

**EMPLOYEE / SPOUSE OF EMPLOYEE
RECEIPT OF SUMMARY PLAN DESCRIPTION**

COVERED PARTICIPANT

I, _____, an employee of _____, do hereby acknowledge receipt of the Montana Health Network Employee Health Benefit Plan Summary Plan Description with an effective date of January 1, 2008. I understand that I am responsible for reviewing the Summary Plan Description and familiarizing myself with the content and coverages contained within the Summary Plan Description of the Montana Health Network Employee Health Benefit Plan. I further understand that if I have any questions or concerns, I can address those to my direct supervisor or management for clarification. It is my responsibility to replace the current summary plan description that I have with the one I am receiving.

Employee: _____
Date: _____

MONTANA HEALTH NETWORK

**PLEASE REMOVE THIS PAGE, SIGN AND RETURN TO
THE PERSONNEL OFFICE**

SPOUSE OF COVERED PARTICIPANT

I, _____, the spouse (if family coverage) of an employee of _____, do hereby acknowledge receipt of the Montana Health Network Employee Health Benefit Plan Summary Plan Description with an effective date of January 1, 2008. I understand that I am responsible for reviewing the Summary Plan Description and familiarizing myself with the content and coverages contained within the Summary Plan Description of the Montana Health Network Employee Health Benefit Plan. I further understand that if I have any questions or concerns, I can address those to Montana Health Network. It is my responsibility to replace the current summary plan description that I have with the one I am receiving.

Spouse: _____
Date: _____

**PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION**

for the

**HEALTH BENEFIT PLAN
FOR THE EMPLOYERS OF
MONTANA HEALTH NETWORK
HEALTH INSURANCE PLAN AND TRUST
MHN OPTION**

This booklet describes the Plan Benefits
in effect as of January 1, 2008

NOTICE

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

Aggregate and Specific Excess Loss Insurance for the Plan is underwritten by an insurance company rated A or better by A.M. Best.

The Plan has been established for the benefit of
Eligible employees and their dependents
of eligible employers of:

**MONTANA HEALTH NETWORK
HEALTH INSURANCE PLAN
AND TRUST**

Claims Processed By:

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
2806 South Garfield Street
PO Box 3018
Missoula, MT 59806-3018

Missoula Area Phone Number: (406) 721-2222
Toll-Free Number: (800) 877-1122

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INTRODUCTION

Effective January 1, 1993, Montana Health Network, Inc., hereinafter referred to as the "MHN" or "Employer", establishes the benefits, rights and privileges which will pertain to participating Employees of Eligible Employers, referred to as "Participants," and the eligible Dependents of such Participants, as defined, and which benefits are provided through a fund established by MHN and referred to as the "Plan." This booklet describes the Plan in effect as of January 1, 2008.

Coverage provided under this Plan for Employees and their Dependents will be in accordance with 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 Health Network (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 3018
Missoula, MT 59806-3018

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

Aggregate and Specific Excess Loss Insurance for the plan is underwritten by an insurance company rated A or better by A.M. Best.

DEDUCTIBLE OPTIONS

THE DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM OPTIONS STATED BELOW ARE ONLY AVAILABLE AS SELECTED BY THE ELIGIBLE EMPLOYERS WITH WHOM THE EMPLOYEE IS EMPLOYED. THE ELIGIBLE EMPLOYER WILL SELECT ONE OF THE OPTIONS THAT FOLLOW WHICH WILL BE AVAILABLE TO ALL ELIGIBLE EMPLOYEES. IN ADDITION, FOR AN ADDED COST, THE ELIGIBLE EMPLOYER MAY, BUT IS NOT REQUIRED TO, ALLOW ELIGIBLE EMPLOYEES TO ENROLL IN AN OPTION WITH LOWER, BUT NOT HIGHER, DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS.

Deductible Options may only be changed during Open Enrollment and only with permission of the Eligible Employer.

All Deductible Options provide coverage for the same benefits

TRADITIONAL MEDICAL PLANS			
	Deductible per Benefit Period	Out-of-Pocket Maximum Per Benefit Period	
		MHN Physician	Non-MHN Physician with Referral
\$500 Deductible	\$500 per Person; \$1,000 per Family	\$2,500* per Person; \$5,000* per Family	N/A
\$1,000 Deductible	\$1,000 per Person; \$2,000 per Family	\$3,000* per Person; \$6,000* per Family	N/A
\$1,500 Deductible	\$1,500 per Person; \$3,000 per Family	\$4,000* per Person; \$8,000* per Family	N/A
\$2,500 Deductible	\$2,500 per Person; \$5,000 per Family	\$5,000* per Person; \$10,000* per Family	N/A
<p>*Includes Annual Deductible</p> <p>The Deductible applies to Expenses Incurred during each Benefit Period, unless specifically waived, as stated in the Schedule of Medical/Dental Benefits, 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 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 Medical/Dental Benefits.</p>			

Out-of-Pocket Maximum (For All Deductible Options)

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, includes amounts applied toward the Deductible, copayments for a Local Primary Care Provider Office Visit and amounts in excess of the Benefit Percentage paid by the Plan for MHN services. 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% for the remainder of the Benefit Period for MHN services. **Any charges for services rendered from a Non-MHN Physician whose services have been referred by an MHN Physician will not serve to satisfy the Out-of-Pocket Maximum and the Benefit Percentage will not increase to 100% after satisfaction of the Out-of-Pocket Maximum.**

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

The Schedule of Medical/Dental 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.

**SCHEDULE OF MEDICAL/DENTAL BENEFITS - MHN Option
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS**

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

ELIGIBLE GROUPS OF PARTICIPANTS

- A - Administrators Employed by Eligible Employers
- B - Physicians and Licensed Health Care Providers Employed by or
Associated with Eligible Employers
- C - Eligible Employees of Eligible Employers
- D - Eligible Employees of MHN

THE BENEFIT PERIOD IS A CALENDAR YEAR

MHN BENEFIT

The Benefit Percentages for Medical Benefits may vary depending on the provider rendering the service or treatment. If a Non-MHN Physician is chosen over an MHN Physician, the Benefit Percentage will be lower (as stated in the following Schedule of Medical/Dental Benefits), unless one of the "Non-MHN Exceptions" stated below applies.

An "MHN Physician" means a Physician or Licensed Health Care Provider, as defined by this Plan, who is on the medical staff of one of the participating member hospitals or facilities within Montana Health Network, or is a Physician designated by Montana Health Network as a qualified "Traveling Physician".

Montana Health Network is an exclusive Provider Network and provider participation in other Preferred Provider Organizations (PPO's) does not automatically qualify a provider as an MHN Physician.

NON-MHN BENEFIT

An "Non-MHN Physician" means a Physician or Licensed Health Care Provider, as defined by this Plan, who does not meet the definition of an MHN Physician. Expenses Incurred for services obtained from a Non-MHN Provider will be subject to the Deductible and payable at 50%.

NON-MHN BENEFIT EXCEPTION

When services, treatments or supplies are provided or ordered by a Non-MHN Physician, charges will be paid as if the service were provided or ordered by an MHN Physician if any of the following Non-MHN Exceptions apply:

1. Services which were incurred due to an Emergency, as defined by the Plan; or
2. Services obtained from a Non-MHN Physician were incurred by a Dependent who resides at least thirty-five (35) miles away from a participating member hospital or facility within the Montana Health Network Trust. Such services must be clearly marked on the claim "outside of MHN community" in order for benefits to be payable as MHN services. If no indication, benefits will be subject to the Deductible, payable at 50%; or

An eligible Dependent who has requested and received a Non-MHN Benefit Exception from the Plan Administrator because the Dependent's residence is different than the Participant's permanent residence and is in an area for which there are no, or limited access to, MHN Physicians. **To obtain the Non-MHN Benefit Exception, the Participant or Dependent must request the exception in writing indicating the name and address of the Dependent, the Participant's name, social security number and group number. This exception will not be deemed granted until written approval is received from the Plan.**

3. Services are obtained by a Participant who is employed by an Eligible Employer that is within the Montana Health Network Trust but which is located outside of the geographical range of Montana Health Network as determined by the Plan Administrator; or
4. The service, treatment or supply is not available from an MHN Physician. **Documentation of unavailability of a MHN Physician is strongly recommended with submission of claim.**

GENERAL MEDICAL EXPENSES

Network Services (MHN Only)

Deductible Applies, Benefit Percentage. 80%

Non-MHN Physician with Referral

Deductible Applies, Benefit Percentage. 80%

Non-MHN* Physician without Referral

Deductible Applies, Benefit Percentage. 50%

***Non-MHN charges, whether with or without a referral, do not apply toward the Out-of-Pocket Maximum and the Benefit Percentage will always remain the same.**

OFFICE VISIT BENEFIT

PROVIDER OF SERVICE	DEDUCTIBLE	BENEFIT PERCENTAGE/ COPAYMENT	OUT-OF- POCKET MAXIMUM
Local Primary Care Provider*	Waived	Copayment* is the greater of 20% or \$16 of the Office Visit charge	Yes
*Refer to Definitions section of this Plan.			
All other MHN Physicians	Applies	80% Benefit Percentage	Yes
Non-MHN Physician with referral**	Applies	80% Benefit Percentage	No
Non-MHN Physician without referral**	Applies	50% Benefit Percentage	No

Office Visit includes charges for treatment of an active illness or injury and routine examinations for the evaluation and management that are performed in an office by the provider. An Office Visit does not include additional charges for lab, x-ray and other diagnostic miscellaneous testing or procedures rendered along with the office visit and charges will be payable according to the General Expense Benefit of this Plan.

Copayments must be paid directly to the Local Primary Care Provider. Copayments will apply toward satisfying the Out-of-Pocket Maximum. After satisfaction of the Out-of-Pocket Maximum, the Copayment will no longer apply.

****Services obtained from a Non-MHN Physician with a referral from an MHN Physician will be paid at the Network Benefit, subject to any plan limitations. A referral is only valid for 6 months from the date of the referral. Services more than 6 months after the date of the referral will require a new referral. Any charges for services rendered from a Non-MHN Physician whose services have been referred by an MHN Physician will not serve to satisfy the Out-of-Pocket Maximum and the Benefit Percentage will not increase to 100% after satisfaction of the Out-of-Pocket Maximum.**

INPATIENT HOSPITAL

Hospital Room and Board Limitation..... Average Semi-Private
 Intensive Care Unit Limitation..... Maximum Eligible Expense

Non-MHN* Physician with Referral

Deductible Applies, Benefit Percentage..... 80%

Non-MHN* Physician without Referral

Deductible Applies, Benefit Percentage..... 50%

***Non-MHN charges, whether with or without a referral, do not apply toward the Out-of-Pocket Maximum and the Benefit Percentage will always remain the same.**

EMERGENCY ROOM FACILITY

Deductible Applies, Benefit Percentage..... 80%

WELL-CHILD CARE (through 7 years of age for Employees who work at a Montana facility and their dependents)

Deductible waived, Benefit Percentage..... 100%
 Maximum Benefit per Benefit Period..... \$300

WELL-CHILD CARE (through 24 months of age for Employees who work at a facility other than Montana and their dependents)

Deductible waived, Benefit Percentage..... 100%
 Maximum Benefit per Benefit Period..... \$300

ROUTINE/DIAGNOSTIC MAMMOGRAMS (X-RAY ONLY)

Deductible waived, Benefit Percentage..... 100%
 Maximum number of Mammograms per Benefit Period..... 1
 (Diagnostic mammograms in excess of 1 per Benefit Period will be subject to the applicable Deductible and Benefit Percentage)

ROUTINE/DIAGNOSTIC PAP SMEARS (LAB ONLY)

Deductible waived, Benefit Percentage..... 100%
 Maximum number of Pap Smears per Benefit Period..... 1
 (Diagnostic pap smears in excess of 1 per Benefit Period will be subject to the applicable Deductible and Benefit Percentage)

ROUTINE/DIAGNOSTIC PROSTATE AND TESTICULAR TESTING (LAB ONLY)

Deductible waived, Benefit Percentage..... 100%
 Maximum number of procedures per Benefit Period..... 1
 (Diagnostic prostate and testicular laboratory testing in excess of 1 per Benefit Period will be subject to the applicable Deductible and Benefit Percentage)

ROUTINE NEWBORN INPATIENT NURSERY/PATIENT CARE

Deductible Applies, Benefit Percentage..... 80%

MENTAL ILLNESS

(Charges Mental Illness in excess of the Benefit Percentage do not apply toward satisfaction of the Out-of-Pocket Maximum. The Benefit Percentage does not change after satisfaction of Out-of-Pocket Maximum.)

Outpatient Expenses

Deductible Waived, Benefit Percentage.	50%
Maximum Visits* per Benefit Period.	15

*"Visit" for the purposes of this benefit means a session involving therapy counseling and testing, which will not exceed one hour and thirty minutes in length, and including all psychological or psychiatric tests ordered during a visit, provided the testing occurs within seventy-two (72) hours after the visit.

Inpatient Expenses*

Deductible Waived, Benefit Percentage.	50%
Maximum Inpatient Confinement Days per Benefit Period.	30
Maximum Lifetime Inpatient Confinement Days.	45

***Includes all services rendered during an "Inpatient Confinement Day"**

One day of Inpatient hospitalization may be exchanged for two days of Partial Hospitalization.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

Outpatient Expenses

Deductible Applies, Benefit Percentage.	80%
Maximum Benefit per Benefit Period.	\$500

Inpatient Expenses

Deductible Applies, Benefit Percentage.	80%
Maximum Benefit in any 24 month Consecutive Period.	\$6,000

Maximum Outpatient and Inpatient Lifetime Benefit. \$12,000

One day of Inpatient hospitalization may be exchanged for two days of Partial Hospitalization.

CHIROPRACTIC CARE

Deductible Applies, Benefit Percentage.	80%
Maximum Benefit per Benefit Period.	\$750
Maximum Benefit for Diagnostic X-rays.	\$100

REHABILITATION THERAPY

(Charges for Rehabilitation Therapy do not apply toward the Out-of-Pocket Maximum. The Benefit Percentage does not change after satisfaction of Out-of-Pocket Maximum.)

Deductible Applies, Benefit Percentage.	80%
Lifetime Maximum Benefit per Covered Person.	\$100,000

HOME HEALTH CARE

Deductible waived, Benefit Percentage.	100%
Maximum number of Visits per Day.	2
Maximum Benefit per Benefit Period.	\$10,000

DURABLE MEDICAL EQUIPMENT, ORTHOPEDIC DEVICES, AND PROSTHETICS

Deductible Applies, Benefit Percentage. 80%

Pre-authorization is strongly recommended for replacements and repairs. Replacements are Paid at 50% and repairs are paid up to the amount payable for replacement.

Charges for replacements or repair do not apply toward the Out-of-Pocket Maximum and the Benefit Percentage does not change after satisfaction of Out-of-Pocket Maximum.

DENTAL BENEFIT

DENTAL BENEFITS ARE AVAILABLE ONLY TO THOSE ELIGIBLE EMPLOYERS WHO HAVE ELECTED TO PROVIDE DENTAL BENEFITS FOR THEIR EMPLOYEES AND ONLY IF THOSE EMPLOYEES ARE ENROLLED FOR SUCH BENEFITS.

Deductible Waived, Benefit Percentage. 100%
 Maximum Benefit per Benefit Period per Covered Person/Family:
 Single Employee Coverage. \$100
 Employee and Spouse Coverage.. . . . \$200
 Employee and Child(ren) Coverage \$275
 Employee, Spouse and Child(ren) Coverage \$425
 (Additional limitations outlined further in this benefit)

SMOKING CESSATION BENEFIT

Deductible waived, Benefit Percentage.. . . . 100%
 Maximum Lifetime Benefit.. . . . \$500

ROUTINE FOOT CARE BENEFIT

Deductible Applies, Benefit Percentage. 80%
 Maximum Benefit per Benefit Period.. . . . \$500

MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES. \$2,000,000

PHARMACY BENEFITS

Prescription charges are payable only through the Plan's Pharmacy Benefit Management (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. **The Pharmacy Benefit Manager (PBM) will provide separate information for details regarding Network pharmacies and Preferred Brand prescriptions upon enrollment for coverage under this Plan.**

Pharmacy charges will apply towards satisfaction of the Pharmacy Deductible (\$100 per Covered Person, per Benefit Period). After satisfaction of the Pharmacy Deductible, the Plan will reimburse amounts in excess of the applicable Pharmacy Copayment.

"Pharmacy Copayment" means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of service as specifically stated below. Pharmacy Copayments apply toward satisfying the Pharmacy Deductible, but are not payable by the Plan and do not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum.

If the Physician does not prescribe "Dispense as Written", and there is a generic alternative for the prescription drug, and the Participant chooses a brand name instead, the Participant must pay the brand copayment amount plus the difference in cost between the generic and brand name medication.

If the Physician prescribes a brand name drug and communicates on the prescription "Dispense as Written" (DAW), the Participant will pay the brand name copayment only.

DEDUCTIBLE/MAXIMUMS	
Pharmacy Deductible per Covered Person per Benefit Period.	\$100
Pharmacy Maximum Per Covered Person per Benefit Period.	\$25,000
The Pharmacy Maximum is the maximum payable under the Pharmacy Benefit	
Special Copayment Maximum per Prescription.	\$250
If a Covered Person agrees to a drug utilization review by the PBM and follows the recommendations made, the Copayment per Prescription will not exceed \$250 per 30-day supply. It is the responsibility of the Covered Person to contact Montana Health Network to request a review.	

COPAYMENTS		
Drug Type	Network Retail or Mail Order	Member Submit
Generic	\$5 or 20% whichever is greater*	
Preferred Brand	\$25 or 20% whichever is greater*	
Non-Preferred Brand	\$40 or 40% whichever is greater*	

WHEN PRIMARY COVERAGE EXISTS UNDER ANOTHER PLAN	
Drug Type	Copayments
Generic	\$5 or 20% whichever is greater*
Brand Name	\$25 or 20% whichever is greater*
<p>If primary coverage is under another plan, including Medicare D, charges for prescription drugs must be submitted to the primary carrier first. Once this Plan receives a copy of the drug receipt or explanation of benefits showing the total charges and amounts paid for eligible prescription drugs from the primary carrier, if applicable, this Plan will reimburse the Participant for the remainder of Maximum Eligible Expenses, subject to the above Copayments:</p> <p>In order to receive reimbursement, the drug receipt must be submitted to Allegiance.</p>	

*If the actual charge for the drug, less any applicable discount, is less than the minimum Pharmacy Copayment stated, the amount payable to the pharmacy by the Covered Person at the time of purchase will not exceed that actual charge.

COVERAGE

Coverage for prescriptions will include only those drugs requiring a written prescription of a licensed Physician and that are Medically Necessary for the treatment of an Illness or Injury, unless otherwise covered.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider for self administered contraceptives. **Contraceptive Management, injectable contraceptives and contraceptive devices are covered under the Medical Benefits of this Plan.**

Pharmacy charges will apply towards satisfaction of the Pharmacy Deductible (\$100 per Covered Person, per Benefit Period). After satisfaction of the Pharmacy Deductible, the Plan will reimburse amounts in excess of the applicable Pharmacy Copayment.

If the Physician does not prescribe "Dispense as Written", and there is a generic alternative for the prescription drug, and the Participant chooses a brand name instead, the Participant must pay the brand copayment amount plus the difference in cost between the generic and brand name medication.

If the Physician prescribes a brand name drug and communicates on the prescription "Dispense as Written" (DAW), the Participant will pay the brand name copayment only.

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:

PBM Network Prescriptions: Available only through a retail pharmacy that is part of the PBM Network. The pharmacy will bill the Plan directly for that part of the prescription cost that exceeds the Pharmacy Copayment (Pharmacy Copayment amount must be paid to pharmacy at time of purchase). **The prescription identification card is required for this option.**

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. **The pharmacy will bill the Plan directly for prescription costs that exceed the Copayment.**

Member Submit Prescriptions: Available only if the prescription identification card cannot be used because a pharmacy is not part of the PBM Network, or the prescription identification card is not used at a PBM pharmacy. **Prescriptions must be paid for at the point of purchase and the prescription receipt must be submitted to the Pharmacy Benefit Manager (PBM), along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription, less the applicable Pharmacy Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription.**

DRUG OPTIONS

The drug options available are:

Generic: Those drugs and supplies listed in the most current edition of the Physicians Desk Reference or by the PBM Program as generic drugs.

Preferred Brand: Non-generic drugs and supplies listed as "Preferred Brand" by the PBM Program as stated in a written list provided to Covered Persons and updated from time to time.

Non-Preferred Brand: Copyrighted or patented brand name drugs (Non-Generic) which are not recognized or listed as Preferred Brand drugs or supplies by the PBM Program.

PRIMARY COVERAGE UNDER ANOTHER PLAN

When primary coverage exists under another Plan, including Medicare D, charges for prescription drugs may be reimbursed by the Plan as specifically stated in the Schedule of Medical Benefits, subject to the following conditions:

1. The prescription drug receipt and explanation of benefits from primary carrier (if applicable) is submitted to the Plan, along with a reimbursement form to Allegiance Benefit Plan Management, Inc..
2. The pharmacy indicates either "generic" or "brand" on the prescription drug receipt.
3. The primary coverage information has been previously submitted to the Plan.

Charges for prescription drugs are not eligible if the above conditions are not met.

QUANTITY LIMITATIONS

Supply is limited to the greater of 34 days or a 90 count, for Member Submit and PBM Network Prescriptions and/or a 90-day supply for Mail Order Prescriptions, except for the following:

Migraine Therapy Quantity Limits/28-Day Period
<i>Amerge</i> : 18 tablets
<i>Axert</i> : 18 tablets
<i>Frova</i> : 27 tablets
<i>Imitrex Nasal Spray 20mg</i> : 3 boxes = 18 unit dose spray devices
<i>Imitrex Nasal Spray 5 mg</i> : 6 boxes = 36 unit dose spray devices
<i>Imitrex</i> Tablets: 18
<i>Imitrex</i> Injection Kits: 8 kits = 16 injections
<i>Imitrex</i> Injection Vials: 16 vials
<i>Maxalt/Maxalt-MLT</i> : 24 tablets
<i>Migranal Nasal Spray</i> : 2 kits = 8 unit dose spray
<i>Zomig 2.5mg and 5mg</i> Tablets: 18 tablets

EXCLUSIONS

Charges for drugs which require a Physician's prescription are covered by this Plan under the Pharmacy Benefit, except for the following which are specifically excluded:

devices and appliances* durable medical supplies* anorexiant (weight reduction) Experimental or Investigational drugs fertility drugs non-legend drugs	Rogaine (or similar products) smoking deterrents** vitamins impotence treatments in excess of 6 doses per month cosmetic drugs, except for Retin-A, Avita and Differin through age 24
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*Eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

**Smoking deterrents are eligible under the Smoking Cessation Benefit of the Medical Benefits this Plan.

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

ELIGIBLE GROUPS OF PARTICIPANTS

- A - Administrators Employed by Eligible Employers
- B - Physicians and Licensed Health Care Providers Employed by or
Associated with Eligible Employers
- C - Eligible Employees of Eligible Employers
- D - Eligible Employees of MHN

VISION BENEFITS ARE AVAILABLE ONLY TO THOSE ELIGIBLE EMPLOYERS WHO HAVE ELECTED TO PROVIDE VISION BENEFITS FOR THEIR EMPLOYEES AND ONLY IF THOSE EMPLOYEES ARE ENROLLED FOR SUCH BENEFITS.

Deductible Waived, Benefit Percentage..... 100%

Vision Examination (applicable for spectacle lenses or contacts lenses)
Exam limited to once per Benefit Period, up to..... \$50

Eyewear Materials

Coverage for Eyewear Materials will begin on the first day of the month immediately following six (6) months from their Enrollment Date. If the Enrollment Date is the first day of the month, the six-month period will begin on the Enrollment Date.

Eyewear Materials are limited to only one of the following eyewear materials during any two Benefit Periods:

- 1 Set of Frames and Lenses; or
- 1 Set of Contacts; or
- 1 year supply of disposable contacts

Maximum Benefit per two Benefit Periods. \$250

EITHER CONTACT LENSES OR SPECTACLE LENSES, BUT NOT BOTH, ARE ELIGIBLE DURING ANY TWO BENEFIT PERIODS.

MEDICAL/DENTAL BENEFIT DETERMINATION REQUIREMENTS

THE DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM OPTIONS STATED UNDER DEDUCTIBLE OPTIONS ARE ONLY AVAILABLE AS SELECTED BY THE ELIGIBLE EMPLOYERS WITH WHOM THE EMPLOYEE IS EMPLOYED. THE ELIGIBLE EMPLOYER WILL SELECT ONE OF THE THREE OPTIONS WHICH WILL BE AVAILABLE TO ALL ELIGIBLE EMPLOYEES. IN ADDITION, FOR AN ADDED COST, THE ELIGIBLE EMPLOYER MAY, BUT IS NOT REQUIRED TO, ALLOW ELIGIBLE EMPLOYEES TO ENROLL IN AN OPTION WITH LOWER, BUT NOT HIGH, DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM LIMITS.

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.

BENEFIT PERCENTAGE

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

MAXIMUM BENEFIT

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

PRIOR PLAN DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM CREDIT

This Plan will be a continuum for an employer who becomes an Eligible Employer under this Plan after the effective date of this Plan. In such circumstances, charges which were used toward satisfying the deductible, coinsurance or out-of-pocket maximum under the prior health benefit plan or insurance coverage of the Eligible Employer, during the year in which the Eligible Employer became effective under this Plan, will apply towards satisfaction of the Maximum Deductible and Out-of-Pocket Maximum for the Option selected with the Eligible Employer during the same Benefit Period upon receipt of documented proof of such full or partial satisfaction. However, such credit of deductible or out-of-pocket maximum will not exceed the Maximum Deductible and Out-of-Pocket Maximum Option selected under the coverage of the Eligible Employer.

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/Dental Benefits and subject to all terms and conditions of this Plan. Medical Benefits include:

1. Charges made by a Hospital for:
 - A. 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/Dental Benefits.
 - B. 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.
 - C. 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.
 - D. 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.

Treatment rendered for stuttering or for behavioral or learning disorders is excluded.

2. 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 surgical facilities 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.
3. 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.
4. Charges for services and supplies furnished by a Birthing Center.
5. Charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility during the first sixty (60) days of convalescent confinement in any one Convalescent Period. 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:
 - A. 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.

- B. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.
 - C. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.
6. Charges made by a Hospice within any one Hospice Benefit Period for:
- A. 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.
 - B. 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.
 - C. Physical Therapy and Speech Therapy, when rendered by a licensed therapist.
 - D. Medical supplies, including drugs and biologicals and the use of medical appliances.
 - E. Physician's services.
 - F. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
7. The services of a legally qualified 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.
8. Charges for Pregnancy, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy.
9. 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.

10. Charges for Registered Nurses (R.N.'s) or Licensed Practical Nurses (L.P.N.'s) for private duty nursing.
11. Charges for midwife services by a Certified Nurse Midwife (CNM) who is a registered nurse and enrolled in either the certification maintenance program or the continuing competency assessment program through the American College of Nurse Midwives (ACNM).

"Certified Nurse Midwife" means an individual who has received advanced nursing training and is authorized to use the designation of "CNM" and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

12. 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.

13. 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.
14. 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 not available through the Pharmacy Benefit regardless of Medical Necessity.

Conditions of coverage for outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Schedule of Benefits and Pharmacy Benefit sections of the Plan.

15. Charges for x-rays, CAT scans, MRIs, microscopic tests, and laboratory tests.
16. Charges for radiation therapy or treatment and chemotherapy.
17. 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.
18. Charges for oxygen and other gases and their administration.
19. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.
20. Charges for the cost and administration of an anesthetic.

21. Charges by a Physician or Licensed Health Care Provider for dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies, except for dental braces or corrective shoes, which are specifically excluded.

Diabetic supplies are only eligible for coverage under the Pharmacy Benefit of this Plan.

22. Charges for adhesive tape, bandages, antiseptics or other over-the-counter first aid supplies except only upon prior approval of the Plan. **Approval will be based on guidelines of cost effectiveness and Medically Necessary treatment of an Illness or Injury as determined by the Plan Administrator.**

23. Charges for the Durable Medical Equipment, Orthopedic Appliances, or Prosthetic Appliances as follows:

- A. 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.
- B. Purchase of Orthopedic Appliances or Prosthetic Appliances, including but not limited to artificial limbs, eyes, larynx.
- C. Replacement or repair of Durable Medical Equipment, Orthopedic Appliances, Prosthetic Appliances.

Pre-authorization of charges for Durable Medical Equipment, Orthopedic Appliances or Prosthetic Appliances that may exceed \$1,000 is strongly recommended. If pre-authorization is not obtained, charges may be denied if the service, treatment or supply is not found to be medically necessary when the claim is submitted. The request for preauthorization must include:

- A. The attending Physician's prescription; and
- B. A written explanation from the Physician as to why rental or purchase, repair or replacement is necessary; and
- C. An itemized rental or purchase, repair or replacement cost statement from the proposed provider of services.

24. Charges for voluntary sterilization for Participants and Dependent spouses only.

25. Charges for Phenylketonuria food supplement for the treatment of Phenylketonuria or related disorders.

26. Charges in connection with non-Experimental or non-Investigational organ or tissue transplant procedures, subject to the following conditions:

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

- C. 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.
 - D. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.
 - E. The Maximum Eligible Expense of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered for payment.
27. 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.
28. Charges for Contraceptive Management, regardless of Medical Necessity. "Contraceptive Management" means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation or placement of any contraceptive device.

HOME HEALTH CARE BENEFIT

Charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. Coverage under this benefit includes 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. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

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

"Home Health Care Plan" 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. Services of any social worker.

4. Transportation services.
5. Housekeeping services.
6. Custodial Care

MENTAL ILLNESS

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. 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.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. 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 an Substance Abuse/Chemical Dependency Treatment Facility.
5. Charges for Inpatient Substance Abuse/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.

CHIROPRACTIC CARE

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. Coverage includes charges incurred for treatment or services rendered by a licensed chiropractor.

REHABILITATION THERAPY

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. Medical Benefits include charges incurred for the following services:

1. Treatment or services rendered by a licensed physical therapist or occupational therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an illness or injury.
2. Treat or services rendered by a licensed speech therapist 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 in 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.

DENTAL EXPENSE BENEFIT

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. Dental Benefits include charges incurred for dental procedures performed by a dentist, denturist or dental hygienist.

ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE

Charges are payable as specifically stated in the Schedule of Medical/Dental Benefits. Routine Newborn Inpatient Nursery/Physician Care including the following services:

1. Routine Nursery Care includes room, board and Hospital Miscellaneous Expenses for a Newborn Dependent child, including circumcision.
2. Routine Physician Care includes charges for services of a Physician for a Newborn Dependent child while Inpatient as a result of the child's birth, including circumcision.

WELL-CHILD CARE (For Employees who work at a Montana facility and their dependents)

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits.

Charges for Well-Child Care are payable as specifically stated under the "Schedule of Medical Benefits". Coverage under this benefit includes Well-Child Care for Dependent children through age seven (7) years for the following routine services:

1. Well-child examinations by a Physician, which will include a medical history, physical examination, developmental assessment, anticipatory guidance and laboratory tests as directed by a Physician, but not to exceed a total of ten (10) visits through twenty-four (24) months of age and one visit per Benefit Period between two (2) and seven (7) years of age.

2. Routine immunizations according to the schedule of immunizations which is recommended by the Immunization Practices Advisory Committee of the United States Department of Health and Human Services.

Expenses payable under this Preventive Care benefit will not be subject to the Medical Necessity provisions of this Plan.

Charges for treatment of an active Illness or Injury are subject to the Deductible and Benefit Percentage and other plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

WELL-CHILD CARE (For Employees who work at a facility other than Montana and their dependents)

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits.

Coverage under this benefit includes charges for Routine Outpatient Well-Child Care for Dependent child through 24 months for the following routine services:

1. Well-child examinations by a Physician, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician, but not to exceed a total of ten (10) visits.
2. One hemoglobin or hematocrit blood test and one urinalysis between birth and two years of age.
3. Routine immunizations according to the schedule of immunizations which is recommended by the Immunization Practices Advisory Committee of the United States Department of Health and Human Services.

Expenses payable under this Preventive Care benefit will not be subject to the Medical Necessity provisions of this Plan.

Charges for treatment of an active Illness or Injury are subject to the Deductible and Benefit Percentage and other plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

ROUTINE/DIAGNOSTIC MAMMOGRAMS (X-RAY ONLY)

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. Coverage includes x-rays charges associated with one annual routine or diagnostic mammogram. X-ray charges incurred during that Benefit Period for subsequent diagnostic mammograms will be subject to the applicable Deductible and Benefit Percentage. X-ray charges incurred during the same benefit period for subsequent routine mammograms are not covered.

ROUTINE/DIAGNOSTIC PAP SMEARS/PROSTATE AND TESTICULAR (LABORATORY ONLY)

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. Coverage includes laboratory charges associated with a routine or diagnostic pap smear, prostate and testicular diagnostic testing, including charges for shipping and handling. Laboratory charges incurred during the same Benefit Period for subsequent diagnostic pap smear, prostate and testicular testing will be subject to the applicable Deductible or Benefit Percentage. Laboratory charges incurred during the same Benefit Period for subsequent routine pap smear, prostate and testicular testing are not covered.

ROUTINE FOOT CARE BENEFIT

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. Coverage includes charges incurred for treatment or removal of corns or callosities, hypertrophy, hyperplasia of the skin, subcutaneous tissues, excision of nail and nail matrix, or wedge excision of skin of nail fold, e.g., for ingrown toenail.

SMOKING CESSATION BENEFIT

Charges are payable as specifically stated and limited in the Schedule of Medical/Dental Benefits. Coverage includes charges incurred for Smoking Cessation services and smoking cessation remedies provided or ordered by an "MHN Physician", or otherwise a program approved in advance by the Plan Administrator.

PREVENTIVE/PROPHYLACTIC MASTECTOMY

Coverage includes charges for a preventive/prophylactic mastectomy if the preventive/prophylactic mastectomy is medically indicated and acceptable only upon prior approval by the Plan Administrator based upon an independent medical review.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

Coverage 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.

SURCHARGE IMPOSED BY STATES

Coverage includes charges for surcharges, taxes or levies, imposed by any state, or a political subdivision thereof, upon medical services, treatment or supplies, for those emergency procedures necessary to treat and stabilize a eligible injury or illness but only to the extent that the same are necessary in order to transport the covered person, at the earliest medically appropriate time, to a hospital or other appropriate treatment facility located in a state that does not impose or assess such a surcharge, tax or levy.

The Plan will not pay for any such surcharge, tax or levy imposed or assessed, by any state or a political subdivision thereof, upon non-emergency services, treatment or supplies of any nature, unless such services, treatments or supplies are Medically Necessary, unavailable in any state that does not impose or assess a surcharge, tax or levy upon the particular service, treatment or supply and are otherwise eligible for coverage under the terms of this Plan in all respects and then coverage for the surcharge, tax or levy will only be provided upon prior written approval of the Plan Administrator.

TELEMEDICINE BENEFIT

“Telemedicine” means the use of medical information exchanged from one site to another via electronic communications for the purpose of providing Medically Necessary health care services to a patient.

This Benefit is an exception to the Plan’s exclusion for treatment which is not rendered by or in the physical presence of a Physician or Licensed Health Care Provider. Charges are payable as specifically stated in the Schedule of Medical/Dental Benefits under the Medical Benefits of this Plan. Coverage includes charges for services that are related to or as a result of Telemedicine, but limited to the following methods:

1. Storing and forwarding medical documentation to a licensed Radiologist or Pathologist for the purpose of reviewing telecommunicated medical documentation at a time which is convenient to the Radiologist or Pathologist’s schedule. This method does not require actual contact between the patient and the provider. **Expenses billed for the use of equipment or transmission charges to transmit the audiovisual information are not covered.**
2. An interactive patient encounter between the Physician or Licensed Health Care Provider being consulted and the patient. This method requires a “live” two way video and audio transmission between the patient and the Physician or Licensed Health Care Provider, and may include one additional provider who is presenting the patient to a specialist for an opinion regarding the patient’s condition. **Expenses billed for the use of equipment or transmission charges to transmit the audiovisual information are not covered.**

Telemedicine does not include charges for teleconsultations, which involves a practitioner seeking advice from a consultant concerning a patient’s condition or course of treatment.

HOSPITAL ADMISSION CERTIFICATION

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 care 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, call the utilization management company 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.

NOTE: PRE-CERTIFICATION 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, 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 THAT PRE-CERTIFICATION OF A COURSE OF TREATMENT BY THE PLAN DOES NOT GUARANTEE PAYMENT OF CLAIMS FOR THE SAME.

CONTINUED STAY CERTIFICATION

Charges for inpatient hospital services for days in excess of any days previously certified by the utilization management 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.

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, call the utilization management company at 1-800-342-6510 for emergency admission certification.

PRE-EXISTING CONDITION EXCLUSIONS

Expenses Incurred resulting from treatment of Pre-existing Conditions are excluded from coverage under the Plan as specified below:

1. For a period of twelve (12) consecutive months from the Enrollment Date.
2. In the case of a Late Enrollee only, for a period of eighteen (18) 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.

MEDICAL BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Medical Benefits in addition to the following Medical Benefit Exclusions:

1. Charges for routine health check-ups or preventive immunizations not necessary for the treatment of an Injury or Illness, except as specifically listed as a Covered Benefit.
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. **This exclusion does not apply when such treatment is specifically listed as a covered expense under "Telemedicine" of the "Medical/Dental Benefits" section of this Plan.**
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. **This exclusion does not apply when such treatment is specifically listed as a covered expense under "Telemedicine" of the "Medical/Dental Benefits" section of this Plan.**
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, hearing aids, or such similar aid devices, except as specifically outlined in the Schedule of Benefits. **This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure performed while coverage is in effect.**
10. Charges for dental treatment in excess of the Dental Expense Benefit; however, in addition to benefits provided by the Dental Expense Benefit, coverage includes treatment required because of accidental bodily Injury to natural teeth. Such expenses must be Incurred within twelve (12) months of the date of accident.

11. 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.
12. Charges in connection with a surrogate pregnancy and delivery and any related complications.
13. Charges for marital counseling, family counseling, recreational counseling or milieu therapy.
14. Group therapy, except for the treatment of Substance Abuse/Chemical Dependency.
15. Charges resulting from or in connection with the reversal of a sterilization procedure.
16. Charges in connection with services or supplies provided for the treatment of obesity and weight reduction, including bariatric surgery or any other related bariatric procedure.
17. Charges for chiropractic treatment which are not related to an actual Illness or Injury or which exceed the maximum benefit as stated in the Schedule of Medical/Dental Benefits.
18. Charges for orthotics, acupuncture, naturopathy, holistic medical procedures, homeopathy, hypnotherapy or rolfing.
19. Charges for routine foot care, including but not limited to the following:
 - A. Non-surgical treatment of bunions;
 - B. Cutting, trimming, clipping, or debridement of toenails; or
 - C. Other hygienic and preventive maintenance care, such as cleaning and soaking of the feet, use of skin creams, or any services performed when there is not a localized illness, injury, or symptom involving the foot.

This exclusion does not apply to charges specifically covered under the Routine Foot Care Benefit.

20. Hair transplant procedures, wigs and artificial hairpieces, or drugs which are prescribed to promote hair growth.
21. 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.
22. 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.
23. Charges related to Custodial Care.
24. Charges for artificial organ implant procedures.
25. Charges for non-prescription contraceptives supplies or devices, or the removal of contraceptive devices, unless Medically Necessary.
26. 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.

VISION BENEFITS

VISION BENEFITS ARE AVAILABLE ONLY TO THOSE ELIGIBLE EMPLOYERS WHO HAVE ELECTED TO PROVIDE VISION BENEFITS FOR THEIR EMPLOYEES AND ONLY IF THOSE EMPLOYEES ARE ENROLLED FOR SUCH BENEFITS.

PAYMENT OF BENEFITS

If a Covered Person, while covered for Vision Benefits, incurs charges for Covered Vision Care Services, benefits are payable under the Plan up to the maximums stated in the Schedule of Vision Benefits.

COVERED VISION SERVICES

Covered Vision Services are those expenses Incurred in connection with the following Vision Care Services:

1. Vision Examination - Vision examination by an ophthalmologist (or other Physician licensed to perform vision examinations and prescribe lenses) or optometrist to evaluate the health and visual status of the eyes.
2. Eyewear Materials:

Coverage for Eyewear Materials will begin on the first day of the month immediately following six (6) months from their Enrollment Date. If the Enrollment Date is the first day of the month, the six-month period will begin on the Enrollment Date. Coverage includes the following:

- A. Corrective lenses and frames provided by an ophthalmologist (or other physician licensed to perform vision examinations and prescribe lenses) or optometrist; or
- B. Non-disposable corrective contact lenses of any type provided by an ophthalmologist (or other physician licensed to perform vision examinations and prescribe lenses) or optometrist; or
- C. disposable contact lenses.

EITHER CONTACTS OR SPECTACLE LENSES, BUT NOT BOTH, ARE ELIGIBLE UNDER THIS BENEFIT DURING ANY TWO BENEFIT PERIODS.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The General Plan Exclusions and Limitations of the Plan apply to Vision Benefits in addition to the following Vision Benefit Exclusions:

1. Services or supplies for which the Covered Person is entitled to benefits under any other section of the Plan or as provided under any other section of the Plan.
2. Non-prescription safety glasses or sunglasses (tinted lenses with a tint other than Tints No. 1 or No. 2 are considered to be sunglasses for the purposes of this exclusion).
3. Extra charges for Cosmetic materials, photosensitive or lens coatings.
4. Cosmetic procedures upon the eye.
5. Cosmetic procedures for lenses or frames, including, but not limited to roll and polish procedures.

6. Services rendered or ordered while not covered for Vision Benefits.
7. Services or supplies not prescribed as necessary by a licensed Physician, optometrist or optician.
8. Replacement of lenses or frames which are lost or broken except at the normal intervals indicated.

**OPTIONAL DENTAL BENEFITS
SCHEDULE OF DENTAL 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 FOLLOWING OPTIONAL DENTAL BENEFITS ARE AVAILABLE ONLY TO THOSE ELIGIBLE EMPLOYERS WHO HAVE ELECTED TO PROVIDE DENTAL BENEFITS FOR THEIR EMPLOYEES AND ONLY IF THOSE EMPLOYEES ARE ENROLLED FOR SUCH BENEFITS.

MUST BE ENROLLED FOR MEDICAL BENEFITS

THE BENEFIT PERIOD IS A CALENDAR YEAR

DEDUCTIBLE

Deductible Per Covered Person per Benefit Period. \$50
Deductible per Family per Benefit Period. \$150

DENTAL EXPENSES

Type A (Preventive Care) Dental Expenses
Deductible. Waived
Benefit Percentage. 100%

Type B (Basic Care) Dental Expenses
Deductible. Applies
Benefit Percentage. 75%

Type C (Major Restorative) Dental Expenses
Deductible. Applies
Benefit Percentage. 50%

MAXIMUM BENEFIT PER BENEFIT PERIOD PER COVERED PERSON. \$ 1,500
(Type A, B and C Expenses)

OPTIONAL DENTAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBILITY PROVISIONS

Employees and their Dependents must meet the eligibility guidelines outlined earlier in this Plan and be enrolled for Medical Benefits to be eligible for Dental Benefits. Dental Benefits are only available to Employees while enrolled for Medical Benefits. Dental Benefits are only available to Dependents of Employees while enrolled for Medical Benefits and who remain enrolled for Medical Benefits. **Dental Benefits are not available for a period of two (2) years to any Covered Person who voluntarily terminates Dental Benefits who is eligible for those benefits.**

Coverage for eligible Employees and their Dependents who have made timely application will begin on the effective date of coverage for Medical Benefits.

WAITING PERIOD FOR LATE ENROLLEES

A Late Enrollee must serve the waiting periods shown below, except for covered dental services for necessary treatment of an accidental non-chewing injury sustained more than ninety (90) days after the beginning of the waiting period:

Type A Expenses:	No Waiting Period Required
Type B Expenses:	12 Months from date of Enrollment
Type C Expenses:	12 Months from date of Enrollment

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

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

1. They are administered, ordered or provided by a Dentist, Denturist, Dental Hygienist or other Licensed Health Care Provider covered by the Plan; and
2. They are Dentally Necessary for the diagnosis and treatment of a dental condition or dental disease unless otherwise specifically included as a benefit; and
3. Charges for such services, treatments and supplies do not exceed the Maximum Eligible Expense of the Plan. If two or more procedures are separately suitable for the correction of a specific condition, the Maximum Eligible Expense will be based upon the least expensive procedure; and
4. They are not excluded under any provision or section of this Plan.

DEDUCTIBLE AND BENEFIT PERCENTAGE

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 Dental 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 Dental Benefits. Dental Benefits are not available at any time to Dependents of Employees once Dental Benefits have been canceled.**

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

MAXIMUM BENEFIT PAYABLE

The Maximum Benefit per Benefit Period as specified in the Schedule of Dental Benefits is the maximum amount that may be paid by the Plan for Expenses Incurred by each individual Covered Person in each Benefit Period as indicated in the Optional Dental Benefits Schedule of Dental Benefits.

EXPENSES INCURRED

For a dental appliance, or modification of a dental appliance, an expense is considered Incurred at the time the impression is made. For a crown, bridge or gold restoration an expense is considered Incurred at the time the tooth or teeth are prepared. For root canal therapy an expense is considered Incurred at the time the pulp chamber is opened. All other expenses are considered Incurred at the time a service is rendered or a supply furnished.

PREDETERMINATION OF BENEFITS

Charges that are expected to exceed five hundred dollars (\$500.00) may be predetermined by having the Dentist complete the Predetermination of Benefits portion of the claim form and listing the procedures he/she is recommending, including an estimate of charges for the procedures and submit the claim form to the Plan Supervisor for Predetermination of Benefits payable.

Upon the Plan's receipt of the Predetermination of Benefits request, the Plan Supervisor will determine the eligibility of the Covered Person and determine the coverage available under the Plan for the recommended dental procedures. After determining the benefits payable under the Plan, the Plan Supervisor will return the claim form to the Dentist. A copy of the predetermination of benefits will also be mailed to the covered Employee, informing the Employee of the amount of benefits estimated to be covered by the Plan for the recommended dental procedures.

A PREDETERMINATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF PLAN BENEFITS IS SUBJECT TO PLAN PROVISIONS AND ELIGIBILITY AT THE TIME SERVICES ARE PERFORMED OR CHARGES ARE INCURRED.

OPTIONAL DENTAL BENEFITS

TYPE A (PREVENTIVE CARE) EXPENSES

The following general dental expenses will be considered "Type A" for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Oral Examination (including prophylaxis--scaling and cleaning of teeth), but not more than twice in any Benefit Period.
2. Topical application of sodium fluoride or stannous fluoride for dependents under sixteen (16) years of age.
3. Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment; also other dental x-rays, but not more than one full mouth x-ray or series in any three Benefit Periods and not more than two sets of supplementary bitewing x-rays in any Benefit Period.
4. Sealants allowed once every thirty-six (36) months on permanent molar teeth for children under age sixteen (16).
5. Space maintainers for dependents under age sixteen (16) only. Service includes all adjustments made within 6 months of installation.

TYPE B (BASIC CARE) EXPENSES

The following general dental expenses will be considered "Type B" for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Palliative care only if no other service is rendered except x-rays.
2. Extractions, except for orthodontic extractions
3. Oral surgery
4. Fillings
5. General anesthesia or conscious intravenous "IV" sedation when Medically Necessary and administered in connection with oral surgery or other Covered Dental Benefits.
6. Treatment, including periodontal surgery of diseased periodontal structures for periodontal and other diseases affecting such structures.
7. Endodontic treatment, including root canal therapy
8. Prophylaxis for periodontal treatment
9. Occlusal adjustment only when performed with periodontal surgery.
10. Injection of antibiotic drugs.

TYPE C (MAJOR RESTORATIVE) EXPENSES

The following general dental expenses will be considered "Type C" for reimbursement purposes and eligible after twelve (12) consecutive months of coverage under the Dental Benefits of this Plan:

1. Occlusal guard

2. Gold fillings, inlays, onlays or crowns (including precision attachments for dentures.)
3. Initial installation of fixed bridgework (including crowns and inlays to form abutments) to replace one or more natural teeth extracted.
4. Replacement of an existing partial denture or fixed bridgework by a new fixed bridgework, or the addition of teeth to an existing fixed bridgework. However, this item will apply only to replacements and additions that meet the "Prosthesis Replacement Rule" below.
5. Initial installation of partial or full removable dentures (including adjustments for the six (6) month period following installation) to replace one or more natural teeth extracted.
6. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or the addition of teeth to an existing partial denture. However, this item applies only to replacements and additions that meet the "Prosthesis Replacement Rule" below.
7. Repair or recementing of crowns, inlays, bridgework or dentures; or relining of dentures.

PROSTHESIS REPLACEMENT RULE

Replacement of or additions to existing dentures or bridgework as described under Type C Expenses will be covered only if evidence satisfactory to the Plan Supervisor is furnished that one of the following applies:

1. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.
2. The existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement.
3. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.
4. The replacement is not for a Pre-existing condition or if so any Pre-existing condition exclusionary period has been reduced to zero by prior creditable coverage.

DENTAL BENEFIT LIMITATIONS

The following examples describe limitations in coverage under the Plan.

1. Restorative:
 - A. Gold, baked porcelain restorations, crowns, jackets: If a tooth can be restored with a material such as amalgam, the Maximum Eligible Expense for the dental procedure actually performed will be limited to the Maximum Eligible Expense appropriate to the procedure using amalgam or a similar material.
 - B. Reconstruction. Benefits will include only the appropriate Maximum Eligible Expense for those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are eligible only under the Orthodontic Treatment Benefit, if provided by this Plan.
 - C. For applicable procedures, the service is deemed to include local anesthesia, all temporary restorations and appliances, and one year follow-up care.
 - D. Replacement of an existing filling is covered only if at least twelve (12) months have passed since the existing filling was placed, unless required by new decay in an additional tooth surface.

2. Endodontics:
 - A. For applicable procedures, the service is deemed to include local anesthesia, x-rays, and routine follow-up care.
3. Prosthodontics:
 - A. For applicable procedures, the service is deemed to include local anesthesia, all temporary restorations and appliances, and one year follow-up care.
 - B. Partial Dentures. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, Maximum Eligible Expenses for the covered dental service performed will be limited to the Maximum Eligible Expense appropriate to the cast chrome or acrylic denture.
 - C. Complete Dentures. The Maximum Eligible Expense for the dental procedure actually performed will be limited to the Maximum Eligible Expense appropriate to the standard procedure.
 - D. Replacement of existing dentures or removable or fixed bridgework. Charges for the replacement of existing dentures or removable or fixed bridgework will be considered only if the existing appliance is not serviceable and cannot be repaired. The Maximum Eligible Expense for the procedure performed will be limited to the Maximum Eligible Expense appropriate for those services which would be necessary to render such appliances serviceable.
4. Periodontics:
 - A. For applicable procedures, the services is deemed to include local anesthesia, all temporary restorations and appliances, and one year follow-up care. Each periodontic procedure is allowed once per quadrant every 18 months.
5. Facility, Ambulatory Surgery Center and Hospital expenses will include only services provided for any of the following reasons:
 - A. If services are Dentally Necessary;
 - B. If the Plan Administrator determines that for other than Dentally Necessary reasons, the services or treatment cannot be performed in the dental service provider's office;
 - C. If for children less than 5 years of age;
 - D. If for covered Persons who are mentally or physically handicapped/challenged.

DENTAL BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Dental Benefits in addition to the following Dental Benefit Exclusions:

1. Charges for dental services or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by a Participant's employer, to the extent that the expenses have been paid by another applicable portion of this Plan or any other insurance or employee benefit plan.
2. Charges for treatment which is not rendered by or in the presence of a Dentist or other Licensed Health Care Provider covered by the Plan except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if the treatment is rendered under the supervision or the direction of the Dentist.

3. Charges for dentures, crowns, inlays, onlays, bridgework or other appliances which are not Dentally Necessary and performed solely or primarily for Cosmetic or personal reasons, personal comfort, convenience, or beautification items, including charges for personalization or characterization of dentures. Charges for veneers, composite, plastic, silicate or similar restorations placed on or replacing any teeth other than the ten (10) upper and lower anterior teeth are considered optional services and not Dentally Necessary. Only the charge for a corresponding amalgam restoration will be covered.
4. Charges for facility, Ambulatory Surgery Center and Hospital charges, except as specifically provided for under Dental Benefit Limitations.
5. Charges for local anesthesia administered in conjunction with covered dental services or procedures, when billed separately (unbundled) from the charge for the Covered Service or procedure.
6. Charges for the replacement of a lost, missing, or stolen appliance device or for an additional (spare) appliance.
7. Charges for any services or supplies which are for Orthodontic Treatment, including orthodontic extractions, except as specifically provided for by the Plan.
8. Charges for root canal therapy for which the pulp chamber was opened before the individual became a Covered Person.
9. Charges for oral hygiene and dietary instructions.
10. Charges for dental implants.
11. Charges for temporary dentures.
12. Charges for extracoronary and other periodontal splinting.
13. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature, including but not limited to correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia. This includes expenses incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.
14. Charges for any services, supplies or appliances which are not specifically listed as a benefit of this Plan.
15. Broken or missed appointments.
16. Charges for infection control (OSHA) fees or claim filing.
17. Charges for non-dental services such as training, education, instructions or educational materials, even if they are performed or provided by a dental service provider.
18. Hypnosis, prescribed drugs, premedications or any euphoric drugs.
19. Biopsies or oral pathology, except as specifically provided for under Covered Dental Services.
20. 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.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

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

1. 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.
2. 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.
3. Charges for services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body.
4. Charges by the Covered Person for all services and supplies resulting from any Illness or Injury which occurs in the course of employment for wage or profit, or in the course of any volunteer work when the organization, for whom the Covered Person is volunteering, has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including Employees' compensation or liability laws of the United States (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though:
 - A. Coverage for the Covered Person under Workers' Compensation provides benefits for only a portion of the services Incurred;
 - B. The Covered Person's employer/volunteer organization has failed to obtain such coverage required by law;
 - C. The Covered Person waived his/her rights to such coverage or benefits;
 - D. The Covered Person fails to file a claim within the filing period allowed by law for such benefits;
 - E. The Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits; or
 - F. The Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective.
 - G. The Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

This exclusion will not apply to household and domestic employment, employment not in the usual course of the trade, business, profession or occupation of the Covered Person or employer, or employment of a Dependent member of an employer's family for whom an exemption may be claimed by the Employer under the Internal Revenue Code.
5. 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.
6. Charges for non-prescription vitamins or nutritional supplements, **except food supplements for treatment of phenylketonuria or related disorders.**

7. 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.
8. Charges for non-medical expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician.
9. Expenses Incurred by persons other than the person receiving treatment.
10. Charges in excess of the Maximum Eligible Expense.
11. 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. **This exclusion will not apply if all of the following conditions are met:**
 - A. The Physician or Licensed Health Care Provider is on the employed staff of the medical facility in the town or city where the Covered Person resides; and,
 - B. There is no other person at the above described medical facility qualified and licensed to provide the treatment, service or supply; and
 - C. The treatment, service or supply is not available from another Physician or Licensed Health Care Provider located within a 35-mile radius of the Covered Person's home; or
 - D. The treatment, service or supply is for an Emergency.
12. Charges that are incurred outside of the United States if the Covered Person traveled to such a location for the purpose of obtaining treatment, services or drugs.
13. 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.
14. Charges for services, treatment or supplies not considered legal in the United States.
15. Travel Expenses Incurred by any person for any reason.
16. 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.
17. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature, including but not limited to correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia. This includes expenses incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.
18. Charges for preparation of reports or itemized bills in connection with claims, unless specifically requested and approved by the Plan.
19. Charges for services or supplies that are not specifically listed as a Covered Benefit of this Plan.
20. 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.

20. 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.
22. 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.
23. Charges for dental braces or corrective shoes.
24. 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.
25. Charges for treatment, services or supplies not actually rendered to or received and used by the Covered Person.
26. Charges for any surcharge, tax or levies imposed by any state or political subdivision thereof, upon any medical services, treatments or supplies, except as specifically set out in the Medical Benefits section of this Plan.

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 MHN 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 Allowable Expenses will be determined equally between the plans.

COORDINATION WITH MEDICARE

Medicare Part A, Part B and Part D 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 Part B or Part D when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment in Part B or Part D.

1. **For Working Aged**

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

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

2. **For 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.

3. **For Covered Persons with End Stage Renal Disease**

Except as stated below*, for Employees 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:

- the date of service;
- the name of the Participant;
- the name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- the diagnosis [code] of the condition being treated;
- the treatment or service [code] performed;
- the 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 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 3018, Missoula, Montana 59806-3018, (406) 721-2222 or 1-800-877-1122 or through any electronic claims submission system or clearinghouse to which the Plan Supervisor 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 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.

INFORMATION REGARDING URGENT CARE CLAIMS AND PRE-SERVICE CLAIMS IS PROVIDED TO YOU UNDER THE DISCLOSURE REQUIREMENTS OF APPLICABLE LAW; HOWEVER, BECAUSE THIS PLAN DOES NOT REQUIRE PREAUTHORIZATION FOR ANY TREATMENT, THESE URGENT CARE AND PRE-SERVICE TIMING REQUIREMENTS DO NOT APPLY. 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.

1. **Urgent Care Claims** - An Urgent Care Claim is any claim for medical care or treatment with respect to which:
 - A. In the judgement of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
 - B. In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

There are no Urgent Care requirements under this Plan.

2. **Pre-Service Claims** - Pre-Service Claims must be submitted to the Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Covered Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are claims decisions that the Plan requires pre-authorization before a Covered Person obtains medical care.
(There are no Pre-Service requirements under this Plan.)
3. **Post-Service Claims** - A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

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

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

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 and the right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on appeal.

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.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action under Section 502(a) of ERISA. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing, and supporting materials may be submitted via mail, 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 thirty (30) days following the date the Plan Supervisor receives the request for reconsideration.

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

SECOND LEVEL OF BENEFIT DETERMINATION REVIEW

The Plan Administrator 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 Plan Administrator who is neither the original decisionmaker nor the decisionmaker's subordinate. The Plan Administrator cannot give deference to the initial benefit determination. The Plan Administrator 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 Plan Administrator 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, which contains the same information as notices for the initial determination, within the following time periods:

1. **Post-Service Claims** - With regard to an appeal on a Post-Service Claim, the Plan will notify the Covered Person of its appeal decision within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan at each level of review.
2. **Concurrent Care Review** - Decisions on appeals will be made within seventy-two (72) hours if the claim is found to be an Urgent Care Claim, or within fifteen (15) days in all other circumstances.

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 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 an Eligible Employer, 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 Eligible Employer. A Dependent will not be eligible for "dual coverage" if covered by another Eligible Employer under the Montana Health Network Trust.

EMPLOYEE ELIGIBILITY

An eligible Employee under this Plan includes only a person who meets all of the following conditions:

1. Is employed by an Eligible Employer on a regular basis for the minimum number of hours required by the Eligible Employer who employs them or MHN, which minimum number of hours will not be more than twenty-five (25) hours per week; and
2. Is not covered as a Participant or Dependent under the Montana Health Network Trust by any other Eligible Employer.
3. Is in an Eligible Group of Participants listed in the applicable Schedule of Benefits; and

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

WAITING PERIOD

Coverage under the Plan will not start until the Employee completes a Waiting Period. The Waiting Period is determined by each Eligible Employer. The following two Waiting Period options are offered under this Plan:

1. The period of time from the Enrollment Date to the first day of the month following the eligible person's Enrollment Date, even if the Enrollment Date is the first day of the month; or
2. The period of time from the Enrollment Date to the first day of the month following ninety (90) days.

The Waiting Period option selected by the Eligible Employer will apply to all Employees of the Eligible Employer.

The Waiting Period will not apply to any employee of any business entity purchased by an Eligible Employer if the Employee:

1. Continues to be employed by the Eligible Employer; and
2. Is eligible under the terms of this Plan on the date of purchase.

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.

DEPENDENT ELIGIBILITY (For Employees who work at a Montana facility and their dependents)

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 has been assigned by the Employer, and who is either:

1. The Participant'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 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 and has a court order or decree stating such from a court of competent jurisdiction.

2. The Participant's unmarried Dependent who meets all of the following "Required Eligibility Conditions":
 - A. Is a natural child; step-child; legally adopted child; a child who has been Placed with the Participant for adoption and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and
 - B. Is less than twenty-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; and
 - C. Is not an employee eligible for coverage under a group health plan offered by the Dependent child's employer for which the child's premium contribution amount is greater than the premium amount for coverage as a Dependent under this Plan.
 - D. Is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage;
 - E. Is not entitled to benefits under Medicare or Medicaid.

DEPENDENT ELIGIBILITY (For Employees who work at a facility other than Montana and their dependents)

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 has been assigned by the Employer, and who is either:

1. The Participant'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 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 and has a court order or decree stating such from a court of competent jurisdiction.

2. The Participant'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 in the physical custody of and is financially dependent upon the Participant. These conditions are waived if the Participant is required to provide coverage due to a court order or divorce decree for a child not in his/her custody or not wholly dependent upon the Participant; and
 - D. Is less than nineteen (19) 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.
3. The Participant's Dependent who meets the preceding "Required Eligibility Conditions", except for the physical custody condition, and who is a Full-time Student or Full-time Volunteer, as those terms are defined by this Plan, and meets the following conditions:
- A. Is less than twenty-five (25) years of age;
 - B. Is dependent upon the Participant for support;
 - C. Proof of the Dependent's Full-time Student or Full-time Volunteer status must be furnished to the Plan Administrator at the commencement of each term of school or upon commencement of volunteer service. Additional proof may be required from time to time.

The Participant's otherwise eligible Dependent will continue to be classified as a Full-Time Student:

- A. During any break between academic periods recognized by the institution that the Dependent is attending, provided that said Dependent re-enrolls as, and attends the next following academic period (except for summer) as a Full-Time Student.
- B. During any one (1) semester or quarter that the Dependent is required to cease full time attendance as a result of Injury or Illness, provided that the Dependent re-enrolls as, and attends the next following semester or quarter, except summer school, as a Full-Time Student.

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 of up to eighteen (18) months 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 as follows:

1. 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 (30) days immediately following the last day of the Waiting Period imposed by this Plan; or
2. With respect to an employer who becomes an Eligible Employer, on the date said employer becomes an Eligible Employer under this Plan, provided that application for such coverage is made on the Plan's enrollment form within thirty (30) days immediately following such date, regardless of whether the Employee was covered under such employer's previous health coverage, if any; or
3. With respect to Employees of a business entity purchased by an Eligible Employer who meet the eligibility requirements of this Plan on the date of purchase, the effective date of coverage will be the date of purchase, provided that application for such coverage is made on the Plan's enrollment form within thirty (30) days after the date of purchase.

An eligible Employee who declines Participant coverage under the Plan during any of the above Initial Enrollment Periods will be able to become covered either during Open Enrollment, or as a result of a Change in Status or Special Enrollment. For further details regarding enrollment under these provisions, refer to specific subsections entitled "Open Enrollment Period", "Special Enrollment Period" or "Change In Status".

DEPENDENT COVERAGE (For Employees who work at a Montana facility and their dependents)

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 (30) days immediately following the last day of the Waiting Period imposed on Employees by this Plan. 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. With respect to an employer who becomes an Eligible Employer if the Employee of such Eligible Employer makes written request on the Plan's enrollment form for dependent coverage within thirty (30) days immediately after the Employee's Enrollment Date, coverage for those persons who were then his dependents will commence on the Participant's Effective Date of Coverage, regardless of whether the Dependent was covered under such employer's previous health coverage, if any. Enrollment under this subsection will not be considered Late Enrollment.
3. 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.

DEPENDENT COVERAGE (For Employees who work at a facility other than Montana and their dependents)

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 (30) days immediately following the last day of the Waiting Period imposed on Employees by this Plan. 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. With respect to an employer who becomes an Eligible Employer if the Employee of such Eligible Employer makes written request on the Plan's enrollment form for dependent coverage within thirty (30) days immediately after the Employee's Enrollment Date, coverage for those persons who were then his dependents will commence on the Participant's Effective Date of Coverage, regardless of whether the Dependent was covered under such employer's previous health coverage, if any. Enrollment under this subsection will not be considered Late Enrollment.
3. 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.
4. In the event that a Dependent child is nineteen (19) years of age or older, was a Full-Time Student or Full-Time Volunteer, and ceased to be Full-Time Student or Full-Time Volunteer, then that child may re-enroll and become covered as a Dependent if he or she again becomes a Full-Time Student or Full-Time Volunteer and is less than twenty-five (25) years of age as follows:
 - A. If an enrollment form is received by the Plan on or before the last day of the month following the month in which the Dependent re-commences attending classes as a Full-Time Student or becomes a Full-Time Volunteer, coverage will begin on the date that classes or Full-Time Volunteer service begins. Enrollment under this subsection will not be considered Late Enrollment; and
 - B. If application for coverage is received at any time other than as stated in (A.) above, or as an applicable Special Enrollment, the Dependent will be considered a Late Enrollee.

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will be November 15th through December 15th of each year. The following may occur during an Open Enrollment Period:

1. An Employee or 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 makes application for Participant coverage or Dependent coverage under this Plan during an Open Enrollment Period will be considered a Late Enrollee, and subject to a maximum eighteen (18) month Pre-existing Condition exclusionary period, except for individuals eligible for the first time or whose initial eligibility coincides with the Open Enrollment Period. Coverage requested during any Open Enrollment Period will become effective on the first day of January immediately following the Open Enrollment Period.
2. This Plan offers multiple Deductible Options. An eligible Employee may change their Deductible Options during an Open Enrollment Period. **Deductible Options may only be changed with permission of the Eligible Employer.** Such change must be requested on a form approved by the

Plan. Change in the Deductible Option will become effective on the first day of January immediately following the Open Enrollment Period. **A person who changes their Deductible Option during an Open Enrollment Period will not be considered a Late Enrollee.**

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 sixty (60) days of the event.

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) may enroll and will become covered on the date of 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;

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 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 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.

For any Special Enrollment event, the Participant may also elect to change Deductible Options to any Deductible Option offered by the Member Group. The Deductible Option 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 Eligible Employer, he/she may continue his/her coverage as a Dependent and/or elect to be covered as a Participant. Application for coverage due to a Change in Status must be made on the Plan's enrollment form, within thirty (30) days immediately following the date of the Change in Status.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of an Eligible Employer, 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 (30) days immediately following the date of the Change in Status.

An Eligible Employee who is employed by an Eligible Employer on a part-time basis but who is not covered under this Plan, may request Participant or Dependent coverage. Coverage will commence on the first day of the month immediately following the Change in Status, provided that application for coverage is made within thirty (30) days following the Change in Status.

A Change in Status will not be deemed to be a break or termination of coverage and will not operate to reduce or increase 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 Section 609(a) of ERISA, the Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified in accordance with ERISA's requirements, to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.
2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:
 - A. Provides for child support for a child of a Participant under this Plan, or;
 - B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and
 - C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act;
3. "Plan" means this self-funded 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.

ERISA REPORTING AND DISCLOSURE REQUIREMENTS

The Plan Administrator will ensure that the Alternate Recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the Alternate Recipient a copy of the Summary Plan Description and any subsequent Summaries of Material Modifications generated by a Plan amendment.

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) work weeks in any twelve (12) month period for certain family and medical reasons. 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.

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 he/she 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; or (3) to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; or (4) because the Employee's own serious health condition prevents the Employee from performing his or her job.

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 Eligible Employer 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 Eligible Employer's current Employee Personnel Policy Manual 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 Eligible Employer 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, the amount of 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.

DEPENDENT TERMINATION (For Employees who work at a Montana facility and their dependents)

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 Eligible Employer 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.

DEPENDENT TERMINATION (For Employees who work at a facility other than Montana and their dependents)

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 Eligible Employer 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 September for any year that the Dependent does not return as a Full-time Student for the Fall term or is not enrolled as a Full-time Student on the last day of September, provided the Dependent completed the prior Spring term as a Full-time Student; or
10. On the last day of January for any year that the Dependent does not return as a Full-time Student for the Spring term or is not enrolled as a Full-time Student on the last day of January, provided the Dependent completed the prior Fall term as a Full-time Student; or
11. On the last day of the month in which the Dependent ceases to be a Full-time Volunteer, unless an otherwise eligible dependent who ceases to be a Full-time Volunteer, enrolls as a Full-Time Student, for the next semester or quarter immediately following loss of Full-Time Volunteer status; or
12. 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.

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 as a result of re-employment or reduction in hours with the same Eligible Employer or re-employment with a different Eligible Employer under the Plan 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 on the first of the month following the date of renewed eligibility, if covered on the date of termination, provided that application for such coverage is made on the Plan's enrollment form within thirty (30) days after the date of renewed eligibility. Reinstatement of Coverage is subject to the following:

1. COBRA Continuation Coverage has been continuously maintained under this Plan until the date coverage is reinstated.
2. 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.
3. 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. However, such carryover amounts will not exceed the Maximum Deductible and Out-of-Pocket Maximum of the Deductible Option selected under the coverage of the subsequent Eligible Employer.
4. The Participant cannot change Medical Deductible Options unless the same Medical Deductible Option selected under the prior Eligible Employer is not available with the subsequent Eligible Employer.
5. Reinstatement is not available if the HSA Option was selected under the prior Eligible Employer but not available under the subsequent Eligible Employer.
5. All prior accumulations toward annual or lifetime benefit maximums will apply.
6. 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.

CONTINUATION COVERAGE AFTER TERMINATION

Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 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.

The Plan Administrator is Montana Health Network at 11 South 7th Street, Suite 241, Miles City, MT 59301; 406-234-1420. 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.
 - 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 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.
2. The divorce or legal separation of the Participant 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 of 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 of 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 of 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 of hours) of employment of the former employee if that former employee enrolled in Medicare before termination (or reduction of 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.; P.O. Box 2097; Missoula, MT 59806 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.
 - A. For purposes of this subsection, a timely manner means the following:
 - 1) 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.
 - 2) 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, age, or full-time student status, 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, age, full-time student status, 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, erroneous, false information or omissions of information provided or omitted by the Employee will be reimbursed to the Plan by the Employee. The Employee's failure to reimburse the Plan after demand is made may result in an interruption in or loss of benefits to the Employee, and could be reported to the appropriate governmental authorities for investigation of criminal fraud and abuse.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine. By receipt of benefits under this Plan, each Covered Person authorizes the deduction of any excess payment from such benefits or other present or future compensation payments.

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

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. Reimbursement means to repay a party who has paid something on another's behalf. If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was actually responsible or liable to pay 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 third parties who are legally responsible to the Covered Person for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover the money paid under the Plan. In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to the Covered Person's accident, Injury, condition or Illness, which the Plan paid, then the Plan is entitled to recover, by legal action or otherwise, the money

paid; in effect, the Plan has the right to “stand in the shoes” of the Covered Person for whom benefits were paid, and to take any action the Covered Person could have undertaken to recover the money paid.

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 third party responsible for an accident, Injury, condition or Illness, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. The Covered Person receiving payment from this Plan will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the Plan’s right of recovery.
3. The Covered Person will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any monies paid by the Plan from any party other than the Covered Person who is liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Plan Administrator, upon request and in a timely manner, of all material facts regarding the accident, Injury, condition or Illness; all efforts by any person to recover any such monies; providing the Plan Administrator with any and all documents, papers, reports and the like regarding demands, litigation or settlements involving recovery of monies paid by the Plan; and notifying the Plan Administrator of the amount and source of any monies received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.
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, notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

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 and their covered Dependents.

It is the intention of MHN to establish a program of benefits constituting an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

EFFECTIVE DATE

The effective date of the Plan is January 1, 1993.

PLAN YEAR

The Plan Year will commence January 1st and end on the last day of December of each year.

PLAN SPONSOR

The Plan Sponsor is Montana Health Network, Inc.

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 the Trust Administration Committee of Montana Health Network, Inc., a Montana corporation, who 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:

MHN will from time to time evaluate the costs of the Plan and determine the amount to be contributed by each Eligible Employer. The amount to be contributed, if any, by each Participant will be determined by the Eligible Employer, subject to the terms and rules of MHN.

Each Eligible Employer provides contributions for coverage under this Plan for at least a portion of the cost of coverage. The Participant may be required to provide a portion of contributions for either Participant or Dependent coverage or a portion of the contribution for both. The determination of the

contribution to be provided by the Eligible Employer and the Participant will be made by the Eligible Employer in accordance with the terms and conditions of the Plan. No portion of contributions for COBRA Continuation Coverage will be paid by the Eligible Employer or the Plan. Specific information regarding the actual amount of any contribution for coverage under this Plan may be obtained from the applicable Eligible Employer. 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.

If MHN terminates the Plan, Eligible Employers and Participants will have no obligation to contribute to the Plan after the date of termination.

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 Trust Administration Committee or any other individual designated by MHN's management. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the Trust Administration Committee or any other individual designated by MHN's management, pursuant to a corporate policy, granting that individual the authority to amend, modify, revoke or terminate this Plan. A copy of the executed policy will be supplied to the Plan Supervisor. 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

MHN reserves the right at any time to terminate the Plan by a written notice. All previous contributions by MHN 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 be issued 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

CERTIFICATION OF CREDITABLE COVERAGE

The Plan will provide Certification of Creditable Coverage for coverage under this Plan as required by the United States Department of Labor 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, Certification 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 exclusion imposed by this Plan for any Pre-existing Condition 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 Certification 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 Certification 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 Certification 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 exclusionary 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 Certification 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.

GUARANTEED RENEWABILITY

This Plan will not refuse to renew, cancel or deny any current or future coverage to any Eligible Employer or its employees except for any of the following reasons:

1. For nonpayment of contributions;
2. For fraud or other intentional misrepresentation of material fact by the Eligible Employer;
3. For noncompliance with material plan provisions;

4. The Plan ceasing to offer any coverage in a geographic area;
5. In the case of a Plan that offers benefits through a network plan, there is no longer any individual enrolled through the Eligible Employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of Eligible Employers or any health status-related factor in relation to such individuals or their dependents; and
6. For failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the Plan, or to employ employees covered by such an agreement.

GENERAL PROVISIONS

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during pendency of the claim hereunder. The Plan will also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

PAYMENT OF CLAIMS

All Plan benefits are payable to a Participant, Qualified Beneficiary or Alternate Recipient, whichever is applicable. All or a portion of any benefits payable by the Plan may, at the Covered Person's option and unless the Covered Person requests otherwise in writing not later than the time of filing the claim, be paid directly to the health care provider rendering the service, if proper written assignment is provided to the Plan. 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 legally qualified Physician, Licensed Health Care Provider or surgeon and the Physician-patient 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 Eligible Employer the right to be retained in the service of an Eligible Employer, or to interfere with the right of an Eligible Employer 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.

ACTIVE SERVICE

“Active Service” means that an Employee is in service with an Eligible Employer on a day which is one of the Eligible Employer's regularly scheduled work days and that the Employee is performing all of the regular duties of his/her employment with the Eligible Employer on a regular basis, either at one of the Eligible Employer's business establishments or at some location to which the Eligible Employer's business requires him/her to travel.

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.

ALCOHOLISM

“Alcoholism” means a morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health, social or economic functioning.

AMBULANCESERVICE

“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 applicable 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 facility staffed by Physicians, which is licensed as a Birthing Center in the jurisdiction where it is located.

CALENDAR YEAR

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

CLOSE RELATIVE

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

COBRA

“COBRA” means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

“COBRA Continuation Coverage” means the coverage provided under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 and its amendments.

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.

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 during each Benefit Period.

DENTAL HYGIENIST

“Dental Hygienist” means a person who is licensed to practice dental hygiene and who works under the supervision and direction of a Dentist.

DENTALLY NECESSARY

“Dentally 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 a Dental condition or dental disease; and,
2. Are ordered by a Dentist or Licensed Health Care Provider and consistent with the symptoms or diagnosis and treatment of the dental condition or dental disease; and,
3. Are not primarily for the convenience of the Covered Person, Dentist 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 dental, medical or other research; and,
7. Do not involve excessive, unnecessary or repeated tests; and,
8. Are commonly and customarily recognized by the dental 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, The Centers for Medicare/Medicaid Services (CMS), or American Dental Association, pursuant to that entity’s program oversight authority based upon the dental treatment circumstances.

DENTIST

“Dentist” means a person holding one of the following degrees—Doctor of Dental Science, Doctor of Medical Dentistry, Master of Dental Surgery or Doctor of Medicine (oral surgeon) -- who is legally licensed as such to practice dentistry in the jurisdiction where services are rendered, and the services rendered are within the scope of his or her license.

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

DENTURIST

A dental technician, duly licensed, specializing in the making and fitting of dentures.

DEPENDENT

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

DEPENDENT COVERAGE

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

DURABLE MEDICAL EQUIPMENT

“Durable Medical Equipment” means equipment which is:

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

ELIGIBLE EMPLOYER

“Eligible Employer” means MHN and a proprietorship, partnership, corporation or other business entity which is a member of the Montana Health Network and has adopted this Plan for its Employees.

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 the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer’s W-2 payroll.

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 Employer as a contract worker, independent contractor, temporary, seasonal or casual employee, whether or not any such persons are on the Employer’s W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as “Kelly,” “Manpower,” etc.

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.

ERISA

“ERISA” refers to the Employee Retirement Income Security Act of 1974, as amended.

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.

FULL-TIME STUDENT

“Full-Time Student” means a person who is currently enrolled in and regularly attending an accredited secondary school, college, university or technical school as a Full-Time Student as that term is defined by such school's admission and attendance policy regarding Full-Time Student status.

FULL-TIME VOLUNTEER

“Full-Time Volunteer” means a person who is currently enrolled as an unpaid volunteer worker in a full-time service project sponsored by an organized religion, non-profit corporation or public agency for a period of time expected to last for ninety (90) days or more.

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.

LOCAL PRIMARY CARE PROVIDER

“Local Primary Care Provider” means a Physician, Physician Assistant or Nurse Practitioner, working in family practice, general practice, internal medicine practice, pediatrics or obstetrics/gynecology (OB/GYN) who is:

1. An active member on the medical staff of an Eligible Employer under which the Covered Person is covered; or
2. If the Eligible Employer under whom the Covered Person is covered has no Primary Care Provider on staff, a Primary Care Provider at the Montana Health Network facility that is geographically closest to the Covered Person’s primary physical residence.

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 lifetime maximum 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 not obtained through the Plan’s Pharmacy Drug Program 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 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 Substance Abuse/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.

MONTANA HEALTH NETWORK (MHN)

“MHN” means the Participating Hospitals and facilities within Montana Health Network, together with a defined geographic area in which most such facilities and hospitals are located.

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 APPLIANCE

“Orthopedic Appliance” 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 Deductible Options, that any Covered Person or Family will pay in any Benefit Period for covered services, treatments or supplies.

OUTPATIENT

“Outpatient” means a Covered Person who is receiving medical care, treatment, services or supplies at a clinic, a Physician’s office, a Licensed Health Care Provider’s office or at a Hospital if not a registered bedpatient at that Hospital, Psychiatric Facility or Substance Abuse/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 Eligible Employer 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 Eligible Employers, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

“Plan Administrator” means MHN and the Trust Administration Committee 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 Employee Retirement Income Security Act of 1974, as amended, and any applicable state legislation of a similar nature, MHN will be deemed to be the Plan Administrator of the Plan unless by action of the Board of Directors, MHN designates an individual or committee to act as 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 ERISA (Employee Retirement Income Security Act) 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, 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 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, or in the case of Covered Dental Benefit, means any device which replaces all or part of a missing tooth or teeth.

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.

QUALIFIED BENEFICIARY

“Qualified Beneficiary” means an Employee, former Employee or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA or Section 609(a) of ERISA in relation to QMCSO's.

“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.

QMCSO

“QMCSO” means Qualified Medical Child Support Order as defined by Section 609(a) of ERISA, as amended.

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.

REHABILITATION THERAPY

“Rehabilitation Therapy” means specialized treatment monitored/provided by a Multi-disciplinary Team providing multi-modality treatment in either an inpatient or outpatient basis for an Injury, Illness or physical deficit, with the purpose of restoring or bringing body function to a condition of function as near as possible to what it was before the illness or loss of body part or body function. Rehabilitative services include, but are not limited to, physical therapy, occupational therapy, speech therapy and cardiac rehabilitation.

Care provided must be under the direction of a qualified physician and have a formal written treatment plan with a specific goal.

“Multi-disciplinary Team” in this context is a group of health service providers who must be either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided.

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.

ROUTINE CARE

“Routine 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.

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 licensed to provide, on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities; and
2. The Facility's services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse; and
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse; and
4. It maintains complete medical records on each patient; and
5. It has an effective utilization review plan; and
6. 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
7. It is approved and licensed 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.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

“Substance Abuse” or “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.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY TREATMENT FACILITY

“Substance Abuse/Chemical Dependency Treatment Facility” means a licensed institution which provides a program for diagnosis, evaluation, and effective treatment of Substance Abuse/Chemical Dependency; provides detoxification services needed with its effective treatment program; provides infirmity-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.

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.

ERISA STATEMENT OF RIGHTS

As a Participant in your Employer's Health Benefit Plan you are entitled to certain rights and protections under the Employees Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report upon request.
4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right receive a written explanation of the reason why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial for a full and fair review and reconsideration by the Plan Administrator, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to one hundred and ten dollars (\$110.00) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part (an Adverse Benefit Determination), you may file suit in a state or federal court once you have exhausted your appeal rights under the Plan's claims and appeals procedures. If you believe the Plan fiduciaries have misused Plan assets, or that you have been discriminated against for asserting your rights under ERISA, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide which party will pay the court costs and legal fees. The court may order the losing party to pay these court costs and fees. You may be ordered to pay these costs and fees if you lose and the court finds your claim to be frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, you should contact the nearest office of the U.S. Department of Labor, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210, (866) 444-3272, or www.dol.gov/ebsa.

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

IDENTIFICATION OF FUNDING: Your benefits under this plan will be paid from employee or employer contributions up to the limits defined in the Plan Document and Summary Plan Description (SPD). Benefits in excess of the amount stated in the stop loss policy are reimbursable to the employer by stop loss insurance, pursuant to the stop loss insurance contract or policy, subject, however, to the terms of this Plan and the stop loss insurance contract.

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 zip code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or plan participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan 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.

**HEALTH BENEFIT PLAN FOR EMPLOYEES OF
THE MONTANA HEALTH NETWORK
HEALTH INSURANCE PLAN AND TRUST
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 HEALTH BENEFIT PLAN FOR PARTICIPANTS IN THE MONTANA HEALTH NETWORK HEALTH INSURANCE PLAN AND TRUST, 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 January 1, 1993.

4. PLAN SPONSOR

Name: Montana Health Network
Address: 11 South 7th Street, Suite 241
Miles City, MT 59301
Phone: 406-234-1420

5. PLAN ADMINISTRATOR

The Plan Administrator is the Plan Sponsor.

6. NAMED FIDUCIARY

Name: Montana Health Network
Address: 11 South 7th Street, Suite 241
Miles City, MT 59301

7. PLAN FISCAL YEAR

The Plan fiscal year ends December 31st.

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: 1000100 et seq.
Employer Identification Number: 81-6073209

10. PLAN SUPERVISOR

Name: Allegiance Benefit Plan Management, Inc.
Address: P.O. Box 3018
Missoula, MT 59806

11. ELIGIBILITY

Employees and dependents of employees of the 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 the employer and employees.

13. AGENT FOR SERVICE OF LEGAL PROCESS

The Plan Administrator has authority to control and manage the Plan and is the agent for service of legal process.
