blood plasma, blood plasma expanders, and packed cells. Storage charges for blood are covered when the Participant has blood drawn and stored for their own use for a planned surgery.
- (7) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered:
 - (a) Under the supervision of a Physician;
 - (b) In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
 - (c) Initiated within 12 weeks after other treatment for the medical condition ends; and
 - (d) In a Medical Care Facility as defined by this Plan.
- (8) **Chemotherapy** or radiation treatment with radioactive substances. The materials and services of technicians are included.
- (9) **Chiropractic services.** See Spinal Manipulation/Chiropractic services.
- (10) **Contact lenses.** Initial contact lenses or glasses required following cataract surgery.
- (11) **Contraception.** Contraceptive devices when prescribed by a Physician including, but not limited to, intrauterine devices (IUD), diaphragms, implantable contraceptives, and including any associated Physician's charges.
- (12) **Diabetic/Dietary/Nutrition Education.** Outpatient self-management training and education when provided by a licensed health care professional. No benefits shall be provided for books or tapes.
- (13) **Durable medical or surgical equipment, Prosthetics, Orthopedic (Orthotic) Services** when prescribed by a Physician and deemed Medically Necessary. For major equipment, rental will be paid up to the purchase price.

"Durable Medical Equipment" means the type of equipment required for therapeutic purposes in the Participant's home.

"Orthopedic devices" are rigid or semi-rigid supportive devices which restrict or eliminate motion of a weak or diseased body part. These devices must be Medically Necessary and prescribed by a Physician. Coverage is limited to braces, corsets, trusses, and splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness.

"Prosthesis" means a device used to replace a body part missing due to an accident, Injury, Illness, or a congenital anomaly.

The Plan will pay for Medically Necessary Durable Medical Equipment (DME) and Prosthetics as shown in the Schedule of Benefits. Payment will be subject to the following:

- (i) When placement of a prosthesis is part of a surgical procedure, it will be payable under the Hospital benefits.

Covered Supplies/Equipment

- (i) Medically Necessary covered Durable Medical Equipment, orthopedic devices, and prosthetics (as defined in this Plan).
- (ii) Repairs: If repairs are required on Durable Medical Equipment or a prosthesis, the Plan will pay up to the amount which would be allowed for replacement of the equipment.
- (iii) Rental: The Plan may approve rental cost of Durable Medical Equipment up to the purchase price.

Please refer to the Plan Exclusions section for information regarding DME not covered under this Plan.

- (14) **Foot Orthotics.** The Plan will pay for foot orthotics provided by a covered provider.
- (15) **Hearing Aid Benefit.** Charges for services or supplies in connection with hearing aids including exams for their fitting, and will be payable up to the limits as stated in the Schedule of Benefits. Subject to Medical Policy.
- (16) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Illness. The diagnosis, care, and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

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

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

- (17) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when they are Medically Necessary and are required for the administration of home infusion therapy regimen, when ordered by and are part of a formal written plan prescribed by a Physician and provided by an accredited home infusion therapy agency. The benefit will include all Medically Necessary services and supplies (and equipment) including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, pharmacy, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor response to therapy, and Skilled Nursing services when billed by a home infusion therapy agency.

Note: Skilled Nursing services billed by a Home Health Agency will be covered under the Home Health benefit under this Plan.

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

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

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

In-Hospital medical benefits are limited to one visit per day per professional provider. If a Physician other than the admitting Physician (or in the case of surgery, the surgeon) provides care for the Participant while confined in the Hospital, this will be covered as concurrent care only if the second Physician is treating the Participant for a medical condition different from the condition for which the Participant had surgery or the nature or severity of the condition requires the skills of separate Physicians.

- (20) **Infertility.** Care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of infertility. *Please refer to Plan Exclusions for information regarding infertility charges not covered under this Plan.*
- (21) **Laboratory studies** and tissue diagnostic exams are covered when Medically Necessary due to an Illness or Injury.
- (22) **Mental Disorders and Substance Abuse.** Covered Charges will be payable for care, supplies and treatment of Mental Disorders and Substance Abuse.
- *23) **'Mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Emergency repair due to Injury to sound natural teeth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

General anesthesia is covered when necessary for a covered accident or oral surgery, when provided by a Physician or Dentist other than the one who performed the procedure requiring the anesthesia. Local anesthesia is not covered as a separate charge.

Services and supplies provided by a Hospital in conjunction with dental treatment will be covered as medical expenses only when a non-dental Illness or Injury exists which makes Hospital care necessary to safeguard the Participant's health. Complexity of dental treatment and length of anesthesia are not considered non-dental physical Illness or Injury.

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

- (24) **Naturopath.** Services provided by a naturopath are covered for services performed within the scope of their licensure.
- (25) **Newborn Nursery/Physician Care.**

Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth, and who is neither injured nor ill, and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth. *Note: Benefits for the Covered Charges of an injured or ill newborn are payable under the normal plan provisions of this Plan.*

Payment is based on the Allowable Fee for nursery care for the newborn child while Hospital confined as a result of the child's birth.

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

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

Physician Care. Payment for routine Physician care benefits are based on the Allowable Fee when provided by a Physician for the newborn child while Hospital confined as a result of the child's birth.

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

- (26) **Obesity Benefit.** Non-surgical treatment for obesity including obesity screening, counseling, including nutritional counseling, and weight loss medications, when prescribed by a Physician.

Surgery, fitness or health club membership will not be Covered a Covered Charge under this Plan

- (27) **Organ transplant benefits.** Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant, that are not considered Investigational/Experimental, are subject to the following criteria (and are subject to the limits as stated in the Schedule of Benefits):

- The transplant must be performed to replace an organ or tissue.
- Transplant of a nonhuman organ or artificial organ implant will not be a Covered Charge under this Plan.
- Licensed ambulance travel for the transplant recipient only to the nearest Hospital with appropriate facilities.
- Prescription drugs directly related to the transplant. (Those purchased at a pharmacy are covered under the Prescription Drug Benefit section under this Plan.)

Organ procurement limits:

Charges for obtaining donor organs or tissues are Covered Charges under the Plan and are payable as follows:

- (i) When both the transplant recipient and donor are Participants under this Plan, both will receive benefits.
- (ii) When the transplant recipient is covered and the donor is not, the recipient will receive the benefits of this Plan, and the donor will receive benefits to the extent that benefits to the donor are not provided under other hospitalization coverage.
- (iii) When the transplant recipient is not covered and the donor is, the donor will receive benefits to the extent that benefits are not provided the donor by hospitalization coverage of the recipient.

The donor benefits under this Plan will be reduced by those payable under the donor's plan.

Donor charges include those for:

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

Note: Expenses related to donor searches and the purchase of any organ will not be covered by the Plan.

Transplant Travel, Lodging and Meals:

- (i) Commercial transportation maximum of \$2,000 per transplant. Includes round trip commercial air or two way ground transportation up to a \$2,000 maximum for the adult transplant recipient and spouse

or a minor child transplant recipient and guardian.

- (ii) \$100 maximum per day for lodging and meals.
- (iii) Spouse of transplant recipient or guardian of minor are included in the travel, lodging and meal benefit and accumulate to the \$2,000 travel maximum and the \$100 lodging and meal maximum.
- (iv) Benefits for travel, lodging and meals are only available if the Participant lives more than 50 miles from the approved facility and the expenses are incurred within 4 days of the procedure to the discharge to home date.
- (v) If services are not performed at a Center of Excellence, travel, lodging and meal expenses are not covered.
- (vi) One post operative visit allowed per calendar year benefit period following the transplant to the Center of Excellence that performed the transplant. The post operative travel benefit is only available for the adult transplant recipient or the minor child transplant recipient and guardian. Spouses are not eligible to receive this benefit. Post Operative travel will have a \$2,000 maximum and will include round trip commercial air or two way ground transportation.
- (vii) Postoperative visit does not include lodging or meal benefits.
- (viii) All travel, lodging and meal expenses must be verified by receipts for reimbursement.
- (ix) If the \$500,000 lifetime maximum benefit for Donor Procurement travel and lodging benefit has been exhausted, no benefits will be provided for travel.

As soon as reasonably possible, but in no event more than ten (10) days after a Participant's attending Physician has indicated that the Participant is a potential candidate for a transplant, it is strongly recommended the Participant or his or her Physician contact Customer Service at 1-855-258-3489.

- In the event a **Centers of Excellence (COE) transplant facility** is utilized, benefits will be payable at the Centers of Excellence benefit level as shown in the Schedule of Benefits.
- *In the event a non-Centers of Excellence (COE) transplant facility is utilized, no benefits will be payable under this Plan.*

A **Centers of Excellence (COE) facility** is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Participant may contact Blue Cross and Blue Shield of Montana to determine whether or not a facility is considered a Centers of Excellence.

Transplant Exclusions

Coverage for the following procedures, when Medically Necessary, will be provided under the regular medical benefits provision under this Plan, subject to any Plan provisions and applicable benefits limitations as stated in the Schedule of Benefits; and therefore, will be excluded under the Organ Transplant Benefit provision of the Plan:

- (1) Cornea transplantation
- (2) Skin grafts
- (3) Artery
- (4) ~~Vein~~

(5) Valve

(6) Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

(7) "Midney

(28) **Outpatient therapies.** Medically Necessary services of a licensed physical therapist, speech therapist or occupational therapist, up to the limits as stated in the Schedule of Benefits. *Please refer to the Plan Exclusions section for information regarding outpatient therapies not covered under this Plan.*

(29) **Physician Care.** The professional services of a Physician for surgical or medical services. The services of a consulting Physician requested by the attending Physician are Covered Charges under this Plan.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Fee that is allowed for the primary procedures; 50% of the Allowable Fee will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.
 - Surgery will not be considered incidental if (1) it involves a major body system different from the primary surgical services; (2) it adds significant time or complexity to the operating session and patient care.
 - If two surgeons are paid as primary or co-surgeons for their multiple surgeries, no allowance as an assistant will be payable to either of the surgeons. Any charges for an additional assistant surgeon will be subject to medical review by the Plan Administrator.
 - (ii) If an operation or procedure is performed in two or more steps, total payment will be limited to the Allowable Fee for the initial procedure;
 - (iii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowable Fee for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Fee for that procedure; and
 - (iv) If an assistant surgeon is required and is a Physician, the assistant surgeon's payment will be limited to 20% of the surgeon's Allowable Fee of the Covered Charge or the assistant's charge, whichever is less;
 - If the assistant surgeon is a non-Physician assistant or surgical technician, the assistant surgeon's payment will be limited to 10% of the surgeon's Allowable Fee allowance of the Covered Charge or the assistant's charge, whichever is less;
 - Benefits are not available when the assistant at surgery is present only because the facility provider requires such services;
 - Benefits for the assistant surgeon will be payable only if the Covered Charges are determined by the Plan Administrator as Medically Necessary;
 - (v) Any charge for a surgical suite outside of the Hospital is included in the Allowable Fee for the surgery.
- (30) **Pregnancy.** Payment is based on the Allowable Fee for the care and treatment of Pregnancy are covered the same as any other Illness.

In general, two routine ultrasounds will be covered under this Plan. Additional ultrasounds may be subject to medical necessity.

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

- (31) **Prescription Drugs** (as defined). Outpatient Prescription Drugs will be payable under the separate Prescription Drug Benefit section under this Plan.
- (32) **Preventive Care - Routine.** Routine Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

In addition to the Preventive Care benefit, the following services are included:

(a) **Lactation Services** - Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. In addition, The Plan will reimburse the Member the actual cost for the purchase of a breast pump once per birth event. Hospital – grade pumps can be rented, in the postpartum period, per Medical Policy criteria. For additional information, access www.bcbsmt.com and click on “new Mothers”.

(b) **Contraceptives** - Food and Drug Administration approved contraceptive methods, including certain contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity.

Well Child Care is routine care by a Physician that is not for an Injury or Illness.

- (33) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.) when ordered by a Physician and deemed Medically Necessary.
- (34) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) Reconstruction of the breast on which a mastectomy has been performed;
- (ii) All stages of surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (iii) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas.

in a manner determined in consultation with the attending Physician and the patient.

- (35) **Post-mastectomy care:** Inpatient care will be covered for the period of time determined to be Medically Necessary by the Participant’s Physician and surgeon, for care following a mastectomy, a lumpectomy, or a lymph node(s) removal for the treatment of breast cancer.
- (36) **Rehabilitation therapy** charges up to the limits stated in the Schedule of Benefits.

Inpatient and Outpatient Care.

- (a) Therapy services must be provided by a multi-disciplinary team under the direction of a qualified Physician.
- (b) Members of the multidisciplinary team may include, but are not limited to, a licensed psychologist, licensed speech therapist, registered physical therapist, or licensed occupational therapist.
- (c) Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery. The Participant must continue to show measurable progress.

“Rehabilitation therapy” is a specialized treatment by a multidisciplinary team for an Injury or physical deficit to restore or bring to a condition of function as near as possible to the former state before the Illness or loss of bodily part or bodily function.

“Multidisciplinary team” means a group of health service providers who must be either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. ***Please refer the Plan Exclusions section for information regarding rehabilitation therapies not covered under this Plan.***

- (37) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
 - (a) The patient is confined as a bed patient in the facility; and
 - (b) The attending Physician certifies that the confinement is Medically Necessary; and
 - (c) The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Participant's care in these facilities are payable up to the limits as described in the Schedule of Benefits.

- (38) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O., or D.C. subject to Medical Necessity.
- (39) **Sterilization** procedures.
- (40) **Substance Abuse.** See Mental Disorders and Substance Abuse.
- (41) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations. Also included are Medically Necessary medical supplies for use outside a Hospital including syringes and related supplies (for conditions such as diabetes); dressings (for conditions such as cancer or burns); splints; catheters; colostomy bags and related supplies; test tape; and supplies for renal dialysis equipment.
- (42) **Tobacco Cessation benefit** will include screening, counseling and treatment. Treatment will include tobacco cessation programs. *Hypnosis and acupuncture will not be considered a form of treatment for Tobacco Cessation under this Plan.*

Tobacco cessation products, when prescribed by a Physician, will be payable under the separate Prescription Drug Benefit section of this Plan.

- (43) **X-rays.** Diagnostic x-rays and medical diagnostic procedures are covered when Medically Necessary due to an Illness or Injury.

SUPPLEMENTARY ACCIDENT CHARGE BENEFITS

This benefit applies when an accident charge is incurred for care and treatment of a Participant's Injury and:

- (1) The Injury is sustained while the person is covered for these benefits; and
- (2) The charge is for a service delivered within 90 days of the date of the accident; and
- (3) To the extent that the charge is not payable under any other benefits under the Plan (other than Medical Benefits).

BENEFIT PAYMENT

Benefits will be paid as described in the Schedule of Benefits.

ACCIDENT CHARGE

An accident charge is a charge incurred for the following:

- (1) Physician services.
- (2) Hospital care and treatment.
- (3) Diagnostic x-rays and lab tests.
- (4) Local professional ambulance service.
- (5) Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations.
- (6) Nursing service.
- (7) Anesthesia.
- (8) Covered Prescription Drugs.
- (9) Use of a Physician's office or clinic operating room.

Exclusions:

- (1) Chiropractic/Spinal Manipulation services. These services will be payable and subject to any limits per the separate Chiropractic/Spinal Manipulation benefit under this Plan.

MEDICAL PLAN EXCLUSIONS

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

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Acupuncture.** Acupuncture for smoking cessation and weight management.
- (2) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (3) **Cosmetic surgery.** Services or supplies related to cosmetic surgery. "Cosmetic surgery" means surgery which improves appearance or corrects a deformity without restoring a function of the body. Some procedures are usually cosmetic but may not always be. Cosmetic/reconstructive surgery required as a result of Illness, Injury, or a birth defect will be considered a Covered Charge.

Any drugs or supplies used for cosmetic purposes or cosmetic treatment will also be excluded under this Plan.
- (4) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as stated as a benefit under this Plan.
- (5) **Dental services** except as specifically stated as a benefit under this Plan.
- (6) **Durable Medical Equipment** (as defined as a benefit under this Plan) does not include, and is not limited to, the following: Exercise equipment; car lifts or stair lifts; biofeedback equipment; humidifiers or dehumidifiers; self-help devices (which are not medical in nature, regardless of the relief they provide for a medical condition); air conditioners and air purifiers; whirlpool baths, hot tubs, or saunas; waterbeds; other equipment which is not always used for healing or curing; "deluxe" equipment such as motor-driven wheelchairs or beds when standard equipment is adequate; equipment, orthopedic devices or prosthetics required primarily for use in athletic activities; replacement of lost or stolen equipment, orthopedic devices, or prosthetics; duplicate equipment purchased as a convenience item.
- (7) **Educational or vocational testing.** Services for educational or vocational testing or training, except as stated as a benefit under this Plan.
- (8) **Excess charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Allowable Fee..
- (9) **Exercise programs.** Exercise programs, including health or weight loss clubs or clinics, for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (10) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
- (11) **Foot care - routine.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) or as otherwise deemed Medically Necessary.
- (12) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services or is not for treatment due to an Illness or Injury.
- (13) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

- (14) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (15) **Holistic medicine.** Services or supplies in connection with holistic medicine.
- (16) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (17) **Hypnotherapy.** Services or supplies in connection with hypnotherapy.
- (18) **Illegal acts.** Charges for services received as a result of an Injury, Illness and/or Illness resulting from or occurring during the commission of a violation of law by the Participant, including but not limited to, a felony, a misdemeanor, and/or engaging in an illegal occupation, riot, or public disturbance. This exclusion does not apply to minor traffic violations. Under no circumstances will operating a motor vehicle while under the influence of alcohol or drugs, or a combination thereof, or operating a motor vehicle with a blood alcohol content (BAC) above the legal limit, be considered a minor traffic violation. For this exclusion to apply, it is not necessary that a fine be imposed or criminal charges be filed, or if filed, that a conviction result or that a sentence be imposed. This exclusion does not apply if the Injury, Illness, and/or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (19) **Inclusive service/procedure.** Any additional charge for any service or procedure which is determined by the Plan Administrator to be an inclusive service/procedure. An inclusive service/procedure is a portion of a service or procedure which is necessary for completion of the service or procedure, or a service or procedure which is already described or considered to be part of another service or procedure.
- (20) **Infertility.** Care, services and supplies for infertility services including, but not limited to, in-vitro fertilization and artificial insemination, except as specifically stated as a benefit under this Plan.
- (21) **Investigational/Experimental or Not Medically Necessary.** Any service, supplies, drugs and devices which are:
- (i) Investigational/Experimental Services.
 - (ii) Not accepted standard medical practice. The Plan may consult with physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice.
 - (iii) Not a Covered Charge.
 - (iv) Not Medically Necessary.
 - (v) Not covered under applicable Medical Policy.
- (22) **Marital or pre-marital counseling.** Care and treatment in connection with marital or pre-marital counseling.
- (23) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (24) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
- (25) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (26) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay or charges that are made only because benefits are available under this Plan. Benefits will not be allowed for professional or courtesy discounts.

- (27) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.
- (28) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (29) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness, except as specifically stated as a benefit under this Plan.
- (30) **Occupational Injury.** Care and treatment of an Injury or Illness that is occupational when the employer has elected or is required by law to obtain coverage of such under state or federal workers' compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This exclusion applies to all services and supplies resulting from work-related Illness or Injury even though:
- (i) Coverage under the government legislation provides benefits for only a portion of the services incurred.
 - (ii) The employer has failed to obtain such coverage required by law.
 - (iii) The Participant waives his or her rights to such coverage or benefits.
 - (iv) The Participant fails to file a Claim within the filing period allowed by law for such benefits.
 - (v) The Participant fails to comply with any other provision of the law to obtain such coverage or benefits.
 - (vi) The Participant was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.
- (31) **Outpatient therapies.** Refer to Therapies – Outpatient and Rehabilitation.
- (32) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds. Also, services and supplies primarily for personal care, hygiene, or convenience which are not primarily medical in nature will not be a Covered Charge under this Plan.
- (33) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse, unless ordered by a Physician and deemed Medically Necessary.
- (34) **Rehabilitation therapies.** Refer to Therapies – Outpatient and Rehabilitation.
- (35) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Participant's home or is related to the Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (36) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.
- (37) **Ridge augmentation.** Services and supplies related to ridge augmentation, implantology, or vestibuloplasty.

- (38) **Rolfing.** Services or supplies in connection with rolfing.
- (39) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically stated as a benefit under this Plan.
- (40) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (41) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment, transformation and reversal of such procedures. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (42) **Sexual dysfunction.** Services and supplies related to sexual inadequacies or dysfunctions.
- (43) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (44) **Surgical sterilization reversal.** Care and treatment for reversal of an elective surgical sterilization.
- (45) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome. Medically Necessary surgical treatment will be a Covered Charge under this Plan. Non-surgical treatment *will not* be a Covered Charge.
- (46) **Therapies – Outpatient and Rehabilitation.** Benefits will not be provided when the primary reason for outpatient or rehabilitation therapy is one of the following:
- Custodial care;
 - Diagnostic admissions;
 - Maintenance*, nonmedical self-help, or vocational educational therapy;
 - Social or cultural rehabilitation.
- * In certain circumstances, a written Plan of Care may be provided to the Claims Administrator for pre-approval to determine the medical necessity of “maintenance” therapy. The Plan of Care should include goals, specific treatment techniques and anticipated frequency and duration of treatment. The Plan of Care should be updated as the Covered Person’s condition changes and treatment should demonstrate a reasonable explanation of improvements, in addition to documentation of continued progress to the goals.
- (47) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges or as defined as a Covered Charge under this Plan.
- (48) **Vitamins or food supplements,** whether or not prescribed by a Physician. However, food supplements for phenylketonuria (PKU) are a Covered Charge under this Plan.
- (49) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

The Coordination of Benefits provisions will not apply to prescriptions purchased at a participating pharmacy.

PHARMACY OPTION – Limited to a 34-day supply

Participating pharmacies have contracted with the Plan to charge Participants reduced fees for covered Prescription Drugs. **Express Scripts** is the administrator of the pharmacy drug benefits.

For more information regarding Express Scripts please contact Express Scripts Member Services toll-free at (877) 583-9057 or access their website at www.express-scripts.com.

Copayments

The copayment is applied to each covered pharmacy drug charge and is shown in the Schedule of Benefits section. The copayment amount is not a Covered Charge under the medical benefits of this Plan. Any one pharmacy prescription is limited to a **34-day supply**.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Participant's ID card is not used, the Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Participant will be required to submit the prescription receipt to **Express Scripts** for reimbursement (minus any applicable copayment as shown in the Schedule of Benefits section).

PHARMACY OPTION – Maintenance Rx – 90-day supply

At select participating pharmacies, the Participant will be able to obtain a **90-day supply**, per prescription, at the copayment level as shown in the Schedule of Benefits section. By using select participating pharmacies, there may be a savings to the Participant on their prescriptions. This option is available for maintenance medications (such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Please ask your pharmacy if they are a 90-Day Retail Network Provider for Express Scripts.

Copayments

The copayment is applied to each covered pharmacy drug charge and is shown in the Schedule of Benefits section. The copayment amount is not a Covered Charge under the medical benefits of this Plan. Any one pharmacy prescription is limited to a **90-day supply**.

MAIL ORDER OPTION –Maintenance Rx - 90- day supply

The mail order drug benefit option is available for maintenance medications (such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Participants significant savings on their prescriptions. The mail order pharmacy is subject to change.

For additional information concerning this benefit, please contact Express Scripts toll free at (877) 583-9057.

Copayments

The copayment is applied to each covered mail order drug charge and is shown in the Schedule of Benefits section. The copayment amount is not a Covered Charge under the medical benefits of this Plan. Any one mail order prescription is limited to a **90-day supply**.

COVERED PRESCRIPTION DRUGS

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

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law and dispensed by a licensed pharmacist but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician.
- (4) Disposable insulin needles/syringes.
- (5) Disposable blood/acetone resting agents/lancets.
- (6) Tretinoin, all dosage forms (e.g. Retin-A), for Participants through 25 years of age.
- (7) Prescribed contraceptives (e.g. oral, implantable, IUDs, diaphragms).
- (8) Prenatal vitamins when prescribed by a Physician.
- (9) Tobacco Cessation products when prescribed by a Physician. This will not include over-the-counter products.

LIMITS TO THIS BENEFIT

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

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

DRUG CLASSIFICATIONS

- (1) **Generic.** Generic drugs are Prescription Drugs which have the equivalency of a Brand Name drug and are approved by the Food and Drug Administration as such. The Participant pays the **lowest copayment** amount when they choose or their doctor prescribes a Generic drug.
- (2) **Formulary.** Brand Name drugs are included on a Formulary list only after a team of pharmacists and physicians evaluate their effectiveness and cost relative to available alternatives. The Participant pays a **moderate copayment** amount when their doctor prescribes a Formulary drug, i.e., a drug that provides the best results for the patient at the lowest cost.
- (3) **Non-Formulary.** Brand Name drugs are considered Non-Formulary when they do not qualify as a Formulary drug. The Participant pays the **highest copayment** amount when their doctor prescribes a Non-Formulary drug.

Note: Brand Name drugs are re-evaluated from time to time, and as such the Formulary and Non-Formulary lists may change. Additional information regarding Prescription Drugs and their classifications may be obtained free of charge from the Plan Administrator, Express Scripts or by accessing the following website: www.express-scripts.com.

EXPENSES NOT COVERED

This benefit will not cover charges for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants or dietary supplements.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, insulin pump and related supplies, artificial appliances, braces, support garments, or any similar device, and other non-medicinal substances, regardless of intended use, except those listed as a Covered Prescription Drug. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Participant.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless deemed Medically Necessary. Prior authorization will be required.
- (9) **Immunization.** Immunization agents, biological sera, blood, or blood plasma.
- (10) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
- (11) **Inpatient medication.** A drug or medicine that is to be taken by the Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (15) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses, other than insulin.
- (16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (17) **Occupational.** Prescriptions which the Participant is entitled to receive without charge from Workers' Compensation laws, or any municipal, state, or federal program.
- (18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

- (19) **Therapeutic equivalent.** Any Prescription drug which has a therapeutic equivalent over the counter will not be covered under this benefit unless the Participant cannot tolerate the therapeutic equivalent drug. A letter of Medical Necessity will be required from the prescribing Physician on an annual basis before such Prescription drug will be covered under this Plan.

- (20) **Vitamins.** Any charge for vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

**BENEFIT MANAGEMENT
PRE-AUTHORIZATION, PLAN NOTIFICATION, CONSULTATIONS
AND OTHER HEALTH CARE MANAGEMENT SERVICES**

Blue Cross and Blue Shield of Montana or its designee provides Benefit Management services to the Participants. Benefit Management using plan notification, Prior Authorization and Case Management is designed to:

1. Provide information regarding Benefits before the Participant receives treatment, services, medicines, or medical supplies;
2. Inform the Participant about Benefits regarding proposed procedures or alternate treatment plans;
3. Inform the Participant of Preferred Providers, including participating out-of-state providers;
4. Assist the Participant in determining out-of-pocket expenses and identify possible ways to reduce such expenses;
5. Help the Participant to avoid reductions in payment which may occur if the services are not Medically Necessary or the setting is not appropriate;
6. If appropriate, assign a case manager to work with the Participant and the providers of care to design a treatment plan.

Although Benefit Management is available, notifying the Plan, obtaining Prior Authorization, or participating in Care Management is not a guarantee of payment by the Plan.

PLAN NOTIFICATION AND PRE-AUTHORIZATION (IN-PATIENT HOSPITAL / FACILITY CARE)

Plan Notification

Plan Notification is strongly recommended for any Inpatient admission, including admissions to a Hospital, chemical dependency treatment center, mental illness treatment center, chemical dependency or psychiatric residential treatment facility, intensive outpatient programs, outpatient surgery, rehabilitation facility and cancer treatment programs or other medical procedures or services as soon as the provider recommends or schedules services to allow the Plan to begin working with the Participant on benefit management.

The Participant or provider should notify the Claim Administrator's Utilization Management/Pre-Certification Department prior to all preplanned admissions or within 24 hours of emergent admissions at 1-800-447-7828, Ext. 6230 or via fax at 1-406-441-3026.

The Participant or provider may also call the number listed for Plan Notification on the inside cover of this Plan Document. **It is NOT necessary to notify the Plan of standard x-ray and lab services or Routine office visits.**

Prior Authorization

Prior Authorization is recommended for certain Benefits under this Plan Document to help the Participant identify potential expenses, payment reductions or denials of claims that the Participant may incur if the Benefits are determined not to be Covered Medical Expenses or determined not to be Medically Necessary. Just because Prior Authorization is not recommended for a service or procedure does not mean the service or procedure is covered under this Plan Document. The Participant is encouraged to obtain Prior Authorization from the Claim Administrator to predetermine coverage of Benefits.

The following services and items are examples of Benefits for which Prior Authorization is strongly recommended by the Plan. This list is not all inclusive and is subject to change by the Claim Administrator, without notice:

- i. Cancer treatment
- ii. Hysterectomy
- iii. Back surgery
- iv. Hospice
- v. Home health
- vi. Cosmetic/reconstructive surgery
- vii. TMJ surgery

- viii. Positron Emission Tomography (PET Scans)
- ix. Transplants
- x. Chronic pain management programs
- xi. Original purchase, repair, or replacement of durable medical equipment and prosthetics over \$500
- xii. Therapy services and rehabilitation services to ensure that the services or treatment continue to promote improvement and demonstrate measurable progress
- xiii. Applied Behavior Analysis (ABA) services for Autism, Pervasive Developmental Disorder and Asperger's Disorder

General Provisions Applicable to All Recommended and Required Prior Authorizations

1. No Guarantee of Payment

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

2. Request for Additional Information

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

3. Failure to Obtain Prior Authorization

If the Participant does not obtain Prior Authorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted to determine whether or not the services, supplies, or treatment were Medically Necessary, performed in the appropriate setting, and otherwise meet the terms and conditions of the Plan. The Participant will be responsible for charges for any Benefits which were not performed in the appropriate setting or which were not Medically Necessary, or did not otherwise meet the terms and conditions of the Plan, including any applicable Medical Policy.

4. Claim for Benefit

A claim for Benefit for which Prior Authorization is recommended is a post-service claim for purposes of the claims and appeals procedures in this Plan Document. A claim for a Benefit for which Prior Authorization is required is a pre-service claim (and potentially and urgent care claims) for purposes of the claims and appeals procedures in this Plan Document.

CANCER TREATMENT

Pre-notification of services, by the Participant, for cancer treatment services is strongly recommended. The pre-notification request to the Claims Administrator must include the Participant's plan of care and treatment protocol. **Pre-notification of services should occur at least 7 days prior to the initiation of treatment.**

For pre-notification of services, call the Claims Administrator at 1-800-447-7828.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Participant receives treatment, services or supplies. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services by Blue Cross and Blue Shield of Montana is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan at the time charges are incurred. A pre-notification is not required as a condition precedent to paying benefits, and cannot be appealed.

CASE MANAGEMENT - MEDICAL

Case Management

The goal of case management is to help the Participant receive the most appropriate care that is also cost effective. If the Participant has an ongoing medical condition or a catastrophic illness, the Participant or their designee should contact Case Management. If appropriate, a case manager will be assigned to work with the Participant and the Participant's providers to design a treatment plan. Case management is a voluntary program. Case management involves Participant education, referral coordination, utilization review, and individual case planning and/or alternative care.

Case management shall be determined on a case-by-case basis. Each treatment plan is individually tailored to a specific Participant and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager collaborates with the Participant, the family and the attending Physician in order to develop a plan of care to meet the Participant's health service needs. Coverage may be provided for noncovered benefits if the result is improved care at a lesser cost. The plan of care may include some of the following;

- i. Personal support and education for the Participant;
- ii. Contacting the family to offer assistance for coordination of medical care needs;
- iii. Monitoring response to treatment;
- iv. Monitoring Hospital or Skilled Nursing Facility;
- v. Determining alternative care options; and
- vi. Assisting in obtaining any necessary equipment and services.

SPECIAL BEGINNINGS (MATERNITY MANAGEMENT)

Special Beginnings is an educational and empowerment program for eligible female Employees and any eligible female Dependents. This program provides a means to positively affect a Pregnancy and the health of the baby.

A Special Beginnings nurse will set up a confidential, personal telephone interview to identify medical history and lifestyles that could have an impact on the outcome of the Pregnancy.

A Special Beginnings nurse is available to assist and coordinate high risk aspects of maternity care. This includes providing information such as access to educational programs and community resources designed to meet the needs identified by the patient or Physician.

Certification Requirements: The Participant should notify Special Beginnings at 1-855-258-3489 during the first trimester of her pregnancy.

PATIENT INFORMATION AND EDUCATION

The patient information and education program is designed to help the Participant understand Benefit Management, health service options, and to provide information about health resources. The Claim Administrator's staff will provide:

- Information on types of medical and community facilities available in the Participant's area;
- Answers to questions about Benefit Management features;
- Information regarding proposed procedures or alternative treatment plans;
- Assistance with medical terminology;
- Identification of Participating Providers in the Participant's community;
- Guidance for the Participant to obtain the latest medical technology information; and
- Claims review.

DEFINED TERMS

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

Allowable Fee is based on, but not limited to, the following:

- (1) Medicare RBRVS based is a system established by Medicare to pay physicians for a “work unit.” The RBRVS value is determined by multiplying a “relative value” of the service by a “converter” to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers’ billed charge; or
- (2) Diagnosis - related group (DRGs) methodology is a system used to classify hospital cases into one of approximately 500 to 900 groups that are expected to have similar hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of hospital resources for the given DRG regardless of the actual hospital resources used. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating providers under the DRG system can be considerably less than the nonparticipating providers’ billed charge; or
- (3) Billed Charge is the amount billed by the provider; or
- (4) Case Rate methodology is an all inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Case Rate system can be considerably less than the nonparticipating providers’ billed charge.
- (5) Per Diem methodology is an all inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Per Diem system can be considerably less than the nonparticipating providers’ billed charge; or
- (6) Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Flat fee per category of service system can be considerably less than the nonparticipating providers’ billed charge; or
- (7) Flat fee per unit of service fixed payment amount for a unit of service, For instance, a unit of service could be the amount of “work units” customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Flat fee per unit system can be considerably less than the nonparticipating providers’ billed charge; or
- (8) Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or
- (9) A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or
- (10) The amount negotiated with the Pharmacy Benefit Manager or manufacturer or the actual price for prescription or drugs; or
- (11) The American Society of Anesthesiologists’ Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a “work unit.” The payment

value is determined by multiplying a “relative value” of the service by a “converter” to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the system can be considerably less than the nonparticipating providers’ billed charge.

Montana law requires Blue Cross and Blue Shield of Montana to provide a summary of a Participant’s coverage for a specific health care service or course of treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or hospital exceeds \$500.

Active Employee is an Employee who is on the regular payroll of the Employer and who is actively performing the duties of his or her job with the Employer.

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

Approved Clinical Trial

Approved clinical trial means a phase I, phase II, phase III, or phase IV, clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other LifeThreatening Condition. The trial must be:

- (1.) Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
- (2.) Exempt from an investigational new drug application; or
- (3.) Approved or funded by:
 - The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
 - A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
 - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes for Health for center support groups; or
 - The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and provide unbiased scientific review by individuals who have no interest in the outcome of the review.

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

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

Blue Cross and Blue Shield of Montana is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, the Claim Administrator for this Plan.

Brand Name means a trade name medication.

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

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

Covered Charge(s) means those expenses incurred for Medically Necessary services, supplies, and medications that are based on the Allowable Fee and are:

- (1) Covered under the Plan,

- (2) In accordance with Medical Policy; and
- (3) Provided to the Participant by and/or ordered by a covered provider for the diagnosis or treatment of and active Illness or Injury or in providing maternity care.

In order to be considered a Covered Charge, the Participant must be responsible for charges for such services, supplies, and medications.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

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

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

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

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship or on an approved leave of absence as described in the Termination of Coverage Section.

Employer is Stillwater Mining Company.

Enrollment Date is the first day an individual becomes eligible to participate in the Plan or the first day of coverage if enrolling during a Special Enrollment or Open Enrollment Period.

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

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

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

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

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins or metabolite, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional

with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

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

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

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

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

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

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, outpatient care, home care, and family counseling for the Participant's immediate family during the bereavement period. "Immediate family" shall mean the Participant's Spouse, Dependent children, parents, or siblings who are covered under this Plan.

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

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

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

- A facility operating legally as a psychiatric Hospital or residential treatment facility which provides treatment for Mental Disorders through multiple modalities or techniques following a written treatment plan approved and monitored by an interdisciplinary team, including a licensed Physician, psychiatric social worker, and psychologist. The facility must also be:
 - Licensed as a mental health treatment facility by the state in which the facility operates;
 - Funded or eligible for funding under federal or state law; or
 - Affiliated with a Hospital with an established system for patient referral.
- A facility operating primarily for the treatment of Substance Abuse if it has received accreditation from CARF (Commission of Accreditation of Rehabilitation Facilities) or JCAHO (Joint Commission of Accreditation of Hospital Organizations) or if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour nursing service by a registered nurse (R.N.); has a

full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

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

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

Investigational/Experimental. A surgical or medical procedure, supply, device, or drug which at the time provided, or sought to be provided, is determined by the Plan to fall into one or more of the following categories:

- (1) has not received the required final approval to market from appropriate government bodies;
- (2) is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
- (3) is not demonstrated to be as beneficial as established alternatives;
- (4) has not been demonstrated to improve the net health outcomes;
- (5) is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting; or
- (6) is not the standard practice or procedure utilized by practicing physicians in treating other patients with the same or similar condition.

Late Enrollee means a Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Participant.

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

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Policy means the Claim Administrator's policy which 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) Are in accordance with any established standards of good medical practice.

Medical Policy is reviewed and modified periodically as is necessary.

Medically Necessary means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

- (1) in accordance with generally accepted standards of medical practice;
- (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- (3) not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a covered provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Participant receives the services, supplies, or medications and a claim is submitted to the Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

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

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

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

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

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), licensed Nurse-Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist

and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the Stillwater Mining Company Bargaining Unit Health Plan, which is a benefit plan for certain Employees of Stillwater Mining Company and is described in this document.

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

Plan Year is the 12-month period ending each December 31st.

PPO-A Preferred Provider Organization is a provider or group of providers which have contracted with the Plan to provide services to Participants covered under PPO Benefit contracts.

PPO Network is a provider or group of providers which have a PPO contract with Blue Cross Blue Shield of Montana. The Participant may obtain a list of PPO providers from Blue Cross Blue Shield of Montana upon request. Payment to a non-PPO Network provider is subject to the non-PPO Network provider reduction shown in the Schedule of Benefits and the Special Provisions section of this document.

Preferred Facility Provider is a facility that has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana. Preferred Facility Providers include, but are not limited to, Hospitals, Home Health Care Agencies, convalescent homes, skilled nursing facilities and freestanding facilities for the treatment of chemical dependency or mental illness and freestanding surgical facilities. Also included in the Preferred Facility Providers are HealthLink PPO Providers which are Hospitals and Surgery Centers.

Preferred Professional Provider is a professional health care provider who has a contract with the Claims Administrator, Blue Cross and Blue Shield of Montana. Preferred Professional Providers include, but are not limited to, Physicians, Physician assistants, nurse specialists, doctors of osteopathy, dentists, optometrists, podiatrists, acupuncturists, Advanced Practice Registered Nurses, naturopathic physicians, Home Infusion Therapy Agencies, speech therapists, occupational therapists and physical therapists. Please read the section entitled Preferred Provider Network.

Pregnancy is childbirth and conditions associated with Pregnancy including, but not limited to, prenatal and postpartum care, delivery of one or more newborns, professional provider medical services for conditions related directly to Pregnancy, and complications of Pregnancy.

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

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

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan, transfer arrangements with one or more Hospitals, and operational policies developed with the advice of and reviewed by a professional group including at least one Physician.

- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally delayed, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare or is accredited by the Joint Commission of Accreditation of Hospitals (JCAHO).
- (8) Maintains permanent and full-time facilities for bed care for five or more resident patients.
- (9) Is operating lawfully in the jurisdiction where it is located.

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

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

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

Surgery Center is a licensed facility that is used mainly for performing outpatient surgery that cannot be appropriately performed in a Physician's office, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

Telemedicine means the use of interactive audio, video, or other telecommunications technology that is:

- (1) Used by a health care provider or health care facility to deliver health care services as a site other than the site where the patient is located; and ;
- (2) Delivered over a secure connection that complies with the requirements of Health Insurance Portability and Accountability Act of 1996, 42 U.S.C 132d, et seq.

The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology. The term does not include the use of audio-only telephone, e-mail, or facsimile transmission.

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

HOW TO SUBMIT A MEDICAL CLAIM

When services are received from a health care provider, a Participant should show his or her **Blue Cross and Blue Shield of Montana Stillwater Mining Company** Identification card to the provider. A Preferred Professional or Facility Provider will always file claims directly with the Claim Administrator.

If it is necessary for a Participant to submit a claim, he or she should request an itemized bill which includes procedure (CPT) and diagnostic (ICD-9) codes from his or her health care provider.

Note: A claim form is not necessary; however an itemized statement must include the following to assist the Claims Administrator in processing the claim:

- Employee's name
- Employee Plan Identification Number from the ID card
- Name of patient
- Patient's date of birth
- Employee's address
- Provider name, address, telephone number
- Provider number
- Type of service
- Procedure code for each service
- Diagnosis
- Charge of each service

In certain instances, the Claim Administrator may require that additional documents or information be submitted, including, but not limited to, accident reports and medical records. This information must be submitted within the time frame requested before payment can be made for the services.

Out-of-State Services – Claims for Family Members Who Live Out of State and All Other Claims for Out-of-State Services

Family Members who live out of state or Participants who have health care services out of state should use Participating Blue Cross and Blue Shield Providers in that state. In most cases providers will file claims directly with the Claim Administrator. Please refer to the Preferred Provider Networks, Out-of-Area Services - The BlueCard Program section. If the provider does not file the claim, the Participant should use the same procedures as outlined in this section.

WHERE TO SUBMIT MEDICAL CLAIMS

Blue Cross and Blue Shield of Montana, is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Blue Cross and Blue Shield of Montana
P.O. Box 7982
Helena, MT 59604
800-447-7828

HOW TO SUBMIT PHARMACY CLAIMS

When obtaining a prescription, a Participant should show his or her **Blue Cross and Blue Shield of Montana Stillwater Mining Company** Identification card to the pharmacist. Participating Pharmacies may submit claims on a Participant's behalf.

If the pharmacy provider is unable to submit the claim, the Participant should request a receipt.

To assist Express Scripts. in processing a claim, the following information must be provided when submitting the claim for processing:

- A copy of the receipt
- Group name and number (**Stillwater Mining Company, Group #JUJA**)
- Employee's name and Identification Number
- Provider Billing Identification Number
- Name of patient
- The prescribing Physician
- The prescription name
- An itemization for each separate prescription
- The date of purchase

WHERE TO SUBMIT PHARMACY CLAIMS

Express Scripts is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Express Scripts, Inc.
Attn: STD ACCTS
P. O. Box 66583
St. Louis, MO 63166-6583

WHEN TO SUBMIT A MEDICAL AND PHARMACY CLAIM

Claims should be filed with the appropriate Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be declined.

The Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. If not, more information may be requested from the Participant. The Plan reserves the right to have a Participant seek a second medical opinion.

COMPLAINTS

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

Most problems can be handled by calling Customer Service at the number appearing on the inside cover of this Plan Document. The Participant may also file a written complaint or grievance with the Claim Administrator. The fax number, email address, and mailing address of the Claim Administrator appears on the inside cover of this Plan Document. Written complaints or grievances will be acknowledged within 10 days of receipt. The Participant will be notified of the Claim Administrator's response within 60 days from receipt of the Participant's written complaint or grievance.

Claims Procedures

Types of Claims

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

1. Pre-Service Claims

A pre-service claim is any claim for a Benefit that, under the terms of this Plan, requires authorization or approval from the Plan prior to receiving the Benefit.

2. Urgent Care Claims

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

3. Post-Service Claims

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

4. Rescission Claims

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

5. Concurrent Care Claim

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

Initial Claim Determination by Type of Claim

1. Pre-Service Claim Determination and Notice

a. Notice of Determination

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

receiving the claim.

b. Notice of Extension

1. For reasons beyond the control of the Plan

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

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

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

2. Urgent Care Claim Determination and Notice

a. Designation of Claim

Upon receipt of a pre-service claim, the Plan will make a determination if the claim involves urgent care. If a physician with knowledge of the Participant's medical condition determines the claim involves urgent care, the Plan will treat the claim as an urgent care claim.

b. Notice of Determination

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

c. Notice of Incomplete or Improperly Submitted Claim

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

3. Post-Service Claim Determination and Notice

a. Notice of Determination

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

b. Notice of Extension

1. For reasons beyond the control of the Plan

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

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

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

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

- a. Request for Extension of Previously Approved Time Period or Number of Treatments
 1. In response to the Participant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Participant's claim involves urgent care, the Plan will review the claim and notify the Participant of its determination no later than 24 hours from the date the Plan received the Participant's claim, provided the Participant's claim was filed at least 24 hours prior to the end of the approved time period or number of treatments.
 2. If the Participant's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Participant's claim will be treated as and decided within the timeframes for an urgent care claim as described in the section entitled, "Initial Claim Determination by Type of Claim."
 3. If the Participant's claim did not involve urgent care, the time periods for deciding pre-service claims and post-service claims, as applicable, will govern.
- b. Reduction or Termination of Ongoing Course of Treatment

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

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

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

- a. The specific reason(s) for the rescission that show the fraud or intentional misrepresentation of a material fact;
- b. A statement that the Participant will have the right to appeal any final decision of the Plan to rescind coverage after the thirty (30) day period;
- c. A reference to the Plan provision(s) on which the rescission is based;
- d. A statement that the Participant is entitled to receive upon request and free of charge reasonable access to, and copies of all documents and records and other information relevant to the rescission.

Notice of an Adverse Benefit Determination

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

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

the adverse benefit determination will be provided, upon request and free of charge.

How to File an Internal Appeal of an Adverse Benefit Determination

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

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

2. Access to Plan Documents

The Participant may at any time during the filing period, receive reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination upon request and free of charge. Documents may be viewed at the Claim Administrator's office, at 560 North Park Avenue, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding holidays. The Participant may also request that copies of all documentation be mailed to the Participant by calling the customer service number listed on the inside cover of this document.

3. Submission of Information and Documents

The Participant may present written evidence and testimony, including any new or additional records, documents or other information that are relevant to the claim for consideration by the Plan during the appeal process.

4. Consideration of Comments

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

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

5. Scope of Review

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

6. Consultation with Medical Professionals

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

Time Period for Notifying Participant of Final Internal Adverse Benefit Determination

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

Type of Claim on Appeal	Time Period for Notification of Final Internal Adverse Benefit Determination
Urgent Care Claim	No later than 72 hours from the date the Plan received the Participant's appeal, taking into account the medical exigency.
Pre-Service Claim	No later than 30 days from the date the Plan received the Participant's appeal.
Post-Service Claim	No later than 60 days from the date the Plan received the Participant's appeal.
Concurrent Care Claim	<ul style="list-style-type: none"> • If the Participant's claim involved urgent care, no later than 72 hours from the date the Plan received the Participant's appeal, taking into account the medical exigency. • If the Participant's claim did not involve urgent care, the time period for deciding a pre-service (non-urgent care) claim and a post-service claim, as applicable, will govern.
Rescission Claim	No later than 60 days from the date the Plan received the Participant's appeal.

Content of Notice of Final Internal Adverse Benefit Determination

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

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

External Review Procedures

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

1. Rescissions of coverage; and
2. Medical judgment, including those adverse benefit determinations that are based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or adverse benefit determinations that certain treatments are experimental or investigational.

External review is not available for:

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

Standard External Review Procedures

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

1. Request for a Standard External Review

The Participant must submit a written request to the Plan for a standard external review within 4 months from the date the Participant receives an adverse benefit determination or a final internal adverse benefit determination.

2. Preliminary Review

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

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

Within 1 day after completing its review, the Plan will notify the Participant in writing if the request is eligible for external review. If further information or materials are necessary to complete the review, the written notice will describe the information or materials and the Participant will be given the remainder of the 4 month period or 48 hours after receipt of the written notice, whichever is later, to provide the necessary information or materials. If the request is not eligible for external review, the Plan will outline the reasons for ineligibility in the notice and provide the Participant with contact information for the U.S. Employee Benefits Security Administration (toll free number 866.444.EBSA (3272)).

3. Assignment of an IRO

Following a preliminary review determination that the Participant's request is eligible for external review, the Plan will assign the Participant's request to an Independent Review Organization (IRO) to perform the external review. To ensure independence of the external review and to minimize potential bias, the Plan will contract with at least three IROs who are accredited by URAC or a similar nationally recognized accrediting organization and will rotate assignments among the three IROs (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO shall not be eligible for any financial incentives based upon the likelihood that the IRO will support the denial of claims.

4. Notice of Acceptance for External Review

The IRO will timely provide the Participant with written notice of the request's eligibility and acceptance for external review. The IRO will inform the Participant that the Participant may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO will consider such additional information in its external review.

5. Plan Submission of Documents to the IRO

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

6. Reconsideration by Plan

On receiving any information submitted by the Participant, the IRO must forward the information to the Plan within 1 business day. The Plan may then reconsider its adverse benefit determination or final internal adverse benefit determination. If the Plan decides to reverse its adverse benefit determination or final internal adverse

benefit determination, the Plan must provide written notice to the Participant and IRO within 1 business day after making the decision. On receiving the Plan's notice, the IRO must terminate its external review.

7. Standard of Review

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

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

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

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

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

9. Compliance with IRO Decision

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

Expedited External Review Procedures

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

1. Request for Expedited External Review

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

- a. If the Participant received an adverse benefit determination that denied the Participant's claim and: (1) the Participant filed a request for an internal urgent care appeal; and (2) the delay in completing the internal appeal process would seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function; or
- b. Upon receipt of a final internal adverse benefit determination which involves: (1) a medical condition of the Participant for which a delay in completing the standard external review would seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function; or (2) an admission, availability of care, a continued stay, or a health care item or service for which the Participant received

emergency services, but has not been discharged from a facility.

2. **Preliminary Review**

Immediately upon receiving the Participant's request for expedited external review, the Plan will determine whether the request is eligible for external review, considering the same preliminary review requirements set forth in the *Preliminary Review* paragraph, *Standard External Review Procedures* section. After the preliminary review is complete, the Plan will immediately notify the Participant in writing if the request is eligible for external review or requires further information or materials to complete the request. The Participant will have until the end of the 4-month period to file a request for external review or 48 hours (whichever is later) to complete the request.

3. **Assignment of an IRO**

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

4. **Standard of Review**

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

5. **Notice of Final External Review Decision**

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

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

6. **Compliance with IRO Decision**

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

7. **Deemed Exhaustion of Internal Appeal Process**

- a. The Participant will be deemed to have exhausted the internal appeal process and may request external review or pursue any available remedies under state law or if applicable, a civil action under 502(a) of ERISA, if the Plan fails to comply with its claims and appeals procedures, except that claims and appeals procedures will not be deemed exhausted based on violations that are:
 1. De minimis;
 2. Non-prejudicial to the Participant;
 3. Attributable to good cause or matters beyond the Plan's control;
 4. In the context of an ongoing, good faith exchange of information between the Participant and the Plan;

and

5. Not reflective of a pattern or practice of violations by the Plan.
- b. Upon request of the Participant, the Plan will provide an explanation of a violation within 10 days. The explanation will include a description of the basis for the Plan's assertion that the violation does not result in the deemed exhaustion of the Plan's internal claims and appeals procedures.
- c. If the Participant seeks external or judicial review based on deemed exhaustion of the Plan's internal claims and appeals procedures, and the external reviewer or court rejects the Participant's request, the Plan will notify the Participant within a reasonable period of time, not to exceed 10 days, of the Participant's right to resubmit the Participant's internal appeal. The timeframe for appealing the adverse benefit determination begins to run when the Participant receives the notice of the right to resubmit the Participant's internal appeal.

COORDINATION OF BENEFITS

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

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

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

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) Any automobile insurance, including but not limited to, No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.
- (7) Any third-party liability insurance, including but not limited to, homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

If the Participant, or someone on behalf of the Participant, has received any compensation and/or benefits from any third-party source, this compensation and/or benefits shall be primary and shall be coordinated with the benefits that they may be eligible to receive through this Plan before they may receive any benefits from this Plan.

Allowable Expense. A Covered Charge including deductible and coinsurance and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Participant does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Participant used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When any payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

- (A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (B) Plans with a coordination provision will pay their benefits up to the Allowable Charge.

The first rule that describes which plan is primary is the rule that applies:

- (1) The benefits of the plan which covers the person directly (that is, as a member/Employee, retiree, or subscriber) (“Plan A”) are determined before those of the plan which covers the person as a Dependent (“Plan B”).

In the event of COBRA. For Qualified Beneficiaries, coordination is determined based on the person’s status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay first.

- (2) Unless there is a court decree stating otherwise, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child’s parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. This rule applies beginning the first of the month after the plan is given notice of the court decree.
- A court decree may state both parents will be responsible for the Dependent child’s health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child’s health care expenses, the order of benefits are as follows:

- 1st The plan covering the custodial parent,
- 2nd The plan covering the spouse of the custodial parent,
- 3rd The plan covering the non-custodial parent, and
- 4th The plan covering the spouse of the non-custodial parent.

- (3) The benefits of a benefit plan which covers a person as a member/Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired member/employee. The benefits of a benefit plan which covers a person as a Dependent of a member/Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or retired member/employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (4) The benefits of a benefit plan which covers a person as a member/Employee who is neither laid off nor retired or a Dependent of a member/Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if rule #1 can be used to determine the order of benefits.
- (5) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Expense when paying secondary.

- (C) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.
- (D) If a Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Participant will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Participant under the Plan.

THIRD PARTY RECOVERY PROVISION

By enrollment in the Plan, a Participant agrees to the provisions of this Section as a condition precedent to receiving benefits under this Plan. If the Participant fails to comply with the requirements of this Section, the Plan may reduce or deny benefits otherwise available under the Plan.

Defined Terms

"Participant" means anyone covered under the Plan, including but not limited to minor dependents and deceased Participants. Participant shall include the parents, trustee, guardian, heir, personal representative or other representative of a Participant, regardless of applicable law and whether or not such representative has access or control of the Recovery.

"Recover," "Recovered," "Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise to compensate for any loss related to any Injury, Sickness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages and/or any other recovery of any form of damages or compensation whatsoever.

"Subrogation" means the Plan's right to exercise the Participant's rights to Recover or pursue Recovery from a Third Party who is liable to the Participant for expenses for which the Plan has paid or may agree to pay benefits.

"Third Party" means any third party including but not limited to another person, any business entity, insurance policy or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), umbrella policy.

Right to Reimbursement

This provision applies when the Participant incurs medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Participant may have a claim against a Third Party for payment of such expenses. To the extent the Plan paid benefits on the Participant's behalf, the Participant agrees that the Plan has an equitable lien on any Recovery whether or not such Recovery(s) is designated as payment for such expenses. This lien shall remain in effect until the Plan is repaid in full.

The Participant, and/or anyone on his or her behalf, agrees to hold in trust for the benefit of the Plan, that portion of any Recovery received or that may be received from a Third Party and to which the Plan is entitled for reimbursement of benefits paid by the Plan on the Participant's behalf. The Participant shall promptly reimburse the Plan out of such Recovery, in first priority for the full amount of the Plan's lien. The Participant will reimburse the Plan first, even if the Participant has not been fully compensated or "made whole" and/or the Recovery is called something other than a Recovery for healthcare, medical and/or dental expenses.

The Plan will not pay or be responsible for attorney fees and/or costs of recovery associated with a Participant pursuing a claim against a Third Party, unless the Plan agrees in writing to such a reduction in its equitable lien, or subject to the terms of a court order.

Right to Subrogation

This provision applies when the Participant incurs medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Participant may have a claim against a Third Party for payment of such expenses.

The Participant agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Participant may have now or in the future against a Third Party who has or may have caused, contributed, aggravated, and or be responsible for the Participant's Injury, Sickness, condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits. The Participant further agrees that the Plan is subrogated to any and all claims

or rights that the Participant may have against any Recovery, including the Participant's rights under the Plan to bring an action to clarify his rights under the Plan. The Plan may assert this Right of Subrogation independently of the Participant. The Plan is not obligated to pursue this right independently or on behalf of the Participant, but may choose to exercise this right, in its sole discretion.

Provisions Applicable to Both the Right to Reimbursement and Right to Subrogation

The Participant automatically assigns to the Plan any and all rights he or she has or may have against any Third Party to the full extent of the Plan's equitable lien. The Participant agrees to:

- a. Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;
- b. Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;
- c. Provide to the Plan in a timely manner any and all facts, documents, papers, information or other data reasonably related to the Participant's Injury, Sickness, condition, and/or accident, including any efforts by another individual to Recover on the Participant's behalf;
- d. Execute all assignments, liens, or other documents that the Plan or its agents may request to protect the Plan's rights under this section;
- e. Obtain the Plan's consent before releasing a Third Party from liability for payment of expenses related to the Participant's Injury, Sickness, condition, and/or accident;
- f. Hold in trust that portion of any Recovery received by the Participant or on the Participant's behalf equal to the Plan's equitable lien until such time as the Plan is repaid in full;
- g. Agree not to impair, impede or prejudice in any way, the rights of the Plan under this section; and
- h. Do whatever else the Plan deems reasonably necessary to secure the Plan's rights under this section.

The Plan may take one or more of the following actions to enforce its rights under this section:

- a. The Plan may require the Participant as a condition of paying benefits for the Participant's Injury, Sickness, condition, or accident, to execute documentation acknowledging the Plan's rights under this section;
- b. The Plan may withhold payment of benefits to the extent of any Recovery received by or on behalf of a Participant;
- c. The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Participant;
- d. The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible; or
- e. The Plan may, to the extent of any benefits paid by the Plan which have not otherwise been reimbursed to the Plan, offset any future benefits otherwise payable under the Plan to the Participant or on the Participant's behalf.

The Plan Administrator is vested with full discretionary authority to interpret and apply the provisions of this section. In addition, the Plan Administrator is vested with the discretionary authority to waive or compromise any of the Plan's rights under this section. Any decision of the Plan Administrator made in good faith will be final and binding. The Plan Administrator is authorized to adopt such procedure as deemed necessary and appropriate to administrate the Plan's rights under this section.

Right to Recover Benefits Paid in Error

The Plan has the right to recover any benefits the Plan paid in error to the Participant or on behalf of a Participant to which the Participant is not entitled, for services which were not covered under the Plan, or for benefits paid in excess of the Plan's allowable charges. The Plan may recover benefits paid in error from the Participant, the provider who received a payment from the Plan on the Participant's behalf, or from any person who may have benefited. The Plan may also offset any future benefits otherwise payable to or on the Participant's behalf, or from any other Participant enrolled through the same covered Employee.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the Covered Employee (or former Employee), Qualified Beneficiary, or any representative acting on behalf thereof. Coverage will end in certain instances, including, but not limited to, if you or your Dependents fail to make timely payment of premiums. You should check with your Employer to see if COBRA applies to you and your Dependents.

What is COBRA Continuation Coverage?

“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer’s plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an Employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse’s hours of employment are reduced;
- Your Spouse’s employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your Spouse; or
- In certain circumstances, you are no longer eligible for coverage under the Plan.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-Covered Employee dies;
- The parent-Covered Employee’s hours of employment are reduced;
- The parent-Covered Employee’s employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a “Dependent child.”

The Employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment or death of the Covered Employee, the Plan Administrator must be notified of the Qualifying Event.

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former Employee) from his or her Spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing notice. Notice must be provided either by U.S. Postal Service or hand delivery to:

Stillwater Mining Company
Plan Administrator
536 East Pike
P.O. Box 1330
Columbus, MT 59019
(406) 322-8930

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice?

Any individual who is the Covered Employee (or former Employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

- Name and address of the Covered Employee or former Employee;
- If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
- A description of the Qualifying Event (for example, divorce, legal separation, cessation of Dependent status, death of the Covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status);
- In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
- In the case of a Qualifying Event that is a Dependent child's cessation of Dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible Dependent (for example, attained limiting age, lost Dependent status, married or other);
- In the case of a Qualifying Event that is the death of the Covered Employee or former Employee, the date of death, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan;
- In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's Notice of Award letter;
- In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce, legal separation or the SSA's Notice of Award letter by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce, legal separation, or the SSA's Notice of Award letter within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation, or the SSA's Notice of Award letter is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event.

If, pursuant to the Plan, the Qualifying Event is the death of the Covered Employee (or former Employee), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

If the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set

forth above. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the Covered Employee or former Employee dies, or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary’s failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first.);
- The first day of the month that begins more than 30 days after the date of the SSA’s determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator and COBRA Administrator:

Stillwater Mining Company
Plan Administrator
536 East Pike
P.O. Box 1330
Columbus, MT 59019
(406) 322-8930

Blue Cross and Blue Shield of Montana
PO Box 4309
Helena, MT 59604
(406) 855- 258-3489

For more information about your rights under COBRA and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) at 1 (866) 444-3272 or visit the EBSA website at www.dol.gov/ebsa.

Current Addresses

In order to protect your family’s rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

RESPONSIBILITIES OF PLAN ADMINISTRATOR

PLAN ADMINISTRATOR. The Stillwater Mining Company Bargaining Unit Health Plan (the Plan) is the benefit plan of Stillwater Mining Company (SMC), also called the Plan Sponsor. The Benefit Plan Committee of SMC is the Plan Administrator. The Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, may be paid by the Plan.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the general assets of the Employer and contributions made by the covered Employees. There is no trust or separate fund associated with this Plan; the Plan is self-funded, which means benefits provided under the Plan are not guaranteed under a contract or policy of insurance and are paid out of the general assets of the Employer.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

CLAIM ADMINISTRATOR'S DISCLOSURES

With the exception of any individual or aggregate stop-loss arrangements provided for in the Administrative Services Agreement ("Agreement") with the Plan Sponsor, Blue Cross and Blue Shield of Montana provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment may be made when an error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

**STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE
HEALTH INFORMATION (THE “PRIVACY STANDARDS”)
ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY
AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)**

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

“Protected Health Information” (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- (2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- (5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- (7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

- (9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- (10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - VP of Human Resources**
 - HR Manager**
 - HR Representative**
 - HR Assistant**
 - Benefit Plan Committee Member**
 - (b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - (c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

**STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED
HEALTH INFORMATION (THE “PRIVACY STANDARDS”)
ISSUED PURSUANT TO
THE HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)**

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and
- Report to the Plan any security incident of which it becomes aware.

CERTAIN PARTICIPANTS RIGHTS UNDER ERISA

Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Participant can take to enforce the above rights. For instance, if a Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Participant or otherwise discriminate against a Participant in any way to prevent the Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person sued to pay these costs and fees. If the Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Stillwater Mining Company Bargaining Unit Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 81-0480654

PLAN EFFECTIVE DATE: January 1, 1993

RESTATED: August 1, 2014

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION

Stillwater Mining Company
536 East Pike
P.O. Box 1330
Columbus, Montana 59019
(406) 322-8930

PLAN ADMINISTRATOR

Benefit Plan Committee
Stillwater Mining Company
536 East Pike
P.O. Box 1330
Columbus, Montana 59019
(406) 322-8930

NAMED FIDUCIARY

Benefit Plan Committee
Stillwater Mining Company
536 East Pike
P.O. Box 1330
Columbus, Montana 59019

AGENT FOR SERVICE OF LEGAL PROCESS

Benefit Plan Committee
Stillwater Mining Company
536 East Pike
P.O. Box 1330
Columbus, Montana 59019

CLAIMS ADMINISTRATOR

Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, Montana 59604
(406) 437-5000
(800) 447-7828

I, SHANNON ARTHUR, certify that I am the Benefit Plan Committee Chair

of the Plan Sponsor/Administrator for the above named Dental Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the above referenced Plan Document and am hereby authorizing its implementation as of the effective date stated above.

Signature: Shannon Arthur

Print Name: SHANNON ARTHUR

Date: 8/1/14

