

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION



EMPLOYEE BENEFITS PROGRAM

MADISON PLAN

with Prescription Drug Reimbursement Benefit

PLAN DOCUMENT EFFECTIVE DATE:
January 1, 2009

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81-0436312

GROUP NUMBER
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INTRODUCTION

Effective January 1, 2009, Montana Municipal Insurance Authority (MMIA), establishes the benefits, rights and privileges which will pertain to Employees of participating MMIA Member Entities, referred to as "Participants," and the eligible Dependents of such Participants, as defined, and which benefits are provided through a fund established by MMIA and referred to as the "Plan." This booklet describes the Plan in effect as of January 1, 2009.

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

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

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

We recommend that you read this booklet carefully before incurring any medical expenses. If you have specific questions regarding coverage or benefits, you are urged to refer to the Plan Document which is available for your review in the Personnel Office or at the office of the Plan Supervisor. If you wish, you may call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions you may have concerning the Plan.

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

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

Pre-authorization by the Plan is strongly recommended for certain services. If you choose not to pre-authorize, the charge could be denied if the service, treatment or supply is not found to be medically necessary when the claim is submitted.

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

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

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN
EXCLUSIONS AND MAXIMUM ELIGIBLE EXPENSE (MEE)

THE BENEFIT PERIOD IS A CALENDAR YEAR

MEDICAL BENEFITS - COST SHARING PROVISIONS	PPO	NON-PPO
<u>ANNUAL DEDUCTIBLE</u> (Applies to all benefits unless specifically indicated as waived) Per Covered Person per Benefit Period Per Family per Benefit Period		\$500 \$1,000
<u>BENEFIT PERCENTAGE</u> (Applies to all benefits unless specifically stated otherwise) Before satisfaction of Out-of-Pocket\ Maximum After satisfaction of Out-of-Pocket Maximum	70% 100%	50% 100%
<u>OUT-OF-POCKET MAXIMUM</u> (Includes the Annual Deductible) Per Covered Person per Benefit Period Per Family per Benefit Period		\$2,000 \$4,000
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES		\$5,000,000

SPECIAL BENEFITS / LIMITATIONS	PPO	NON-PPO
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ACCIDENTAL INJURY BENEFIT
(Expenses incurred within 90 days of the date of the Injury)

Deductible Waived, Benefit Percentage Maximum Benefit per Accident / \$300*	100%
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*Charges in excess of Maximum Benefit will be considered for payment under Medical Benefits

Chiropractic Services and naturopathy are excluded under this benefit.

CANCER SCREENING AND RELATED OFFICE VISIT
(First one performed during Benefit Period regardless of diagnosis)

Deductible Waived, Benefit Percentage	100%
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Benefit Limits:

- Mammograms every two Benefit Periods for ages 40 to 49
- Mammograms once per Benefit Period starting at age 50
- Pap Test and Pelvic Examination once per Benefit Period starting at age 18
- Colonoscopy once per Benefit Period starting at age 50
- Prostate Screening once per Benefit Period starting at age 50

SPECIAL BENEFITS / LIMITATIONS	PPO	NON-PPO
CHEMICAL DEPENDENCY TREATMENT		
Outpatient Expenses (Professional and Facility Provider) Deductible Waived, Benefit Percentage	70%	50%
Inpatient Professional Provider Deductible Waived, Benefit Percentage	70%	50%
Inpatient Facility Provider Deductible Applies, Benefit Percentage	70%	50%
Benefit Limits: Combined Inpatient and Outpatient Professional and Facility Services per 12-month period / \$6,000 Inpatient Expenses Maximum Lifetime Benefit / \$12,000 After Inpatient Expenses Maximum Lifetime Benefit has been satisfied, Combined Inpatient and Outpatient Maximum Benefit per Benefit Period / \$2,000		
CHIROPRACTIC CARE		
Deductible Waived, Benefit Percentage Treatments/Office Visit Maximum Benefit per Benefit Period / \$400 X-rays Maximum Benefit per Benefit Period / \$100	70%	50%
DIABETIC EDUCATION BENEFIT		
Deductible Waived, Benefit Percentage	100%	
DIAGNOSTIC SERVICES		
Professional Provider Services Deductible Waived, Benefit Percentage	70%	50%
Facility Provider Deductible Applies, Benefit Percentage	70%	50%
DURABLE MEDICAL EQUIPMENT		
Rental (up to purchase price) or purchase Deductible Waived, Benefit Percentage	70%	50%
Repair and Replacement Deductible Waived, Benefit Percentage	50%	50%
Charges in excess of the Benefit Percentage do not apply toward the Out-of-Pocket Maximum, and the Benefit Percentage does not change after satisfaction of the Out-of-Pocket Maximum		
EMERGENCY ROOM CARE		
Deductible Applies, Benefit Percentage	70%	50%
EMPLOYEE ASSISTANCE PROGRAM (EAP)		
Deductible Waived, Benefit Percentage	100%	
Referral by United Behavioral Health is required. Five (5) face-to-face counseling visits are covered. To access benefit call toll-free 1-866-248-4094		

SPECIAL BENEFITS / LIMITATIONS	PPO	NON-PPO
HOME HEALTH CARE		
Deductible Waived, Benefit Percentage Maximum Visits per Benefit Period / 180	50%	
Charges in excess of the Benefit Percentage do not apply toward the Out-of-Pocket Maximum, and the Benefit Percentage does not change after satisfaction of the Out-of-Pocket Maximum		
HOSPICE CARE		
Deductible Waived, Benefit Percentage	100%	
HOSPITAL & OTHER FACILITY SERVICES (Inpatient and Outpatient)		
Deductible Applies, Benefit Percentage Inpatient Room and Board limited to average semi-private room Intensive Care Unit limited to the MEE	70%	50%
MATERNITY SERVICES (Professional Provider and Facility Services)		
Professional Provider Expenses (Inpatient and Outpatient) Deductible Waived, Benefit Percentage	70%	50%
Facility Provider Expenses (Inpatient and Outpatient) Deductible Applies, Benefit Percentage	70%	50%
MENTAL ILLNESS		
Not including Severe Mental Illness - See General Definitions		
Outpatient Expenses (Professional and Facility Provider) Deductible Waived, Benefit Percentage	70%	50%
Inpatient Professional Provider Deductible Waived, Benefit Percentage	70%	50%
Inpatient Facility Provider Deductible Applies, Benefit Percentage	70%	50%
Benefit Limits: Maximum Inpatient Confinement Days per Benefit Period / 21* *Coverage includes all services rendered during an "Inpatient Confinement Day"		
One day of Inpatient hospitalization may be exchanged for two days of Partial Hospitalization.		
NEWBORN INITIAL CARE (while mother is hospitalized)		
Deductible Waived, Benefit Percentage	70%	50%
OBESITY SURGERY OptumHealth Approved Bariatric Center of Excellence		
Deductible Applies, Benefit Percentage	70%	50%
Provider other than OptumHealth Bariatric Center of Excellence is Not Covered		

SPECIAL BENEFITS / LIMITATIONS	PPO	NON-PPO
ORGAN/TISSUE TRANSPLANTS OptumHealth Approved Center of Excellence. Provider other than OptumHealth approved Center of Excellence is Not Covered.		
Professional Provider Expenses Deductible Waived, Benefit Percentage Facility Provider Expenses Deductible Applies, Benefit Percentage	70%	50%
Benefit Limits: Maximum Lifetime Benefit for all Transplants / \$500,000 Benefits in addition to Maximum Lifetime Benefit for all transplants: <ul style="list-style-type: none"> • Maximum Benefit for Organ Procurement Services per transplant / \$25,000 • Maximum Benefit for Ambulance or Commercial Air Transportation incurred as a direct result of the transplant / \$10,000 per transplant. 		
ORTHOPEDIC DEVICES		
Professional Provider Expenses Deductible Waived, Benefit Percentage Facility Provider Expenses Deductible Applies, Benefit Percentage	70%	50%
PRESCRIPTION DRUGS - Outpatient		
Deductible Applies*, Benefit Percentage *Deductible is waived for Generic drugs	70%	
PROFESSIONAL PROVIDER SERVICES - INPATIENT AND OUTPATIENT		
Deductible Waived, Benefit Percentage	70%	50%
PROSTHETIC APPLIANCES		
Purchase of Prosthetic Appliance Deductible Waived, Benefit Percentage Repair and Replacement of Prosthetic Appliance Deductible Waived, Benefit Percentage	70%	50%
Charges in excess of the Benefit Percentage do not apply toward the Out-of-Pocket Maximum, and the Benefit Percentage does not change after satisfaction of the Out-of-Pocket Maximum		
REHABILITATION THERAPY		
Deductible Waived, Benefit Percentage Maximum Lifetime Benefit / \$100,000	70%	50%
Charges in excess of the Benefit Percentage do not apply toward the Out-of-Pocket Maximum, and the Benefit Percentage does not change after satisfaction of the Out-of-Pocket Maximum		

SPECIAL BENEFITS / LIMITATIONS	PPO	NON-PPO
SEVERE MENTAL ILLNESS		
Professional Provider Expenses (Inpatient and Outpatient) Deductible Waived, Benefit Percentage	70%	50%
Facility Provider Expenses (Inpatient and Outpatient) Deductible Applies, Benefit Percentage	70%	50%
SKILLED NURSING FACILITY		
Deductible Applies, Benefit Percentage Maximum Number of Days per Benefit Period / 60	70%	50%
THERAPIES - OUTPATIENT		
Includes Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehabilitation Therapy		
Deductible Waived, Benefit Percentage	70%	50%
Maximum Benefit per Benefit Period for all Facility and Professional Provider Services / \$3,000		
WELL-CHILD CARE SERVICES (through 7 years of age)		
Deductible Waived, Benefit Percentage	70%	50%

PRESCRIPTION DRUG REIMBURSEMENT BENEFIT

Prescription drug charges are payable only through the Plan's Pharmacy Benefit Manager (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. Prescription Drug Products may be obtained using an Outpatient pharmacy or mail-order service. The Covered Person must pay for the prescription at the time of dispensing. The Participant will be reimbursed by the Plan, subject to the Medical Benefits Cost Sharing Provisions stated in the Schedule of Benefits. This Benefit provides preferred pricing so prescriptions may cost less at a participating pharmacy. To use the mail-order service, the Participant must send an order form and the prescription to the address listed on the mail service form.

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

DISPENSING LIMITATIONS

The Plan will cover Outpatient Prescription drugs for the amount normally prescribed by a Physician, not to exceed a 30-day supply, except for certain maintenance prescription drugs that may be dispensed for up to a 90-day supply and not to exceed recommended dose as determined by the U.S. Food and Drug Administration (FDA).

Prescription Drug Products furnished by the mail service pharmacy will be limited to a 90-day supply per purchase. To obtain Benefits, the Participant must send an order form and the prescription to the address listed on the mail service pharmacy order form. A Participant may obtain a list of approved pharmacies from the Pharmacy Benefit Manager.

BENEFITS

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

1. It is Medically Necessary;
2. It is provided while the person is a Participant.
3. Are approved for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed;
4. Are listed in the American Medical Association Drug Evaluation, Physicians Desk Reference, or Drug Facts and Comparisons;
5. Require a Physician's written prescription;
6. It is considered an eligible Prescription Drug Product.

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

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

COVERED PRESCRIPTION DRUGS

The following Prescription Drug Products are covered:

1. Legend drugs - Drugs and medications requiring written prescriptions and dispensed by a licensed pharmacist for treatment of an illness or injury.
2. Compounded medication of which at least one ingredient is a legend drug. The national drug code (NDC) number must be provided for reimbursement.
3. Specialty Pharmaceuticals are a Benefit only when obtained through a Specialty Care Pharmacy.
4. One prescription oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug administration.
5. Insulin on prescription.
6. Disposable insulin needles/syringes.
7. Devices for self-monitoring of glucose levels (including those for the visually impaired).
8. Test strips.
9. Lancets.
10. Tretinoin, all dosage forms (e.g., Retin-A, Renova), for individuals through age 25.
11. Oral contraceptives or injections prescribed by a Physician.
12. Any other drug which, under the applicable state law, may only be dispensed upon the written prescription of a Physician or other lawful prescriber and is a covered medical expense.

EXCLUDED PRESCRIPTION DRUGS

1. Nonlegend drugs other than insulin.
2. Anabolic Steroids.
3. Any drug used for the purpose of weight loss, unless Prior Authorization is obtained through the Bariatric Resource Services program administered by OptumHealth.
4. Fluoride supplements.
5. Minerals. Certain minerals, requiring a prescription may be covered, if Medically Necessary and the Participant receives Prior Authorization.
6. Over-the-counter drugs.
7. Prescription drugs for which a therapeutic equivalent is available as an over-the-counter drug. Certain prescription drugs, for which a therapeutic equivalent is available as an over-the-counter drug may be covered, if Medically Necessary and the Participant receives Prior Authorization.

8. Drugs for cosmetic purposes, including the treatment of alopecia (hair loss) (e.g., Minoxidil, Rogaine).
9. Vitamins, singly or in combination. Certain vitamins, requiring a prescription may be covered, if Medically Necessary and the Participant receives Prior Authorization.
10. Drugs used for erectile dysfunction. Certain drugs used for erectile dysfunction may be covered, if Medically Necessary and the Participant receives Prior Authorization.
11. Therapeutic devices or appliances, including needles, syringes, support garments and other nonmedicinal substances, regardless of intended use, except those otherwise covered under this section.
12. Diabetic infusion sets, which include a cassette, needle and tubing, and one insulin pump during the warranty period. Diabetic infusion sets and accessories for insulin pumps are covered under the medical supply Benefit. Insulin pumps are covered under the durable medical equipment Benefit.
13. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Participant is charged for the drug.
14. Immunization agents, biological sera, blood, or blood plasma.
15. Medication which is to be taken by or administered to the Participant, in whole or in part, while the Participant is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility's charge.
16. Outpatient prescription drugs dispensed from a pharmacy within a Hospital or other facility.
17. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
18. Smoking deterrent medications or aids, unless Prior Authorization is obtained and proof of enrollment in a smoking cessation program.
19. Replacement prescriptions due to loss, theft or spoilage.
20. Prescription that a Participant is entitled to receive without charge from any Workers' Compensation laws, or any municipal state, or federal program.

PROVIDERS OF CARE

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

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

Facility providers include, but are not limited to, Hospitals, home health agencies, Convalescent Homes, skilled nursing facilities, freestanding facilities for the treatment of Chemical Dependency or Mental Illness, and freestanding surgical facilities (surgery center).

This Plan provides benefits through a Preferred Provider Organization (PPO). A "PPO Provider" means a Participating Professional Provider or Participating Facility Provider who is a Physician or other licensed health care provider that agrees to provide services as part of the Preferred Provider Organization. The Plan's Preferred Provider Organization (PPO) is any PPO Provider with whom the Plan Supervisor has a contract or agreement which provides access to the PPO's Providers.

To determine if a Physician or health care provider qualifies as an eligible PPO Provider under this Plan, please consult Allegiance's website at www.abpmtpa.com/MMIA to access links for directories of PPO Providers or call customer service at 1-866-339-4308.

The Benefit Percentages for Medical Benefits may vary depending on the type of service and provider rendering the service or treatment. If a Non-PPO Provider is chosen over a PPO Provider, the Non-PPO Benefit Percentage will apply as stated in the Schedule of Benefits, unless one of the "Non-PPO Benefit Exceptions stated below applies.

NON-PPO BENEFIT EXCEPTION

A Non-PPO Provider is a Physician or Licensed Health Care Provider which is not under contract with a PPO recognized by this Plan. When a covered service is rendered by a Non-PPO provider, charges will be paid as if the service were rendered by a PPO Provider, unless one of the following circumstances apply:

1. Charges for an Emergency as defined by this Plan, limited to only those emergency medical procedures necessary to treat and stabilize an eligible injury or illness and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time to a PPO Hospital, clinic or other facility, or discharged; or
2. Charges which are incurred as a result of and related to confinement in or use of a Participating or "PPO" Hospital, clinic or other facility only for Non-PPO services and providers over whom or which the Covered Person does not have any choice in or ability to select.

MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

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

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider; and
2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary; and
3. Charges do not exceed the Maximum Eligible Expense of the Plan; and
4. They are not excluded under any provision or section of this Plan.

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

DEDUCTIBLE

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

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

BENEFIT PERCENTAGE

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

OUT-OF-POCKET MAXIMUM

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

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

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

The Schedule of Benefits specifically states that certain types of expenses do not apply toward the Out-of-Pocket Maximum and that the Benefit Percentage remains the same after satisfaction of the Out-of-Pocket Maximum.

MAXIMUM BENEFIT

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

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

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

CHANGES IN COVERAGE CLASSIFICATION

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

MEDICAL BENEFITS

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

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

“Ambulatory Surgical Center” (also called same-day surgery center or Outpatient surgery center) means a licensed establishment with an organized staff of Physicians and permanent facilities, either freestanding or as a part of a Hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous Physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for ambulatory surgery centers in the state in which the facility is located.

“Ambulatory Surgical Center” does not include an office or clinic maintained by a Dentist or Physician for the practice of dentistry or medicine, a Hospital emergency room or trauma center.

2. Charges made by an Urgent Care Facility when treatment has been rendered.

“Urgent Care Facility” means a free-standing facility which is engaged primarily in diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention. A clinic or office located in or in conjunction with or in any way made a part of a Hospital will be excluded from the terms of this definition.

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

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

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

5. Charges for Surgical Procedures.

When two or more Surgical Procedures occur during the same operative session, charges will be considered as follows:

- A. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, 100% of the Maximum Eligible Expense will be considered for the Major Procedure; and 50% of the Maximum Eligible Expense will be considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services will be reimbursed at the contracted or negotiated rate.
- B. When an incidental procedure is performed through the same incision, only the Maximum Eligible Expense for the Major Procedure will be considered. Examples of incidental procedures are: excision of a scar, appendectomy at the time of other abdominal surgery, lysis of adhesions, etc.

When an assisting Physician is required to render technical assistance during a Surgical Procedure, the charges for such services will be limited to 25% of the primary surgeon’s Maximum Eligible Expense for the Surgical Procedure. When an assisting non-physician is required to render technical assistance during an operation, charges for such services will be limited to 10% of the surgeon’s Maximum Eligible Expense for the Surgical Procedure.

6. Charges for Advanced Practice Registered Nurses, Registered Nurses (R.N.'s) or Licensed Practical Nurses (L.P.N.'s) for private duty nursing.
7. Charges for home infusion services ordered by a Physician and provided by a home infusion therapy organization licensed and approved within the state in which the services are provided. A home infusion therapy organization is a health care facility that provides home infusion therapy services and skilled nursing services. Home infusion therapy services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a home infusion therapy organization. Services also include education for the Covered Person, the Covered Person's caregiver, or a family member. Home infusion therapy services include pharmacy, supplies, equipment and skilled nursing services when billed by a home infusion therapy organization.

Skilled nursing services billed by a home health agency are covered under the Home Health Care Benefit.

8. Charges for services provided by a licensed naturopathic provider.
9. Charges for Ambulance Service to the nearest facility where Emergency care or treatment can be rendered; or from one facility to another for care; or from a facility to the patient's home when Medically Necessary.
10. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs regardless of Medical Necessity.

Conditions of coverage for outpatient prescription drugs and supplies are stated in the Prescription Drug Reimbursement Benefit section of the Plan.

11. Charges for radiation therapy or treatment and chemotherapy.
12. Charges for blood transfusions, blood processing costs, blood transport charges, blood handling charges, administration charges, and the cost of blood, plasma and blood derivatives. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Maximum Eligible Expense.
13. Charges for oxygen and other gases and their administration.
14. Charges for the cost and administration of an anesthetic.
15. Charges by a Physician or Licensed Health Care Provider for dressings, sutures, casts, splints, crutches, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies, except for dental braces or corrective shoes, which are specifically excluded.
16. Charges for diabetic supplies. Insulin pumps and accessories to insulin pumps are covered under the Durable Medical Equipment benefit.
17. Charges for adhesive tape, bandages, antiseptics or other over-the-counter first aid supplies only if approved by the Plan based on guidelines of cost effectiveness and Medically Necessary treatment of an Illness or Injury.
18. Charges for voluntary sterilization for Participants and Dependent spouses only.
19. Reasonable charges for producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Charges that exceed limits for such charges imposed by applicable law will not be deemed to be reasonable.

20. Charges for Contraceptive Management, regardless of Medical Necessity. "Contraceptive Management" means Physician fees related to a contraception, contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation or placement of any contraceptive device.
21. Charges for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes are excluded under this Plan; however, benefits will be payable for treatment required because of accidental bodily Injury to natural teeth. Such expenses must be Incurred within one (1) year from the date of accident. Dental implants provided as the result of an accident will be covered, subject to Medical Necessity. This benefit will not in any event be deemed to include charges for treatment for the repair or replacement of a denture.

ACCIDENTAL INJURY BENEFIT

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

Expenses not eligible under this benefit may be considered under the Medical Benefits of this Plan.

Chiropractic Care Services and naturopathy charges are specifically excluded under this benefit.

Coverage under this benefit includes charges in connection with an Accidental Injury. Expenses Incurred under this benefit are not subject to the Deductible. Charges in connection with an Accidental Injury are payable at 100% of the Maximum Eligible Expense, up to the maximum benefit stated in the Schedule of Benefits. Any portion of the charges exceeding the maximum benefit will be considered under the Medical Benefits Section of the Plan, subject to all Plan conditions, exclusions and limitations. An Accidental Injury must be sustained subsequent to the Covered Person's effective date of coverage. Services and supplies must be ordered by a Physician and furnished within a ninety-day period beginning with the date the Covered Person sustained those injuries.

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

CANCER SCREENING AND RELATED OFFICE VISITS

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

Coverage under this benefit includes charges for the first test performed during the Benefit Period regardless of diagnosis for the following services. Subsequent tests and related office visits will be covered under the Medical Benefits:

1. Mammograms:
 - A. Once every 2 Benefit Periods for women ages 40 to 49;
 - C. Once per Benefit Period for women ages 50 years or older.
2. Pap test and pelvic examination once per Benefit Period for women ages 18 and over.
3. Colonoscopy once per Benefit Period for ages 50 and older.
4. Prostate screening once per Benefit Period for ages 50 and older.

CHEMICAL DEPENDENCY TREATMENT

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

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary treatment, including but not limited to group therapy.
2. Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.
3. Charges for in-patient hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.
4. Charges for Medically Necessary treatment, including aftercare, at a Chemical Dependency Treatment Facility.
5. Charges for Inpatient Chemical Dependency benefits: One day of Inpatient hospitalization may be exchanged for two days of Partial Hospitalization. **Partial Hospitalization is considered Inpatient hospitalization for purposes of benefit adjudication under this Plan.**

“Partial Hospitalization” means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

Benefit limits for Chemical Dependency do not apply to medical detoxification.

CHIROPRACTIC SERVICES

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

Coverage includes charges for services of a licensed chiropractor.

DIABETIC EDUCATION BENEFIT

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

Coverage under this benefit includes charges for outpatient self-management training and education services for the treatment of diabetes provided by a Physician or Licensed Health Care Provider with expertise in diabetes.

DIAGNOSTIC SERVICES

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

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

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

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

DURABLE MEDICAL EQUIPMENT

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

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

1. Rental of, up to the purchase price of, a wheelchair, Hospital bed, respirator or other Durable Medical Equipment required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less. For Durable Medical Equipment for which purchase is not medically feasible, rental charges will be paid without limitation based upon purchase price.
2. Replacement or repair of Durable Medical Equipment.

Charges for replacement of a Durable Medical Equipment will not be subject to the reduced Benefit Percentage stated in the Schedule of Medical Benefits if it has been at least five (5) years since the original purchase price or the Durable Medical Equipment no longer meets the medical needs of the Covered Person due to physical changes or a deteriorating medical condition.

EMPLOYEE ASSISTANCE PLAN

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

This Program provides assistance and support, including short-term counseling services and referrals to more extended care for conditions such as depression, anxiety, stress, substance abuse, workplace problems or conflicts, parenting and funding issues and child and elder care.

There is no cost for referrals or for seeing a PPO provider for up to five (5) visits, including consultation with financial and legal experts.

For more details about this program contact United Behavioral Health at www.liveandworkwell.com or call toll-free 1-866-248-4094.

HOME HEALTH CARE BENEFIT

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

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

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

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

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

Home Health Care specifically excludes the following:

1. Services and supplies not included in the approved Home Health Care Plan.
2. Services of a person who ordinarily resides in the home of the Covered Person, or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services.
3. Transportation services.
4. “Meals-on-Wheels” or similar food arrangements.
5. Domestic or housekeeping services.
6. Maintenance or Custodial Care.
7. Services for mental or nervous conditions.

HOSPICE SERVICES

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

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

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.
2. Nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a public health nurse who is under the direct supervision of a Registered Nurse.
3. Physical Therapy and Speech Therapy, when rendered by a licensed therapist.
4. Medical supplies, including drugs and biologicals and the use of medical appliances.
5. Physician's services.
6. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
7. Counseling and other support services, including bereavement counseling, provided to meet the physical, psychological, spiritual, and social needs of the terminally ill patient.

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

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

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

HOSPITAL SERVICES

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

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

1. Daily Room and Board in a Semi-Private Room (or private room if no Semi-Private room is available or when confinement in a private room is Medically Necessary) and general nursing services, or confinement in an Intensive Care Unit, not to exceed the applicable limits shown in the Schedule of Medical Benefits.
2. Medically Necessary Hospital Miscellaneous Expenses other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use for an Emergency only, Physical Therapy treatments, hemodialysis, and x-ray.
3. Nursery neonatal units, general nursing services, including Hospital Miscellaneous Expenses for services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities or premature delivery incurred by a Newborn Dependent.
4. Therapy has been prescribed by the speech pathologist or Physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all above conditions are met.

IN-VITRO FERTILIZATION

Coverage under this benefit includes charges for medical or surgical services and supplies related to in vitro fertilization. This benefit is limited to one attempt at in vitro fertilization per Covered Person per lifetime.

Note: The Plan will not pay for in vitro fertilization services if the Covered Person has had an elective sterilization procedure.

MATERNITY SERVICES

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

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

1. Prenatal and postpartum care.
2. Delivery of one or more newborns, miscarriage, and any medical complications arising out of or resulting from Pregnancy.

3. Hospital Inpatient care for conditions related directly to the Pregnancy.

MENTAL ILLNESS

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

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment.
2. Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.
3. Charges for in-patient hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.
4. Charges for Medically Necessary treatment at a Psychiatric Facility.
5. Charges for Inpatient Mental Illness benefits: One day of Inpatient hospitalization may be exchanged for two days of Partial Hospitalization. **Partial Hospitalization is considered Inpatient hospitalization for purposes of benefit adjudication under this Plan.**

“Partial Hospitalization” means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

Benefits described above do not include benefits for Severe Mental Illness. Refer to the Severe Mental Illness Benefit for those benefits.

NEWBORN INITIAL CARE

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

Coverage under this benefit includes charges for the following services:

1. The initial care of a Newborn at birth provided by a Physician, including circumcision.
2. Standby care provided by a pediatrician at a cesarean section.
3. Nursery Care - Includes room, board and Hospital Miscellaneous expenses for the Newborn, while the mother is receiving Inpatient Care services for the delivery, including circumcision.

NEW YORK STATE EXPENSES

Coverage for charges incurred in New York are limited to only those emergency medical procedures necessary to treat and stabilize an eligible injury or illness and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time, to a Hospital or other appropriate treatment facility at a location outside the State of New York. The Plan will not pay any surcharge or tax of any nature imposed by the State of New York upon services, treatments or supplies.

OBESITY SURGERY

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

Coverage under this benefit includes charges for surgical treatment of morbid obesity only if the Covered Person meets all of the following conditions:

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

ORGAN/TISSUE TRANSPLANTS

The Schedule of Benefits describes special payment provisions for these services. Provider other than OptumHealth approved Center of Excellence is Not Covered.

Coverage includes charges in connection with non-Experimental or non-Investigational organ or tissue transplant procedures. Transplant services include the following:

1. Organ procurement including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ, and transportation of the donor or donor organ to the location of the transplant operation.
2. Donor services including the preoperative services, transplant related diagnostic lab and x-ray services, and the transplant surgery hospitalization. Transplant related services are covered for up to six months after the transplant.
3. Hospital Inpatient Care services.
4. Professional provider, diagnostic Outpatient services, surgical services and anesthesia.
5. Licensed Ambulance Service or commercial air travel for the Covered Person receiving the treatment to the nearest Hospital with appropriate facilities.

Payment by the Plan is subject to the following conditions:

1. If the donor is covered under this Plan, expenses Incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.
3. If the recipient is covered under this Plan, expenses Incurred by the recipient will be considered for benefits. Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, will be considered for payment to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the Maximum Lifetime Benefit still available to the recipient.
4. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.

ORTHOPEDIC DEVICES

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

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

PROSTHETIC APPLIANCES

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

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

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

Charges for replacement of a Prosthetic Appliance will not be subject to the reduced Benefit Percentage stated in the Schedule of Medical Benefits if it has been at least five (5) years since the original purchase price of the Prosthetic Appliance or the Prosthetic Appliance no longer meets the medical needs of the Covered Person due to physical changes or a deteriorating medical condition.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

Coverage under this benefit includes charges for reconstructive breast surgery subsequent to any mastectomy, limited to charges for the following:

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

Specifically excluded from this benefit are expenses for the following:

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

REHABILITATION THERAPY

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

Coverage under this benefit includes charges billed by a Rehabilitation Facility provider or a Professional Provide as follows:

1. Inpatient Care - Services billed by a Facility Provider for the following
 - A. Room and board accommodations; and
 - B. Miscellaneous Rehabilitation Facility services, including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy.

2. Inpatient Care - Services billed by a Professional Provider who is a psychiatrist or other Physician directing the Covered Persons Rehabilitation Therapy.
3. Outpatient Rehabilitation - Services billed by a Facility or Professional Provider.

“Rehabilitation Facility” means a facility, or a designated unit of a facility, licensed, certified or accredited to provide Rehabilitation Therapy including:

1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or a facility associated or co-located with a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital;
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Covered Person, regardless of the category of facility licensure.

“Rehabilitation Therapy” means a specialized, intense and comprehensive program of therapies and treatment services (including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy) provided by a Multidisciplinary Team for treatment of an Injury or physical deficit. A Rehabilitation Therapy program is provided by a Rehabilitation Facility in an Inpatient Care or outpatient setting; provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals; designed to restore the patient’s maximum function and independence; and Medically Necessary to improve or restore bodily function and the Covered Person must continue to show measurable progress.

"Multidisciplinary Team" is a group of health service providers who are either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. For the purposes of Rehabilitation Therapy, 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.

SEVERE MENTAL ILLNESS

The Schedule of Benefits describes special payment provisions for these services. Benefits are paid the same as any other illness.

Coverage includes charges for Inpatient Care Services, Outpatient Care services, rehabilitation services, and medication for the treatment of Severe Mental Illness as defined.

“Severe Mental Illness” means the following disorders as defined by the American Psychiatric Association:

1. Schizophrenia;
2. Schizoaffective disorder;
3. Bipolar disorder;
4. Major depression;
5. Panic disorder;
6. Obsessive-compulsive disorder; and
7. Autism.

SKILLED NURSING FACILITY**The Schedule of Benefits describes special payment provisions for these services.**

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

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.
2. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.
3. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.

THERAPIES - OUTPATIENT**Charges are payable as specifically stated in the Schedule of Medical Benefits.**

Coverage includes charges for the following services:

1. Physical Therapy or Occupational Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Inpatient or Outpatient basis. Physical Therapy or Occupational Therapy must be ordered by a Physician and rendered by a licensed physical or occupational therapist.
2. Charges made by a licensed speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders. The Plan will provide benefits for Speech Therapy when all of the following criteria are met:
 - A. There is a documented condition or delay in development that can be expected to improve with therapy within a reasonable time.
 - B. Improvement would **not** normally be expected to occur without intervention.
 - C. Treatment is **not** rendered for stuttering.
 - D. Treatment is **not** rendered for behavioral or learning disorders.
 - E. Treatment is rendered for a condition that is the direct result of a diagnosed neurological, muscular, or structural abnormality affecting the organs of speech.
 - F. Therapy has been prescribed by the speech language pathologist or Physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all above conditions are met.
3. Cardiac Rehabilitation Therapy, which is the process of restoring optimal function status after a cardiac event, including an ECG-monitored exercise component.

WELL-CHILD CARE

Charges are payable as specifically stated in the Schedule of Medical Benefits.

Coverage under this benefit includes charges for the following routine services, subject to the following limitations:

1. Well-Child Care from the moment of birth through seven (7) years of age provided by a Physician or Licensed Health Care Provider and which includes a medical history, physical examination, developmental assessment and anticipatory guidance.
2. Laboratory tests according to the schedule of visits adopted under the early and periodic screening, diagnosis and treatment services program provided for in Montana law.
3. Routine immunizations according to the schedule of immunizations which is recommended by the Advisory Committee on Immunization Practices (ACIP) of the United States Department of Health and Human Services.

PRE-EXISTING CONDITION EXCLUSIONS

No Pre-existing Condition Exclusion applies if enrollment occurs during Initial Enrollment or Special Enrollment Period. However, if enrollment occurs during any Annual Open Enrollment Period, expenses Incurred resulting from treatment of Pre-existing Conditions are excluded from coverage under the Plan for a period of twelve (12) consecutive months from the Enrollment Date.

All Pre-existing Condition exclusionary periods will commence on the Enrollment Date.

All Pre-existing Condition exclusionary periods set out in this Plan will be reduced on a day for day basis for any period(s) of Creditable Coverage that occurred prior to a Covered Person's Enrollment Date, provided there has been no break in the Creditable Coverage exceeding sixty-three (63) consecutive days prior to the Covered Person's Enrollment Date. The Waiting Period imposed by this Plan will not be considered to be a break in Creditable Coverage.

Pre-existing Condition Exclusions will not apply to any of the following:

1. Pregnancy related expenses.
2. Newborns, or any child who is adopted or Placed for Adoption before the child attains eighteen (18) years of age, provided that said child is covered under any Creditable Coverage within thirty (30) days after birth, adoption or Placement for Adoption. Further, if such Newborn or child had Creditable Coverage within thirty (30) days after the date of birth, adoption or Placement for Adoption, whichever is applicable, and is subsequently enrolled for coverage under this Plan not later than sixty-three (63) days after cessation of such Creditable Coverage, no Pre-existing Condition exclusion may be imposed.
3. A genetic predisposition to a disease or condition without a diagnosis of a condition related to the genetic information.

"Pre-Existing Condition" means an Injury or Illness of a Covered Person, except for Pregnancy or results of genetic testing, for which the Covered Person has been under the care of a Physician or Licensed Health Care Provider, or has received medical advice, diagnosis, treatment, services or care, including prescription drugs, within the six (6) month period immediately preceding his/her Enrollment Date. Pregnancy or the results of genetic testing will never be considered a Pre-Existing Condition for any reason.

GENERAL EXCLUSIONS AND LIMITATIONS

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

1. Charges for any services or supplies not necessary for treatment of an actual Illness or Injury, including but not limited to, annual physical examinations; insurance, premarital, athletic, and employment physicals; routine examinations and routine immunizations, except as specifically covered otherwise.
2. Charges in connection with the care or treatment of, surgery performed for, or as the result of, a Cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury or an Illness, or when rendered to correct a congenital anomaly for a covered Dependent child.**
3. Charges for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a Covered Benefit of this Plan.
4. Charges for elective abortions.
5. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury.
6. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician.
7. Charges for Licensed Health Care Providers' fees for any treatment which is not rendered by or in the physical presence of a Licensed Health Care Provider.
8. Special duty nursing services are excluded:
 - A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or
 - B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.
9. Charges in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses. **This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.**
10. Charges in connection with hearing aids or such similar aid device.
11. Charges for dental services except as specifically covered due to accidental bodily Injury to natural teeth.
12. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, or any other assisted reproductive technique, except as specifically covered under the In-Vitro Fertilization benefit.

13. Group therapy, except for the treatment of Chemical Dependency.
14. Charges resulting from or in connection with the reversal of a sterilization procedure.
15. Charges for services or supplies for the medical and/or surgical treatment of obesity, including any benefits, services or supplies for medical and or surgical treatment of Morbid Obesity, whether rendered for weight control or any other condition, except as specifically covered under the Obesity Surgery Benefit.
16. Charges for services or supplies related to any of the following treatments or related procedures:
 - A. Acupuncture.
 - B. Acupressure.
 - C. Homeopathy.
 - D. Hypnotherapy.
 - E. Rolfing.
 - F. Holistic medicine.
 - G. Marriage counseling, religious counseling, family counseling, recreational counseling or milieu therapy.
 - H. Self-help programs.
 - I. Stress management.
17. Charges for foot care, including, but not limited to:
 - A. Routine foot care.
 - B. Treatment or removal of corns or callosities.
 - C. Hypertrophy, hyperplasia of the skin or subcutaneous tissues.
 - D. Cutting or trimming of nails.
 - E. Any treatment of congenital flat foot.
 - F. Injections and nonsurgical treatment of acquired flat foot, fallen arches, or chronic foot strain.
 - G. Any treatment of flat foot purely for the purpose of altering the foot's contour where no medical or functional impairment exists.
 - H. Orthotic appliances or impression casting for orthotic appliances.
 - I. Padding and strapping.
 - J. Fabrication.
18. Charges for foot orthotic appliances provided for the treatment of any medical condition.

19. Hair transplant procedures, wigs and artificial hairpieces, or drugs which are prescribed to promote hair growth.
20. Charges for any services, care or treatment for sexual dysfunction, trans-sexualism, gender dysphoria or sexual reassignment including related drugs, medications, surgery, medical or Psychiatric Care or treatment.
21. Charges for any surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism.
22. Charges related to Custodial Care.
23. Charges for nonhuman organ or artificial organ implant procedures.
24. Charges for non-prescription contraceptives supplies or devices, or the removal of contraceptive devices, unless Medically Necessary.
25. Charges for services of a direct-entry midwife or lay midwife or the practice of direct-entry midwifery. A Direct-entry midwife is one practicing midwifery and licensed pursuant to M.C.A. 37-27-101 et seq.

"Direct-entry midwife" means a person who advises, attends, or assists a woman during pregnancy, labor, natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.
26. Charges for services rendered or started, or supplies furnished prior to the effective date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions.
27. Charges which are caused by or arising out of war or act of war, (whether declared or undeclared), civil unrest, armed invasion or aggression or caused during service in the armed forces of any country.
28. Charges for services or supplies which the Covered Person is entitled to receive or does receive from the United States or any city, county, state, or country. This exclusion applies to any programs of any agency or department of any government. This exclusion is not intended to exclude from coverage if a Covered Person is a resident of a Montana state institution when services are provided.

Note: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Covered Person from the Plan. When such a circumstance occurs, the Covered Person will receive an explanation of benefits.
29. Charges by the Covered Person for all services and supplies which are provided to treat any Illness or Injury arising out of employment or in the course of an occupation. **However, this exclusion does not apply to charges for services and supplies as the result of an Illness or Injury which occurs in the course of employment if the Participant is a corporate officer, sole proprietor, working partner of a partnership or working member of a member-managed limited liability company who is not required to have Workers's Compensation coverage and either the Participant or their employer has not elected to obtain Workers' Compensation coverage pursuant to the provisions of Title 39, Chapter 71, MCA.**
30. Charges for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
31. Charges for vitamins or food nutritional supplements, whether or not prescribed by a Physician.

32. Charges for services or supplies used primarily for cosmetic, personal comfort, convenience, beautification items, television or telephone use that are not related to treatment of a medical condition.
33. Charges for non-medical expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician.
34. Expenses Incurred by persons other than the Covered Person receiving treatment.
35. Charges in excess of the Maximum Eligible Expense.
36. Charges for services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person, or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services.
37. Charges for professional services on an Outpatient basis in connection with disorders of any type or cause, that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis.
38. Charges for services, treatment or supplies not considered legal in the United States.
39. Travel Expenses Incurred by any person for any reason, except as specifically covered under the Transplant Benefit.
40. Charges for services, treatments or supplies that may be useful to persons in the absence of Illness or Injury such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, dehumidifiers, exercise equipment, health club memberships, etc., whether or not they have been prescribed or recommended by a Physician.
41. Charges for nonsurgical treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction (TMJ) anterior or internal dislocations, derangements and myofascial pain syndrome, orthodontics dentofacial orthopedics), or related appliances.
42. Charges for preparation of reports or itemized bills in connection with claims, unless specifically requested and approved by the Plan.
43. Charges for services or supplies that are not specifically listed as a Covered Benefit of this Plan.
44. Charges for any services or supplies to the extent that benefits are otherwise provided under this Plan, or under any other plan of group benefits that the Participant's Employer contributes to or sponsors.
45. Charges to the extent that the Covered Person could have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid.
46. Charges for incidental supplies or common first-aid supplies, such as, but not limited to, adhesive tape, bandages, antiseptics, analgesics, etc., except as specifically listed as a Covered Benefit.
47. Charges for dental braces or corrective shoes.

48. Charges for the following treatments, services or supplies:
 - A. Charges related to or connected with treatments, services or supplies that are excluded under this Plan.
 - B. Charges that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan.
49. Charges for treatment, services or supplies not actually rendered to or received and used by the Covered Person.
50. Charges for computerized items including, but not limited to: Durable Medical Equipment, prosthetic limbs and communication devices.
51. Charges for any services, treatments or supplies Incurred in the State of New York, except for those specifically set out as a benefit of this Plan. The Plan will not pay any surcharge or tax of any nature imposed by the State of New York upon services, treatments or supplies.

BENEFIT MANAGEMENT

PRE-CERTIFICATION AND PLAN NOTIFICATION

"Pre-Certification" is a determination of the medically appropriate number of Inpatient days for any particular Inpatient treatment or service. Pre-certification is not a determination that treatment is medically necessary or is a covered service under the Plan.

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

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

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

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

PRE-ADMISSION CERTIFICATION REVIEW

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

To pre-certify, contact OptumHealth at 1-877-281-4308 for pre-admission certification review.

Most certifications occur over the phone. Once a final decision is made regarding the request for certification, a notice of pre-certification will be sent to the physician, to the Covered Person, to the Plan Supervisor and to the hospital. This notice is not required, and therefore, cannot be appealed.

CONTINUED STAY CERTIFICATION

Charges for inpatient hospital services for days in excess of any days previously certified by the cost containment company are subject to all terms, conditions and exclusions of the Plan, and should be certified by the Plan's utilization management company.

Certification for additional days should be obtained in the same manner as the pre-admission certification. This determination is not required, and therefore, cannot be appealed.

To notify the Plan of a continued stay certification, contact OptumHealth at 1-877-281-4308.

EMERGENCY NOTIFICATION/CERTIFICATION

The Covered Person, or his or her representative, should notify the utilization management company for the Plan regarding any Emergency Hospital Admission within seventy-two (72) hours immediately following admission.

To notify the Plan of an emergency admission, contact OptumHealth at 1-877-281-4308 for emergency admission certification.

PRIOR AUTHORIZATION

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

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

Examples of services for which Prior Authorization is **recommended** include, but are not limited to:

1. All elective inpatient hospitalizations
2. Transplants
3. All elective inpatient surgeries

Prior Authorization is **recommended** for the following selected outpatient surgeries:

1. Blepharoplasty
2. Vein stripping/ligation/schlerotherapy
3. Accidental dental surgeries
4. Obesity Surgery
5. Breast Reduction or Reconstruction
6. Abdominoplasty
7. Cosmetic/Experimental surgeries

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

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

Contact OptumHealth at 1-877-281-4308 for Prior Authorization.

NOTE: PRE-CERTIFICATION AND PRIOR AUTHORIZATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT OF THE CLAIM(S). ELIGIBILITY FOR CLAIM PAYMENTS IS DETERMINED AT THE TIME CLAIMS ARE ADJUDICATED SINCE THE AMOUNT OF BENEFIT COVERAGE, IF ANY, IS SUBJECT TO ALL PLAN PROVISIONS INCLUDING, BUT NOT LIMITED TO, NETWORK PROVIDER DESIGNATION, MEDICAL NECESSITY, PATIENT ELIGIBILITY, DEDUCTIBLES, CO-PAYMENTS AND ANY PLAN LIMITATIONS OR MAXIMUMS IN EFFECT WHEN THE SERVICES ARE PROVIDED. PROVIDERS AND COVERED PERSONS ARE INFORMED AT THE TIME CLAIMS ARE PRE-CERTIFIED OR AUTHORIZED THAT PRE-CERTIFICATION OR AUTHORIZATION OF A COURSE OF TREATMENT BY THE PLAN DOES NOT GUARANTEE PAYMENT OF CLAIMS FOR THE SAME.

COORDINATION OF BENEFITS

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

In the event of a motor vehicle or premises accident; or an act of violence with the intent to disrupt electronic, communications, or any other business system, this Plan will be secondary to any auto "no fault" and traditional auto "fault" type contracts, homeowners, commercial general liability insurance and any other medical benefits coverage.

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

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

DEFINITIONS

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

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
 - A. Hospital indemnity benefits; and
 - B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims; or
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans; or
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision; or
4. A licensed Health Maintenance Organization (H.M.O.); or
5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or
6. Any coverage under a Governmental program, and any coverage required or provided by any statute; or
7. Automobile insurance; or
8. Individual automobile insurance coverage on an automobile leased or owned by MMIA or any responsible third-party tortfeasor; or
9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage; or
10. Homeowner or premise liability insurance, individual or commercial.

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

ORDER OF BENEFIT DETERMINATION

1. Non-Dependent/Dependent

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

2. Child Covered Under More Than One Plan

A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

- 1) The parents are married;
- 2) The parents are not separated (whether or not they have ever been married), or
- 3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

B. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

C. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s spouse does, the spouse’s plan is primary. This subparagraph will not apply with respect to any claim determination period, Benefit Period or Plan Year during which benefits are paid or provided before the entity has actual knowledge.

D. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and the parents’ spouses (if any) is:

- 1) the plan of the custodial parent
- 2) the plan of the spouse of the custodial parent
- 3) the plan of the non-custodial parent
- 4) the plan of the spouse of the non-custodial parent

3. Active or Inactive Employee

The Plan that covers a person as an employee who is neither laid-off nor retired (or as that employee’s dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.

4. Longer or Shorter Length of Coverage

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

A. To determine the length of time a person has been covered under a plan, two plans will be treated as one if the Covered Person was eligible under the second within 24 hours after the first ended.

- B. The start of a new plan does not include:
- 1) A change in the amount or scope of a plan's benefits
 - 2) A change in the entity that pays, provides, or administers the plan's benefits; or
 - 3) A change from one type of plan to another (such as from a single employer plan to that of a multiple-employer plan).
- C. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

5. No Rules Apply

If none of these preceding rules determines the primary plan, the amount payable will be determined equally between the plans.

COORDINATION WITH MEDICARE

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

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

1. For Working Aged

A covered Employee who is eligible for Medicare Part A, Part B or Part D as a result of age may be covered under this Plan and be covered under Medicare, in which case this Plan will pay primary, unless the Employee is employed by a Participating Employer who regularly employs less than 20 employees, and the Plan has affirmatively requested an exception* to this rule from Medicare. A covered Employee, eligible for Medicare Part A, Part B or Part D as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

A covered Dependent, eligible for Medicare Part A, Part B or Part D as a result of age, of a covered Employee may also be covered under this Plan and be covered under Medicare, in which case the Plan again will pay primary, unless the Employee is employed by a Participating Employer who regularly employs less than 20 employees, and the Plan has affirmatively requested an exception* to this rule from Medicare. A covered Dependent, eligible for Medicare Part A, Part B or Part D as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

*If a Participating Employer which regularly employs less than twenty (20) employees, refuses or declines to request the exception described above, the Plan will pay claims as primary to Medicare for those persons covered through such Participating Employer under the Working Aged rule. However, the Plan will calculate for each such claim, the amount it would have paid as secondary payor to Medicare and the Participating Employer will be liable to and must pay the Plan the difference between the amount(s) paid and the amount(s) that would have been paid by the Plan as secondary payor to Medicare.

2. For Retired Persons

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

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

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

3. For Covered Persons who are Disabled

For employers with fewer than 100 Employees, Medicare is primary and the Plan will be secondary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability.

For employers with 100 Employees or more, the Plan is primary and Medicare will be secondary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability, if the Employee is actively employed by the Employer.

For employers with 100 Employees or more, the Plan is secondary and Medicare will be primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

4. For Covered Persons with End Stage Renal Disease

Except as stated below*, for Employees or Retirees and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above:

- A. The Covered Person has no dialysis for a period of twelve (12) consecutive months and then resumes dialysis, at which time the Plan will again become primary for a period of thirty (30) months; or
- B. The Covered Person undergoes a kidney transplant, at which time the Plan will again become primary for a period of thirty (30) months.

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

COORDINATION WITH MEDICAID

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

COORDINATION WITH TRICARE/CHAMPVA

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

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

PROCEDURES FOR CLAIMING BENEFITS

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

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

When completed, the claim must be sent to the Plan Supervisor, Allegiance Benefit Plan Management, Inc., at P.O. Box 5066, Missoula, Montana 59806-5066, (406) 721-2222 or 1-800-877-1122 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

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

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

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

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

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

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

THE PLAN DOES NOT MAKE TREATMENT DECISIONS. ANY DECISION TO RECEIVE TREATMENT MUST BE MADE BETWEEN THE PATIENT AND HIS OR HER HEALTHCARE PROVIDER; HOWEVER, THE PLAN WILL ONLY PAY BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THIS PLAN.

In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim. Upon written notice to the Covered Person of the circumstances requiring an extension and the date by which the Plan expects to render a decision, this time period may be extended fifteen (15) days for reasons beyond the Plan's control. If the extension is necessary due to a failure of the claimant to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the claimant will be afforded forty-five (45) days from receipt of the notice within which to provide the specified information. Once sufficient information is received to decide the claim, the Plan will provide timely notice of the determination after receiving sufficient information.

APPEALING AN UN-REIMBURSED CLAIM

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

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

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

This Plan provides for three levels of benefit determination review for any Adverse Benefit Determination, including all medical and pharmacy benefits. Each level of review is mandatory and must be utilized.

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan Supervisor at P.O. Box 5066, Missoula, MT 59806-5066 in writing, and supporting materials may be submitted via mail, the electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

FIRST LEVEL OF BENEFIT DETERMINATION REVIEW

The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within sixty (60) days following the date the Plan Supervisor receives the request for reconsideration.

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

SECOND LEVEL OF BENEFIT DETERMINATION REVIEW

The second level of benefit determination review is done by the MMIA Program Manager in consultation with the Plan Supervisor and independent medical reviewer when necessary. The MMIA Program Manager will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the second level of review will be sent to the Covered Person within sixty (60) days following the date the Plan Supervisor receives the request for reconsideration.

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

THIRD LEVEL OF BENEFIT DETERMINATION REVIEW

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

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, within a reasonable time, but no later than sixty (60) days from the date the appeal is received by the Plan. Such notice will contain the same information as notices for the initial and second determination.

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

ELIGIBILITY PROVISIONS

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

EMPLOYEE ELIGIBILITY

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

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

WAITING PERIOD

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

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

No Waiting Period will be considered a break in coverage for purposes of applying Creditable Coverage even if an eligible person maintains no Creditable Coverage during said Waiting Period.

RETIREE ELIGIBILITY

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

The Retiree's termination of coverage from the Plan does not apply to the Retiree's spouse, provided the Retiree is terminating because of Medicare coverage. The spouse of a Retiree is permitted to maintain coverage unless the spouse is also eligible for Medicare coverage or the spouse has or is eligible for equivalent coverage.

DEPENDENT ELIGIBILITY

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

1. The Participant's or Retiree's legal spouse of the opposite sex, according to the marriage laws of the state where the marriage was first solemnized or established. Proof of common-law marriage must be furnished to the Plan Administrator upon request, including a copy of the Participant's or Retiree's most recent Federal tax return and signed affidavit.

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

2. The Participant's or Retiree's Dependent who meets all of the following "Required Eligibility Conditions":
 - A. Is unmarried; and
 - B. Is a natural child; step-child; legally adopted child; a child who has been Placed with the Participant for adoption and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and
 - C. Is less than twenty-five (25) years of age. This requirement is waived if the Participant's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time.
 - D. Is not an employee eligible for coverage under a group health plan offered by the child's employer.

3. The Participant's or Retiree's Domestic Partner and their children only if eligibility is allowed by the Member Entity as specifically stated in the applicable Member Entity's written personnel policy. Domestic Partner means the person, regardless of gender, named in the Affidavit of Domestic Partnership that has been submitted to and approved by the Employer. See General Definitions.

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

Dependents on active military duty for more than thirty-one (31) consecutive days are not eligible.

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

Each Employee will become eligible for Dependent Coverage on the latest of: 1) the date the Employee becomes eligible for Participant coverage; or 2) the date on which the Employee first acquires a Dependent.

DECLINING COVERAGE

If an eligible person declines coverage under this Plan, he/she will state his/her reason(s) for declining, in writing. Failure to provide those reasons in writing may result in the Plan refusing enrollment at a later date or imposing a Pre-existing Condition Limitation period as a Late Enrollee.

EFFECTIVE DATE OF COVERAGE

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

PARTICIPANT COVERAGE

Participant coverage under the Plan will become effective on the date the Employee satisfies the applicable eligibility requirements and Waiting Period, provided that application for such coverage is made on the Plan's enrollment form within thirty-one (31) days immediately following the last day of the Waiting Period imposed by the Member Entity. The Waiting Period is determined by the applicable MMIA Member Entity's written personnel policy.

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

DEPENDENT COVERAGE

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

1. On the Participant's effective date of coverage, if application for Dependent Coverage is made on the Plan's enrollment form within thirty-one (31) days immediately following the last day of the Waiting Period imposed on Employees by the MMIA Entity. This subsection applies only to Dependents who are eligible on the Participant's effective date of coverage. Enrollment under this subsection will not be considered Late Enrollment.
2. In the event a Dependent is acquired after the Participant's effective date of coverage as a result of a legal guardianship or in the event that a Participant is required to provide coverage as a result of a valid court order, or if the Dependent is acquired as a result of operation of law, Dependent Coverage will begin on the first day of the month following the Plan's receipt of an enrollment form and copy of said court order, if applicable. Enrollment under this subsection will not be considered Late Enrollment.

LATE ENROLLMENT/OPEN ENROLLMENT PERIOD

Any eligible person who makes application for Participant or Dependent coverage under the Plan other than during the Initial Enrollment Period or Special Enrollment Period will be considered a Late Enrollee. Coverage for a Late Enrollee may be requested during the Annual Open Enrollment Period during which an Employee and the Employee's eligible Dependents, who are not covered under this plan, may request Participant or Dependent coverage. Coverage must be requested on the Plan's enrollment form. A person who enrolls during an Open Enrollment Period will be considered a Late Enrollee, and may be subject to a Pre-existing Condition exclusionary period, except for individuals eligible for the first time or whose initial eligibility coincides with the Open Enrollment Period.

If an MMIA Member Entity offers multiple health benefit plans, employees may choose a different health plan during an Open Enrollment Period. Such change must be requested on a form approved by the Plan. Change in the Deductible Option will become effective on July 1st following the Open Enrollment Period. **A person who makes changes in health benefit plans during an Open Enrollment Period will not be considered a Late Enrollee.**

The Open Enrollment Period will be May 15th through June 15th of each year.

Coverage or changes requested during any Annual Open Enrollment Period will begin on July 1st following the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

Other than the Initial Enrollment Period and Open Enrollment Period allowed by this Plan, certain persons may enroll during Special Enrollment Period. An eligible person who makes a special enrollment request during any such applicable Special Enrollment Period will not be considered a Late Enrollee.

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

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

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

2. A Participant may enroll eligible Dependents, including step children, acquired under the following specific events:
 - A. Marriage to the Participant;
 - B. Birth of the Participant’s child; or
 - C. Adoption of a child by the Participant, provided the child is under the age of 19; or
 - D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

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

4. The following individuals may enroll and become covered when coverage under another health care plan or health insurance is terminated due to loss of eligibility or if employer contributions to the other coverage have been terminated, subject to the following:
- A. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
 - B. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

Further, Loss of Coverage means only one of the following:

- A. COBRA Continuation Coverage under another plan and the maximum period of COBRA Continuation Coverage under that other plan has been exhausted; or
- B. Group or insurance health coverage that has been terminated as a result of termination of Employer contributions** towards that other coverage; or
- C. Group or insurance health coverage (includes other coverage that is Medicare or Medicaid) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:
 - 1) Legal separation or divorce of the eligible Employee;
 - 2) Cessation of Dependent status;
 - 3) Death of the eligible Employee;
 - 4) Termination of employment of the eligible Dependent;
 - 5) Reduction in the number of hours of employment of the eligible Dependent;
 - 6) Termination of the eligible Dependent's employer's plan; or
 - 7) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or
 - 8) Any loss of eligibility for individual or group coverage because the eligible Employee or Dependent no longer resides, lives or works in the service area of the HMO or other such plan; or
 - 9) Any loss of eligibility for coverage because the eligible Employee or Dependent incurs a claim for benefits that would meet or exceed the Maximum Lifetime Benefit for all causes.

**Employer contributions include contributions by any current or former employer that was contributing to the other non-COBRA coverage.

A loss of eligibility for coverage does not occur if coverage was terminated due to a failure of the Employee or Dependent to pay premiums on a timely basis or coverage was terminated for cause.

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

CHANGE IN STATUS

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

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

Pursuant to the Public Health Service Act (PHSA), the Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. Employer adopts ERISA standards to comply with child support enforcement obligation of Part D of Title IV of the Social Security Act of 1975 as amended.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.
2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:
 - A. Provides for child support for a child of a Participant under this Plan, or;
 - B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and
 - C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.
3. "Plan" means the MMIA Employee Health Benefit Plan, including all supplements and amendments in effect.
4. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Plan Administrator to meet the qualification requirements as outlined under "Procedures" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and
2. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

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

1. The Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the Plan's procedures for determining whether Medical Child Support Orders are qualified orders; and
2. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination.

NATIONAL MEDICAL SUPPORT NOTICE

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

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

DEFINITIONS

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

1. "Member of the Armed Forces" includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation, or therapy
2. "Next of Kin" means the nearest blood relative to the service member
3. "Parent" means Employee's biological parent or someone who has acted as Employee's parent in place of Employee's biological parent when Employee was a son or daughter.
4. "Serious health condition" means an illness, injury impairment, or physical or mental condition that involves:
 - A. Inpatient care in a hospital, hospice, or residential medical facility; or
 - B. Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services).
5. "Serious injury or illness" means an injury or illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform his or her military duties.
6. "Son or daughter" means Employee's biological child, adopted child, stepchild, foster child, a child placed in Employee's legal custody, or a child for which Employee is acting as the parent in place of the child's natural blood related parent. The child must be:
 - A. Under the age of eighteen (18); or,
 - B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.
7. "Spouse" means Employee's husband or wife as defined or recognized under State law in the State where the Employee resides.

EMPLOYERS SUBJECT TO FMLA

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

ELIGIBLE EMPLOYEES

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

REASONS FOR TAKING LEAVE

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

ADVANCE NOTICE AND MEDICAL CERTIFICATION

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

PROTECTION OF JOB BENEFITS

For the duration of FMLA leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same conditions as coverage would have been provided if the Employee had been in active service during FMLA leave period. Taking FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave, unless the loss would have occurred even if the Employee had been in active service.

UNLAWFUL ACTS BY EMPLOYERS

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

ENFORCEMENT

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

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

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

1. On the last day of the month in which the Participant's employment terminates; or
2. On the last day of the month in which the Participant ceases to be eligible for coverage; or
3. The date the Participant fails to make any required contribution for coverage; or
4. The date the Plan is terminated; or
5. The date the MMIA Member Entity terminates the Participant's coverage; or
6. The date the Participant dies; or
7. The date the Participant enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days; or
8. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Participant.

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

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

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

RETIREE TERMINATION

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

1. The date the Retiree or their dependents are no longer eligible to receive benefits in accordance with the applicable MMIA Member Entity's written personnel policy; or
2. The date the Retiree fails to make any required contribution for coverage; or
3. The date the Plan is terminated; or
4. The date the MMIA Member Entity terminates the Retiree's coverage; or
5. The date the Retiree dies; or
6. The date the Retiree enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days.

REINSTATEMENT OF COVERAGE

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

1. The Pre-existing Condition exclusionary period of this Plan will apply only to the extent it applied on the date of termination, reduced by any Creditable Coverage maintained after the date of termination.
2. Credit will be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.
3. All prior accumulations toward annual or lifetime benefit maximums will apply.
4. Enrollment under this subsection will not be considered Late Enrollment.

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

DEPENDENT TERMINATION

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

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

1. On the last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan; or
2. On the last day of the month in which the Participant's coverage terminates under the Plan; or
3. On the last day of the month in which the Participant ceases to be eligible for Dependent Coverage; or
4. The date the Participant fails to make any required contribution for Dependent Coverage; or
5. The date the Plan is terminated; or
6. The date the MMIA Member Entity terminates the Dependent's coverage; or
7. On the last day of the month in which the Participant dies; or
8. The date the Dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty-one (31) days; or
9. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Dependent whose coverage is to be terminated.

CONTINUATION COVERAGE AFTER TERMINATION

Under the Public Health Service Act, as amended, Employees and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more Employees. **A Participant's Domestic Partner is not eligible for COBRA Continuation Coverage.**

The Plan Administrator is Montana Municipal Insurance Authority (MMIA); 3115 McHugh; P.O. Box 6669; Helena, MT 59604-6669; 406-443-0907. The Plan Administrator is responsible for administering COBRA Continuation Coverage.

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

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

NOTIFICATION RESPONSIBILITIES

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

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

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

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

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

ELECTION OF COVERAGE

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

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

MONTHLY PREMIUM PAYMENTS

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

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).
2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.
3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:
 - A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce or legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.
 - B. If the second Qualifying Event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to the Plan Administrator.

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

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the former employee dies or becomes divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to the Plan Administrator. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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

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

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

WHEN COBRA CONTINUATION COVERAGE ENDS

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

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance, unless the other group health plan contains a provision excluding or limiting coverage for a Pre-existing Condition applicable to a condition of the Qualified Beneficiary under this Plan. However, if the exclusionary period does not apply due to prior Creditable Coverage, COBRA continuation coverage ends. Coverage will not be terminated as stated until the pre-existing exclusionary period of the other coverage is no longer applicable.

This exception applies to all Qualified Beneficiaries.

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

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to the Plan Administrator or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

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

COVERAGE FOR A MILITARY RESERVIST

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

1. In any case in which a Covered Person has coverage under this Plan, and such Covered Person is absent from employment with Employer by reason of service in the uniformed services, the Covered Person may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:
 - A. The twenty-four (24) month period beginning on the date on which the Covered Person's absence begins; or
 - B. The period beginning on the date on which the Covered Person's absence begins and ending on the day after the date on which the Covered Person fails to apply for or return to a position of employment, as required by USERRA.
2. An eligible person who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.
3. In the case of a person whose coverage under the Plan is terminated by reason of service in the uniformed services, an exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who notifies the Employer of his or her intent to return to employment in a timely manner as defined by USERRA, and is reemployed and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee. **This provision will not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.**

COVERAGE FOR A MONTANA NATIONAL GUARD MEMBER

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

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

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

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

- A. For State Active Duty of thirty (30) days but not more than one hundred eighty (180) days, the next regularly scheduled day of active service following fourteen (14) days after the termination of State Active Duty.
 - B. For State Active Duty of more than one hundred eighty (180) days, the next regularly scheduled day of active service following ninety (90) days after the termination of State Active Duty.
2. An eligible Covered Person who elects to continue Plan coverage under this Section may be required to pay:
 - A. Not more than one hundred percent (100%) of the contribution required from a similarly situated active Employee until such Covered Person becomes eligible for coverage under the State of Montana Health Benefit Plan as an employee of the Department of Military Affairs.
 - B. Not more than one hundred two percent (102%) of the contribution required from a similarly situated active employee for any period of time that the Covered Person is also eligible for coverage under the State of Montana Health Benefit Plan as an employee of the Department of Military Affairs.
 3. In the case of a person whose coverage under the Plan is terminated by reason of State Active Duty, a Pre-Existing Condition Exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if such an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who is reemployed in a timely manner as defined by MMSERA and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee.
 4. **In no event will this Plan cover any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State Active Duty.**

FRAUD AND ABUSE

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

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

1. Falsifying eligibility criteria for a Dependent, including such as marital status, domestic partnership, or age, to get or continue coverage for that Dependent when not otherwise eligible for coverage;
2. Falsifying or withholding medical history or information required to calculate benefits or determine pre-existing conditions when no creditable coverage exists;
3. Falsifying or altering documents to get coverage or benefits;
4. Permitting a person not otherwise eligible for coverage to use a Plan ID card to get Plan benefits; or
5. Submitting a fraudulent claim or making untruthful statements to the Plan to get reimbursement from the Plan for services that may or may not have been provided to a Covered Person.

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

MISSTATEMENT OF AGE

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

MISREPRESENTATION OF ELIGIBILITY

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

MISUSE OF IDENTIFICATION CARD

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

REIMBURSEMENT TO PLAN

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

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

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

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

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

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

REIMBURSEMENT

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

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

SUBROGATION

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

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

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

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

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

RIGHT OF OFF-SET

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

PLAN ADMINISTRATION

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of the claim. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees, Retirees and their covered Dependents.

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

EFFECTIVE DATE

The effective date of the Plan is October 1, 2004.

PLAN YEAR

The Plan Year is July 1st through June 30th.

PLAN SPONSOR

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

PLAN SUPERVISOR

The Supervisor of the Plan is Allegiance Benefit Plan Management, Inc.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is Montana Municipal Insurance Authority (MMIA), an entity organized and existing under an interlocal governmental agreement, which has the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

PLAN INTERPRETATION

The Named Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Final authority to interpret and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator made in good faith will be final and binding.

CONTRIBUTIONS TO THE PLAN

The amount of contributions to the Plan are to be made on the following basis:

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

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

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Plan Document contains all the terms of the Plan and may be amended at any time by the Plan Administrator. Any changes will be binding on each Participant and on any other Covered Persons referred to in this Plan Document. The authority to amend the Plan is delegated by the Plan Administrator to the Chief Executive Officer or his or her equivalent, whichever is applicable, of the MMIA. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the Chief Executive Officer or his or her equivalent, whichever is applicable, of the MMIA, granting that individual the authority to amend, modify, revoke or terminate this Plan. Written notification of any amendments, modifications, revocations or terminations will be given to Plan Participants within one-hundred and twenty (120) days of such decision, except for notices of reduction of benefits.

NOTICE OF REDUCTION OF BENEFITS

All changes or amendments to this Plan that directly or indirectly reduce any benefit or coverage under the Plan, including any increase in contribution for coverage required from a Participant, will be reported to all eligible Participants and Dependents within sixty (60) days of the date such change or amendment is adopted.

TERMINATION OF PLAN

MMIA reserves the right at any time to terminate the Plan by a written notice. All previous contributions by an MMIA Member Entity will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

SUMMARY PLAN DESCRIPTIONS

Each Participant covered under this Plan will have continuous access to a Summary Plan Description (SPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits and the limitations and exclusions of the Plan.

CREDITABLE COVERAGE PROCEDURES

CERTIFICATE OF CREDITABLE COVERAGE

The Plan will provide Certificate of Creditable Coverage for coverage under this Plan as required by the United States Public Health Service to any Covered Person or the Covered Person's designated and authorized agent, guardian, conservator, health care plan or health insurance as follows:

1. At the time the Covered Person ceases to be covered under this Plan; and,
2. At the time a Covered Person ceases to be covered by the COBRA Continuation Coverage provided by this Plan, if any; and,
3. At any other time that a request is made on behalf of the Covered Person for such certification, but not later than twenty four (24) months after cessation of coverage as set out in subparagraphs 1 and 2 above, whichever is later.

CREDITABLE COVERAGE

An eligible Employee or Dependent under this Plan may submit to the Plan, Certificate of Creditable Coverage from any prior health insurance or health care plan under which said Employee or Dependent had coverage, for the purpose of reducing, on a day for day basis, any Pre-existing Condition Exclusion imposed by this Plan for which the eligible Employee or Dependent had applicable Creditable Coverage under any prior insurance or health care coverage.

An eligible Employee or Dependent has a right to request and receive a Certificate of Creditable Coverage from any insurance carrier or health care plan under which he/she had coverage on or after July 1, 1996.

In the event that the eligible Employee or Dependent is unable to obtain a Certificate of Creditable Coverage from a prior insurance carrier or health care plan, the Plan Administrator may provide assistance to obtain the same.

CREDITABLE COVERAGE REVIEW

Upon the Plan's receipt of a Certificate of Creditable Coverage regarding prior coverage by any enrollee for coverage under this Plan, the Plan acting on its own or through a firm contracted to provide services to the Plan, will send to such enrollee a written confirmation of the amount of prior Creditable Coverage, if any, to which the enrollee will be entitled against any Pre-existing Condition Exclusion period under this Plan. Such written confirmation will be provided to the enrollee within thirty (30) days of receipt of the certification by the Plan.

In the event that an enrollee disagrees with the Plan's calculation of any prior Creditable Coverage, the enrollee will send written notice of said disagreement to the Plan, together with a written request for review of the calculation, within fifteen (15) days of receipt of the Plan's written confirmation. Failure to submit a written notice of disagreement and request for review of the calculation within the time limit required in this section will be deemed a waiver of any further review.

Upon receipt by the Plan of a notice of disagreement and request for review, the Plan will review the calculations, and will either affirm those calculations or revise its calculation and determination of prior Creditable Coverage. The Plan Administrator will notify the enrollee, in writing, of its decision after review within thirty (30) days after receipt of the notice of disagreement and request for review. The Plan Administrator's decision regarding prior Creditable Coverage will be final and binding upon the Plan and any Covered Person under the Plan.

DETERMINATION OF PRIOR CREDITABLE COVERAGE WHEN A CERTIFICATION IS UNAVAILABLE

If an enrollee is unable to obtain a Certificate of Creditable Coverage, for prior coverage, after having exhausted all reasonable efforts to obtain the same, such an enrollee may request in writing that the Plan make a determination whether he or she is entitled to prior Creditable Coverage based upon other evidence and information. Said request must be submitted to and received by the Plan within sixty (60) days of the effective date of coverage of the person for whom the request is made.

Upon receipt by the Plan of a request to determine prior Creditable Coverage in the absence of a Certification, the Plan will require that the person for whom the request is made provide to the Plan all evidence in support of such request within sixty (60) days of the initial request. A longer period of time, up to an additional sixty (60) days, may be granted, to submit evidence, upon written request and good cause for the same. Evidence submitted will include in every case, a sworn affidavit by the person for whom the determination is to be made, or by that person's parent or guardian, if the person is a minor, or is incompetent or unable to execute such an affidavit. The affidavit will contain the following information:

1. The name of the prior insurance carrier(s), benefit plan(s) or other payor(s) of medical benefits under which prior Creditable Coverage is asserted to exist.
2. The date(s) that coverage commenced and ended under any such prior insurance, benefit plan or other payor.
3. The address, if known, of the insurance carrier(s), benefit plan(s) or other payor(s).
4. The nature of the coverage under the prior insurance, benefit plan(s) or other benefit payor(s).
5. A description of the efforts undertaken to obtain Certifications of prior Creditable Coverage, and the results of those efforts.
6. The names, and addresses or telephone numbers, of former employers, insurance agents, human resource personnel, third party administrators, HMO's or medical providers that may have knowledge of the asserted prior coverage.
7. Any other information that the affiant deems relevant.

The affidavit, together with any other documentation submitted, including, but not limited to Summary Plan Descriptions or Policies indicating prior coverage, pay stubs indicating deduction of premium amounts, Explanations of Benefits from prior coverage, written statements from persons with knowledge of prior coverage, and medical bills indicating payment by insurance or benefit plans, will be reviewed and considered by the Plan. Subsequent to such review, the Plan will provide a written determination of prior Creditable Coverage, if any, within thirty (30) days after the submission of the last item of evidence on behalf of the enrollee, or ninety (90) days from the enrollee's initial request for determination under this section, whichever occurs first. The Plan's determination will be final and binding upon the Plan and all Covered Persons under the Plan.

GENERAL PROVISIONS

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined, at the expense of the Plan, whenever Injury or Illness is the basis of a claim when and so often as it may reasonably require to adjudicate the claim. The Plan will also have the right to have an autopsy performed in case of death to the extent permitted by law.

PAYMENT OF CLAIMS

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

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

LEGAL PROCEEDINGS

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

NO WAIVER OR ESTOPPEL

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

VERBAL STATEMENTS

Verbal statements or representations of the Plan Administrator, its agents and Employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and Employees, or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF PHYSICIAN

The Covered Person will have free choice of any licensed Physician, Licensed Health Care Provider or surgeon and the patient-provider relationship will be maintained.

WORKERS' COMPENSATION NOT AFFECTED

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

CONFORMITY WITH LAW

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

MISCELLANEOUS

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

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

FACILITY OF PAYMENT

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

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

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which will become due to any Participant, the Plan Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Plan Document constitutes the primary authority for plan administration. The establishment, administration and maintenance of this Plan will not be deemed to constitute a contract of employment, give any Participant of an MMIA Member Entity the right to be retained in the service of an MMIA Member Entity, or to interfere with the right of an MMIA Member Entity to discharge or otherwise terminate the employment of any Participant.

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below. If the defined term is not used in this document, the term does not apply to this Plan.

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

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

ACCIDENTAL INJURY

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

ADVANCED PRACTICE REGISTERED NURSE

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

ADVERSE BENEFIT DETERMINATION

“Adverse Benefit Determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant’s or beneficiary’s eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

CARDIAC REHABILITATION THERAPY

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

CENTER OF EXCELLENCE

“Center of Excellence” is where a “best practices” approach is utilized by health care professionals with extraordinary expertise.

CHEMICAL DEPENDENCY TREATMENT FACILITY

“Chemical Dependency Treatment Facility” means a licensed institution which provides a program for diagnosis, evaluation, and effective treatment of alcoholism and/or Chemical Dependency; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services or arranges with a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards.

AMBULANCE SERVICE

“Ambulance Service” means an entity, its personnel and equipment, including, but not limited to, automobiles, airplanes, boats or helicopters, which are licensed to provide Emergency medical and Ambulance services in the state in which the services are rendered.

BENEFIT PERCENTAGE

“Benefit Percentage” means that portion of Maximum Eligible Expenses payable by the Plan, which is stated as a percentage in the Schedule of Benefits.

BENEFIT PERIOD

“Benefit Period” refers to a time period of one year, which is either a Calendar Year or other annual period, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or
2. The day the Maximum Lifetime Benefit applicable to the Covered Person becomes paid; or
3. The date the Plan terminates.

BIRTHING CENTER

A “Birthing Center” means a freestanding or hospital based facility which provides obstetrical delivery services under the supervision of a Physician, and through an arrangement or an agreement with a Hospital.

CALENDAR YEAR

“Calendar Year” means a period of time commencing on January 1 and ending on December 31 of the same year.

CHEMICAL DEPENDENCY

“Chemical Dependency” means the physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine, caffeine or eating disorders are not included in this definition.

CLOSE RELATIVE

“Close Relative” means the spouse, parent, brother, sister, child, or in-laws of the Covered Person.

COBRA

“COBRA” means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. § 300bb-1 through § 300bb-8], which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

“COBRA Continuation Coverage” means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of “COBRA”.

CONVALESCENT NURSING FACILITY

See “Skilled Nursing Facility”.

CONVALESCENT PERIOD

“Convalescent Period” means a period of time commencing with the date of confinement by a Covered Person in a Skilled Nursing Facility. Such confinement must meet all of the following conditions:

1. Such confinement must commence within fourteen (14) days of being discharged from an accredited Hospital; and
2. Said Hospital confinement must have been for a period of not less than three (3) consecutive days; and
3. Both the Hospital and convalescent confinements must have been for the care and treatment of the same illness or injury.

A Convalescent Period will terminate when the Covered Person has been free of confinement in any and all institutions providing Hospital or nursing care for a period of ninety (90) consecutive days. A new Convalescent Period will not commence until a previous Convalescent Period has terminated.

COPAYMENT

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

COSMETIC

“Cosmetic” means services or treatment ordered or performed solely to change a Covered Person's appearance rather than for the restoration of bodily function.

COVERED PERSON

“Covered Person” means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

CREDITABLE COVERAGE

“Creditable Coverage” means health or medical coverage under which a Covered Person was covered, prior to that Covered Person's Enrollment Date under this Plan, which prior coverage was under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Part A, Part B or Part C of Title XVIII of the Social Security Act (Medicare).
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (program for distribution of pediatric vaccines).
5. Chapter 55 of Title 10, United States Code (TRICARE).
6. A medical care program of the Indian Health Service or a tribal organization.
7. A state health benefits risk pool.
8. The Federal Employee Health Benefits Program.

9. A public health plan, including any plan established or maintained by a State, the US Government, a foreign country or any political subdivision of the foregoing.
10. A health benefit plan under Section 5 (e) of the Peace Corps Act.
11. The State Children's Health Insurance Program.

CUSTODIAL CARE

"Custodial Care" means the type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEDUCTIBLE

"Deductible" means a specified dollar amount that must be incurred before the Plan will pay any amount for any benefit to which the Deductible applies during each Benefit Period.

DEPENDENT

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

DEPENDENT COVERAGE

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

DOMESTIC PARTNER

"Domestic Partner" means a person who meets the following definition:

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

DURABLE MEDICAL EQUIPMENT

“Durable Medical Equipment” means equipment which is:

1. Able to withstand repeated use, i.e., could normally be rented, and used by successive patients; and
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of illness or injury.

EMERGENCY

“Emergency” means a medical condition manifesting itself by acute symptoms which occur suddenly and unexpectedly and for which the Covered Person receives medical care no later than 48 hours after the onset of the condition. Emergency is any medical condition for which a reasonable and prudent layperson, possessing average knowledge of health and medicine, would expect that failure to seek immediate medical attention would result in death, more severe or disabling medical condition(s), or continued severe pain without cessation in the absence of medical treatment. Emergency may include, but is not limited to, severe injury, hemorrhaging, poisoning, loss of consciousness or respiration, fractures, convulsions, injuries reasonably likely to require sutures, severe acute pain, severe burns, prolonged high fever and symptoms normally associated with heart attack or stroke.

“Emergency” will specifically exclude usual out-patient treatment of childhood diseases, flu, common cold, pre-natal examinations, physical examinations and minor sprains, lacerations, abrasions and minor burns, and other medical conditions usually capable of treatment at a clinic or doctor’s office during regular working hours.

EMPLOYEE

“Employee” means a person employed by an MMIA Member Entity on a continuing and regular basis who is a common-law Employee and who is on the MMIA Member Entity’s W-2 payroll.

“Employee” shall also include any officer or former officer of the MMIA Member Entity for whom the MMIA Member Entity is contractually bound by written agreement to provide health benefits.

Employee does not include any employee leased from another employer, including but not limited to those individuals defined in Code Section 414(n), or an individual classified by the MMIA Member Entity as a contract worker, independent contractor, temporary, seasonal or casual employee, whether or not any such persons are on the MMIA Member Entity’s W-2 payroll, or any individual who performs services for the MMIA Member Entity but who is paid by a temporary or other employment agency such as “Kelly,” “Manpower,” etc.

EMPLOYER

“Employer” means an MMIA Member Entity.

ENROLLMENT DATE

“Enrollment Date” means the date a person becomes eligible for coverage under this Plan or the eligible person’s effective date of coverage under this Plan, whichever occurs first. For Late Enrollees, Enrollment Date will always be the effective date of coverage under this Plan.

EXPERIMENTAL/INVESTIGATIONAL

“Experimental/Investigational” means:

1. Any drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. Any drug, device, medical treatment or procedure for which the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. That the drug, device or medical treatment or procedure is under study, prior to or in the absence of any clinical trial, to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or
4. That based upon Reliable Evidence, the drug, device, medical treatment or procedure is the subject of an on-going phase I or phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not considered Experimental or Investigational); or
5. Based upon Reliable Evidence, any drug, device, medical treatment or procedure that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or
6. Any drug, device, medical treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, The Centers for Medicare and Medicaid Services (CMS), American Dental Association, American Medical Association).

“Reliable Evidence” means only reports and articles published in authoritative medical and scientific literature; the written protocol or protocols used by a treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

FAMILY

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

FMLA

“FMLA” means Family and Medical Leave Act.

HIPAA

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

HOSPICE

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

HOSPICE BENEFIT PERIOD

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

HOSPITAL

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

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

HOSPITAL MISCELLANEOUS EXPENSES

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

ILLNESS

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

INCURRED EXPENSES OR EXPENSES INCURRED

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

INITIAL ENROLLMENT PERIOD

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

INJURY

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

INPATIENT

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

INPATIENT CONFINEMENT DAY

“Inpatient Confinement Day” means any day a person is classified as Inpatient. An Inpatient Confinement Day will commence at 12:01 A.M. and will be calculated using a calendar day.

INTENSIVE CARE UNIT

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

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

LATE ENROLLMENT OR LATE ENROLLEE

“Late Enrollment” or “Late Enrollee” means an eligible person who makes application for Participant or Dependent Coverage under this Plan other than during the Initial Enrollment Period or a Special Enrollment Period.

LICENSED HEALTH CARE PROVIDER

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

LICENSED PRACTICAL NURSE

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

LICENSED SOCIAL WORKER

“Licensed Social Worker” means a person holding a Masters Degree (M.S.W.) in social work and who is currently licensed as a social worker in the state in which services are rendered, and who provides counseling and treatment in a clinical setting for Mental Illnesses.

MAXIMUM ELIGIBLE EXPENSES or MEE

“Maximum Eligible Expense” or “MEE” means the maximum amount considered for payment by this Plan for any covered treatment, service, or supply, subject however, to all Plan annual and Maximum Lifetime Benefit limitations. The following criteria will apply to determination of the Maximum Eligible Expense:

1. For services of a Physician or Licensed Health Care Provider:
 - A. A contracted amount as established by a preferred provider or other discounting contract; or,
 - B. An amount established based upon a published prevailing fee schedule for the geographic area in which the claim was incurred, and adopted by the Plan and Plan Supervisor if a contracted amount does not exist.
 - C. If neither A or B above apply; an amount equal to 80% of the Provider’s average billed charge for the service.
2. For facility charges:
 - A. The contracted amount as established by a preferred provider or other discounting contract; or,
 - B. A schedule maintained by the Plan Supervisor and based upon the average billed charge, reduced by a maximum of 20%, which may be adjusted for type, size, and geographic location of the facility.
3. For all prescription drugs while undergoing either inpatient or outpatient treatment, including injectable drugs:
 - A. The contracted amount as established by a PPO or other discounting contract;
 - B. 125% of the current Medicare allowable fee, if a contracted amount does not exist; or
 - C. The billed charge if less than A or B above.
4. For Durable Medical Equipment:
 - A. The contracted amount as established by a PPO or other discounting contract;
 - B. The allowable charge established by application of the Medicare DME Fee Schedule;
 - C. The billed charge if less than A or B above.
5. For Air Ambulance:
 - A. The contracted amount as established by a preferred provider or other discounting contract;
 - B. 250% of the allowable charge established by application of the Medicare Ambulance Fee Schedule; or
 - C. The billed charge if less than A or B above.

MAXIMUM LIFETIME BENEFIT

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

MEDICALLY NECESSARY

“Medically Necessary” means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose an Illness or Injury; and,
2. Are ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and,
3. Are not primarily for the convenience of the Covered Person, Physician or other Licensed Health Care Provider; and,
4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person; and,
5. Are not of an Experimental/Investigational or solely educational nature; and,
6. Are not provided primarily for medical or other research; and,
7. Do not involve excessive, unnecessary or repeated tests; and,
8. Are commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and,
9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration (FDA) or The Centers For Medicare/Medicaid Services (CMS), pursuant to that entity’s program oversight authority based upon the medical treatment circumstances.

MEDICAID

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

MEDICARE

“Medicare” means the programs established under the “Health Insurance for the Aged Act,” Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those who are eligible for Medicare Part A, Part B or Part D as a result of age, those with end-stage renal disease, or with disabilities.

MENTAL ILLNESS

“Mental Illness” means a medically recognized psychological, physiological, nervous or behavioral condition, affecting the brain, which can be diagnosed and treated by medically recognized and accepted methods, **but will not include Chemical Dependency or other addictive behavior**. Conditions recognized by the Diagnostic Statistical Manual (the most current edition) will be included in this definition.

MMSERA

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

MMIA MEMBER ENTITY

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

NAMED FIDUCIARY

“Named Fiduciary” means the Plan Administrator which has the authority to control and manage the operation and administration of the Plan.

NEWBORN

“Newborn” refers to an infant from the date of his/her birth until the initial Hospital discharge or until the infant is fourteen (14) days old, whichever occurs first.

OCCUPATIONAL THERAPY

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

ORTHOPEDIC DEVICE

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

OUT-OF-POCKET MAXIMUM

“Out-of-Pocket Maximum” means the maximum dollar amount, as stated in the Schedule of Benefits, that any Covered Person or Family will pay in any Benefit Period for covered services, treatments or supplies. The Out-of-Pocket Maximum includes amounts applied toward the Deductible and any amounts in excess of the Benefit Percentage paid by the Plan.

OUTPATIENT

“Outpatient” means a Covered Person who is receiving medical care, treatment, services or supplies at a clinic, a Physician’s office, a Licensed Health Care Provider’s office or at a Hospital if not a registered bedpatient at that Hospital, Psychiatric Facility or Chemical Dependency Treatment Facility.

PARTIAL HOSPITALIZATION

“Partial Hospitalization” means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

PARTICIPANT

“Participant” means an Employee of an MMIA Member Entity who is eligible and enrolled for coverage under this Plan.

PHYSICAL THERAPY

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

PHYSICIAN

“Physician” means a person holding the degree of Doctor of Medicine, Dentistry or Osteopathy, or Optometry who is legally licensed as such.

“Physician” does not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

PLACEMENT OR BEING PLACED FOR ADOPTION

“Placement” or “Being Placed for Adoption” means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child’s adoption. The child’s placement for adoption with such person ends upon the termination of such legal obligation.

PLAN

“Plan” means the Health Benefit Plan for Employees of the MMIA Member Entities, the Plan Document and any other relevant documents pertinent to its operation and maintenance of the Plan.

PLAN ADMINISTRATOR

“Plan Administrator” means MMIA and/or its designee which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purposes of the Public Health Service Act, Section 1310, as amended, and any applicable state legislation of a similar nature, the MMIA will be deemed to be the Plan Administrator of the Plan unless by action of the board of directors, the MMIA designates an individual or committee to act as the Plan Administrator of the Plan.

PLAN SUPERVISOR

“Plan Supervisor” means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Plan Supervisor is Allegiance Benefit Plan Management, Inc. The Plan Supervisor provides ministerial duties only, exercises no discretion over plan assets and will not be considered a fiduciary as defined by the Public Health Service Act, Section 1310, or any other State or Federal law or regulation.

PRE-EXISTING CONDITION

“Pre-Existing Condition” means an Injury or Illness of a Covered Person, except for Pregnancy or results of genetic testing, for which the Covered Person has been under the care of a Physician or Licensed Health Care Provider, or has received medical advice, diagnosis, treatment, services or care, including prescription drugs, within the six (6) month period immediately preceding his/her Enrollment Date. Pregnancy or the results of genetic testing will never be considered a Pre-Existing Condition for any reason.

PREGNANCY

“Pregnancy” means a physical condition commencing with conception, and ending with miscarriage or birth.

PREVENTIVE CARE

“Preventive Care” means routine examinations or services provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, which is not provided for treatment or diagnosis of any Injury or Illness.

PROSTHETIC APPLIANCE

“Prosthetic Appliance” means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance.

PSYCHIATRIC CARE

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

PSYCHIATRIC FACILITY

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

PSYCHOLOGIST

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

QMCSO

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

QUALIFIED BENEFICIARY

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

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

REGISTERED NURSE

“Registered Nurse” means an individual who has received specialized nursing training and is authorized to use the designation of “R.N.” and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

RETIREE

For Montana governmental entities: “Retiree” means an Employee who retires under a retirement program authorized by law and eligible to continue coverage with the Employer pursuant to the terms of 2-18-704 MCA as amended from time to time.

ROOM AND BOARD

“Room and Board” refers to all charges which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SEMI-PRIVATE

“Semi-Private” refers to the class of accommodations in a Hospital or Skilled Nursing Facility in which at least two patient beds are available per room.

SKILLED NURSING FACILITY

“Skilled Nursing Facility” means an institution, or distinct part thereof, which meets all of the following conditions:

1. It is currently licensed as a long-term care facility or skilled nursing facility in the state in which the facility is located;
2. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders; and
3. It is certified by Medicare.

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

SPEECH THERAPY

“Speech Therapy” means a course of treatment, ordered by a Physician, to treat speech deficiencies or impediments.

TOTAL DISABILITY (TOTALLY DISABLED)

“Total Disability” means the physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. In the case of a Participant, the Covered Person from engaging in any business or occupation or from performing any work activity as a volunteer; and
2. In the case of a Dependent, the Covered Person from engaging in Major Life Functions associated with a similarly situated non-disabled person of like age and gender. Major Life Function, as used herein, refers to the definition of the same stated in the Americans with Disabilities Act, and court opinions pursuant to that Act which construe the term.

USERRA

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act, as amended.

HIPAA PRIVACY AND SECURITY STANDARDS

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

“Protected Health Information” (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the physical or mental health of an individual; health care that individual has received; or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an employer.

“Summary Health Information” means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the zipcode; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or plan participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Documents have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law. Such uses or disclosures may be for the purposes of plan administration, including but not limited to, the following:
 - A. Operational activities such as quality assurance and utilization management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.
 - B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for medical necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.
 - C. For purposes of this certification, plan administration does not include disclosing Summary Health Information to help the plan sponsor obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a participant in; is an enrollee of or has disenrolled from the group health plan.
2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

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

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

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan Documents have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.
2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.
3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.
4. Report to the Plan Administrator or the Named Fiduciary of the Plan any attempted breach, or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

**MADISON PLAN WITH PRESCRIPTION REIMBURSEMENT BENEFIT
PLAN SUMMARY**

The following information, together with the information contained in this booklet, form the Summary Plan Description.

1. PLAN

The name of the Plan is the MADISON PLAN WITH PRESCRIPTION DRUG REIMBURSEMENT BENEFIT, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

This Plan provides benefits for covered expenses incurred by eligible participants for:

Hospital, Surgical, Medical, Maternity, other eligible medically related, necessary expenses.

3. PLAN EFFECTIVE DATE

This Plan was established effective October 1, 2004, and amended July 1, 2008.

4. PLAN SPONSOR

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

5. PLAN ADMINISTRATOR

The Plan Administrator is the Plan Sponsor.

6. NAMED FIDUCIARY

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

7. PLAN FISCAL YEAR

The Plan fiscal year ends June 30th.

8. PLAN TERMINATION

The right is reserved by the Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

9. IDENTIFICATION NUMBER

Plan Number: 501
Group Number: 8001XXX
Plan Sponsor's Identification Number: 81-0436312

10. PLAN SUPERVISOR

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

11. ELIGIBILITY

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

12. PLAN FUNDING

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

13. AGENT FOR SERVICE OF LEGAL PROCESS

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

**CHIP REINACTMENT OF HIPAA COMPLIANCE AMENDMENT
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION**

**MMIA - EMPLOYEE BENEFITS PROGRAM
MADISON PLAN WITH PRESCRIPTION DRUG REIMBURSEMENT BENEFIT- Group #8001XXX**

Effective April 1, 2009, the Madison Plan with Prescription Drug Reimbursement Benefit is amended as follows:

Within the “**EFFECTIVE DATE OF COVERAGE**” section, the “SPECIAL ENROLLMENT PERIOD” subsection is replaced as follows:

SPECIAL ENROLLMENT PERIOD

In addition to other enrollment time allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below. An eligible person who makes a special enrollment request during any such applicable Special Enrollment Period will not be considered a Late Enrollee.

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

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

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

2. A Participant may enroll eligible Dependents, including step children, who are acquired under the following specific events:
 - A. Marriage to the Participant;
 - B. Birth of the Participant’s child; or
 - C. Adoption of a child by the Participant, provided the child is under the age of 19; or
 - D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

3. The spouse of a Participant (Covered Employee), or the spouse of a Retiree who is covered at the time of the Special Enrollment event, may enroll and will become covered on the date of the following specific events:
 - A. Marriage to the Participant or Retiree;
 - B. Birth of the Participant’s or Retiree’s child; or

- C. Adoption of a child by the Participant or Retiree, provided the child is under the age of 19; or
 - D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.
4. A Retiree who is covered at the time of a special enrollment event may enroll his/her eligible Dependents, including step children who are acquired under the circumstances below:
- A. Marriage to the Retiree;
 - B. Birth of the Retiree's child; or
 - C. Adoption of a child by the Retiree, provided the child is under the age of 19; or
 - D. Placement for Adoption with the Retiree, provided such Retiree has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.
5. The following individuals may enroll and become covered when coverage under another health care plan or health insurance is terminated due to loss of eligibility or if employer contributions to the other coverage have been terminated (Loss of Coverage), subject to the following:
- A. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
 - B. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.
 - C. If an eligible Dependent of a Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.

Further, Loss of Coverage means only one of the following:

- A. COBRA Continuation Coverage under another plan and the maximum period of COBRA Continuation Coverage under that other plan has been exhausted; or
- B. Group or insurance health coverage that has been terminated as a result of termination of Employer contributions** towards that other coverage; or
- C. Group or insurance health coverage (includes other coverage that is Medicare, *Medicaid* or any state children's insurance program recognized under the *Children's Health Insurance Program Reauthorization Act of 2009*) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:
 - 1) Legal separation or divorce of the eligible Employee;
 - 2) Cessation of Dependent status;
 - 3) Death of the eligible Employee;
 - 4) Termination of employment of the eligible Dependent;
 - 5) Reduction in the number of hours of employment of the eligible Dependent;
 - 6) Termination of the eligible Dependent's employer's plan; or
 - 7) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or
 - 8) Any loss of eligibility for individual or group coverage because the eligible Employee or Dependent no longer resides, lives or works in the service area of the HMO or other such plan; or

- 9) Any loss of eligibility for coverage because the eligible Employee or Dependent incurs a claim for benefits that would meet or exceed the lifetime maximum of benefits for all causes.

**Employer contributions include contributions by any current or former employer that was contributing to the other non-COBRA coverage.

A loss of eligibility for coverage does not occur if coverage was terminated due to a failure of the Employee or Dependent to pay premiums on a timely basis or coverage was terminated for cause.

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

- A. *A request for enrollment must be made either verbally or in writing within sixty (60) days after this special enrollment event, and written application for such coverage must be made within ninety (90) days after such event.*
- B. *If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.*
- C. *If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.*
- D. *If an eligible Dependent of a Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.*

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

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

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

MONTANA MUNICIPAL INSURANCE AUTHORITY (MMIA)

BY: _____

TITLE: _____

AMENDMENT #1
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

MONTANA MUNICIPAL INSURANCE AUTHORITY (MMIA)
EMPLOYEE BENEFITS PROGRAM
MADISON PLAN WITH PRESCRIPTION DRUG REIMBURSEMENT BENEFIT - Group #8001XXX

Effective January 1, 2009, the Madison Plan With Prescription Drug Reimbursement Benefit is amended as follows:

Within the “**SCHEDULE OF BENEFITS**”, “**OBESITY SURGERY**” is replaced as follows:

SPECIAL BENEFITS / LIMITATIONS	PPO	NON-PPO
OBESITY BENEFIT		
Requires enrollment through OptumHealth. See “Obesity Benefit” for further details.		
Surgical Expenses (Professional and Facility Provider) Deductible Applies, Benefit Percentage	70%	50%
<i>Non-surgical expenses related to obesity or bariatric surgery are payable the same as any other medical condition only if incurred while enrolled in the obesity program through OptumHealth.</i>		
Provider other than OptumHealth Bariatric Center of Excellence for surgical expenses is Not Covered.		

Within the “**MEDICAL BENEFITS**” section, “OBESITY SURGERY” is replaced as follows:

OBESITY BENEFIT

The Schedule of Benefits describes special payment provisions for these services. This benefit is only available if enrolled in the obesity program through OptumHealth. Charges for services related to obesity or bariatric surgery are not covered that are incurred prior to enrollment.

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

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

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

Within the “**GENERAL EXCLUSIONS AND LIMITATIONS**” section, item number 15 is replaced as follows:

15. Charges for services or supplies for the medical and/or surgical treatment of obesity, except as specifically covered under the Obesity Benefit.

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

MONTANA MUNICIPAL INSURANCE AUTHORITY (MMIA)

BY: _____

TITLE: _____

**AMERICAN RECOVERY AND REINVESTMENT ACT AMENDMENT
TO THE**

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

**MONTANA MUNICIPAL INSURANCE AUTHORITY (MMIA)
EMPLOYEE BENEFITS PROGRAM**

MADISON PLAN WITH PRESCRIPTION DRUG REIMBURSEMENT BENEFIT - Group #8001XXX

Effective March 1, 2009, the Madison Plan With Prescription Drug Reimbursement Benefit is amended as follows:

Within the “**CONTINUATION COVERAGE AFTER TERMINATION**” section, the following subsection entitled “**AMERICAN RECOVERY AND REINVESTMENT ACT RIGHTS**” is added to the end of the section:

AMERICAN RECOVERY AND REINVESTMENT ACT RIGHTS

The American Recovery and Reinvestment Act (ARRA) created additional COBRA rights for a limited period of time.

For the period March 17, 2009 through December 31, 2009, certain Qualified Beneficiaries, as defined in this section, will have the right to request and obtain a subsidy for COBRA premiums of sixty-five percent (65%) of the monthly premium. This subsidy applies to all tiers of COBRA premium charged by the Qualified Beneficiary's employee health benefit plan. The sixty-five percent (65%) subsidy will be calculated upon the premium amount actually due and owing and to be paid by the Qualified Beneficiary. A Qualified Beneficiary who is entitled to the subsidy is known as an “Assistance Eligible Individual” (AEI).

To be considered to be an AEI, the following conditions must be met:

- 1. The individual's Qualifying Event and loss of coverage as or through an active employee must occur between February 17, 2009 and December 31, 2009; and*
- 2. The initial Qualifying Event must be an involuntary termination of employment; and*
- 3. The involuntary termination of employment cannot have been caused by gross misconduct; and*
- 4. The Qualifying Beneficiary's adjusted gross income for 2009 federal income tax cannot be greater than \$145,000 for a Qualifying Beneficiary filing as single, or \$290,000 for a Qualifying Beneficiary filing a joint return. For Qualifying Beneficiaries whose 2009 adjusted gross income is between \$125,000 and \$145,000 filing single, or between \$250,000 and \$290,000 filing jointly, the amount of subsidy available will be less than sixty-five percent (65%), based upon a pro rated scale to be issued by the Internal Revenue Service.*

The duration of the ARRA COBRA premium subsidy will be a maximum period of nine (9) consecutive months. The subsidy period may terminate sooner than nine months as a result of any of the following events:

- 1. If COBRA Continuation Coverage terminates as a result of failure to pay premium, as a result of becoming covered under other coverage, including Medicare, after election of COBRA Continuation Coverage or, as a result of the Qualifying Beneficiary reaching the end of the maximum COBRA Continuation Coverage period; or,*
- 2. If the Qualified Beneficiary becomes eligible for other group health plan coverage or for Medicare at any time during the 9 month premium subsidy period.*

In the event a Qualified Beneficiary requests the ARRA COBRA premium subsidy, and the Qualified Beneficiary's Employer, or that Employer's designee, denies the application for the reason that the Qualifying Event was not an involuntary termination of employment, in such event, the Qualified Beneficiary shall have a right to appeal to the United States Department of Health & Human Services. Specific information regarding the location to which an appeal must be sent will be provided in the ARRA COBRA Premium Subsidy Qualification Denial Notice. A decision on the appeal will be made by the applicable governmental agency within fifteen (15) days after receipt of complete appeal.

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

MONTANA MUNICIPAL INSURANCE AUTHORITY (MMIA)

BY: _____

TITLE: _____

AMENDMENT #2
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

MONTANA MUNICIPAL INSURANCE AUTHORITY (MMIA)
EMPLOYEE BENEFITS PROGRAM
MADISON PLAN WITH PRESCRIPTION DRUG REIMBURSEMENT BENEFIT - Group #8001XXX

Effective July 1, 2009, the Madison Plan With Prescription Drug Reimbursement Benefit is amended as follows:

The name of the Plan is changed to **Montana Municipal Interlocal Authority (MMIA)** and any references of Montana Municipal Insurance Authority are hereby deleted throughout the Plan Document/Summary Plan Description.

Within the “**SCHEDULE OF BENEFITS**” “REHABILITATION THERAPY” is replaced as follows:

SPECIAL BENEFITS / LIMITATIONS	PPO	NON-PPO
REHABILITATION THERAPY		
Deductible Waived, Benefit Percentage	70%	50%

Within the “**PRESCRIPTION DRUG CARD BENEFIT**” section, the following are added under “EXCLUDED PRESCRIPTION DRUGS”:

- 21. *Proton Pump Inhibitor (PPI).*
- 22. *Non-sedating antihistamines (NSAID).*

The “**CONTINUATION COVERAGE AFTER TERMINATION**” section, is replaced as follows, including name change and ARRA Compliance Amendment:

CONTINUATION COVERAGE AFTER TERMINATION

Under the Public Health Service Act, as amended, Employees and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more Employees. **A Participant’s Domestic Partner is not eligible for COBRA Continuation Coverage.**

The Plan Administrator is Montana Municipal *Interlocal* Authority (MMIA); 3115 McHugh; P.O. Box 6669; Helena, MT 59604-6669; 406-443-0907. *COBRA Continuation Coverage for the Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, 406-721-2222.*

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

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

NOTIFICATION RESPONSIBILITIES

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

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

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

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

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

ELECTION OF COVERAGE

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

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

MONTHLY PREMIUM PAYMENTS

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

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).
2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.
3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:
 - A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce or legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.
 - B. If the second Qualifying Event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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

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

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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

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

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

WHEN COBRA CONTINUATION COVERAGE ENDS

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

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance, unless the other group health plan contains a provision excluding or limiting coverage for a Pre-existing Condition applicable to a condition of the Qualified Beneficiary under this Plan. However, if the exclusionary period does not apply due to prior Creditable Coverage, COBRA continuation coverage ends. Coverage will not be terminated as stated until the pre-existing exclusionary period of the other coverage is no longer applicable.

This exception applies to all Qualified Beneficiaries.

2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A, B or D);
3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to the Plan Administrator.
4. On the date the Employer ceases to provide any group health plan coverage to any Employee.
5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.
6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:
 - A. Eighteen (18) months for a former employee who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment;
 - B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen month period entitling that Dependent to an additional eighteen (18) months;

- C. For the Dependent who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment of the former employee if that former employee enrolled in Medicare before termination, or reduction in hours, of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.
 - D. On the first day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.
 - E. Twenty-nine (29) months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.
 - F. Thirty-six (36) months for all other Qualified Beneficiaries.
7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to *Allegiance COBRA Services, Inc.* or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

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

AMERICAN RECOVERY AND REINVESTMENT ACT RIGHTS

The American Recovery and Reinvestment Act (ARRA) created additional COBRA rights for a limited period of time.

For the period March 1, 2009 through December 31, 2009, certain Qualified Beneficiaries, as defined in this section, will have the right to request and obtain a subsidy for COBRA premiums of sixty-five percent (65%) of the monthly premium. This subsidy applies to all tiers of COBRA premium charged by the Qualified Beneficiary's employee health benefit plan. The sixty-five percent (65%) subsidy will be calculated upon the premium amount actually due and owing and to be paid by the Qualified Beneficiary. A Qualified Beneficiary who is entitled to the subsidy is known as an "Assistance Eligible Individual" (AEI).

To be considered to be an AEI, the following conditions must be met:

1. The individual's Qualifying Event and loss of coverage as or through an active employee must occur between February 17, 2009 and December 31, 2009; and
2. The initial Qualifying Event must be an involuntary termination of employment; and
3. The involuntary termination of employment cannot have been caused by gross misconduct; and

4. The Qualifying Beneficiary's adjusted gross income for 2009 federal income tax cannot be greater than \$145,000 for a Qualifying Beneficiary filing as single, or \$290,000 for a Qualifying Beneficiary filing a joint return. For Qualifying Beneficiaries whose 2009 adjusted gross income is between \$125,000 and \$145,000 filing single, or between \$250,000 and \$290,000 filing jointly, the amount of subsidy available will be less than sixty-five percent (65%), based upon a pro rated scale to be issued by the Internal Revenue Service.

The duration of the ARRA COBRA premium subsidy will be a maximum period of nine (9) consecutive months. The subsidy period may terminate sooner than nine months as a result of any of the following events:

1. If COBRA Continuation Coverage terminates as a result of failure to pay premium, as a result of becoming covered under other coverage, including Medicare, after election of COBRA Continuation Coverage or, as a result of the Qualifying Beneficiary reaching the end of the maximum COBRA Continuation Coverage period; or,
2. If the Qualified Beneficiary becomes eligible for other group health plan coverage or for Medicare at any time during the 9 month premium subsidy period.

In the event a Qualified Beneficiary requests the ARRA COBRA premium subsidy, and the Qualified Beneficiary's Employer, or that Employer's designee, denies the application for the reason that the Qualifying Event was not an involuntary termination of employment, in such event, the Qualified Beneficiary shall have a right to appeal to the United States Department of Health & Human Services. Specific information regarding the location to which an appeal must be sent will be provided in the ARRA COBRA Premium Subsidy Qualification Denial Notice. A decision on the appeal will be made by the applicable governmental agency within fifteen (15) days after receipt of complete appeal.

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

MONTANA MUNICIPAL INTERLOCAL AUTHORITY (MMIA)

BY: _____

TITLE: _____

AMENDMENT #3
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

MONTANA MUNICIPAL INTERLOCAL AUTHORITY (MMIA)
EMPLOYEE BENEFITS PROGRAM
MADISON PLAN WITH PRESCRIPTION DRUG REIMBURSEMENT BENEFIT - Group #8001XXX

Effective January 1, 2010, the Madison Plan With Prescription Drug Reimbursement Benefit is amended as follows:

Within the “**SCHEDULE OF BENEFITS**”, “**OBESITY SURGERY**”, as amended, is replaced as follows:

SPECIAL BENEFITS / LIMITATIONS	PPO	NON-PPO
OBESITY BENEFIT		
<i>Requires Prior Authorization and enrollment through StarPoint. See “Obesity Benefit” for further details.</i>		
Surgical Expenses (Professional and Facility Provider) Deductible Applies, Benefit Percentage	70%	50%
<i>Non-surgical expenses related to obesity or bariatric surgery are payable the same as any other medical condition only if incurred while enrolled in the obesity program through StarPoint.</i>		

Within the “**SCHEDULE OF BENEFITS**”, “**ORGAN/TISSUE TRANSPLANTS**” is replaced as follows:

SPECIAL BENEFITS / LIMITATIONS	PPO	NON-PPO
ORGAN/TISSUE TRANSPLANTS		
Provider other than Center of Excellence is Not Covered.		
Professional Provider Expenses Deductible Waived, Benefit Percentage	70%	50%
Facility Provider Expenses Deductible Applies, Benefit Percentage	70%	50%
Benefit Limits		
Maximum Lifetime Benefit for all Transplants / \$500,000		
Benefits in addition to Maximum Lifetime Benefit for all transplants:		
<ul style="list-style-type: none"> • Maximum Benefit for Organ Procurement Services per transplant / \$25,000 • Maximum Benefit for Ambulance or Commercial Air Transportation incurred as a direct result of the transplant / \$10,000 per transplant. 		

Within the “**PRESCRIPTION DRUG CARD BENEFIT**” section, under subsection “**EXCLUDED PRESCRIPTION DRUGS**” number 3 is replaced as follows:

3. Any drug used for the purpose of weight loss, unless Prior Authorization is obtained through the Bariatric Resource Services program administered by StarPoint.

Within the “**MEDICAL BENEFITS**” section, “OBESITY SURGERY”, as amended, is replaced as follows:

OBESITY BENEFIT

The Schedule of Benefits describes special payment provisions for these services. This benefit is only available if *Prior Authorized* and enrolled in the obesity program through *StarPoint*. Charges for services related to obesity or bariatric surgery are not covered that are incurred prior to enrollment.

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

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

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

Within the “**MEDICAL BENEFITS**” section, “ORGAN/TISSUE TRANSPLANTS” is replaced as follows:

ORGAN/TISSUE TRANSPLANTS

The Schedule of Benefits describes special payment provisions for these services. Provider other than Center of Excellence is Not Covered.

Coverage includes charges in connection with non-Experimental or non-Investigational organ or tissue transplant procedures. Transplant services include the following:

1. Organ procurement including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ, and transportation of the donor or donor organ to the location of the transplant operation.
2. Donor services including the preoperative services, transplant related diagnostic lab and x-ray services, and the transplant surgery hospitalization. Transplant related services are covered for up to six months after the transplant.
3. Hospital Inpatient Care services.
4. Professional provider, diagnostic Outpatient services, surgical services and anesthesia.
5. Licensed Ambulance Service or commercial air travel for the Covered Person receiving the treatment to the nearest Hospital with appropriate facilities.

Payment by the Plan is subject to the following conditions:

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

2. If the recipient is covered under this Plan, expenses Incurred by the recipient will be considered for benefits. Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, will be considered for payment to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the Maximum Lifetime Benefit still available to the recipient.
3. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.

Within the “**BENEFIT MANAGEMENT**” section, the following subsections are replaced as follows:

PRE-ADMISSION CERTIFICATION REVIEW

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

To pre-certify, contact StarPoint at 1-800-342-6510 for pre-admission certification review.

Most certifications occur over the phone. Once a final decision is made regarding the request for certification, a notice of pre-certification will be sent to the physician, to the Covered Person, to the Plan Supervisor and to the hospital. This notice is not required, and therefore, cannot be appealed.

CONTINUED STAY CERTIFICATION

Charges for inpatient hospital services for days in excess of any days previously certified by the cost containment company are subject to all terms, conditions and exclusions of the Plan, and should be certified by the Plan's utilization management company.

Certification for additional days should be obtained in the same manner as the pre-admission certification. This determination is not required, and therefore, cannot be appealed.

To notify the Plan of a continued stay certification, contact StarPoint at 1-800-342-6510.

EMERGENCY NOTIFICATION/CERTIFICATION

The Covered Person, or his or her representative, should notify the utilization management company for the Plan regarding any Emergency Hospital Admission within seventy-two (72) hours immediately following admission.

To notify the Plan of an emergency admission, contact StarPoint at 1-800-342-6510 for emergency admission certification.

PRIOR AUTHORIZATION

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

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

Examples of services for which Prior Authorization is **recommended** include, but are not limited to:

1. All elective inpatient hospitalizations
2. Transplants
3. All elective inpatient surgeries

Prior Authorization is **recommended** for the following selected outpatient surgeries:

1. Blepharoplasty
2. Vein stripping/ligation/schlerotherapy
3. Accidental dental surgeries
4. Breast Reduction or Reconstruction
5. Abdominoplasty
6. Cosmetic/Experimental surgeries

Prior Authorization and enrollment is required for Obesity Surgery. Please refer to the "Obesity Benefit" for further details.

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

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

Contact StarPoint at 1-800-342-6510 for Prior Authorization.

NOTE: PRE-CERTIFICATION AND PRIOR AUTHORIZATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT OF THE CLAIM(S). ELIGIBILITY FOR CLAIM PAYMENTS IS DETERMINED AT THE TIME CLAIMS ARE ADJUDICATED SINCE THE AMOUNT OF BENEFIT COVERAGE, IF ANY, IS SUBJECT TO ALL PLAN PROVISIONS INCLUDING, BUT NOT LIMITED TO, NETWORK PROVIDER DESIGNATION, MEDICAL NECESSITY, PATIENT ELIGIBILITY, DEDUCTIBLES, CO-PAYMENTS AND ANY PLAN LIMITATIONS OR MAXIMUMS IN EFFECT WHEN THE SERVICES ARE PROVIDED. PROVIDERS AND COVERED PERSONS ARE INFORMED AT THE TIME CLAIMS ARE PRE-CERTIFIED OR AUTHORIZED THAT PRE-CERTIFICATION OR AUTHORIZATION OF A COURSE OF TREATMENT BY THE PLAN DOES NOT GUARANTEE PAYMENT OF CLAIMS FOR THE SAME.

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

MONTANA MUNICIPAL INTERLOCAL AUTHORITY (MMIA)

BY: _____

TITLE: _____

AMENDMENT #4
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

MONTANA MUNICIPAL INTERLOCAL AUTHORITY (MMIA)
EMPLOYEE BENEFITS PROGRAM
MADISON PLAN WITH PRESCRIPTION DRUG REIMBURSEMENT BENEFIT - Group #8001XXX

Effective February 3, 2010, the Madison Plan With Prescription Drug Reimbursement Benefit is amended as follows:

Within the “**PROCEDURES FOR CLAIMING BENEFITS**” section, “SECOND LEVEL OF BENEFIT DETERMINATION REVIEW” is replaced as follows:

SECOND LEVEL OF BENEFIT DETERMINATION REVIEW

The second level of benefit determination review is done by *HealthSmart Care Management Solutions, LP* in consultation with the Plan Supervisor and independent medical reviewer when necessary. *HealthSmart Care Management Solutions, LP* will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the second level of review will be sent to the Covered Person within sixty (60) days following the date the Plan Supervisor receives the request for reconsideration.

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

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

MONTANA MUNICIPAL INTERLOCAL AUTHORITY (MMIA)

BY: _____

TITLE: _____