



Missoula County Employee Benefits Plan Summary Plan Description

July 1, 2020

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July 2020

Benefit Plan Members:

This booklet is a summary of the Missoula County Employee Benefits Plan (MCEBP). It contains information regarding the medical, dental and vision benefits available through MCEBP. Life insurance benefits are described in a separate document. This booklet and other benefit information are available on the internet at www.mcebp.com.

The medical, dental and vision benefits are self-funded programs. Claims administration is managed by the Missoula County Risk and Benefits Office. If you are a county employee, you can obtain eligibility and enrollment assistance from the Human Resources Office. If you are an outside agency employee, you can obtain this information from your designated employer representative. All MCEBP members may contact the Risk and Benefits Office with questions about their claims or benefits.

The following list presents the employers who participate in MCEBP and the benefits for which you may be eligible:

Employer	Medical	Dental	Vision	Life
Missoula County	YES	YES	YES	YES
Airport Authority	YES	YES	YES	YES
Art Museum	YES	YES	YES	YES
Frenchtown Fire District	YES	YES	YES	NO
Larchmont Golf Course	YES	YES	YES	YES
Missoula Aging Services	YES	YES	YES	YES
Missoula Rural Fire District	YES	YES	YES	NO
Seeley Lake Rural Fire District	YES	YES	YES	NO
Special Education Cooperative	YES	YES	YES	YES
Missoula Urban Transportation District	YES	YES	YES	NO

You should take advantage of a written preauthorization whenever possible. It is your medical care, and you deserve to know how much it will cost. Call us if you have any questions.

Sincerely,
Erica Grinde
Plan Administrator

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Introduction

Missoula County has prepared this booklet to help you understand your benefits. Please read it carefully. Your benefits are affected by certain limitations and conditions. Also, benefits are not provided for certain kinds of treatments or services, even if your physician or dentist recommends them.

As used in this booklet, the word, “year,” refers to the benefit year. The benefit year is the 12-month period beginning July 1 and ending June 30. All annual benefit maximums accumulate during the benefit year, except as otherwise specified in MCEBP.

Your medical, dental and vision benefits are grouped under separate coverages. You may not necessarily have all coverages.

As a covered member of MCEBP, your rights and benefits are determined by the provisions of the plan. Although this plan may be continued indefinitely, the employer does have the right to change or terminate it at any time.

All medical, dental and vision coverages provided by MCEBP comply with federal and state legislation as amended for self-insured municipal plans. MCEBP is not in lieu of, and does not affect, any requirements for coverage by Workers’ Compensation insurance.

Benefits described in this booklet are effective July 1, 2020.

If any conflicts should arise between this booklet and MCEBP, or if the booklet does not adequately describe a plan provision, the terms of the actual plan document will prevail. A copy of MCEBP is available in the Risk and Benefits Office and online at www.mcebp.com.

Neither this booklet nor the plan document is to be construed as an employment agreement.

Missoula County Employee Benefits Plan HIPAA Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Use and Disclosure of Health Information

MCEBP may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for purposes of making or obtaining payment for your care and conducting health care operations. MCEBP has established a policy to guard against unnecessary disclosure of your health information. MCEBP may use or disclose your health information for the following reasons.

To Make or Obtain Payment

MCEBP may use or disclose your health information to make payments to or collect payments from third parties, such as health plans or providers, for the care you receive. For example, MCEBP may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations

MCEBP may use or disclose health information for its own operations to facilitate the administration of MCEBP and as necessary to provide coverage and services to all MCEBP participants. Health care operations include such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development, including cost management and planning-related analysis and formulary development.
- Business management and general administrative activities of MCEBP, including customer service and resolution of internal grievances.

For Treatment Alternatives

MCEBP may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services

MCEBP may use or disclose your health information to provide information to you on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor

MCEBP may disclose your health information to the plan sponsor for plan administration functions performed on behalf of MCEBP. In addition, MCEBP may provide summary health information to the plan sponsor to solicit premium bids from health insurers to modify, amend or terminate the plan. Also, MCEBP may disclose information on whether you are participating in the health plan.

When Legally Required

MCEBP will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities

MCEBP may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. MCEBP, however, may not disclose your health information if you are the subject of an investigation; and the investigation does not arise out of, or is not directly related to, your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings

As required by state law, MCEBP may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request or other lawful process, but only when MCEBP makes reasonable efforts either to notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes

As required by state law, MCEBP may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, 1) a suspicion that your death was the result of criminal conduct or, 2) an emergency requiring the report of a crime.

In the Event of a Serious Threat to Health or Safety

MCEBP may, consistent with applicable law and ethical standards of conduct, disclose your health information if MCEBP, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions

In certain circumstances, federal regulations require MCEBP to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security, intelligence activities, protective services for the President and others, and correctional institutions and inmates.

For Workers' Compensation

MCEBP may release your health information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.

Authorization to Use or Disclose Health Information

Except as stated above, MCEBP will not disclose your health information without your written authorization. If you authorize MCEBP to use or disclose your health information, you may revoke that authorization in writing at any time.

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on MCEBP disclosure of your health information to someone involved in the payment of your care. However, MCEBP is not required to agree to your request.

Right to Receive Confidential Communications

You have the right to request that MCEBP communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that MCEBP only communicate with you at a certain telephone number or by email. MCEBP will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. Any request must be in writing. If you request a copy of your health information, MCEBP may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request that MCEBP amend the records. Your request may be made as long as the information is maintained by MCEBP. Any request must be in writing. MCEBP may deny the request if, 1) it does not include a reason to support the amendment, 2) your health information records were not created by MCEBP, 3) the health information you are requesting to amend is not part of MCEBP records, 4) the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or 5) MCEBP determines the records containing your health information are accurate and complete.

Right to an Accounting

You have the right to request a list of certain disclosures of your health information that MCEBP is required to keep according to the privacy rule, such as disclosures for public purposes authorized by law, or disclosures that are not in accordance with the plan's privacy policies and applicable law. The request must be in writing. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2004. Accounting requests may not be made for periods of time dating back more than six (6) years. MCEBP will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. MCEBP will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice

You have the right to request a paper copy of this notice at any time, even if you have received it previously or agreed to receive it electronically.

Duties of MCEBP

By law, MCEBP is required to maintain the privacy of your health information and to provide you with this notice. Additionally, MCEBP is required to abide by the terms of this notice, which may be amended from time to time. MCEBP reserves the right to change the terms of this notice and to make the new notice provisions effective for all health information that it maintains. If MCEBP changes its policies and procedures, it will revise the notice and will provide a copy to you within sixty (60) days of the change. You have the right to express complaints to MCEBP and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to MCEBP should be in writing. MCEBP encourages you to express any concerns you may have regarding the privacy of your information. No retaliation will result for filing a complaint.

Contact Person

MCEBP has designated the Plan Administrator as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person by mail at 200 West Broadway, Missoula, MT 59802, by telephone at (406) 523-4876, by fax at (406) 523-4731, or by email at benefits@missoulacounty.us.

Effective Date

This notice became effective April 14, 2004

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 Ensure that the adequate separation required between the Plan and the Plan Sponsor is established.
10. 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.

Definitions

The following terms define specific wording used in MCEBP. These definitions should not be interpreted to extend coverage, unless specifically provided for under Medical Benefits, Dental Benefits or Vision Benefits. Other terms are defined where they are first used in the text of MCEBP.

Accident

A definitive impairment of function or a traumatic injury to the body, resulting from external unintentional causes beyond the control of the injured person.

Adverse benefit determination

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:

- (1) based on a determination of an Employee's or Dependent's eligibility to participate in the Plan;
- (2) a benefit resulting from the application of any utilization review; and
- (3) an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational Treatment or not Medically Necessary or appropriate.

An Adverse Benefit Determination includes a rescission of coverage, whether or not the rescission creates an adverse effect on any particular benefit at the time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect.

Affordable Care Act

The rights and obligations prescribed in the Patient Protection and Affordable Care Act of 2010 (ACA), as amended.

Alternative medicine

A benefit category limited to:

- Acupuncture
- Biofeedback/neurofeedback,
- Body talk
- Compound pharmaceuticals from a licensed pharmacist when not covered by the pharmacy benefit.
- Massage therapy
- Phototherapy light boxes
- Portable air cleaner with a maximum of one per plan year.
- Rolfing therapy
- Weight loss program overseen by a medical professional with a maximum of one program per plan year.

Ambulance

A specifically designed and equipped automobile or other vehicle such as an airplane, boat or helicopter which meets all local, state and federal regulations for transporting the sick and injured.

Ambulatory surgical facility/surgical center

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. Facilities must have an organized medical staff of physicians, maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures, and supply registered professional nursing services whenever a patient is in the facility.

Amendment

A formal document signed by the Board of County Commissioners of Missoula County. The amendment adds, deletes or changes the provisions of MCEBP.

Authorized representative

A person that acts on behalf of the Claimant with respect to claims and/or appeals processes. No person will be recognized as an Authorized Representative without a signed form of release by the Claimant except in the case of an urgent care claim, in which case the provider of services has the authority to act as the Authorized Representative. A health care provider or other assignee is not an Authorized Representative simply by virtue of the assignment of benefits.

Benefit year

The 12-month period beginning July 1 and ending June 30.

Claim

A claim for a Plan benefit that is made in accordance with the Plan's claims procedures.

Claimant

A person, or his or her Authorized Representative, who makes a Claim for a Plan benefit under Plan's claims procedures.

COBRA

Rights and obligations regarding continuation of insurance that are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

Coinsurance

The portion of covered charges that, after the deductible, is the responsibility of the covered person.

Cosmetic procedure

A procedure performed to improve a covered person's appearance rather than to improve or restore a bodily function.

Covered person

An employee, retired employee or dependent, who meets eligibility standards, who has completed the enrollment requirements, and for whom an appropriate contribution or payroll deduction has been made for the current month; also, anyone eligible for continued coverage as required by COBRA.

Deductible

The amount of covered medical and/or prescription drug expenses that you and your covered dependent(s) have to pay each benefit year before MCEBP will start to pay benefits. The deductibles apply only to medical and prescription drug benefits, not to dental or vision.

Dependent

The legal spouse of an employee or retired employee, the domestic partner of an employee or retired employee, or any child of the employee or domestic partner who is under 26 years of age.

Domestic partner

The unmarried person at least 18 years of age who has lived with the employee on a continuous basis for at least 12 months in a common residence, has no other domestic partner, is not related to the employee by blood or marriage and is financially interdependent with the employee. The employee and the domestic partner must be engaged in a committed relationship of mutual caring and support and intend to remain so indefinitely. The employee and the domestic partner shall sign a sworn statement in evidence of their relationship and provide such further proof of domestic partnership as required by the employer and the Plan Administrator.

Durable medical equipment

Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury.

Elective surgical procedure

Any nonemergency surgical procedure, which may be scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment.

Employee

Person employed by Missoula County at least 20 hours per week on a regular and continuous basis, or an employee of an outside organization, bureau or agency, as approved by the Plan Administrator.

Employer

Missoula County, or any participating outside organization, bureau or agency that has the written approval of Missoula County and has adopted MCEBP for its employees.

Expenses incurred

Costs for which a covered person becomes obligated to pay. The expense of a service is incurred on the day the service is provided and the expense of supplies is incurred on the day the covered person receives them.

Experimental/investigational treatment

See Medical Expenses Not Covered.

External appeal

A review of an Adverse Benefit Determination, after the internal appeal process has been exhausted, conducted in accordance with applicable state or federal external review procedures.

Hospice

A program or facility designed to provide palliative and supportive care to individuals who have been diagnosed with a terminal illness. Supportive care is provided to the terminal patient and to eligible family members. A hospice must be licensed or certified under the laws of the state.

Hospital

A facility that provides diagnostic and treatment services for inpatient surgical and medical care of persons who are injured or ill. It must be licensed under applicable laws as a general hospital or accredited by the Joint Commission on Accreditation of Hospitals. Its services must be under the supervision of a staff of physicians and must include 24-hour-a-day nursing services by registered nurses.

Facilities that are primarily for rest, old age or custodial care, are not hospitals.

Veterans' hospitals are eligible for reimbursement, except when the treatment is related to military services.

Illness

Any bodily sickness, pregnancy, disease or mental/nervous disorder.

Incidental procedure

A non-covered surgical procedure performed at the same operative site as a covered procedure.

Incomplete claim

A claim that fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan's claims procedures.

Incorrectly filed claim

A claim for a Plan benefit that is not made in accordance with the Plan's claims procedures.

Internal appeal

A review by the Plan Administrator of an Adverse Benefit Determination pursuant to the Plan's internal claims and appeals procedures.

Injury

A condition independent of an illness, resulting from an accident or external force.

Inpatient/outpatient psychiatric or chemical dependency treatment facility

A hospital or other facility, accredited by the Joint Commission on Accreditation of Hospitals, which provides full-day acute treatment of alcoholism, drug addiction or mental illness and is licensed to admit patients who require 24-hour-a-day skilled nursing care.

The chemical dependency treatment center must be approved by the appropriate state agency. The mental and nervous treatment facility must be certified as an eligible provider by Medicare.

Maternity care

Regular obstetrical care, including delivery and cesarean section for a covered employee or covered spouse of an employee.

Maximum Allowance

The maximum amount considered for payment of any covered treatment, service or supply, subject to all Plan maximum benefit limits – shall be determined as follows:

1. A contracted amount as established by a preferred provider or other discounting contract; or,
2. An amount established based upon a prevailing fee schedule for non-facility; or,
3. An amount not to exceed 200% of Medicare allowable fee for facility charges.

Medical emergency

An illness or injury which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible hospital equipped to furnish care, to prevent the death or serious impairment of the covered person.

Such conditions include, but are not limited to, suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in accident cases and other acute conditions.

Medically necessary

Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluation, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standard of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

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

Medically necessary (for Autism, Asperger's Disorder and Pervasive Developmental Disorder)

Any care, treatment, intervention, service, or item that is prescribed, provided or ordered by a physician or psychologist and that will or is reasonably expected to,

- Prevent the onset of an illness, condition, injury, or disability,
- Reduce or improve the physical, mental, or developmental effects of an illness, condition, or injury, or disability; or
- Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for the child of the same age.

Network provider

An in-network provider is one contracted with the Plan to provide services to plan members for specific pre-negotiated rates. An out-of-network provider is one not contracted with the Plan. Typically, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider. Though there are some exceptions, in many cases, the Plan will either pay less or not pay anything for services you receive from out-of-network providers.

Orthotics, Custom

A medically necessary custom-molded orthotic.

Outpatient

Treatment either outside of a hospital setting or at a hospital where room and board charges are not incurred.

Plan

The Missoula County Employee Benefits Plan (MCEBP).

Plan Administrator

Person responsible for the day-to-day functions and management of the plan.

Plan document

The written legal description of the plan.

Plan sponsor

Missoula County.

Preauthorization

Approval by the plan for coverage of specific services, supplies, or drugs before they are provided to the member.

Preventive services

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Professional provider

Professionals acting within the scope of their state license, providing eligible services covered by MCEBP, including:

- Advanced practice registered nurse,
- Acupuncturist,
- Board Certified Behavior Analyst for the treatment of autism,
- Chiropractor,
- Dentist (doctor of medical dentistry or doctor of dental surgery),
- Hospice employee,
- Licensed professional counselor, licensed chemical dependency counselor or licensed social worker,
- Massage therapist, licensed or certified professional provider,
- Midwife,
- Naturopath,
- Nurse practitioner,
- Licensed or Registered Nutritionist/Dietician,
- Occupational therapist,
- Ophthalmologist,
- Optometrist,
- Physical therapist,
- Physician (doctor of medicine or osteopathy),
- Physician's assistant or other class of physician employees who provide services to patients at the direction of the physician,
- Podiatrist,
- Psychiatrist,
- Psychologist
- Registered nurse,
- Speech therapist.

Psychiatric treatment

Treatment or care for a mental disease or disorder or functional nervous disorder by a licensed psychiatrist, psychologist, physician, licensed professional counselor, licensed chemical dependency counselor, licensed social worker or psychiatric advanced practice registered nurse.

Qualified medical support order

Any child of a Covered Employee who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan. Plan Administrator approval is required. A Covered Individual of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Retired employee

An employee who has retired from active service with the employer, is eligible for retirement benefits through the Montana Public Employees Retirement System (MPERS) and has elected in writing to continue with the plan for medical, dental or vision benefits.

Retired employee also refers to an employee who would have been eligible for retirement benefits, except for the optional membership of MPERS.

An employee of an outside agency that participates in this plan, but does not participate in MPERS, is eligible to continue health insurance as a retired employee, provided the employee, in the opinion of the Plan Administrator, would have qualified for retirement benefits of MPERS if the employee had been a member of MPERS.

The surviving spouse or domestic partner of a deceased employee is eligible to continue his benefits, provided the deceased employee was, on the date of death, eligible for retirement benefits through MPERS.

Risk and Benefits Office

The people who process claims and payments of benefits according to MCEBP.

Standard of care

A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance. The level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

Surgery

An operative or diagnostic procedure for treatment of illness or injury through an incision or natural body opening by cutting, laser, or use of any instrument. Surgery also includes treatment of fractures, dislocations and burns.

Trust

MCEBP bank account maintained for medical, dental, vision, life and disability coverages.

Chart of Eligibility

Late enrollment applies to Medical and Dental, but not Vision.

If This...	Then This...
Employee (E.)	
E.1 Employee enrolls within 31 days of initial eligibility.	Coverage is effective on the 1st day of the month, following 60 continuous days of employment.
E.2 Employee does not enroll within 31 days of initial eligibility, but signs a waiver on account of other coverage and later wants to enroll due to losing other coverage. A waiver is not required for those employed before July 1, 1998.	Employee may enroll in a special enrollment if he loses other coverage and can document it. Employee must enroll within 31 days of losing other coverage. Coverage is effective on the 1st day of the month following enrollment.
E.3 Employee does not enroll within 31 days of initial eligibility, but signs a waiver on account of other coverage and later wants to enroll for reasons other than losing other coverage.	Employee is able to enroll only in a late enrollment in the month of May with coverage effective July 1st. However, employee may enroll in a special enrollment upon gaining new dependents, e.g., spouse, domestic partner, dependent child(ren). Employee must enroll within 31 days of gaining the spouse, domestic partner or dependent child(ren). Coverage is effective on the 1st day of the month following enrollment; however, coverage added for newborn, newly adopted or newly placed for adoption dependent children (and other eligible dependents added at this time) will be effective retroactive to the date of birth, adoption or placement.

If This...

Then This...

E.4

Employee does not enroll within 31 days of initial eligibility, does not sign a waiver on account of other coverage and later wants to enroll due to losing other coverage.

Employee may not enroll in a special enrollment if he loses other coverage, unless he was employed before July 1, 1998. Employee is able to enroll only in a late enrollment in the month of May with coverage effective July 1st.

However, employee may enroll in a special enrollment upon gaining new dependents, e.g., spouse, domestic partner, dependent child(ren). Employee must enroll within 31 days of gaining the spouse, domestic partner or dependent child(ren). Coverage is effective on the 1st day of the month following enrollment; however, coverage added for newborn, newly adopted or newly placed for adoption dependent children (and other eligible dependents added at this time) will be effective retroactive to the date of birth, adoption or placement.

E.5

Employee does not enroll within 31 days of initial eligibility, does not sign a waiver on account of other coverage and later wants to enroll due to a change in employment status resulting in higher employer contributions.

Employee may enroll in a special enrollment. Employee must enroll within 31 days of the status change. Coverage is effective on the 1st day of the month following enrollment.

Employee Dependent (ED.)

ED.1

Employee enrolls self, eligible spouse, domestic partner and/or dependent child(ren) within 31 days of employee's initial eligibility.

Coverage is effective on the 1st day of the month following 60 continuous days of employment.

ED.2

Employee enrolls self, but signs a waiver and does not enroll eligible dependent(s) within 31 days of employee's initial eligibility on account of other coverage. A waiver is not required for those employed before July 1, 1998.

An eligible dependent may enroll in a special enrollment if he loses other coverage and can document it. Eligible dependent(s) must enroll within 31 days of losing other coverage. Coverage is effective on the 1st day of the month following enrollment.

If This...

Then This...

ED.3

Employee enrolls self, does not enroll eligible dependent(s) within 31 days of employee's initial eligibility, and signs a waiver, but later wants to enroll eligible dependent(s) for reasons other than losing other coverage.

An eligible dependent may enroll only in a late enrollment in the month of May with coverage effective July 1st. However, an eligible dependent may enroll in a special enrollment when employee gains a spouse, domestic partner or other dependent child(ren). Employee and eligible dependent(s) must enroll within 31 days of employee gaining the spouse, domestic partner or dependent child(ren). Coverage is effective on the 1st day of the month following enrollment; however, coverage added for newborn, newly adopted or newly placed for adoption dependent children (and other eligible dependents added at this time) will be effective retroactive to the date of birth, adoption or placement.

ED.4

Employee does not enroll self and eligible dependent(s) within 31 days of employee's initial eligibility, but signs a waiver on account of other coverage and later wants to enroll due to losing other coverage.

Employee and eligible dependent(s) may enroll in a special enrollment if they lose other coverage and can document it. Employee and eligible dependent(s) must enroll within 31 days of losing other coverage. Coverage is effective on the 1st day of the month following enrollment.

ED.5

Employee does not enroll self and eligible dependent(s) within 31 days of employee's initial eligibility, but signs a waiver on account of other coverage and later wants to enroll self and eligible dependent(s) for reasons other than losing other coverage.

Employee and eligible dependent(s) may enroll only in a late enrollment in the month of May with coverage effective July 1st. However, employee and eligible dependent(s) may enroll in a special enrollment when employee gains a spouse, domestic partner, other dependent child(ren). Employee and eligible dependent(s) must enroll within 31 days of employee gaining the spouse, domestic partner or dependent child(ren). Coverage is effective on the 1st day of the month following enrollment; however, coverage added for newborn, newly adopted or newly placed for adoption dependent children (and other eligible dependents added at this time) will be effective retroactive to the date of birth, adoption or placement.

If This...

Then This...

ED.6

Employee does not enroll self and eligible dependent(s) within 31 days of employee's initial eligibility, does not sign a waiver on account of other coverage, but later wants to enroll due to loss of other coverage.

Employee and eligible dependent(s) may not enroll in a special enrollment if they lose other coverage. Employee and eligible dependent(s) may enroll only in a late enrollment in the month of May with coverage effective July 1st.

However, employee and eligible dependent(s) may enroll in a special enrollment when employee gains a spouse, domestic partner or other dependent child(ren). Employee and eligible dependent(s) must enroll within 31 days of employee gaining the spouse, domestic partner or dependent child(ren). Coverage is effective on the 1st day of the month following enrollment; however, coverage added for newborn, newly adopted or newly placed for adoption dependent children (and other eligible dependents added at this time) will be effective retroactive to the date of birth, adoption or placement.

ED.7

Employee does not enroll self and eligible dependent(s) within 31 days of initial eligibility, does not sign a waiver on account of other coverage and later wants to enroll due to a change in employment status resulting in higher employer contributions.

Employee and eligible dependent(s) may enroll in a special enrollment. Employee and eligible dependent(s) must enroll within 31 days of the status change. Coverage is effective on the 1st day of the month following enrollment.

ED.8

Employee is enrolled and later gains an eligible dependent, e.g., spouse, domestic partner, newborn child, adopted child, and wants to enroll the dependent.

An eligible dependent may enroll in a special enrollment. Eligible dependent(s) must enroll within 31 days of the qualifying event, e.g., marriage, birth, adoption. Coverage is effective on the 1st day of the month following enrollment for spouse, dependent child or domestic partner and effective on the date of birth or adoption placement for newborn or adopted child.

ED.9

Employee is enrolled and later gains an eligible dependent, e.g., spouse, domestic partner, newborn child, adopted child, and does not enroll the dependent on account of other coverage, but later wants the enrollment due to loss of other coverage.

An eligible dependent may enroll in a special enrollment if he loses other coverage and can document it. Eligible dependent(s) must enroll within 31 days of losing other coverage. Coverage is effective on the 1st day of the month following enrollment for spouse, dependent child or domestic partner and effective on the date of birth or adoption placement for newborn or adopted child.

If This...

Then This...

ED.10

Employee is enrolled and later gains an eligible dependent, e.g., spouse, domestic partner, newborn child, adopted child, and does not enroll the dependent within 31 days of eligibility, but later wants the enrollment for reasons other than losing other coverage.

An eligible dependent may enroll only in a late enrollment in the month of May, with coverage effective July 1st.

Retiree (R.)

R.1

Employee is rehired from the Missoula County Layoff Pool and enrolls self and eligible dependents within 31 days of rehire date.

Coverage is effective on the 1st day of the month following enrollment.

R.2

Employee is rehired from the Missoula County Layoff Pool and does not enroll self and eligible dependents with 31 days of rehire date.

Employee is able to enroll self and eligible dependents only in late enrollment in the month of May, with coverage effective July 1st.

Termination (T.)

T.1

Employee and eligible dependent(s) are enrolled; employee does not participate in flex plan premium conversion and wants to terminate coverage.

Employee and dependent(s) may terminate coverage by providing written notification to the Human Resources Office or an employee representative. Termination is effective on the last day of the pay period after providing the notification (last day of the month for outside agencies).

T.2

Employee and eligible dependent(s) are enrolled; employee does not participate in flex plan premium conversion and employee wants to terminate coverage of dependent(s).

Eligible dependent(s) may terminate coverage by providing written notification to the Human Resources Office or an employee representative. Termination is effective on the last day of the pay period after providing the notification (last day of the month for outside agencies).

Under HIPAA, special enrollment rights are triggered when an employee or dependent loses other coverage or eligibility. Loss of eligibility includes loss of coverage due to legal separation, divorce, voluntary or involuntary termination of employment, reduction in hours, children's aging out of coverage, or movement out of an HMO service area. It also includes the termination of employer contributions toward an individual's other coverage, regardless of whether the individual is still eligible for coverage under the

other plan. It does not include loss of coverage due to premium increases or to a failure of the individual to pay premiums on a timely basis or termination of coverage for cause.

The term, "other coverage," includes any group health plan or health insurance coverage. If the other coverage was COBRA continuation of coverage, special enrollment can be requested only after the COBRA continuation of coverage is exhausted. If the other coverage was not COBRA continuation of coverage, special enrollment can be requested when the individual loses eligibility for the other coverage.

Eligibility and Participation in MCEBP

Employee

You are eligible to participate in MCEBP if you are a regular full-time employee or a regular part-time employee scheduled to work at least 20 hours per week on a continuous basis. Temporary employees working for a period of fewer than 12 months are not eligible to participate in this plan. Independent contractors are not eligible to participate in this plan.

Waiting Period

Coverage is effective on the 1st day of the month following 60 continuous days of employment.

Dependent

Eligible dependents must be a resident of the same country in which you reside, and can participate as follows:

- Your lawful spouse as defined by applicable state law. (Spouses or domestic partners may be dependents of each other when both are employed and eligible for this plan.)
- Your natural child, and/or your stepchild. (Children may be dependents of both parents who are employed and eligible for this plan.)
- Your adopted child, from the date of placement for adoption, regardless of whether the adoption is final.
- A child related to you by blood or marriage for whom you are the legal guardian. (A court order showing legal guardianship is required.)
- Your domestic partner as defined by the plan.
- The natural child, stepchild, adopted child of your domestic partner, or child related to your domestic partner by blood or marriage for whom your domestic partner is the legal guardian. (Evidence of legal guardianship is required.)
- Your dependent, who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan. A Covered Individual of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.
- A dependent child must be under 26 years of age, except that any mentally or physically disabled child shall remain covered beyond the maximum age,

provided the child is incapable of performing self-sustaining employment and is receiving principal support from the employee. The child must reside with the employee and continue to qualify for coverage in all aspects other than age. MCEBP may require you, at any time, to obtain a physician's statement certifying the mental or physical disability. You may be required to provide a determination of disability from Social Security after 12 months of coverage beyond the maximum age limitation of the plan.

Retired Employee

If you are a retired employee, you may continue to carry your medical, dental or vision insurance benefits under this plan. However, if you terminate a benefit, i.e., medical, dental, vision, you may not re-enroll in that benefit. The necessary forms must be completed within 31 days from the date of retirement.

The full premium amount can be withheld from your retirement check if you are a member of the Montana Public Employees Retirement System (MPERS), the Montana Sheriffs' Retirement System (MSRS), or the Teachers Retirement System (TRS). Also, you may self-pay your premiums. Premiums are subject to change.

At retirement, the retired employee has the option to select the standard deductible plan; or the high deductible plan. Note: Once the deductible selection is made, it cannot be changed.

Adding and Deleting Dependents

Once you have selected benefits for you and your family, you may make some changes.

Family status changes include the following:

Event	Action
Marriage/Children acquired through marriage	You must complete a Benefits Enrollment/Change form within 31 days.
Divorce	You must notify the Human Resources Office or your employer representative, in writing, within 60 days.
Domestic Partner	You must notify the Human Resources Office or your employer representative, and complete a Benefits Enrollment/Change form within 31 days.
Death/Birth/Adoption Placement/ Legal Guardianship	You must complete a Benefits Enrollment/Change form within 31 days.
Dependent child no longer meets the definition of an eligible dependent	You must notify the Human Resources Office or your employer representative, in writing, within 60 days.

If you do not take the appropriate action outlined, within the time stated, you will lose your COBRA rights or become subject to late enrollment requirements. If you have previously revoked coverage for eligible dependents and not re-enrolled them under the

provisions for regular enrollment or special enrollment, the eligible dependents may only be re-enrolled in a late enrollment. They will be subject to the plan's provisions regarding limitations for dental benefits.

End of Coverage

Coverage under MCEBP ends as follows:

- For outside agencies, coverage ends the last day of the month for which premium payment is paid.
- For Missoula County employees, coverage ends the last day of the pay period for which premium payment is paid.
- For self-pay plan participants, i.e., retired employee, leave without pay, COBRA, FMLA, USSERA, coverage ends the last day of the month for which premium payment is paid.

For you and your dependents, coverage ends the earliest of:

- The last day of the pay period in which your employment ends. For outside agencies, coverage ends the last day of the month in which your employment ends.
- The last day of the pay period after you notify the Human Resources Office, in writing, you are terminating coverage. For outside agencies, coverage ends the last day of the month in which you notify your employer representative.
- The date you are no longer eligible to participate in MCEBP.
- The date MCEBP is terminated.
- The date of your death.
- For your spouse, the date a legal separation or divorce is granted (not final).
- The date a dependent child no longer meets the eligibility requirements.
- The date of a dependent's death.
- For your domestic partner and the dependents of your domestic partner, the date the domestic partner no longer meets the eligibility requirements.

Loss of Eligibility

Following any qualified loss of eligibility, your coverage may continue at your own expense, unless the reason for termination was gross misconduct. You or your dependents must provide a written request to the Human Resources Office or your employer representative to extend coverage in this way.

Ceasing active work is not always treated as a termination of coverage. See the Human Resources Office or your employer representative for information regarding leave of absence and termination of employment.

Benefit Charts

Chart of Medical Benefits

Standard Deductible Plan

Benefit Year Deductible.....	\$500 Individual/\$1,000 Family
(Family deductible is cumulative.)	
Benefit Year Out-of-Pocket Maximum for Medical	\$3,500 Individual/\$7,000 Family
(Family out-of-pocket maximum is cumulative.)	
(Out-of-pocket maximums do not include prescriptions.)	
<u>Prescriptions</u>	
Benefit Year Deductible for Prescription Card.....	\$150 Individual/\$300 Family
(Deductible does not apply to mail order prescriptions)	
Benefit Year Out-Of-Pocket Maximum for Prescription Card	
.....	\$2,450 Individual/\$4,900 Family
Benefit Year and Lifetime Benefit Maximum	Unlimited

High Deductible Plan

Benefit Year Deductible.....	\$2,500 Individual/\$5,000 Family
(Family deductible is cumulative.)	
Benefit Year Out-of-Pocket Maximum	\$2,000 Individual/\$4,000 Family
(Family out-of-pocket maximum is cumulative.)	
(Out-of-pocket maximums do not include prescriptions.)	
<u>Prescriptions</u>	
Benefit Year Deductible for Prescription Card.....	\$500 Individual/\$1,000 Family
(Deductible does not apply to mail order prescriptions)	
Benefit Year Out-Of-Pocket Maximum for Prescription Card	
.....	\$1,600 Individual/\$3,200 Family
Benefit Year and Lifetime Benefit Maximum	Unlimited

The following charts summarize coinsurance amounts paid by you and MCEBP, benefit maximums and additional explanations of your benefits. The out-of-pocket maximum is your coinsurance after the deductible has been met. Other expenses may not be covered due to specific limitations of the plan.

Please refer to the text of the plan document for additional provisions which may affect your benefits. Payment is based on maximum allowable charges. All covered expenses must be for medically necessary treatment.

Chart of Medical Benefits

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Affordable Care Act (ACA) Preventive Services			<u>All Services must be provided by an In-Network Provider</u> <i>A complete list of ACA services is available at https://www.healthcare.gov/coverage/preventive-care-benefits/</i>
Preventive services currently recommended in the United States Preventive Services Task Force with an "A" or "B" rating, which include but are not limited to the following	0%	100%	
<ul style="list-style-type: none"> • Breast cancer • Birth control, • Colorectal cancer, • Cholesterol, • Depression, • Diabetes, • Osteoporosis, • Sexually Transmitted Infections, • Sterilizations, • Well Child exams 	0%	100%	Screenings/Mammograms age 40 and older May be subject to pharmacy benefit Routine colonoscopy age 50 and older Screening Screening Screening Bone Density age 60 and older Screening
Immunizations	0%	100%	To age 22-Recommendations for Pediatric Health Care Bright Futures/American Academy of Pediatrics
Intensive behavioral dietary counseling and behavioral interventions to promote sustained weight loss in adults and children	0%	100%	Recommended by the Advisory Committee of the Immunizations Practices of the Center for Disease Control and Prevention
Routine exams	0%	100%	Adults from age 22, one exam each benefit year

The deductible applies to all eligible medical expenses, unless otherwise stated.

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Alternative Medicine (acupuncture, biofeedback/neurofeedback, body talk, compound pharmaceuticals, massage therapy, phototherapy boxes, portable air cleaner, rolfing therapy, weight loss program)	30%	70%	Maximum benefit payable is \$750 per benefit year.
Ambulance	30%	70%	Services must be to nearest hospital qualified to provide necessary treatment.
Anesthesia	30%	70%	
Breast Pump	0%	100%	Maximum benefit is \$200, limited to one per pregnancy
Catastrophic Case Management	30%	70%	Individual treatment program arranged by MCEBP.
Chiropractic Care	30%	70%	Maximum benefit payable for eligible services is \$1,000 per benefit year.
Colonoscopy (Standard)	30%	70%	Non-preventive
Colonoscopy (Virtual)	30%	70%	Maximum benefit payable is \$700, limited to once in any 60-consecutive month period.
Diagnostic X-ray and Laboratory	30%	70%	Payment is made for treatment of illness, injury or tests related to routine office visit.
Durable Medical Equipment and Supplies	30%	70%	
Emergency Room	30%	70%	
Hearing Aids	30%	70%	Maximum benefit payable for each ear is \$1,200, limited to once in any 60-consecutive month period.
Hospice	30%	70%	

The deductible applies to all eligible medical expenses, unless otherwise stated.

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Hospital Inpatient	30%	70% with utilization review; otherwise 50% of payable benefit.	Payment is made for semi-private room and necessary services and supplies; coverage for intensive or coronary care unit, when needed.
Hospital Outpatient	30%	70%	Payment is limited to the covered facility charges.
Immunizations (includes flu shots)	30%	70%	Affordable Care Act limits apply.
Maternity Hospital Services	30%	70%	Payment is made only for covered employee or covered spouse of an employee. No benefit will be paid if coverage has ended before the date of delivery or the date the pregnancy otherwise terminates.
Mental, Nervous Disorder, Chemical Dependency (including Alcoholism)	<u>Inpatient</u> -30%	<u>Inpatient</u> -70% with utilization review; otherwise 50% of payable benefit.	Must complete program for inpatient stay in order for service to be covered.
	<u>Outpatient</u> -30%	<u>Outpatient</u> -70%	
Orthotics, custom	30%	70%	Maximum benefit payable for eligible services is \$250 per foot per benefit year.
Naturopathy	30%	70%	
Nutritional Counseling	30%	70%	Maximum benefit payable is \$250 per benefit year.
Occupational and Speech Therapy	30%	70%	Coverage is limited to therapy performed by a qualified physical therapist or physician. Physician referral and treatment plan required.

The deductible applies to all eligible medical expenses, unless otherwise stated.

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Physical Therapy	30%	70%	Coverage is limited to 21 visits per benefit year. Must have physician referral and treatment plan required.
Physician Visits: Office/Hospital/ Emergency Room	30%	70%	
Radiation/ Chemotherapy	30%	70%	
Rehabilitation Facility	30%	70% with utilization review; otherwise 50% of payable benefit.	Confinement must be within 14 days of a hospital stay; 120 days lifetime maximum.
Routine Medical Exam	In-Network 0% Out-of-Network 30%	In-Network 100% Out-of-Network 70%	Note: Deductible does not apply. Coverage is limited to one office visit each benefit year.
Sleep Apnea	30%	70%	Preauthorization required for equipment. Home sleep study not covered.
Surgery	30%	70%	A second opinion may be required for payment.
Assistant Surgeon (medically necessary)	30%	70%	Payment is limited to 20% of primary surgeon's allowable expense; 10% if physician's assistant is used in lieu of assistant surgeon.
Well Child Care	In-Network_ 0% Out of Network 30%	In-Network 100% Out of Network 70%	Note: Deductible does not apply. Affordable Care Act limits apply

Chart of Dental Benefits

Deductible	None
Maximum Benefits Payable per Benefit Year	\$1,200 per Individual (Including Type A, B and C Benefits, but excluding orthodontia)
Lifetime Maximum Benefits Payable for Orthodontia.....	\$1,700 per Individual

If a person is a late enrollee, the maximum benefit is \$250 per person for the first 12 months of coverage and \$500 per person for the 13th through 24th month of coverage. After 24 months, the maximum payable per benefit year is \$1,200 per person. The orthodontia benefit is also subject to the above-stated late enrollment limits.

The following chart summarizes coinsurance amounts paid by you and MCEBP, benefit maximums and additional explanation of your dental benefits. Please refer to the text of the plan for additional provisions which may affect your benefits. Payment is based on maximum allowable charges.

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Type A Preventive Services		100%	Coverage includes cleaning, exam, and fluoride treatment paid twice in each benefit year. Bitewing x-rays paid once in each benefit period. Sealants of pits or fissures, as needed.
Type B Restorative Services	20%	80%	Coverage includes fillings, extractions, periodontal, endodontic treatment, and anesthesia.
Type C Major Services	30%	70%	Coverage includes dentures, inlays, gold fillings, crowns, veneers, bridges.
Orthodontia	50%	50%	Lifetime maximum benefit payable is \$1,700, including, but not limited to, examinations, banding of teeth, appliances, and night guard.

Chart of Vision Benefits

Note: There is no late enrollment provision for vision coverage, **but the employee must maintain coverage for a minimum of one plan year.**

DeductibleNone

Coverage is limited to one exam per benefit year. Standard lenses and frames, contacts, or corrective eye surgery will be covered once per benefit year.

MCEBP will pay 100% of covered expenses, to the maximum amounts shown below:

Vision Examination.....	\$74
Single Vision Lenses/Frames.....	\$158
Bifocal Lenses/Frames.....	\$189
Trifocal Lenses/Frames.....	\$226
Progressive Lenses/Frames.....	\$226
Contact Lenses	\$158
Necessary Contact Lenses	\$236
Corrective Eye Surgery	\$158 both eyes

Medical Benefits

The deductible applies to all eligible medical expenses, unless otherwise stated.

You and your eligible dependents have a plan applicable worldwide for health care services provided by covered licensed professional providers for illness, injury and certain preventive care.

You are responsible for an individual deductible: 1) standard deductible \$500 and family \$1,000 or, 2) high deductible \$2,500 individual and \$5,000 family.

You are responsible for coinsurance for some services up to the maximum out-of-pocket limit of \$3,500 per person and \$7,000 per family (for standard deductible plan and \$2,000 per person and \$4,000 per family for high deductible plan). When the individual or family limit is reached, 100% payment will be made for covered services during the same benefit year.

Payment is based on maximum allowable charges. The maximum lifetime benefit is unlimited. Benefits are subject to eligibility and enrollment requirements, utilization review, and limitations and exclusions described later in this section.

Services and/or supplies must be medically necessary for benefits to be paid.

This plan does not cover treatment of an illness or accident when Workers' Compensation has accepted liability, or any claim which would have been covered if you had followed Workers' Compensation guidelines for filing a claim.

If you have any questions, contact the Risk and Benefits Office for clarification.

Utilization Review (UR) for Inpatient Hospital Admission

MCEBP provides medical services review of all inpatient admissions. When your physician recommends hospitalization, you or your authorized representative must notify MCEBP prior to the event.

You need to obtain certification for the proposed admission. Also, you must confirm the need for any pre-operative days. You can call MCEBP at 406-523-4876.

For UR, MCEBP will 1) screen the information against the established medical criteria, 2) indicate approval, or 3) refer the case to a physician advisor. The physician advisor may 1) approve the case, 2) deny it, or 3) consult with your physician. You or your physician may appeal a negative decision. The appeal procedure is established by MCEBP.

To obtain UR for yourself or a dependent, MCEBP requires the patient name, address, phone number, identification number, date of birth and employer's name.

If an emergency situation requires a hospital admission, you or your authorized representative must call MCEBP within 48 hours of the admission, or on the first business day following weekend or holiday admissions. You need to provide the same information as noted above.

In maternity cases, under federal law, the minimum hospital stay for childbirth is 48 hours following a normal vaginal delivery, or 96 hours following a delivery by cesarean section. The plan does not require preauthorization for a hospital stay for childbirth within the applicable 48-hour or 96-hour period.

UR applies to all types of inpatient facilities covered under the plan, including mental health and substance abuse facilities.

If you fail to obtain UR from MCEBP prior to being admitted on a nonemergency basis, or after admission on an emergency basis, your payable benefits will be reduced by 50%. Additionally, your payable benefits will be reduced by 50% for any portion of a hospital stay that has not been approved. If UR determines the hospital stay is not medically necessary, no benefit is payable.

Preauthorization

A few medical services, equipment, and supplies require prior authorization in order to receive benefits.

Some of these are:

- Breast Reduction
- Class II schedule narcotics
- Inpatient hospitalizations
- Scheduled air ambulance
- Sleep apnea equipment
- Total hip replacement
- Total knee replacement
- Transplants
- Specialty Drugs

Case Management

Case management is a program designed for you and your eligible dependents in the event you suffer from complex illnesses requiring ongoing medical care. Under this program, a case management consultant will coordinate services, resources and information with you and your family, the health care providers and the Risk and Benefits Office. Alternate cost-effective forms of care, treatment or treatment facilities may be recommended as part of the case management program.

Covered Medical Expenses

Accidental injury to natural teeth

If services or treatments are received within six months of the accident, coverage is 70% of maximum allowance. Injury to teeth from chewing is not accidental for purposes of this coverage. Other expenses may be covered under the dental plan.

Alternative medicine

This benefit is limited to:

- Acupuncture
- Biofeedback/neurofeedback
- Body Talk
- Compound pharmaceuticals from a licensed pharmacist when not covered by the pharmacy benefit.
- Massage therapy
- Phototherapy Boxes
- Portable air cleaners with a maximum of one per plan year.
- Rolfing therapy
- Weight loss program overseen by a medical professional with a maximum of one program per plan year.

Covered expenses are paid at 70% of maximum allowance, up to a combined maximum of \$750 each benefit year, subject to all other terms and conditions of MCEBP.

Ambulance

MCEBP will pay 70% of maximum allowance for ambulance service fees for each accident or illness, if services are provided to the nearest hospital qualified to provide the necessary treatment. Certified air ambulance transportation will be covered if it is medically necessary. Preauthorization is required for nonemergency ambulance service.

Breast Pump

Coverage is 100% for one standard electric breast pump (non-hospital grade) with a maximum benefit of one per birth with a payable benefit not to exceed \$200. Breast pumps will be covered at 100% with deductible and co-insurance waived.

Breast Reduction

Coverage is 70% of maximum allowance when treatment is medically necessary and conservative treatment has failed to alleviate the symptoms. Preauthorization is mandatory and clinical eligibility requirements must be met. Only one reduction mammoplasty procedure is covered per lifetime.

Blood transfusions

While employee is hospitalized, coverage includes the cost of blood and blood plasma at 70% of maximum allowance. The cost of donating your own blood for a scheduled hospitalization is covered at 70%.

Catastrophic case management

Individual treatment programs arranged by the Plan Administrator, UR, physician, and patient are covered at 70%.

Chemical dependency (drug and alcohol)/mental and nervous conditions

Benefits for the treatment of chemical dependency are paid only when it is certified the covered person has completed the program. A chemical dependency treatment center must be approved by the appropriate state agency and Joint Commission certified treatment center.

A facility providing treatment of mental and nervous conditions must be certified as an eligible provider by Medicare and state approved.

The plan will pay 70% of eligible inpatient and related expenses. You must use UR for any inpatient treatment. **If you do not use UR, your payable benefit will be reduced by 50%.**

Eligible outpatient expenses are covered at 70% of maximum allowance.

Chiropractic care

Services are covered at 70% of maximum allowance with a maximum benefit payable of \$1,000 per benefit year.

Circumcision

Services are covered at 70% of maximum allowance.

Colonoscopy- non-preventive

Standard procedure is covered at 70% of maximum allowance.

Virtual colonoscopy is covered at 70% up to a maximum benefit payable of \$700, to be paid no more than once in any 60-consecutive-month period.

Compression stockings

One pair of stockings are covered only for post-surgical treatment.

Cosmetic surgery

Services are covered at 70% of maximum allowance when necessary as a result of an accident which occurs while the person has coverage under MCEBP. The procedure must be performed within six months of the accident, except when it is medically

advisable to do the procedure later and it has been approved by the Plan Administrator. Breast implants and other cosmetic prostheses are not covered.

Diabetic supplies

Glucometer and testing supplies are covered at 70% of maximum allowance. Use of the prescription drug card may be required.

Diagnostic X-ray and lab services

For treatment of illness or injury, or services related to a routine office visit, coverage is 70% of maximum allowance. When using Computerized Axial Tomographic (CAT) Scanner and Magnetic Resonance Imaging (MRI) for diagnosis of a specific disease, illness or injury, hospital and physician services are covered at 70% of maximum allowance.

Durable medical equipment and supplies

Medically necessary casts, splints, trusses, braces, crutches, artificial limbs, eyes, rental of wheelchair, hospital bed, oxygen equipment, traction or similar equipment are covered at 70% of maximum allowance, when ordered by a physician. General maintenance and repairs are covered at 70% of maximum allowance. The Plan Administrator may approve the purchase versus rental of an item.

Emergency room

Facility charges are covered at 70% of maximum allowance.

Hearing aid

The device is covered at 70% of maximum allowance with a maximum benefit payable of \$1,200 per ear, to be paid only once in any 60-consecutive-month period. Batteries are not covered.

Hearing aid repairs

The deductible does not apply. Repairs for hearing aids are covered at 70% of maximum allowance with a maximum benefit payable of \$100 per benefit year. Batteries are not covered.

Home health care/Nursing services

Services are covered at 70% of maximum allowance when provided by a licensed graduate nurse who does not reside in a covered person's home or is not a relative. Custodial care not covered. Preauthorization from the Risk and Benefits Office is required. Treatment plan is required for preauthorization.

Hospice

The plan covers hospice services, including palliative and supportive care, to terminally ill patients and to eligible family members. Requires a prescription from the physician

indicating patient is terminally ill with a life expectancy of six months or less. The treatment plan must be pre-approved by the Risk and Benefits Office.

Hospital services

Provided UR is used, MCEBP pays 70% of maximum allowance for the following services:

- Room and board (intensive and coronary care units and semi-private).
- Tests, treatments and inpatient supplies and inpatient prescriptions.
- Routine pre-admission diagnostic tests performed within 48 hours of scheduled inpatient admission.

If you do not use UR, your payable benefit will be reduced by 50%. If no days are approved, no benefit is payable.

Immunizations

Services, including flu shots, are covered if recommended by the Advisory Committee of the Immunizations Practices of the Center for Disease Control and Prevention.

International Travel

Services are covered only for emergency medical treatment.

Mastectomy

Benefits required by the Women's Health and Cancer Rights Act of 1998 are as follows:

- Reconstructive surgery for the affected breast,
- Surgery on the other breast to achieve symmetry,
- Prostheses,
- Treatment for physical complications from all stages of the mastectomy, including lymphedemas.

Maternity

MCEBP covers maternity care expenses the same as any other illness for a covered employee or a covered spouse of an employee. You should notify MCEBP as soon as the due date is known. Coverage is 70% of maximum allowance. Under federal law, the minimum hospital stay in connection with childbirth is 48 hours following a normal vaginal delivery or 96 hours following a delivery by cesarean section. The plan does not require pre-certification for a hospital stay for childbirth within the applicable 48-hour or 96-hour period.

You must be a covered employee or a covered spouse of an employee to be eligible for these benefits. Dependent children are not covered for these benefits. Outpatient hospital services are payable at 70% of maximum allowance.

All physician and midwife fees will be combined and subject to the total obstetrical care maximum allowance. MCEBP pays prenatal care and surgical services including delivery, cesarean section and abortion at 70% of maximum allowance.

Medical supplies

When medically necessary, items including dressings, catheters, colostomy supplies, syringes and needles are covered at 70% of maximum allowance.

Mental and nervous conditions/Chemical dependency (drug and alcohol)

Benefits for the treatment of chemical dependency are paid only when it is certified that the covered person has completed the program. A chemical dependency treatment center must be approved by the appropriate state agency and Joint Commission Certified.

A facility providing treatment of mental and nervous conditions must be certified as an eligible provider by Medicare and a center of excellence.

The plan will pay 70% of eligible inpatient and related expenses. You must use UR for any inpatient treatment. If you do not use UR, your payable benefit will be reduced by 50%.

Eligible outpatient expenses are covered at 70% of maximum allowance.

Naturopathy

Services are covered at 70% of maximum allowance for office consultations or for services allowable, only within the scope of the provider license. The services must be related to treatment or diagnosis of an actual injury or medically recognized illness, excluding non-prescription items such as herbs, remedies, vitamins or wellness/health maintenance items.

Nursery inpatient care

Nursery charges for hospital care during the mother's stay will be covered at 70% of maximum allowance if (1) you are a covered employee or spouse of a covered employee, (2) you have enrolled the newborn within 31 days from the date of birth, and (3) you have paid the premium.

A newborn is covered for illness or injury while hospitalized if (1) the newborn has been enrolled as an eligible dependent within 31 days from the date of birth, and (2) the premium has been paid.

Nutritional counseling

Services are payable at 70% of maximum allowance, with a maximum of \$250 per benefit year.

Occupational and speech therapy

A physician referral and treatment plan is required. Treatment must be provided by a qualified therapist or physician, not a chiropractor, masseur, physical culturist, physical education instructor or health club attendant. Services are covered at 70% of maximum allowance.

Orthotics, custom

Casting, molding and fitting, are covered at 70% of maximum allowance with a maximum benefit payable of \$250 per foot per benefit year.

Physical Therapy

A physician referral and treatment plan is required. Treatment must be provided by a qualified therapist or physician, not a chiropractor, masseur, physical culturist, physical education instructor or health club attendant. Services have a maximum of 21 visits per plan year. Services are covered at 70% of maximum allowance.

Physician services

Coverage includes:

- Surgery and surgical supplies are covered for both inpatient and outpatient treatment. Surgery is defined as an operative or diagnostic procedure for treatment of illness or injury through an incision or natural body opening by cutting or by using an instrument or laser. Surgery also includes treatment of fractures, dislocations, and burns. Coverage applies to the primary surgeon. A second opinion may be required.
- Eligible procedures are paid at 70% of the maximum allowance.
- Charges by an assistant surgeon, if medically necessary, are eligible for coverage of 20% of the surgical maximum allowance or 10% if a physician assistant is used in lieu of an assistant surgeon. Once maximum allowance is determined, 70% will be paid.
- Anesthesiologist or certified anesthetist fees are covered at 70% of maximum allowance.
- Office visits, hospital visits and maternity care are covered at 70% of maximum allowance.

Prescription drugs

- If enrolled in the standard deductible plan, the deductible is \$150 per person/\$300 per family per benefit year, for all covered medications purchased with the prescription drug card provided by MCEBP. The out-of-pocket maximum is \$2,450 per person/\$4,900 per family per benefit year for all covered medications purchased with the prescription drug card provided by MCEBP.

- If enrolled in the high deductible plan, the deductible is \$500 per person/\$1,000 per family per benefit year for all covered medications purchased with the prescription drug card provided by MCEBP. The out-of-pocket maximum is \$1,600 per person/\$3,200 per family per benefit year for all covered medications purchased with the prescription drug card provided by MCEBP.
- Medication requiring a written prescription and provided by a licensed pharmacist or physician is covered subject to the MCEBP adopted formulary. The formulary is a list of covered and preferred drug agents. The preferred drug agents will be the least expensive while the non-preferred drug agents will be the most expensive. A list of the most popular drugs covered through the formulary can be viewed on MCEBP website (www.mcebp.com). This is updated quarterly.
- The following co-insurance and co-pay maximums apply:
 - Tier 1 (generic):** 15% co-insurance with a \$20.00 co-pay maximum
 - Tier 2 (formulary):** 30% co-insurance with a \$50.00 co-pay maximum
 - Tier 3 (non-formulary):** 40% co-insurance with a \$150.00 co-pay maximum
 - Tier 4 (specialty medications):** 40% co-insurance with a \$300 co-pay maximum

Your co-insurance does not accrue toward the benefit year out-of-pocket maximum for covered medical expenses.
- If a prescription is purchased through one of the plan's mail-order drug purchase program it is not subject to deductible.
- All specialty drugs require preauthorization.
- MCEBP does not pay for prescription drugs unless it is the primary plan. A prescription drug card is provided if MCEBP is your primary plan. MCEBP will not pay for prescription drugs unless they are purchased with this prescription drug card, except for hospital take-home drugs, medical emergencies, or preauthorized drug expenses, subject to the medical deductible.

Rehabilitation facility

Confinement in an inpatient facility that is not designated as a full-service hospital, such as a skilled nursing or step-down facility, designed for the patient's recovery from an illness or injury not requiring inpatient hospitalization. The facility must be pre-certified through UR and approved by Medicare. Confinement must be within 14 days of a hospital stay; 120 days lifetime maximum.

Services at this type of facility can only be provided within 14 days of hospital discharge and for no more than 120 days of facility confinement, per lifetime. When the purpose of admission is for custodial services, coverage is not provided.

Routine exams

An office visit is covered at 100% of the maximum allowable at an in-network provider or 70% of the maximum allowable at an out-of-network provider. The routine exam is limited to one office visit each benefit year.

Sleep apnea

Testing for, and treatment of, sleep apnea is covered. **Preauthorization of equipment is required. Home sleep studies are not covered.**

Sterilization surgery

When performed by a licensed physician, coverage is 100% of maximum allowance.

Surgery

When covered multiple or bilateral surgical procedures are performed during a single operative session, the following schedule applies:

First (primary procedure).....	100% of eligible charges paid at 70%.
Second procedure.....	50% of eligible charges paid at 70%.
Third procedure.....	50% of eligible charges paid at 70%.

Telemedicine

Telemedicine services are only covered if such services are explicitly contracted between the provider and MCEBP. Non-contracted telemedicine services are excluded from coverage.

Temporomandibular Joint Dysfunction (TMJ)

Treatment of TMJ is limited to covered physical therapy medical expenses as defined by MCEBP.

Transplant surgery

Only certain human organ or tissue-to-tissue transplant procedures are covered: cornea, renal (kidney), bone marrow (including stem cell, when treatment is identified as the standard of care), heart, lung, liver, pancreas and small bowel. Other transplants are excluded. When a transplant is medically necessary and approved, the coverage is 70% of maximum allowance. Contact the Risk and Benefits Office as soon as you become aware of a possible transplant procedure. If any other group or individual insurance does not cover the donor of the transplant organ, benefits for surgical, medical and hospital services may be approved under MCEBP through a claim made by the organ recipient.

Well child care

Services are covered at 100% of maximum allowable at an in-network provider or 70% of maximum allowance at an out-of-network provider, Affordable Care Act limits apply.

Medical Expenses Not Covered

MCEBP does not cover the following:

1. Services or supplies not specifically listed as a benefit of the plan.
2. Treatment of complications, infections, or any other conditions arising out of services or supplies not covered by the plan.
3. Charges incurred prior to effective date of coverage or after coverage has ended.
4. Charges exceeding maximum allowable charges.
5. Treatment that is not considered medically necessary, except for preventive care as specified by the plan.
6. Experimental/investigational treatment – Experimental or investigational drugs, devices, medical treatments or procedures in or out of a hospital. The terms, “experimental or investigational,” are defined as follows:
 - If the drug or device 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.
 - If the drug, device, medical treatment or procedure, or 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.
 - If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, or is in the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.
 - If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.

The term, “reliable evidence,” means 1) published reports and articles in authoritative medical and scientific literature, 2) the written protocol(s) used by the treating facility, 3) the written protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure, or 4) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Note: Stem cell transplants that are identified as the standard of care for a disease are not excluded solely by the experimental/investigational exclusion.

7. Services provided under any government-sponsored medical or health plan, except as coordinated with Medicare, or charges billed by the United States Government for:
 - Services rendered by Veterans' Administration facilities to a veteran for treatment of a non-service connected disability,
 - Inpatient medical care provided by military hospitals to non-active military personnel and their dependents
8. Treatment of an illness or accident when Workers' Compensation has accepted liability, or any claim which would have been covered if you had followed Workers' Compensation guidelines for filing a claim.
9. Charges for any services or treatment for which the covered person is not obligated to pay, or for charges which would not have been made without medical coverage in force.
10. Services or supplies for which no charge is made or for which a charge is increased because insurance is available.
11. Treatment for services and supplies for an illness, injury or condition caused by you or your dependents while voluntarily participating in a riot, armed invasion or aggression, insurrection or rebellion or sustained by you, or your dependent arising directly from an act deemed illegal by an officer or a court of law.
12. Court-ordered or employer-mandated services and treatments, such as alcohol counseling resulting from a DUI conviction, or drug counseling resulting from a failed drug test.
13. Any illness or injury as a result of war or an act of war.
14. Charges for providing and preparing medical records and reports or itemized bills for services.
15. Telephone consultations or electronic communications, including, but not limited to, internet and telecommuting except as allowed by the plan.
16. Travel or lodging expenses of 1) a covered person, 2) a physician treating a covered person, or 3) a person accompanying a covered person.
17. Psychoanalysis or psychotherapy that can be credited toward earning a degree or furthering education.
18. Care in a facility not licensed as a hospital, alcoholism or drug abuse treatment center, or rehabilitation center.
19. Hospitalization determined during UR to be medically unnecessary.
20. Hospitalization for experimental services, dental treatment, custodial care or cosmetic surgery, except as allowed by the plan.
21. Hospitalization primarily for diagnostic tests, observation or examination, when treatment of illness or injury does not require bed care.
22. Special duty nursing ordinarily provided by hospital staff, requested for convenience of the patient and/or family, or provided by a private duty nurse who is a relative.
23. Convalescent care or custodial care, including skilled nursing, except as stated elsewhere in the plan or as provided under Case Management.

24. Custodial treatment related to, or the result of, chronic brain syndrome or senile deterioration, for example, Alzheimer's disease or dementia.
25. Prescription drugs when medical consultants named by the Plan Administrator determine that there is overuse or evidence of drug abuse.
26. Prescription drugs, services or supplies, when the quantity requested would extend into the following benefit year, or after coverage is terminated.
27. Drugs and medicines available without a prescription, even when a prescription is written.
28. Naturopath non-prescription items such as herbs, remedies, vitamins, or wellness/health maintenance items.
29. Items such as heating pads, hot water bottles, blood pressure cuffs, mastectomy bras, compression stockings (except when following surgery), wheelchair lifts and ramps, motor vehicle parts or labor, modifications to homes or vehicles, or other health aids readily available.
30. Items that may be useful to persons in the absence of sickness or injury, such as air conditioners, hearing aid batteries, purifiers, special furniture, bicycles, wigs, whirlpools, humidifiers, exercise equipment or health club memberships.
31. Knee braces, or other medical equipment, related to participation in sports or recreational activities.
32. Items such as arch supports, inserts, heel lifts, orthotic appliances and corrective shoes, or charges for casting, molding or fitting, except as covered under Custom Orthotics.
33. Breast implant(s), reconstruction, or replacement of breast implants, except as required by the Women's' Health and Cancer Rights Act of 1998.
34. Breast reduction, except a preauthorized mammoplasty.
35. Incidental procedure performed through the same incision.
36. Special education, social, image counseling, therapy or care for learning disorders, recreational or behavioral problems except as provided by law.
37. Chiropractic or acupuncture expenses for supplies, appliances, or other expenses, except as stated elsewhere in the plan.
38. Holistic medical procedures and supplies.
39. Hair transplant procedures.
40. Cosmetic surgery, except to correct conditions from accidental injury, which occurs while the person has coverage under MCEBP, and is performed within six months of the accident, or as approved by the Plan Administrator.
41. Bariatric surgery, gastric bypass surgery, or any other weight loss surgery by any other name.
42. Services, supplies or prescriptions for weight reduction or treatment of obesity. Nutritional counseling is covered.
43. Fertility drugs.
44. Services related to, and complications resulting from, artificial insemination, in vitro impregnation, or any treatment of infertility.
45. Reversal of sterilization.

46. Services, care or treatment for non-organic sexual dysfunction, transsexualism, gender dysphoria, sexual reassignment or change.
47. Eye refractions, orthoptics, radial keratotomy, lasik surgery, corrective eye surgery, FDA approved visual therapy, or providing, replacing or fitting glasses.
48. Treatment of teeth, gums or alveolar processes.
49. Services related to damaged or injured teeth as a result of chewing.
50. Services and supplies to change the position of a bone of the upper or lower jaw, except when necessary due to an accidental injury that occurred while covered under the plan.
51. Treatment of temporomandibular joint dysfunction (TMJ) and associated myofacial pain and related diagnoses. Except as allowed by the plan. May be treated by a physical therapist.
52. Expenses for additional treatment of a fractured jaw, or accidental injury to natural teeth after six months following an accident.

Dental Benefits

You and your eligible dependents may enroll in the dental program. Refer to the list of employers in the Plan Administrator's letter preceding the Table of Contents. The maximum benefit payable for covered expenses in each benefit year is \$1,200 per person. The lifetime orthodontia benefit is \$1,700 per individual. The orthodontia benefit is separate from the dental yearly maximum. Payment is based on the maximum allowable charge. There is no deductible for dental benefits.

In addition to the definitions, the following words relate to dental care:

Dentist

A doctor of dental surgery or of dental medicine (D.D.S. or D.M.D.), acting within the scope of the provider's state license.

Denturist

A person licensed to provide limited prosthetic service, acting within the scope of a valid license.

Dental hygienist

A person acting within the scope of a valid license and working under the direction of a dentist.

Type A – Preventive

MCEBP will pay 100% of maximum allowance of covered charges each benefit year for the following Type A dental expenses:

Services for routine care available twice each benefit year:

- Routine prophylaxis (scaling and cleaning of teeth).
- Routine oral examination of the mouth and teeth.
- Topical fluoride application (sodium or stannous fluoride),

Services available as stated:

- Dental x-rays: Limited to one full mouth x-ray in 36 consecutive months,
- Bitewing x-rays covered once per benefit year,
- Sealants: Coverage for the treatment of pits and fissures.

Type B – Basic Restorative

MCEBP will pay 80% of maximum allowance of covered charges each benefit year for the following Type B dental expenses:

- Diagnostic services.
- Space maintainers.
- Extractions.

- Nitrous oxide.
- Oral surgery, including surgical extractions.
- Fillings, including sedative fillings.
- General anesthesia when medically necessary and administered for oral surgery.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth, including periodontal surgery.
- Endodontic treatment, including root canal therapy.
- Injection of antibiotic drugs.
- Repair or recementing of crowns, veneers, inlays, onlays, bridgework or dentures; or relining of dentures.
- Prophylaxis for periodontal treatment.
- Emergency dental treatment rendered by a physician.

Type C – Major Restorative

MCEBP will pay 70% of maximum allowance of covered charges each benefit year for the following Type C dental expenses:

- Inlays, onlays, gold fillings, crowns, or veneers, including precision attachments for dentures.
- Initial installation of fixed bridgework (including inlays and crowns as abutments) to replace one or more natural teeth.
- Implants to replace natural teeth.
- Initial installation of partial or full removable dentures (including adjustments for the six-month period following installation) to replace one or more natural teeth.
- 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.
- Replacement of, or additions to, existing crowns, veneers, dentures or bridgework, covered only if satisfactory evidence is given to the Risk and Benefits Office regarding one of the following:
 - The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.
 - The existing crown, veneer, denture, or bridgework cannot be made serviceable or was installed at least five years prior to its replacement.
 - The existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture is required. Such replacement must take place within 12 months from the date of the initial installation and the immediate temporary denture was placed while insured under the plan.

Orthodontic Treatment

- There is no age limit for orthodontic treatment.
- MCEBP provides benefits for orthodontic treatment including non-surgical treatment of the following conditions: temporomandibular joint dysfunction, sleep apnea, bruxism and myofacial pain.
- Night guards
- Coverage for dental services and supplies related to orthodontia is 50% of covered expenses. The maximum lifetime benefit for an individual is \$1,700.

Treatment Plan Provision

If your dental treatment will exceed \$500, you should submit a pre-treatment plan to the Risk and Benefits Office before beginning treatment. A pre-treatment plan is a report written by the attending dentist to include:

- Recommended treatment for the complete correction of the dental condition,
- Period during which treatment will be provided,
- Estimated cost of the recommended treatment and necessary appliances, and
- Supporting x-rays.

Dental Benefit Year Maximum

The maximum benefit for dental expenses is \$1,200 per person per benefit year for Type A, B and C services. If a person is a late enrollee, the maximum benefit is \$250 per person for the first 12 months of coverage and \$500 per person for the 13th through 24th month of coverage. After 24 months, the maximum payable per benefit year is \$1,200 per person. The orthodontia benefit is also subject to the above-stated late enrollment limits.

Alternate Procedures Covered

- If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, and the dentist and/or covered person elect(s) a more elaborate or precision appliance, the covered expenses will be limited to the maximum allowable charges appropriate to the standard procedure, unless excluded by the plan.

Dental Expenses Not Covered

MCEBP does not cover the following:

1. Treatment by a provider other than a dentist, except for 1) dental emergency services rendered by a physician, or 2) scaling or cleaning teeth and topical application of fluoride that may be done by a licensed dental hygienist under the direction of a dentist.
2. Hospital or surgical center facility and related charges.

3. Services or supplies cosmetic in nature, including bleaching, personalization, or characterization of dentures, and dental consultations.
4. Dentures, veneers, crowns, inlays, onlays, bridgework or other appliances or services to increase vertical dimension, except for orthodontia.
5. Charges for any services or treatments for which the covered person is not obligated to pay, or for which a charge is either made or increased because insurance is available.
6. Charges that exceed maximum allowable charge.
7. Dental expenses for disease, defect, or injury from employment, or for which the covered person is entitled to benefits under any Workers' Compensation or occupational disease law.
8. Extracoronary and other periodontal splinting.
9. Temporary dental work.
10. Root canal therapy for which the pulp chamber was opened before coverage under the plan.
11. Periodontal charting.
12. Oral hygiene and dietary instructions.
13. Recording of jaw movements and positions.
14. A fee for writing a prescription for drugs, or for filling out claim forms.
15. Services provided by a dentist or a denturist which are beyond the scope of his license.
16. Specialized dental technology.
17. Dentures, veneers, crowns, inlays, onlays, bridgework or other appliances or services which were ordered before coverage under the plan.
18. Services and items not specifically covered by the plan.
19. Expenses incurred for any procedure(s) or treatment(s) started before the effective date, or after the termination date, of your coverage.

Vision Benefits

You and your eligible dependents may enroll in the vision program. Refer to the list of employers in the Plan Administrator's letter preceding the Table of Contents. You may be eligible to receive basic vision care from a provider, subject to a maximum benefits schedule. There is no late enrollment provision for vision coverage. There is no deductible for vision benefits.

In addition to the definitions, the following words relate to vision care:

Blended/progressive lenses

Multifocals with no visible dividing line.

Coated lenses

A substance added to a finished lens on one or both surfaces.

Materials

Lenses, frames, contact lenses and related professional services.

Orthoptics

The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Photochromatic lenses

Lenses, which change color with intensity of sunlight.

Provider

A legally licensed ophthalmologist, optometrist and/or dispensing optician.

Plano lenses

Lenses with no refractive power.

Professional service

Examination, material selection, fitting, and related adjustments.

Tinted lenses

Lenses with an additional substance added to produce a constant tint.

Necessary contact lenses

Lenses which, following cataract surgery, correct extreme visual acuity problems that cannot be corrected with spectacle lenses, or are necessary because of anisometropia or keratoconus (Plan Administrator preapproval required).

Vision Examination

You are covered up to the scheduled allowance for one complete eye examination during each benefit year.

Vision Materials

You are covered for either one pair of lenses and frames, or contact lenses, or corrective eye surgery during each benefit year subject to the maximum benefits schedule. You may be eligible to receive an additional pair of lenses and frames or contact lenses after cataract surgery if your prescription has changed due to cataract surgery.

Benefit Year Schedule of Maximum Benefits Payable

MCEBP will pay 100% of covered expenses, to the maximum amounts shown below:

Vision Examination.....	\$74
Single Vision Lenses/Frames.....	\$158
Bifocal Lenses/Frames.....	\$189
Trifocal Lenses/Frames.....	\$226
Progressive Lenses/Frames.....	\$226
Contact Lenses	\$158
Necessary Contact Lenses	\$236
Corrective Eye Surgery	\$158 both eyes

Vision Expenses Not Covered

1. Medical or surgical treatment of the eyes.
2. Orthoptics, plano lenses or two pair of glasses in lieu of bifocals.
3. Replacement of lenses or frames furnished under this program which are lost, broken, missing or damaged.
4. Services or supplies not specifically listed as a benefit of the plan.

Claims Administration

Overview

Claims will be considered for payment according to the plan's terms and conditions, as well as industry-standard claims processing guidelines and administrative practices and policies consistent with the terms of the plan. This document provides a summary of the plan's claims procedures. Contact the Missoula County Risk and Benefits Plan Office (MCEBP) for detailed claims procedures. For simplicity, the term "you" throughout this section refers to the person claiming plan benefits.

Claims by Providers

While you may assign your right to payment from the plan to your health care provider, only you or your authorized representative (a person that acts on behalf of you with respect to claims and or/appeals processes) may make a claim or appeal under the plan. A health care provider or other assignee is not an authorized representative simply by virtue of the assignment of benefits. No person will be recognized as an authorized representative without a form of release signed by you - except in the case of an urgent care claim, in which case the provider of services has the authority to act as your authorized representative.

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.

Notice of Claim

The plan must receive complete information in order to process claims. A complete claim must, at a minimum, include the following information:

- Date of service;
- Name of the covered employee;
- Name and date of birth of the patient receiving the treatment or service and his/her relationship to the covered employee (e.g., spouse, dependent);
- Diagnosis [code] of the condition being treated;
- Procedure or service [code] performed;
- Amount charged by the provider for the treatment or service; and
- Sufficient documentation, in the sole determination of the claims administrator, to support the medical necessity of the treatment or service being provided and to enable adjudication of the claim pursuant to the terms and conditions of the plan, which may include your Social Security Number if you are over 44 years of age or are covered by Medicare.

Completed claim forms can be personally delivered or mailed to the MCEBP at the address identified on the last page of this summary plan description.

Any person who claims benefits under the plan must provide all information, including medical records and physician referrals upon request needed to process the claim in accordance with the plan.

You must file a completed claim form whenever requested by the MCEBP (or other designated claims administrator). A claim that fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan is considered an “incomplete claim.” Any claim not submitted in accordance with the plan’s claims procedures is considered an “incorrectly filed claim.”

Initial Claim Determinations

When you (or the health care provider to whom you assign your right to payment) submit a claim for payment, every attempt will be made to process it promptly and accurately. Claims submitted later than 12 months after the date of service will be paid only if you are able to show reasonable cause for the delay; however, a delay of more than 90 days beyond the 12-month period is presumed unreasonable.

Claims will not be deemed submitted until they are received by the designated claims administrator. Once submitted, eligibility and initial claims decisions will be made within the time periods stated below.

- **Urgent care claims** decisions will be made within **72 hours**, or sooner if possible taking into account the medical exigencies involved.

A claim involving urgent care is determined by your attending provider, and is generally a claim for medical care or treatment with respect to which the application of the regular claim determination periods could seriously jeopardize your life or health or your ability to regain maximum function; or, in the opinion of the physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The plan will defer to the attending provider in determining whether a claim involves urgent care.

If the plan is unable to process an urgent care claim because it is incorrectly filed or incomplete, you (or your health care provider if applicable) will be notified as soon as possible (within 24 hours) and will be afforded at least an additional 48 hours to submit a completed claim. Then, the plan’s benefit determination will be made within 48 hours of either the plan’s receipt of such information or the end of the period given to supply the requested information, whichever is earlier.

- **Pre-service claim** decisions will be made within a reasonable time (not later than **15 days**) appropriate to the medical circumstances.

When plan benefits require “preauthorization” or other prior approval as a condition of payment, your request for pre-approval is a **pre-service claim**, which you must submit before the medical treatment or service is received.

If MCEBP is unable to process a pre-service claim because it is incorrectly filed or incomplete, you will be notified as soon as possible (within 5 days for incorrect filing; 15 days for incomplete claim information) and will be afforded an additional 45 days to submit your completed claim. Then, the plan will have 15 days to make a claim determination.

- **Post-service claim** decisions will be made within a reasonable time, but not later than **30 days**.

Any claim for payment of plan benefits that does not require pre-approval (i.e. is not a pre-service claim) is a post-service claim.

If MCEBP is unable to process a post-service claim because it is incorrectly filed or incomplete, you will be notified as soon as possible (within 5 days for incorrect filing; 30 days for incomplete claim information) and will be afforded an additional 45 days to re-submit your completed claim. Then, the plan will have 15 days to make a claim determination.

- **Concurrent care claim** decisions, in response to a request to extend a course of treatment, will be made according to the normal decision deadlines otherwise applicable to the course of treatment in question: pre-service (15 days) or post-service (30 days). Urgent concurrent care claim decisions will be made no later than 24 hours after receipt of the claim, provided that the request is made within 24 hours before the end of the initially approved time.

A decision by the Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination (see below - “Determining Continued Medical Necessity”), and MCEBP will notify you sufficiently in advance to allow you to make a concurrent care claim for uninterrupted continuing care before the benefit is reduced or terminated.

Determining Continued Medical Necessity

If a covered person is receiving benefits and a question arises about the medical necessity of continued care, the MCEBP claims administrator can ask an attending provider to submit evidence to support the judgment that continued care is medically necessary according to the plan terms. Unless the provider provides medical information clearly indicating that continued care is medically necessary, the plan can discontinue benefits for that care. The plan can request proof of medical necessity once every 30 days, or more frequently if circumstances may change more quickly according to information from an attending provider.

Appealing an Adverse Decision

If your claim is approved, then the plan will cover or pay your benefits in accordance with plan terms. If the plan denies your claim in whole or in part (an “Adverse Benefit Determination” – see definition below) you can request a claim review by the Plan Administrator, which is called an “**internal appeal**.” After the internal appeal process is exhausted (and in certain urgent care situations) you may request an external review of an Adverse Benefit Determination by an Independent Review Organization (IRO), which is called an “**external appeal**.”

An “Adverse Benefit Determination” means 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 an employee’s or family member’s eligibility to participate in the plan;
- a benefit resulting from the application of any utilization review; and
- an item or service for which benefits are otherwise provided because it is determined to be experimental/investigational treatment or not medically necessary or appropriate.

An Adverse Benefit Determination includes a rescission of coverage, whether or not the rescission creates an adverse effect on any particular benefit at the time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, but does not include rescission of coverage to the extent you have not paid premiums or contributions for the cost of such coverage. Note, however, that the plan has the right to rescind coverage in the event of fraud or an intentional misstatement of material fact.

If the plan denies your claim, you will receive written notification of the Adverse Benefit Determination, typically in the form of an “Explanation of Benefits” (EOB). The EOB or denial notice will set forth the reason your claim was denied, reference to the specific plan provision or rule upon which the decision was based, any additional information needed to perfect your claim, and information concerning your rights to appeal. You will have the ability to review the applicable claim file and present evidence and testimony as part of the internal appeals process.

If you do not understand the reason for any Adverse Benefit Determination, you should contact the designated MCEBP claims administrator at the address or telephone number shown on the claim denial or EOB. Requests concerning diagnostic or treatment coding, by themselves, will not be considered appeals.

Internal Appeal Process

You must appeal, in writing, **within 180 days** after the Adverse Benefit Determination. Address a written appeal to the Plan Administrator at 200 West Broadway, Missoula, MT 59802-4292, and provide any relevant documentation to support your appeal. You should include any additional information supporting the appeal (and any information requested by the MCEBP which was not initially provided) and forward it to the Plan

Administrator within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the initial determination final and binding. Any appeal received after the 180-day time period has expired will receive no further consideration.

Your internal appeal will be reviewed by the Plan Administrator, and you will receive a written decision within the following time periods:

- **urgent care** internal appeal decisions will be sent as soon as possible, taking into account medical exigencies, but no later than **72 hours** following the date the Plan Administrator receives the request for appeal.
- **pre-service** internal appeal decisions will be sent within a reasonable time appropriate to the medical circumstances, but no later than **30 days** following the date the Plan Administrator receives the request for appeal.
- **post-service** internal appeal decisions will be sent within a reasonable time, but no later than **60 days** following the date the Plan Administrator receives the request for appeal.
- **concurrent care** internal appeal decisions will be sent according to the normal internal appeal deadlines otherwise applicable to the course of treatment in question: urgent care (72 hours) pre-service (30 days) or post-service (60 days) claims. The plan will provide continuing coverage for concurrent care claims pending the outcome of the internal appeal process.

You must exhaust the plan's internal review procedures before pursuing external review or judicial action claiming plan benefits. An internal appeal is deemed exhausted if no written decision is made by the Plan Administrator.

The Board of County Commissioners will not participate in appeals of claims or determination of eligibility for benefits.

External Appeal Process

NEW LAW CHANGES: Please ask the MCEBP office for up-to-date information about External Appeal procedures.

After exhaustion of the Internal Appeal Process stated above, or in the event of an urgent claim, you may request a final independent External Appeal of any Adverse Benefit Determination involving questions (1) involving medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (2) involving rescission.

To assert this right to External Appeal, you must request such External Appeal in writing within four (4) months after an Internal Appeal decision is made. If your original claim was an urgent care claim, expedited External Appeal may be requested.

A preliminary review of your External Appeal request will be conducted to determine:

- whether you were covered under the plan at the time the services were rendered,
- that the benefit denial does not relate to eligibility,
- that you have exhausted the Internal Appeals process, and
- that you have provided all necessary information needed to process the External Appeal.

If the information needed for preliminary review is incomplete you will be asked to provide additional information needed to make a determination and you will have an additional 48 hours (or the remainder of the 4-month period, if later) to submit the requested information.

If the preliminary review determines that your request is not eligible for an External Appeal, you will receive a notice stating the reason for the ineligibility and providing you with a contact number at the Employee Benefit Security Administration (EBSA) (1-866-444-3272), one of the government agencies involved in the oversight of the claims procedures regulations.

If your request is eligible for an External Appeal, the plan will assign an accredited Independent Review Organization (IRO) or other Federal External Review Agency to perform the External Appeal review. Within five (5) days after the date an external reviewer is assigned, the plan will provide the external reviewer with documents and information considered in making the benefits denial. The external reviewer will notify you of its procedures to submit further information. The plan is allowed to reconsider its benefits denial, though such reconsideration will not delay the External Appeal process. External Appeal decisions are typically made in 45 days unless you have requested and are eligible for expedited review.

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

Medical Information, Examination, Consultation

The plan can require you to undergo a medical examination, when and as often as may be reasonable, and can require you to submit or authorize the release of any medical records it deems necessary to properly adjudicate the claim or appeal. 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 or appeals that involve specialized medical knowledge or judgment.

Recovery and Subrogation

Benefits Paid in Error

If MCEBP makes a payment in error to you or a provider, on your behalf, or it pays a claim that is not covered, the plan has the right to recover the payment.

MCEBP may recover amounts paid in error by any method that the Plan Administrator determines to be appropriate. By receiving benefits under the plan, you authorize the deduction of any excess payment from your benefits or other present or future compensation. This deduction right includes the right to deduct the amount paid in error from future benefit payments to you or on your behalf. The plan may also deduct the amount paid in error to, or on behalf of, any family member from future benefit payments to, or on behalf of, any other family member.

You must reimburse any payment of benefits by MCEBP for spouses or children who are eligible for coverage under the plan, but for whom benefits were paid based upon inaccurate, erroneous, or false information, or upon omissions of information provided by you. Your failure to reimburse the plan, after demand is made, may result in an interruption, or loss, of benefits to you and may be reported to the appropriate governmental authorities for investigation of criminal fraud and abuse.

The provisions of this section may apply to any licensed healthcare provider who receives payment of benefits under the plan. If any provider refuses to refund improperly paid claims, the plan may refuse to pay future payments directly to that provider.

Right to Reimbursement

If MCEBP pays benefits for medical, dental, or vision expenses on your behalf, and another party was actually responsible or liable to pay those expenses, the plan has a right to be reimbursed by you for the amounts paid. MCEBP's right to reimbursement is separate from, and in addition to, its right of subrogation.

If you, or anyone on your behalf, settles, is reimbursed for, or recovers money from, any 1) person, 2) corporation, 3) entity, 4) liability coverage, 5) no-fault coverage, 6) uninsured motorist coverage, 7) underinsured motorist coverage, or 8) other insurance policies or funds, for any accident, injury, condition or illness for which benefits were provided by the plan, you agree to:

- Hold the money received in trust for the benefit of the plan, and
- Reimburse the plan, in first priority, from any money recovered from a liable third party, for the full amount paid by the plan to you, or on your behalf, or that will be paid as a result of the accident, injury, condition, or illness.
- Reimbursement to MCEBP will be paid first, in its entirety, even if you are not paid for your entire claim for damages, and regardless of whether the payment you receive is for healthcare, medical, disability or other expenses or damages.

Right to Subrogation

With its right to subrogation, MCEBP can exercise your rights and remedies to recover from third parties that are legally responsible to you for a loss paid by the plan. This means that MCEBP can proceed through litigation or settlement in your name, with or without your consent, to recover the money paid by the plan. MCEBP's right to subrogation is separate from, and in addition to, its right to reimbursement.

You agree to subrogate to MCEBP, all claims, causes of action, or rights that you have against any entity who has contributed to the accident, injury, condition or illness for which the plan has paid benefits. Also, you agree to subrogate any claims, causes of action, or rights you have against any other coverage, including, but not limited to, 1) liability coverage, 2) no-fault coverage, 3) uninsured motorist coverage, 4) underinsured motorist coverage, and 5) other insurance policies.

If you decide not to pursue a claim against any third party or insurer, you must:

- Notify the plan,
- Automatically authorize the plan, in its sole discretion, to sue for, compromise, or settle any such claims in your name,
- Cooperate fully with the plan in the prosecution of the claims, and
- Execute all documents necessary to pursue those claims.

Additional Reimbursement/Subrogation Provisions

The following provisions apply to both reimbursement and subrogation:

MCEBP is not required to pay any claim if there is evidence of third party liability, unless you sign a reimbursement agreement and follow the requirements of this section. However, the plan, in its discretion, may elect to allow payment of benefits while the liability of the third party is being legally determined. If MCEBP requests that you sign a reimbursement agreement, its right of recovery through reimbursement and/or subrogation remains in effect, whether the reimbursement agreement is actually signed.

Without its written consent, MCEBP will not pay for expenses associated with your pursuit of a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation. You must repay the plan in full, in first priority, notwithstanding any statute, regulation, court decision, or common law theories, unless a reduction or compromise settlement is agreed to, in writing, or required pursuant to a court order.

If MCEBP makes a payment that you, or any party on your behalf, may be entitled to recover against any third party responsible for an accident, injury, condition or illness, the plan has a right of recovery, through reimbursement, subrogation, or both, to the extent of its payment. You must execute all papers, and do anything necessary to preserve the plan's right of recovery.

You must cooperate fully with the Plan Administrator, its agents, attorneys, and assigns for the recovery of any payment made by the plan from any third party who is liable. This cooperation includes the following:

- Providing full disclosure and information to the Plan Administrator, upon request and in a timely manner, all material facts regarding the accident, injury, condition or illness.
- Providing the Plan Administrator with all documents regarding demands, litigation or settlement for the recovery of payment made by the plan.
- Notifying the Plan Administrator of the amount and source of payment received, as well as all attempts to recover from third parties as compensation or damages, against which the plan may have a reimbursement or subrogation claim.
- Responding within 10 days to all inquiries of the plan about the status of any claim it may have against any third parties or insurers, including, but not limited to, liability, no-fault, uninsured motorist coverage and underinsured motorist coverage. Further, you must notify the plan immediately of the name and address of any attorney you engage to pursue any personal injury claim on your behalf.
- Making sure that you do not engage in any conduct directly, indirectly, or through third parties, either before or after payment by the plan, to interfere with the plan's rights to recovery. Further, you must not conceal the fact that recovery has occurred, or will occur.

Right of Offset

MCEBP has a right of offset to satisfy reimbursement claims against you for money you received from a third party, including any insurer. If you fail to reimburse the plan, it may deny payment of future claims for benefits for members of your family, to the full amount paid by the plan and subject to reimbursement. This right of offset applies to all reimbursement claims owing to MCEBP, whether formal demand is made by the plan, and notwithstanding any statute, regulation, court decision, or common law theories.

Fraud and Abuse

Criminal penalties may be imposed under federal or state law against any person who receives plan benefits by committing fraud or abuse.

Fraudulent and abusive acts

Any person who commits a fraudulent or abusive act may be subject to criminal prosecution, fine or imprisonment. The Plan Administrator may take additional action against persons who commit fraud and abuse, including notice that coverage will be terminated.

Acts considered fraud or abuse against MCEBP include the following:

- Falsifying, withholding, omitting or concealing information to obtain coverage.
- Misrepresenting eligibility criteria for dependents to obtain or continue coverage for a person who would not otherwise meet the dependent eligibility criteria defined in the plan.
- Making or using any false writing to obtain coverage or payment for health benefits, including falsifying or altering a claim form or medical records.
- Permitting an uncovered person to use a plan identification card or other plan identifying information to obtain covered services or payment.
- Making fraudulent representations to obtain payment for health benefits, or being untruthful to obtain reimbursement.
- Obtaining medical care or covered services under the plan by false or fraudulent pretenses.

Misstatement of Age

If age is a factor to determine eligibility or the amount of a benefit, and if there has been a misstatement of a person's age on an enrollment form or claims filing, the covered person's eligibility, amount of benefits, or both, will be adjusted immediately to reflect the person's true age. If the person's true age renders a person ineligible for coverage or for the amount of benefits received, the plan is entitled to recover any benefits paid, as outlined in the recovery provision of the plan. Any misstatement of age will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force.

Misrepresentation of Eligibility

If a person misrepresents a dependent's eligibility information (including marital status, age, dependent child relationship, or the right to claim the person as a tax dependent) to obtain coverage for a person who would not otherwise meet the plan's definition of dependent, coverage for the person will be terminated as though never effective.

Misuse of Identification Card

If a covered person permits an uncovered person to use any identification card, the Plan Administrator may terminate the coverage.

Reimbursement to Plan

A covered person must reimburse the plan for payment of benefits for ineligible persons, if the payment was based on 1) inaccurate, erroneous or false information, 2) concealed, withheld, omitted, or undisclosed information, or 3) falsified or altered documents. Failure to reimburse the plan after demand is made may result in interruption or loss of benefits to the person and dependents.

Coordination of Benefits (COB)

Purpose of COB

You may be covered by more than one health plan. For example, you and your spouse may both work and have coverage under different health plans. COB rules determine the order in which various plans pay benefits, and the total amount of benefits to be provided. MCEBP will neither provide benefits that duplicate coverage under other plans nor make payments that, when added to the allowable expenses of other plans, exceed the total allowable expenses under the plan, whether a claim is filed for benefits under any other plans. MCEBP does not coordinate prescription benefits.

MCEBP recognizes the programs listed below that provide healthcare benefits, payments, reimbursements, or services and with which the plan may coordinate benefits when presented with a claim.

- Group health plans, including prepaid, HMO, reimbursement, health service and indemnity plans, whether funded on an insured, partially insured, or uninsured basis.
- Individual health coverage plans containing COB provisions similar to MCEBP's provisions.
- Student health coverage plans provided by, or through, a school or educational institution.
- Government-provided health coverage plans, including Medicare, Medicaid (where permitted by law), CHAMPUS-TriCare and Indian Health Services.
- Coverage required under any statute, unless the statute prohibits coordination.
- Motor vehicle coverage, including coverage on both private and business vehicles from any source.
- No-fault, casualty, liability, homeowners, office and all other premise-based coverage plans.

Coordination Procedures

MCEBP will coordinate benefits, except for prescription drugs, with all other relevant plans under which you are eligible for benefits, provided the allowable expense is less than the sum of the benefits of MCEBP and the benefits of the other plans. If needed, you must provide authorization for MCEBP to 1) obtain information required to recover overpayments, or 2) determine benefits and/or services under other plans. Please refer to the following chart.

MCEBP determines its order of benefits using these rules:

If	Then																
The other plan does not have a provision for coordination of benefits.	The other plan becomes the primary plan and pays first.																
Both plans have a coordination of benefits provision.	MCEBP is a secondary plan; the other plan will pay benefits first.																
	But Coverage for dependents will be paid first by the plan of the parent whose birthday falls earlier in the year. If both parents have coordination of benefits, but one does not use the birthday rule, the father's coverage is primary for the dependent(s).																
	<table border="0"> <tr> <td style="text-align: left;">If</td> <td style="text-align: left;">Then</td> </tr> <tr> <td>The birthdays are on the same day.</td> <td>The plan that has covered the dependent(s) longer becomes primary and pays first.</td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td style="text-align: left;">If</td> <td style="text-align: left;">Then</td> </tr> <tr> <td>The dependent child's parents are separated or divorced.</td> <td>If a court order requires one parent to provide health care coverage, that parent's plan will pay first.</td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td style="text-align: left;">If</td> <td style="text-align: left;">Then</td> </tr> <tr> <td>There is no court order</td> <td>The primary plan will be determined in the following order: <ol style="list-style-type: none"> 1. The parent with legal custody. 2. The spouse of the parent with legal custody. 3. The parent without custody. 4. The spouse of the parent without custody. </td> </tr> </table>	If	Then	The birthdays are on the same day.	The plan that has covered the dependent(s) longer becomes primary and pays first.			If	Then	The dependent child's parents are separated or divorced.	If a court order requires one parent to provide health care coverage, that parent's plan will pay first.			If	Then	There is no court order	The primary plan will be determined in the following order: <ol style="list-style-type: none"> 1. The parent with legal custody. 2. The spouse of the parent with legal custody. 3. The parent without custody. 4. The spouse of the parent without custody.
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The plan of an active employee pays before the plan of an inactive employee.

The benefits of the plan that covers you as an active employee are determined before those of the plan that covers you as a dependent.

If none of the rules apply, the plan that covered the claimant longest pays first.

Continuation of Health Care Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires employers to offer employees and/or their dependents continuation of medical coverage at group rates in certain instances if there is a loss of group insurance coverage.

Eligibility

The term, “qualified beneficiary,” under COBRA refers to someone who will lose coverage under MCEBP as a result of a “qualifying event,” defined below. A covered employee, and the employee’s spouse and dependent children, may be qualified beneficiaries. A qualified beneficiary also includes a child born to, or a child placed for adoption with, a covered employee during the coverage period. Domestic partners, and the dependents of domestic partners, however, are not qualified beneficiaries and thus, are not eligible for continuation coverage under COBRA.

Employee

As an employee covered by MCEBP, you have the right to elect continuation of coverage, if coverage is lost due to one of the following qualifying events:

- Termination, for reasons other than gross misconduct, of your employment.
- Reduction in the hours of your employment.

Spouse

As a spouse of an employee covered by MCEBP, you have the right to elect continuation of coverage due to one of the following qualifying events:

- Your spouse’s death.
- Termination, for reasons other than gross misconduct, of your spouse’s employment.
- Reduction in the hours of your spouse’s employment.
- Divorce or legal separation from your spouse.
- Your spouse’s entitlement to Medicare benefits.

Dependent Child

As a dependent child of an employee covered by MCEBP, you have the right to elect continuation of coverage due to any one of the following qualifying events:

- Your employee-parent’s death.
- The termination, for reasons other than gross misconduct, of your employee-parent’s employment.
- Reduction in the hours of your employee-parent’s employment.
- Your employee-parent’s divorce or legal separation.
- Ceasing to be a dependent child under the plan.
- Your employee-parent’s entitlement to Medicare benefits.

Loss of Coverage under COBRA

Coverage is lost in connection with the qualified events when an employee, spouse, or dependent child ceases to be covered under the same plan terms and conditions as in effect immediately before the qualifying event (such as an increase in the premium or contribution that must be paid for the coverage of an employee, a spouse, or a dependent child.)

If coverage is reduced or eliminated in anticipation of an event (for example, the employer eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee eliminating the coverage of his spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event actually causes the loss of coverage.

A loss of coverage need not occur immediately after the event, as long as it occurs before the end of the maximum coverage period.

Notices and Election

MCEBP provides that coverage terminates for a spouse due to legal separation or divorce, or for a child who loses dependent status. If you, your spouse, or dependents lose coverage for any of these reasons, you must notify the Human Resources Office or employer representative, in writing, within 60 days of the event.

Upon notification that one of these events has occurred, the Human Resources Office or employer representative must notify the qualified beneficiary of the right to elect continuation of coverage; and the Risk and Benefits Office will provide information to continue coverage.

If a qualified beneficiary is determined under the Social Security Act to be disabled at any time during the first 60 days of COBRA coverage, the continuation of coverage period may be extended 11 additional months. The disability that extends the 18-month coverage period must be determined under the Social Security Act. To be entitled to the extended coverage period, the disabled qualified beneficiary must provide notice to the Human Resources Office or employer representative within the initial 18-month coverage period and within 60 days after the date of the determination of disability. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.

In the event of a covered employee's termination of employment, reduction in work hours, death, Medicare entitlement or loss of retiree benefits due to bankruptcy, the Human Resources Office or employer representative must notify the qualified beneficiary of the right to elect continuation of coverage.

Whether you contact the Human Resources Office or employer representative first or the Risk and Benefits Office contacts you first, you have 60 days from receiving the COBRA notice, or from the date your coverage would otherwise be lost, whichever is later, to elect continued coverage. Continuation of coverage must be elected within 60

days after plan coverage ends, or if later, 60 days after the date of the notice of the right to elect continuation of coverage. If continuation of coverage is not elected within the 60-day period, the right to elect coverage under the plan will end.

An employee may elect continuation of coverage for all covered dependents, even if the spouse or all covered dependents are covered under another group health plan (as an employee or otherwise), prior to the election.

The covered employee, spouse and dependent child, however, each have an independent right to elect continuation of coverage. Thus, a spouse or dependent child may elect continuation of coverage even if the covered employee does not elect it.

Coverage will not be provided during the election period. However, if the employee makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost.

If coverage is waived before the end of the 60-day election period, and the waiver is revoked before the end of the 60-day election period, coverage will be effective on the date the election of coverage is sent to the Human Resources Office or employer representative.

Maximum Continuation of Coverage Period

Continuation of coverage may last up to:

- 18 months for a covered employee, spouse, and/or dependent(s) whose group coverage ended due to termination of the employee's employment, or reduction in the employee's hours of employment.
- 36 months for a spouse whose coverage ended due to a covered employee's death, retirement, divorce, or entitlement to Medicare, at the time of the initial qualifying event.
- 36 months for a dependent child whose coverage ended due to a covered employee's death, divorce, entitlement to Medicare, or child's ineligibility under the plan, at the time of the initial qualifying event.

Disability

An 11-month continuation of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability must start prior to the 60th day of COBRA continuation of coverage, and must last at least until the end of the 18-month period of continuation of coverage. The qualified beneficiary must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage.

Each qualified beneficiary who has elected continuation of coverage will be entitled to the 11-month disability extension if one of them qualifies. If SSA determines that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the plan of that fact within 30 days after SSA's determination.

Additional Qualifying Event

An 18-month continuation of coverage will be available to spouses and dependent children who elect continuation of coverage, if an additional qualifying event occurs during the first 18 months of continuation of coverage. The maximum amount of coverage available when an additional qualifying event occurs is 36 months.

The additional qualifying event may include your death, divorce, separation, entitlement to Medicare benefits (under Part A, Part B, or both), or a dependent child's ineligibility under the plan. An additional qualifying event allows continuation of coverage only if it would have caused the qualified beneficiary to lose coverage under the plan if the first qualifying event had not occurred. A qualified beneficiary must notify the plan within 60 days after the additional qualifying event to receive continuation of coverage.

Termination Before the End of Maximum Coverage Period

Continuation of coverage will terminate before the end of the maximum period for any of the following reasons:

- Missoula County no longer provides group health coverage to any of its employees.
- The payment for continuation of coverage is not paid timely.
- The individual on continuation of coverage becomes covered under another group health plan.
- The individual on continuation of coverage becomes entitled to Medicare benefits.
- If SSA makes a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled, continuation of coverage will not end until the month that begins more than 30 days after the determination.
- An event, such as a fraudulent claim, permits termination of coverage for cause under the plan.

Termination of continuation of coverage is final. In addition, if you are eligible for other continuation of coverage privileges required by state law, they will run concurrently with your continued coverage under COBRA.

Type of Coverage

If continuation of coverage is elected, the coverage must be identical to that provided under MCEBP to similarly situated non-COBRA beneficiaries. Therefore, if the coverage for similarly situated non-COBRA beneficiaries is modified, continuation of coverage for the individual will be modified.

Payment for Continuation of Coverage

You must pay the full premium and an administrative fee for continuation of coverage. The Risk and Benefits Office must receive the first payment within 45 days after you first elect to continue coverage. The initial payment includes premiums back to the date the continuation of coverage began. All other monthly payments are due in the Risk and Benefits Office by the 1st of each month. Coverage will terminate if payment is not received on or before the last day of each month. Missoula County will provide the individual with a quote of the total monthly payment.

The payment for COBRA continuation of coverage includes a 2% administration charge. However, for qualified beneficiaries who are receiving up to 11 months additional coverage (beyond the first 18 months) due to disability extension (and not an additional qualifying event), the payment for COBRA continuation of coverage may be up to 150% of the applicable payment for the additional months. Qualified beneficiaries who do not take the additional 11 months of special coverage will pay up to 102% of the payment cost. Payment for continuation of coverage may be increased. However, payment may not be increased more than once in any determination period, which is a 12-month period established by the plan.

The monthly payment may include your share and any portion previously paid by Missoula County. Also, it must be a reasonable estimate of the cost of providing coverage under the plan for similarly situated non-COBRA beneficiaries.

Employment Affected by International Trade

Workers whose employment is adversely affected by international trade (increased import or shift in production to another country) may become eligible to receive Trade Adjustment Assistance (TAA) under the 2002 Trade Act. TAA provides a second 60-day COBRA election period for those who become eligible for assistance under TAA. The Human Resources Office or employer representative requires documentation proving eligibility of TAA benefits. The burden for evidencing TAA eligibility is on the individual applying for coverage under MCEBP.

Plan Contact Information

It is important for you and your qualified beneficiaries to keep the Human Resources Office or employer representative informed of any changes in marital status and address.

Additional information regarding rights and obligations under MCEBP and under federal law may be obtained by contacting the Human Resources Office or your employer representative at the following address and phone number:

Missoula County Risk and Benefits
200 West Broadway
Missoula, MT 59802
(406) 523-4876

Family and Medical Leave Act of 1993 (FMLA)

For leaves of absence taken under the Family and Medical Leave Act of 1993 (FMLA), the employer will continue to provide coverage in accordance with the law during the leave, and upon return from the leave, on the same basis provided during active employment. If the employee does not return to work when FMLA leave ends, a COBRA qualifying event will occur on the last day of the FMLA leave.

The Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA)

Federal law requires that health plans offer continuation of coverage for employees who are absent due to service in the uniformed services. Coverage also extends to dependents, and may continue for up to 18 to 24 months after the date the employee is first absent due to uniformed service. Your dependents who have coverage under the plan immediately prior to the date of your covered absence may elect continuation under USERRA.

Eligibility

You are eligible for continuation of coverage under USERRA if you are absent from employment because of your voluntary or involuntary performance of duty in the 1) Armed Forces, 2) Army National Guard, 3) Air National Guard, 4) the commissioned corps of the Public Health Service, or 5) any other category designated by the President of the United States of America in a time of war or emergency. Duty includes 1) active duty, 2) active duty for training, 3) initial active duty for training, 4) inactive duty training, and 5) duty fitness determination by an examination.

Payment for Continuation of Coverage

If continuation of coverage is elected under USERRA, you and/or your dependent(s) are responsible for payment of the applicable cost of coverage. If you are absent for no longer than 12 months, the cost will be the amount you would otherwise pay for coverage.

Duration of Continuation of Coverage

Continuation of coverage under USERRA continues until the earliest of:

- 18 months beginning the first day of absence from employment due to service in the uniformed services for elections made prior to 12/10/04, or
- 24 months beginning the first day of absence from employment due to service in the uniformed services for elections beginning on or after 12/10/04, or
- The day after you fail to apply for, or return to, employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA runs concurrently with the COBRA period available to you and/or your eligible dependents.

Summary Plan Description

Plan Sponsor.....Missoula County, Montana

Name of Employer.....Missoula County
.....200 West Broadway
.....Missoula, MT 59802-4292

Employer Identification No.81 6001397

Plan Number501

Plan YearFiscal year, July 1st through
.....June 30th of each year

Type of PlanMedical, Dental, Vision

Type of Administration.....Self-insured benefit plan with
.....Medical, Dental and Vision
.....coverages. Claims paid under the
.....terms and conditions of the plan
.....by the Plan Administrator

Type of FundingMajority of cost paid by employer

Plan Administrator.....Erica Grinde
.....Missoula County
.....223 W. Alder
.....Missoula, MT 59802-4292

Agent for Legal ServicesErica Grinde
.....Missoula County
.....223 W. Alder
.....Missoula, MT 59802-4292

Trustee.....First Interstate Bank
.....101 E. Front St.
.....Missoula, MT 59802-4303